COMMERCIAL SEX WORK AND SEXUAL HEALTH: AN ETHNOGRAPHIC STUDY OF H.I.V. PREVENTION IN CALCUTTA

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ABSTRACT

COMMERCIAL SEX WORK AND SEXUAL HEALTH: AN ETHNOGRAPHIC STUDY OF HIV PREVENTION IN CALCUTTA

This thesis presents the results of ethnographic research conducted from 1995 to 1997 among sex workers in two Calcutta redlight areas where a STD/HIV Intervention Project (SHIP) is being implemented.

The thesis provides an in-depth study of sex workers' lives, their concepts of sexual health and their relationship to the SHIP. This material is used to critically consider a number of key concepts currently informing HIV prevention practice, specifically, sexual health, community participation, empowerment and behaviour change.

Initial chapters set the background to the study and describe the complex world of the Calcutta sex trade and sex workers' struggle to construct a meaningful social identity. Subsequent chapters consider sex workers' and other actors' varying responses to, and interpretations of, the SHIP. These are related to an analysis of the process of project implementation, revealing the context-dependent, strategic, meaningful and contested nature of community, identity, participation and empowerment, and also highlighting the significance of different constructions of agency for the ways in which these concepts are expressed by different actors. The thesis goes on to examine sex workers' own (vis a vis biomedical) perceptions of sexual health and, drawing upon the SHIP as an example, analyses the representations, meanings and strategic uses of different kinds of knowledge and its perceived role in behaviour change. The next chapter looks at the varying meanings that sexual practices take on for sex workers in the context of their social and occupational position. It examines women's strategies around safer sex and uses this material to critique conventional theories of behaviour change, arguing for a perspective that acknowledges sex workers' agency yet recognizes the ways in which its expression is shaped and constrained by micro and macro level socio-cultural and economic forces.

The thesis concludes by arguing that in-depth ethnographic research on sex workers' lives combined with a contextually embedded analysis of the processes and meanings of an intervention yields important insights for understanding, developing and replicating effective HIV prevention initiatives among this group.

CONTENTS

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ACRONYMS

ACTION	Partner NGO in SHIP's Conglomerate
AIDS	Acquired Immuno-Deficiency Syndrome
AIIHPH	All India Institute of Hygiene and Public Health
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CDA	Contagious Diseases Act
CPI-M	Communist Party of India (Marxist)
DFID	(British) Department for International Development
DMSC	*Durbar Mahila Samanwaya Committee*
GoI	Government of India
GPA	Global Programme on AIDS
HIP	Partner NGO in SHIP's Conglomerate
HIV	Human Immuno-Deficiency Virus
IEC	Information, Education, Communication
LITE	NGO helping the MS in Sett Bagan
MLA	Member of Legislative Assembly
MP	Member of Parliament
MS	*Mahila Sangha*
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
NORAD	Norwegian Bi-lateral Aid Agency
NSWP	Network of Sex Worker Projects
ODA	(British) Overseas Development Administration. Now called DFID – Department for International Development

PE	Peer Educator
PID	Pelvic Inflammatory Disease
PSH	Partnerships for Sexual Health
REST	Partner NGO in SHIP's Conglomerate
SB	Sett Bagan
SHIP	STD/HIV Intervention Project
START	NGO with whom the MS developed some connections.
STD	Sexually Transmitted Disease
SW	Sex Worker
TAP	NGO who collaborated with the AIIHPH's initial research project in Sonagachi
TI	Targeted Intervention
VDRL	Name of the blood test for syphilis.
WBSHP	West Bengal Sexual Health Project
WHO	World Health Organisation

INTRODUCTION

Crossing the Barriers of Prohibition

> Most people are ignorant of our world. The redlight area means a 'prohibited place'. The story of this prohibited place is one thing in novels and tales, but in reality another.....in order to know and understand, one must cross the barriers of prohibition and come to us (*Mahila Sangha*, a sex workers' self-help group in Calcutta, 1993)

With the advent of the HIV epidemic in India in the late eighties, public attention (as in other countries) first and foremost turned to the nation's brothels. Female and male sex workers are now the subject of HIV prevention and research initiatives across the country. In spite of the heightened concern however, detailed information on local sex trades, on how sex workers live and construct their social worlds, on how they themselves perceive HIV and related 'sexual health' issues, and on their response to HIV prevention activities, is limited. This information is important however, for ensuring that the realities of sex workers' lives are understood, that sex workers' own perspectives are adequately represented in public discussion, and that HIV does not further a public health tradition of enhancing social exclusion among this group (Brandt 1987, Walkowitz 1980, Chatterjee 1992). This information is, additionally, also important for public health experts and social scientists, charged with developing effective HIV prevention programmes, to further their understanding of sexual health and of the mechanisms of social change and intervention processes.

In this thesis, I make a start at 'crossing the barriers of prohibition' to document female sex workers' lives[1] and to consider HIV prevention within the socio-economic and political context of the sex trade in Calcutta, capital city of the state of West Bengal. The thesis is based on ethnographic research undertaken from 1995-1997 among women living in two of the city's eighteen redlight areas – Sonagachi and Sett Bagan. The former is Calcutta's largest redlight area whereas the latter is a small adjoining lane but is rather unique as it is the base for a small sex workers' self-help group called the *Mahila Sangha* (quoted above), formed in response to exploitation from local gangs in the 1980's. Since 1992, these and other areas have been the focus of a large and widely acclaimed STD/HIV Prevention Project (SHIP) based on a peer education community outreach model. The SHIP appears to have brought about significant behaviour change (assessed in terms of increased condom use) and, in

[1] In this thesis, I have focused solely upon female sex workers. Male sex work goes on in Calcutta but its structure and social organisation is different from female brothel based sex work and its inclusion would have been impossible given time and human resource constraints. For information on male sex work, see Boyce 1996, Nag 1996, Khan 1994.

addition, has encouraged sex workers' mobilisation through supporting the *Mahila Sangha* and, more recently, fostering the development of another, much larger sex workers' rights organisation, the *Durbar Mahila Samanwaya Committee* (DMSC) which currently has a state-wide membership of over 40,000. The SHIP is currently funded by the British Department for International Development (DFID) through a state-wide West Bengal Sexual Health Project (WBSHP). It was initially led by the Department of Epidemiology, All India Institute of Hygiene and Public Health (AIIHPH), but its management has been progressively transferred to sex workers themselves, who, since 1999, are now entirely responsible for running the project (Jana et al 1998).

My own involvement with women living in Calcutta's redlight areas dates back to the early nineties when my husband, an Indian medical doctor, started doing voluntary work with the *Mahila Sangha* in Sett Bagan. My interest in HIV prevention stemmed from previous nursing experience with people with AIDS in the UK and I wanted to find out more about the situation in Calcutta where I was living at the time. In 1994, following a Master's degree in Anthropology of Development, I obtained funding from DFID[2] to undertake a pilot study in Sett Bagan, looking at sex workers' and other women's 'health-seeking strategies' and profiling the socio-economic structure of the locality (Evans & Lambert 1997). The present thesis was designed to expand on this initial research and I intended, through a traditional community based study, to explore in more detail sex workers' experiences in the sex trade and their own perceptions and practices around sexual health and HIV. However, in the course of my work, the research focus shifted much more explicitly onto HIV prevention initiatives, specifically, intervention processes. This was a result of the very profound influence that the SHIP was having upon women in Sett Bagan and other areas. I found myself uniquely positioned to document sex workers' and other local actors' responses to an external intervention, to observe the complex and fascinating ways in which the SHIP was operating at the community level, and to compare this with 'official' HIV prevention discourse. The result is an in-depth study of sex workers' lives, their concepts of 'sexual health' and of their relationship to an intervention project. This ethnographic material is subsequently used to examine some of the key concepts currently informing HIV prevention/sexual health discourse and practice.

[2] At that time, it was named the British Overseas Development Administration (ODA).

Internationally, there now exists a growing consensus in the public health field on what constitutes a 'good' HIV prevention intervention among sex workers (and also more generally), of which the SHIP is often cited as an example (NACO 1999a&b). According to various 'Best Practice' documents, interventions should, ideally, be able to draw upon multi-sectoral support, should be community based, participatory, focus on empowerment and address sex workers' health needs holistically in the context of their other needs and problems (NSWP 1997, WHO/Alexander 1993, UNAIDS 1998, Gordon & Sleightholme 1996, AIDSCAP 1997, IHAA 1998). Within public health discourse, behaviour change is conceived as being brought about by such interventions through a combination of strategies that address obstacles to change at individual, community and societal levels. This holistic emphasis has meant that the rhetoric of 'HIV prevention' is now often re-phrased as 'sexual health' implying a broad inclusive perspective whose emphasis is upon health promotion rather than disease prevention.

These 'Best Practice' guidelines have arisen largely from the results of field experiences rather than theories of behaviour change which have, in fact, been shown to be of only limited use in developing effective intervention strategies (Aggleton 1993, King 1999). Indeed, AIDS has served to illuminate the wide gaps in current understanding of human/sexual behaviour as well as the inadequacies of conventional models of behaviour change (Pollack et al 1992, Hornik 1989). These have been vigorously pointed out by anthropologists for whom HIV has presented an unprecedented opportunity to become involved in an applied field, and they have been instrumental in utilising the discipline's theoretical insights to develop better understandings of sexual/health practice (cf. Hart & Boulton 1995, Brummelhuis & Herdt 1995, Parker & Gagnon 1992, Herdt & Lindenbaum 1992).

Anthropological research from other applied fields such as 'development' has also shown that the promotion of concepts such as 'empowerment' or 'participation' as key features of interventions (and thereby also of behaviour change) may require critical analysis as these concepts in themselves are contested and may be used and interpreted in very different ways to serve very different agendas (Nelson & Wright 1995a&b, Hobart 1993, Pottier 1993, Long & Long 1992, Scoones & Thompson 1994, Gardner & Lewis 1996). However, while anthropologists are now increasingly called in to contribute their expertise at various stages of the planning and implementation of an HIV project, this contribution is often rather piece meal and tends to focus upon investigating the characteristics of the so-called beneficiaries and their communities rather than analysing the intervention itself (and related policy-forming institutions) as important social actors, even though experience from other sectors in

development have shown that this is crucial for developing more complete understandings of processes of social change.

In this thesis then, I make a start at filling this gap by means of a detailed ethnography that situates sex workers' own responses to HIV, to the SHIP, and to the challenge of 'behaviour change' within the local and macro-level contexts of the social structure and organisation of the Calcutta sex trade and of social/gender power relationships in Indian society more generally through which national/international HIV-related policies are implemented. The SHIP, the meanings it takes on, the interactions that take place between different actors, and the implications of these for understanding processes of behaviour change, participation or empowerment are also accorded a central role in the analysis.[3] My aim is that this work will contribute to a better understanding of Calcutta sex workers' lives, of the complex ways in which they try to protect their well being, and of the role the SHIP has played in this. In doing so, the research will also contribute to the on-going endeavour to understand better the impact of HIV interventions and processes of social change.

[3] This is not, however, an organisational ethnography. The SHIP is analysed primarily from the perspective of sex workers. Nor was there scope in this thesis to include as actors in the analysis, the various national and international agencies that have been involved in funding and advising the SHIP and that have played a key role in developing ideas around 'Best Practice'. It is my belief that such a multi-layered ethnography would add important insights to an understanding of the dialectical relationships between policy, practice and social change but this must wait for another study.

CHAPTER ONE

SEX WORK, HIV PREVENTION AND SOCIAL SCIENCE RESEARCH: EVOLVING PARADIGMS

Introduction

Below, I set out a detailed theoretical framework for the study that highlights the key issues around sex work and HIV, and that traces the development of intervention practice and social science research in this field. In doing so, I outline some key areas worthy of further research which are subsequently explored in the thesis, and provide a description of, and rationale for, the theoretical approach adopted to do so. This is followed by an outline of the ensuing chapters.

The HIV Epidemic and Vulnerability

HIV, the virus that causes AIDS, is transmitted through infected blood (by transfusion, injection, pregnancy or childbirth) or semen during unprotected anal or vaginal intercourse. Heterosexual intercourse comprises the main route of HIV transmission in developing countries but other routes of infection such as contaminated blood or blood products, injecting drug use and anal intercourse between men also contribute to its spread (World Bank 1997). Globally, over 33 million people are thought to be infected with HIV and, despite an enormous international prevention effort, the numbers continue to rise.

From an epidemiological perspective, factors that influence the spread of HIV include having multiple sexual partners, having penetrative sex without a condom, having other concurrent sexually transmitted diseases (STDs)[1], and being female[2]. Means of prevention include reducing the number of sexual partners, using a condom or having non-penetrative sex (referred to as 'safe sex'), and treating existing STDs.

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[1] The presence of STDs is thought to increase the risk of HIV infection by a factor of 3-5. The risk of infection from a single exposure increases 10-300 fold in the presence of a genital ulcer (Adler 1996). Recent studies have provided clear evidence that effective treatment of STDs in a population can significantly reduce the incidence of HIV (Grosskurth et al 1995).

[2] There is some evidence to suggest that, other factors being equal, women are twice as likely to become infected with HIV during unprotected sex than men. This is because there may be more HIV in semen than in vaginal mucus and therefore more HIV to transmit. Secondly, the lining of the vagina is more vulnerable to infection than the penis because the mucus membrane surface can be more easily penetrated by a virus. Finally, semen remains

HIV is also characterised by a distinct social epidemiology that greatly influences who is most vulnerable to infection and under what circumstances. Social and economic changes linked to processes such as globalisation, market liberalisation and structural adjustment have led to increased labour migration within and between countries that has created 'sexual bridges' along which HIV can spread, and that has also disrupted traditional social and family structures leading to an increase in casual multi-partner sexual alliances (Sweat & Denison 1995, Sanders & Sambo 1991, de Zalduondo & Bernard 1995). Vulnerability to HIV is also closely linked to widespread poverty, particularly in developing countries, that affects access to condoms, adequate health services and reliable sources of information (Panos 1988, Farmer 1997). Moreover the increasing 'feminisation of poverty' pushes many women into situations where selling or exchanging sexual services in unsafe conditions becomes a strategy for survival. In addition, the low status of women in many countries severely constrains the space within which they can act to protect their health (Patton 1994, Panos 1990, ABVA 1990, Berer 1993). Thus it is the poor, the uneducated, the dispossessed and women who are most vulnerable to HIV. Their marginalisation is reflected in a general lack of participation and/or representation in governmental or civic institutions through which policies are formulated and resources allocated. As a result, there exists a double vulnerability - to HIV, and to the socio-economic consequences of mainstream policy making.

It is now well recognised that HIV is a 'development' problem and its prevention cannot be separated from broader dimensions of social, economic and human development. There is general agreement that AIDS prevention efforts require a co-ordinated multi-sectoral effort at national and international levels. This has been reflected in the establishment of a UN body (UNAIDS) that is distinct from the World Health Organisation (WHO) and whose mandate includes developing the mechanisms for a multi-sectoral response. In practice however, HIV still tends to be seen as a mainly medical problem and most related activities are located within health ministries (World Bank 1997).

Sex Work and HIV

In this thesis I generally use the term *sex worker* rather than prostitute to reflect a perspective that views prostitution: "not as an identity – a social or psychological characteristic of women...but as an income generating activity or form of labour" (Kempadoo 1998a:3). The

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longer at body temperature in the vagina than vaginal mucus does on the penis so there is more time for exposure to occur (Clemetson et al 1990, Wykoff et al 1988, Peterman et al 1985).

emphasis upon sex work as a form of labour challenges dominant representations about 'prostitutes' that are found in many societies (including India) and that are linked to patriarchal constructions of womanhood and sexuality. These set up an image of a good, moral woman (often a virgin, or strictly monogamous wife, whose sexuality is controlled by men, usually within the institution of the family), against that of a sex worker - a woman who transgresses such social norms and, consequently, is often represented as immoral and as a threat to the social order. At the same time however, in many societies a patriarchal double standard is at work whereby sex workers are simultaneously seen as a necessary evil, providing an outlet for men's uncontrollable sexual 'needs'. They are thus 'required' but despised and, in many cases, being publicly labelled a 'prostitute' creates a deeply internalised life long stigma. Other, more sympathetic representations of prostitution, try to relate and explain women's participation in the profession to dysfunctional social, economic and psychological processes of which they are said to have become victim and from which they need rescuing and rehabilitation.

Research has shown however that the universalising category 'prostitute' masks an enormous diversity among women who do sex work which is reflected in equally diverse sex trade structures and working conditions (de Zalduondo 1991a). Likewise, the ways in which women experience sex work, and the extent to which a sense of identity or self is shaped around their work varies greatly. It is also becoming clear that sex workers do not necessarily accept or conform to dominant representations of themselves as 'victim' or 'deviant', but that their resistances to, or contestations of such representations and associated exploitative social structures have, until recently, been more or less invisible (Kempadoo 1998a).

Sex work may be a woman's main form of income generation, it may take place simultaneously with other activities or it may be a coping strategy only in times of acute need. A woman's sex work may be short lived, long term or part of a seasonal labour cycle. Over the course of a life time however, sex work is usually only one of a variety of income generating strategies. Though all classes of women engage in sex work and for different reasons, Kempadoo (1998a:4) notes that in modern societies, especially in developing countries, it is primarily (though by no means exclusively) a working class occupation, and that:

> In most cases, sex work is not for individual wealth but for family well being or survival; for working class women to clothe, feed and educate their children; and for young men and women to sustain themselves when the family income is inadequate.....For the majority, participation in sex work entails a life in the margins.

Sex workers, therefore, are often among the poorest and most disadvantaged women in a society. Research indicates that for them, sex work represents an economic or social survival strategy in which sexuality is experienced as a resource that is strategically employed (de Zalduondo & Bernard 1995).

As described above, women from poor working class backgrounds are particularly vulnerable to HIV. In the case of sex work however, the nature of women's work, which involves multi-partner sex, and, importantly, its social and legal context, add further dimensions to this vulnerability.

Socio-Legal Context of Sex Work and HIV Transmission

Predominant social attitudes towards sex work are often reinforced through laws and regulations surrounding sex work which have a profound effect upon sex workers' lives and upon their ability to protect themselves against HIV.

Three main types of legal system exist, classified as prohibition, toleration and regulation (NSWP 1997, Alexander 1987). Prohibition refers to a situation where sex work is illegal and women must operate outside the law in situations of extreme insecurity. Examples of this kind of system are found in some parts of the USA and Germany. Prohibition gives rise to a criminalised underground sex trade structure where women may be forced to depend upon third parties for protection or management of business. In such a context, women may be unable or unwilling to access statutory health services and may be working in coercive conditions with limited personal autonomy. A similar situation exists under the 'toleration' system where selling sex itself is not illegal (as long as it is not in a public space) but almost all associated activities (such as soliciting) are illegal, making it almost impossible for women to work without committing a crime. Sex work is thus effectively criminalised. India and the UK are examples of this system. In countries such as Turkey, Senegal or Peru where the sex trade is legal, sex workers are required to register with the State and must submit to mandatory health checks and other occupational controls. Many sex workers resist such regulation (or are ineligible for it because they are immigrants) and continue to work outside the officially monitored system, giving rise to a two tiered sex market. Women who go underground are similarly reluctant or unable to access health services and may also work in insecure or coercive conditions. Thus, in many countries, the socio-legal context of the sex trade creates criminalised, insecure, sometimes highly controlled or coercive occupational structures that exist in the informal or unorganised economic sector. In these situations, sex

workers are deprived of the protection of standard regulations governing working conditions, workers rights and occupational health.

Vulnerability to HIV is magnified in various ways by existing laws and regulations. Sex workers may, for example, have to keep on the move to avoid arrest which increases the potential spread of HIV. Harassment by police means that sex workers may be reluctant to carry condoms with them as these are sometimes used as evidence of sex work. Fear of arrest may also result in hurried and covert sexual encounters where negotiation of safer sex (which may be very time consuming) may be difficult. In exploitative or coercive working conditions sex workers may have little control over their own lives and bodies, and violence (or fear of it) from customers or other trade controllers also affects a sex worker's ability to practise safe sex. Sex workers may not be able to access condoms or treatment, and even where it is theoretically possible, they may fear social exposure or stigmatisation. Finally, the poverty that underlies many women's involvement in the sex trade makes life insecure and creates 'day to day' livelihood strategies where condom use for an abstract disease whose threat hovers in the future may not make sense (NSWP1997).

An additional problem is that the unorganised nature of many sex trades and their ambiguous legal status makes it difficult for women to collectively organise for change, though sex workers' rights organisations and movements do exist, albeit on a relatively small scale in many countries (predominantly the industrialised nations). These groups argue that the stigmatisation and legal contexts that characterise sex work deny women basic civil rights and freedoms which are a pre-requisite to health and well being. Many sex workers' groups (now including the Calcutta-based DMSC) are thus calling for a decriminalisation of the sex trade and other legal reforms[3] (Shrage 1994, Kempadoo & Doezema 1998, NSWP 1997, Scambler & Scambler 1997).

Sex Work and the Evolution of HIV Prevention Policies

Targeted Interventions among Sex Workers: Key Issues

Since the beginning of the HIV epidemic in the early 1980s, sex workers have been subject to increased public scrutiny and have almost universally been classified as a 'risk group' and

[3] This is a controversial demand and it is opposed by many women's rights groups and social activists – see Shrage (1994) for a detailed account of different social, moral and legal perspectives on sex work. There is a general consensus however that the present situation in many countries is unsatisfactory and disadvantageous to women in the sex trade and that some kind of change is required.

have been targeted by HIV/STD interventions. The public health rationale for this lies in the epidemiology of STDs/HIV, which, in the initial stages of an epidemic, are usually clustered within so-called 'core groups' comprised of individuals who share common factors of vulnerability or who practise common risky behaviours (such as multi-partner unprotected sex). Public health measures are designed to particularly target these core groups so as to limit the impact of the diseases within them, and to prevent STDs/HIV spreading out into the more general population. In the initial stages of an STD/HIV epidemic, interventions targeted at specific groups are considered to be more cost-effective, efficient and easier to implement than measures that target the entire population. In the case of HIV, most AIDS control programmes combine such targeted interventions (TIs) with measures to raise awareness among the general population (AIDSCAP.STD, Brunham & Ronald 1991, World Bank 1997, Adler et al 1996).

Presently, there are 3 main components of a TI (though not all interventions include all of these and some include much more): - health education (also referred to as 'behaviour change communication', or 'BCC'[4]), condom promotion and STD care. The aim of most TIs is to change behaviour (usually measured by increased condom use), to increase knowledge/awareness of HIV, to improve 'health seeking behaviour' so that STDs are promptly treated, and to reduce STD/HIV incidence and prevalence.
The nature of TIs undertaken with sex workers has varied considerably and has evolved as knowledge about HIV and factors that determine vulnerability have advanced. In the initial stages of national HIV epidemics, it was common for sex workers to be stigmatised and blamed for the spread of HIV. In some countries they have been subject to coercive HIV testing or detainment and there have been renewed attempts to regulate or abolish the sex trade, to little effect. In time however, most countries have adopted a pragmatic (or harm minimisation) approach whose aim is usually to change behaviour so as to increase safer sexual practices within the sex trade (through condom promotion and health education) and to tackle high rates of STD prevalence through provision of STD services.

Group-based targeting however is not without its controversies. With respect to sex work, it has been argued that the epidemiological discourse of risk and concern with preventing disease transmission into wider society implies that the main goal of HIV interventions is to protect the general population rather than helping sex workers. One result is that many TIs are

[4] In the HIV field, the terminology of BCC has to a large extent replaced that of 'health education' with its emphasis upon information, education and communication (IEC). BCC refers to a strategy that aims to impart knowledge about HIV but also includes strategies to assist people to act upon new knowledge such as skill and confidence building, counselling, and addressing environmental blocks to behaviour change.

limited to medical service provision or social welfare and only rarely begin to address the issues that are of primary concern to sex workers themselves (e.g. police harassment and legal rights), and which may involve challenging entrenched social attitudes (Alexander 1995).

Another objection concerns the danger of classifying sex workers as a homogeneous 'risk group' – an issue that has been raised with respect to many other so-called risk groups that are targeted by interventions. Sex workers' rights activists argue that while many HIV risk factors certainly apply to particular members of their profession, an undifferentiated analysis is inaccurate, contributes to stigmatization and may lead services in the wrong direction. Studies have shown that HIV rates vary tremendously among sex workers. Variations relate to differences in the socio-economic and legal context of the sex trade in different parts of the world and to differences in working styles and sex market structures within and between countries. Research has shown that HIV prevalence among sex workers in western industrialised countries is, in fact, rather low and that condom use with customers is concurrently high. The exception is those sex workers who also inject drugs. In these cases HIV is thought to be have been primarily acquired through use of unclean injecting equipment rather than during sex work[5] (Cohen & Alexander 1995, NSWP 1997:6, World Bank 1997). Thus, acquisition of HIV is associated with practising particular risky behaviours, rather than with group membership. It is quite false therefore, to represent *all* sex workers in many western countries as a major HIV risk group. The situation is quite different however in the developing world where commercial sex often takes place in conditions of extreme poverty or coercion. Here, sex work is generally characterised by low or non-existent condom use and high rates of STDs (but very little injecting drug use). In such conditions sex workers are extremely vulnerable to HIV and prevalence rates are generally high but nonetheless show considerable regional variation[6] (Cohen & Alexander 1995, NSWP 1997).

Other problems that have been raised with respect to group-based targeting are that it may lead to a false sense of security among those who do not consider themselves part of the 'group' (e.g. a belief that HIV is only a problem of sex workers). Alternatively, TI strategies may miss those who do practise risky behaviour but who do not primarily identify themselves by their sex work (e.g. 'housewives' who do occasional sex work but who not identify with

[5] Studies in western countries have shown HIV prevalence among sex workers who also inject drugs to range from 2-48%, in contrast to rates of 0-11% among those who do not inject drugs (Darrow 1992, Van Doorum et al 1990, Mak et al 1990, Casabona et al 1990, Stary et al 1991, Darrow et al 1990).

[6] In sub-Saharan Africa rates vary from 0.5% among sex workers in Mogadishu, Somalia, to 65.6% in Nairobi, Kenya, rising to a staggering 87.9% in Ngoma, Rwanda (Burans et al 1990, Simonsen et al 1990). In Asia, 44% HIV prevalence was found among sex workers in Chiang Mai, Thailand (Rojanapithayakorn & Hanenberg 1996)

popular images of sex workers such as brothel-based or street workers). Moreover, as previously noted, sex workers are extremely diverse. Defining them as a 'group' may assume a commonality that does not exist and which may pose problems in terms of who and how to 'target'. Academics and activists have cautioned that TIs must take care not to conflate behaviour with social identity (Asthana & Oostvogels 1996, Gordon & Sleightholme 1996, NSWP 1997, Cohen & Alexander 1995, WHO 1993)[7].

Another potentially problematic dimension of risk construction in relation to social identity concerns the almost exclusive focus of TIs upon sex workers' identity as 'workers' and thus upon their occupational risks. Sex workers' lives however do not revolve solely around their work. They also have other social roles and identities such as being a mother, wife or girlfriend. Hence, the occupational focus of projects may miss other aspects of sex workers' vulnerability to HIV. Studies have repeatedly shown that even when condom use is high with customers, sex workers rarely use condoms in their personal sexual relationships and that the negotiation of safer sex in this context is extremely difficult. Personal relationships involve different dynamics of power than the commercial encounter and are influenced by prevailing cultural expectations of gender roles. Sex workers' sexual autonomy may be constrained by the need for economic or social security that their personal relationships may provide. Moreover, a desire for intimacy and love may cause the condom to become viewed as symbolic of their work, with no place in a special relationship. Issues of power, dependence or trust in relationships are common to all women and sex workers are no exception. In this case their vulnerability bears little relation to their occupation, indeed, studies have suggested that in some cases, sex workers may be at greater risk from their partners than from their customers (Day 1988, NSWP 1997, Evans & Lambert 1994, Cohen & Alexander 1995, Baily et al 1992, Cohen et al 1992, WHO 1993).

The concerns raised above have now to a large extent been acknowledged in HIV circles. There is an awareness in theory (though not always in practice) of the need to question and 'deconstruct' epidemiological categories and to refocus upon particular risky *behaviours* and *situations* as much as upon 'groups'[8]. Nonetheless, group categorisation is often still necessary as a starting point for an intervention. In such cases, in-depth pre-intervention 'situation assessment' research is recommended to define the nature of vulnerability and the

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and Latin American rates vary from 0-11% (Guerena-Burgueno et al 1991, Fernandez et al 1992, Multare et al 1989).

[7] The same argument has been made with respect to another HIV risk 'group' - men who have sex with men who may not necessarily identify themselves as 'gay' (cf. contributors in Parker & Gagnon 1995, Kahn 1994, 1995).

[8] This is a general critique of the social construction of HIV risk and is not just applicable to sex workers (cf. Kane & Mason 1992, Sibthorpe 1992, Kendall 1995, & contributors in Herdt & Lindenbaum 1992).

characteristics of those practising risk behaviour (Cohen & Alexander 1995, Hart 1995, NSWP 1997, WHO 1993, Gordon & Sleightholme 1996).

Approaches to Targeted Interventions among Sex Workers: Concepts, Philosophy and Practice

In this section, I describe some of the main forms and underlying principles of TIs that have been implemented among sex workers in different parts of the world and go on to trace the evolution of current thinking on 'best practice'.

Top-Down TIs

In countries that practise mandatory health screening and registration of sex workers, TIs have tended to work within this system to improve the services or their 'reach' (e.g. Sweden, Austria, some states of Germany, Senegal). However, in spite of the popularity of mandatory registration as a public health measure, it is of limited effectiveness as the majority of sex workers remain unregistered and vulnerable. In Dakar, Senegal for example, it is estimated that only 800-900 of an estimated 16,000 sex workers are registered (Alexander 1992:8, Tandia 1998). In a variation of this approach, some countries (e.g. the Philippines and Indonesia) have attempted to carry out mass STD prophylaxis among registered sex workers (AIDSCAP.STD:263). This policy is also of questionable efficacy however. STD levels increase as soon as mass treatment is stopped, it does nothing to address the problem of STDs in clients who may continue to spread HIV if condoms are not used, and it completely misses the unregistered sex workers.

Other forms of TIs, common in Western Europe, involve improving access, referral and networking with existing health services (such as STD clinics) in a non-coercive manner. However, while offering valuable services, these kind of TIs have been criticised for doing little to meet sex workers' non-medical needs and for failing to address the underlying issues that affect sex workers' health. Where pre-existing services have attempted to become more sex worker-oriented, it has sometimes proved difficult to obtain the requisite funding from health authorities who may see little reason to fund ancillary services such as a drop-in-centre (NSWP 1997, Day & Ward 1997, Ward & Day 1998).

Another type of sex industry TI programme is a '100% condom policy' that has been implemented in Thailand, with proven success in reducing the incidence of HIV/STDs among

sex workers and the general population (Rojanapithayakorn & Hanenberg 1996, Visrutaratna et al 1995). In this programme, health workers persuaded brothel keepers to ensure 100% condom use in their establishments through a system of health/peer education and condom distribution backed up with police sanctions for non-compliance. The programme has been lauded for its success and is cited as an example of what can be achieved when there is the political commitment at policy level to enforce change. However, there is evidence that the controls and publicity associated with HIV and brothel based commercial sex has also had negative consequences and has begun to change the structure of the sex industry itself. There has allegedly been a growth in the non-brothel based sex trade where clients perceive HIV risk to be lower. In addition, there are reports that fewer Thai women are willing to work in brothels or in the sex industry at all and there has been an increase in immigrant sex workers, who, because of their illegal status will be missed by the present TI strategy (Hanenberg & Rojanapithayakorn 1996, Maticka-Tyndale et al 1997).

In addition to the above efforts, there have been numerous short-term TIs undertaken with sex workers where the main emphasis has been upon imparting information and condom use skills through individually-oriented one-off health education programmes. However, there is some evidence to indicate that short-term programmes of this kind have not succeeded in achieving lasting changes in behaviour. Rather, reported condom use appears to increase immediately following the intervention, but thereafter decreases again (Fox et al 1993, Visrutaratna et al 1995, Asamoah-Adu et al 1994).

The TIs described above can be considered examples of a rather narrow and top-down approach. Some programmes are imposed upon sex workers whereas others provide services that are structured around meeting public health goals rather than sex workers' needs. There is no involvement of sex workers. Intervention efforts privilege the transfer of knowledge and skills as a key to behaviour change, rather than addressing other factors (e.g. working conditions) that may affect the practise of safer sex. Likewise (with the exception of the Thai example above), efforts are generally focused upon individuals rather than, for example, upon the broader sex industry environment. These TIs are labour and cost-intensive measures. There is no available evidence as to their sustainability over the long term and, in some cases, even their efficacy is in doubt. Experience from other health programmes however suggests that the reliance on technical expertise, institutionally based services or upon coercion to facilitate individual behaviour change makes it unlikely that improvements in sex workers' health will be sustained in the long term (Alexander 1992, WHO/Alexander 1993). Indeed, top-down health programmes such as these were explicitly rejected in favour of a broader,

more holistic, participatory and multi-sectoral approach enshrined in the internationally endorsed policy of 'Primary Health Care' (WHO 1978). In spite of this however, top-down, technically oriented health programmes continue to predominate in many health fields (Gish 1982, Rifkin & Walt 1986, 1988).

Community Based TIs and 'Best Practice' Models: Evolution of a Discourse of 'Sexual Health'

Other TIs among sex workers have developed into broader based community efforts that are more congruent with the philosophy of Primary Health Care and that are increasingly recommended as 'best practice'.

When it became clear that HIV was sexually transmitted, existing sex workers' organisations (mainly in developed countries) mobilised to ensure that sex workers' perspectives were included in HIV policy debates. They criticised TIs (such as those above) for their narrow approach and some sex worker groups helped to develop community-based HIV services for sex workers that involved provision of outreach as well as institutional services (Alexander 1992). The success of these (largely self-help) initiatives caught the attention of health workers and policy makers. Charged with developing TIs among sex workers, they were themselves grappling with the challenge of gaining access to women who have traditionally been excluded and hidden from 'mainstream society', many of whom are locked into complex occupational power structures, and who may be extremely suspicious of external interference. As a strategy for overcoming these difficulties, some health authorities provided direct funding to sex workers' groups to run their own interventions. Others enlisted sex workers' participation into TI projects to help with conducting outreach work as peer educators (PEs), acting as a bridge between project staff and sex trade actors[9].

As TIs among sex workers began to be developed, a large research effort also began, as part of this, to document the nature of sex industries and of women's lives. This research has uncovered, and forced attention onto, the socio-economic, cultural and legal constraints on women's ability to protect their own health. As with other marginalised groups, it has become clear that sex workers are more receptive to TIs whose framework prioritises their overall well being, of which health is but one (albeit inter-linked) part (King 1999, WHO/Alexander

[9] Using members of a peer group as health workers has become a common strategy in HIV initiatives among a wide range of target groups. Use of PEs is thought to overcome class and other socio-cultural differences (such as age or gender) that may inhibit open communication and the development of trust between a target group and project workers (AIDSCAP.PE, Williams 1996).

1993, NSWP 1997, Gordon & Sleightholme 1996, Scambler & Scambler 1997, Kempadoo & Doezema 1998, Lewis-Renuad 1997, Ward & Day 1997).

Accordingly, some TIs have re-framed their purpose towards addressing those situations and structures which create vulnerability and deprive sex workers of their perceived right to live and work safely (NSWP 1997, WHO/Alexander 1993). This perspective is often coupled with a change in rhetoric from HIV prevention to '*sexual health*'. The term 'sexual health' has come to define a two-pronged discourse that calls for: (1) a holistic and broad based approach to sexuality and to interventions where the aim is to improve overall health and well being, and (2) support for behaviour change by tackling the *causes* of disease and vulnerability, not just the disease itself. Sexual health has been described in various ways. The WHO describes sexual health as:

> The integration of physical, emotional, intellectual and social aspects of sexuality in a way that positively enriches and promotes personality, communication and love.

In Calcutta, the West Bengal Sexual Health Project considers the concept as follows:

> Sexual health is a state of physical, psychological and social well being made possible through: (1) adequate and equitable provision of easily accessible, quality health care to the growing number of people with STDs, including HIV infection, and removal of barriers that hinder men and women's access to sexual health services; (2) an overall environment of gender equity, enabling men and women to have complete choice and control of their self-defined sexuality, sexual behaviour and sexual practices; (3) reduction of social vulnerability to STD/HIV by improving social, economic, political, educational, legal and health status of women and men; (4) a greater focus upon adopting a public health rationale for being non-moralistic and non-judgemental about sex and sexuality and overcoming stigmatisation related to sex and sexuality" (West Bengal Sexual Health Project 1996)

And, in relation to sex worker TIs, the Network of Sex Worker Projects conceives of sexual health as:

> Understanding one's body and sexuality, knowing how to negotiate and enjoy safe sexual services, and having access to health services and other support systems are the foundations of sexual health for sex workers and their clients" (NSWP 1997:28).

TIs that adopt this broader framework usually include the 3 standard TI components (behaviour change communication, condom promotion, STD care), but also refer to the need to create what they term an 'enabling environment'. Best Practice documents and TI guides recommend including strategies that are described as *persuasive* and also *enabling* (Gordon & Sleightholme 1996, WHO 1993, NSWP 1997, Tawil, Verster & O'Reilly 1995, Adler et al 1996, AIDS Action 1995, IHAA 1998, King 1999). Persuasive approaches refer to imparting knowledge and skills and to fostering the motivation to change behaviour (often carried out by peer educators), whereas enabling approaches refer to broader strategies to change the

environment within which this behaviour occurs in order to *enable* the desired change. These strategies are advocated at 3 different levels - individual, community and societal. The strategies and 'levels' are not mutually exclusive. For example, persuasive strategies (health education, counselling) may be targeted at sex workers, but also at trade controllers and other third parties (e.g. clients). In so far as this may make others supportive of an individual sex worker's desire to use condoms, these strategies are also enabling. Creating a supportive environment can refer simply to facilitating access to condoms or health care, or it may include, for example, advocacy at the community and societal levels (e.g. convincing sex trade controllers of the value of condom use, providing awareness training to the police, or lobbying for legal reform). Achieving significant environmental change is often difficult as it involves negotiating with many different interest groups within entrenched structures of power. Hence, in addition to doing advocacy work, some projects explicitly aim to challenge existing exploitative power dynamics and to 'empower' sex workers. In the context of sex worker TIs, empowerment is also often described as a process involving change at the individual, community and societal levels. Community development, participation and mobilisation are seen as important strategies to this end. Strategies for empowerment have included helping sex workers on a practical level (such as fostering safer sex negotiating skills or assisting with other non-health related problems such as child care, legal help or credit facilities), and on a more political level through the encouragement of community or collective organisation.

Bringing sex workers together has been found to foster a sense of collective identity and solidarity that they may previously have lacked due to the isolation and marginalisation of the sex trade (Peterson & Szterenfeld 1992, AIIHPH 1997, Gordon & Sleightholme 1996, Garcia 1994, AIDSCAP. AR 1995, SWOP 1994, NSWP 1997, WHO 1993, Tandia 1998, Petzer & Issacs 1998, Brussa 1998, Longo 1998). Collective organising activities have also been found to bolster self-esteem, and, with the right support, may lead sex workers themselves to demand improved services and changes in working conditions. Indeed, a number of TIs, including the SHIP have resulted in the formation of independent sex workers' organisations who are themselves undertaking and expanding sexual health initiatives in their respective regions (Pal et al 1998, Cannings et al 1998, Kempadoo 1998b, Esu-Williams 1994). In addition, through their activities, some of these groups (including the DMSC), have achieved remarkable successes in raising public awareness about the sex trade and have been able to join regional, national and international debates on the sex trade from which they had traditionally been excluded. For these groups, paradoxically, AIDS has represented a platform

from which they can begin to address a wide range of issues that concern them (cf. Kempadoo & Doezema 1998).

By the mid-1990's, field experiences from regions as diverse as South Asia, Africa and South America with pilot TIs that took a broad holistic approach have been yielding concrete results in terms of mobilising sex workers *and* bringing about significant and, apparently, *lasting*, behaviour change (Jana et al 1998, Kempadoo 1998, AIDSTECH 1992, Evans 1999). The 'success' of these community based sexual health interventions has largely been attributed to the way in which the peer education strategy is operationalised. With the right support, it has been found that PEs can (and should) play a dual role, both helping to implement specific (persuasive) project components but also facilitating community development and organisation:

> Peer education....can help to give the group a stronger sense of community which can be very important for sex workers, since they often feel alone and outside of any community..... helping sex workers develop a sense of community and common purpose (i.e. surviving this epidemic) is essential to their ability to prevent HIV/AIDS infection (WHO 1993/Alexander:13).

An expanded PE role is also usually tied to a participatory working style whereby PEs are seen to represent the voice of sex workers. Thus, as in other sectors of development, participation of PEs and other sex workers in a project is recommended as a way of making a project responsive to local needs, enhancing ownership and thus long term sustainability of the initiative.

Thus, global experiences with sex worker projects have led to a shift in thinking about TIs at a policy level (as reflected in policy documents), so that the involvement of sex workers, community outreach work, peer education and project strategies that focus upon empowerment and community development as well as sexual health are increasingly being considered trade marks of 'best practices' in sex worker interventions (Evans 1999). The extent to which 'best practice' is actually practised however varies widely. Concepts such as 'persuasion', 'enabling environment', participation, empowerment, community development and, indeed, sexual health are essentially social constructions that can be interpreted and operationalised in many different ways. There has been very little research that has analysed the actual implementation and role of these elements within a sexual health/HIV intervention. In addition, given that a key aim of interventions is to enable or bring about behaviour change and, (in some cases), empowerment-processes, the ways in which TI components and strategies relate to mechanisms of such behavioural/social change and to improved 'sexual health' has likewise rarely been theorised or critically examined (Hornik 1991, Smith 1991,

Bunton et al 1991, Chen & Ross 1983, Tawil, Verster & O'Reilly 1995). In the next section I consider how such research might be undertaken, focusing particularly upon the development of an appropriate theoretical framework.

Behaviour Change, Targeted Interventions and Sexual Health: A Research Agenda

Though not always explicit, the different ways in which TIs have been undertaken among sex workers reflect different attitudes towards the sex trade and different perspectives on processes of behaviour/social change and on what constitutes (sexual) health (Seidel 1993). As such, in order to study sexual health and behaviour change, it is first necessary to locate these constructs within existing social discourses and to consider how the latter may affect the structure of the subsequent research process. Below, I suggest that notions of sexual health and behaviour change are situated within, and are evolving from, two different (though overlapping) paradigms of health whose practices and discourses are predicated upon particular conceptions of the relationship between disease, behaviour, the individual and society that can generally be considered 'modernist' or 'positivist'. These paradigms are shifting however as a result of the conceptual and practical challenges posed by HIV.

Paradigms of Health and Behaviour Change and the Role of Anthropology

Health as Absence of Disease

In this first paradigm, health is defined by its absence, attributed to disease, or to a lack of correct knowledge and behaviour (Sartre 1956, Das 1989). In this sense, the meaning of sexual health is absence of STDs and HIV. This view of health is strongly linked to the western, biomedical, Cartesian tradition which takes a mechanical and reductionist view of the body. It is also part of a deterministic empiricist paradigm that seeks an ultimate cause or 'truth' through the application of rational thought, considered to be a uniquely human characteristic. Thus, the investigations of large complex systems (such as the body or society) proceed by conceptually breaking them down into their constituent parts. Accordingly, studies of human action within this paradigm tend to hold an implicitly individualist and utilitarian view of society that is considered to be made up of the aggregate of actions taken by rational, calculating and self-interested individuals. Sexual health behaviour is, therefore, largely attributed to individual volition.

In this paradigm, the use of the word 'health' is something of a misnomer as interventions and research are primarily *disease* oriented. So, for example, HIV policies emphasise STD control and condom use. As a strongly empiricist paradigm that emphasises the existence of ultimate truths, in this case, with respect to disease, policies are framed by 'experts' who alone are considered to possess the requisite knowledge and, therefore, power and authority to define what must be done about a particular problem. Interventions thus often stress the importance of possessing this correct knowledge in order to prevent disease. The result is a policy emphasis upon providing 'health education', where non-experts are considered ignorant and in need of enlightenment. The underlying individualism means that health education activities are usually directed at individuals on the assumption that, having received the 'correct' knowledge they will then freely and rationally opt to change their behaviour in accordance with expert guidelines (Kemm 1991).

Experience has shown however that the relationship between knowledge and behaviour change is rarely as straightforward and linear as described above, and a wide range of 'models' of varying complexity have been developed (usually in the disciplines of cognitive and social psychology) that attempt to theorise and also predict behaviour change. These are predominantly individualistic theories, focusing upon the cognitive steps that must be taken for knowledge to be translated into behaviour change. The most commonly cited are the 'Health Belief Model' (Maiman & Becker 1974, Rosenstock et al 1988, Janz & Becker 1984) and the 'Theory of Reasoned Action' (Ajzen & Fishbein 1980). These attempt to model decision making processes, and suggest that individuals evaluate new information in a kind of cost-benefit analysis, so that where the benefits of changing behaviour outweigh the costs, medical advice will be followed. These and other theories also draw attention to factors that may influence an individual's decision or ability to change behaviour. These are thought to include, for example, whether the desired behaviour results in a reward which would then reinforce the behaviour ('social learning', Seligman 1975), or whether the individual has the skills or resources to undertake the required change and feels confident in his/her ability to change ('self-efficacy', Bandura 1986). In addition, certain personality traits are considered important, such as the extent to which an individual feels in control of his/her life ('locus of control', Wallson et al 1978, Lau & Ware 1981). Another range of theories, the 'Social Expectation' models, attempt to factor in a social dimension to cognitive processes by suggesting that individual behaviour is substantially a result of conformity to the expectations of others (Hornik 1991). These place less emphasis on the role of informed rational decision making, stating that conformity may or may not be a result of a conscious decision. In the latter case it is suggested that conformity may reflect demands of a social network without

any reflective process producing awareness of these demands, and includes behaviour that can be described as 'habitual' (e.g. smoking or having multi-partner sex).

The 'persuasive' approach being advocated within sexual health interventions implicitly or explicitly derives from these theories of behaviour change (Van Landingham et al 1995, Catania et al 1990, Fishbein et al 1991, Bandura 1990, Petosa & Jackson 1991, Tawil et al 1995:1299). However, strategies developed by TIs based upon any single theory have generally been found to be inadequate and most TIs take a rather eclectic approach, drawing upon elements from a wide range of theories though this is rarely explicitly recognised (King 1999, Hornik 1991, Smith 1991). There have been some attempts to formalise such an eclectic approach into a sexual health-specific 'model'. For example, it has been suggested that for behaviour to change, individuals must perceive the following (AIDSCAP STD:63): (1) that they are at personal risk (relevant information must be given); (2) that changing their behaviour will result in benefits that are relevant to them (e.g. behaviour change will potentially save their life or reduce suffering from disease); (3) that social norms will support their actions at each stage (e.g. condom use should be widely accepted); (4) that they have the skills and resources needed to make the changes (that condoms are accessible and that they are confident in negotiating safer sex).

Anthropology's role within this paradigm is relatively recent. For a long time health interventions concentrated upon providing technical medical facilities and health education. These strategies did not yield the expected results however, and practitioners felt that culture or cultural beliefs may be related to a population's intransigence in accepting new knowledge, and turned to anthropology for help (Inhorn & Brown 1997b). Researchers commissioned to work within this paradigm however find there is little sympathy for anthropological theory, and that research findings are expected to be presented in accordance with the empirical tradition (Lambert 1998). Thus, the discipline becomes reduced to its methods, which in turn are adapted to deliver results as rapidly as possible, and are mainly utilised to identify and describe 'beliefs' and 'practices', representing 'culture' as an objective 'variable' of health behaviour (for example, Green 1992 & 1987, Pelto et al 1990, Pelto & Pelto 1990, Pelto 1994, Bentley et al 1988, Kendall et al 1984). With respect to HIV for example, this would include uncovering a 'set' or 'list' of local beliefs and practices surrounding STDs, HIV and sexual relations with the aim of helping health workers devise appropriate educative strategies.

Within this paradigm, illness denotes pathology as opposed to, for example, a subjective experience of distress. Interventions aim to establish appropriate 'illness-' or 'health seeking

behaviour', i.e. a congruence between biomedical and lay responses to bodily symptoms, so that patients do not delay seeking treatment for serious afflictions, comply with medical advice and do not trouble practitioners with 'trivial' complaints (Nettleton 1995: chap.3). In the case of STDs for example, doctors feel that patients should have the knowledge to recognise which symptoms indicate a serious STD, and to seek treatment from a properly trained doctor rather than using indigenous practitioners or remedies or medicating themselves (as is common). 'Inappropriate' illness behaviour is often constructed as a lack of knowledge - both about the body and, implicitly, about who is the holder of 'correct' expert medical knowledge. Individually oriented education is again seen as the solution.

Health as Well Being

The second paradigm by contrast, constructs health by its presence, reifying it as a "state of complete physical, mental, and social well being" (WHO 1986). This paradigm rejects the kind of scientific reductionism characteristic of biomedicine and aims for a more holistic approach (Kelly & Charlton 1995). The definitions of sexual health given in the previous section fall into this paradigm which rejects the narrow biomedical model of absence of STD/HIV for a more positive view of healthy sexuality. This paradigm emerged out of a realisation that the biomedical construction of health and its related interventions had only limited success in changing behaviour and preventing disease. It was increasingly recognised that health status is determined not only by knowledge and the availability of technical medical services but is inextricably linked to social, political and economic inequality and that this must addressed if health is to improve long term (Parish 1995). As mentioned previously, this has given rise to a discourse of Primary Health Care (PHC) and, later, to the discipline of Health Promotion. These propose that health is to be promoted (rather than disease prevented) through social, economic and political change, fostered by multi-sectoral collaboration and public participation (WHO 1978, 1984). To some extent, health promotion challenges the authority of the biomedical discourse but retains an inherent determinism and empiricism that constructs health as a 'state' that is affected by certain identifiable, though complex, variables and systems (Bunton & MacDonald 1992).

Within a discourse of health promotion, the extent to which individuals can change their behaviour is recognised as being highly dependent upon broader social and environmental forces, though correct knowledge is still seen as crucial:

> Health promotion is....any combination of health education and related organisational, political and economic intervention designed to facilitate behavioural and environmental adaptations which will improve or protect health (Andersen 1983).

Behaviour change is conceptualised as obstructed by certain 'obstacles'. Interventions aim to identify obstacles, ameliorate their effects and, therefore, 'enable' change. The 'enabling' approach within sexual health stems from this discourse (Tawil et al 1995). Obstacles are often related to structural inequalities such as poverty, gender and lack of access to and control over resources (e.g. information or medical services). With respect to illness/health seeking behaviour, again, a primary focus concerns the removal of obstacles to appropriate treatment seeking and compliance which may be both individual (e.g. lack of knowledge) or structural (e.g. lack of affordable medical facilities in a poor neighbourhood).

The emphasis on structural inequality and public participation within health promotion has, as in mainstream development, given rise to a discourse of 'empowerment' and overall community development that advocates putting people first (i.e. making interventions people-centred, rather than driven by external imperatives), respecting and building upon their existing knowledge and skills, and facilitating their self-development and participation in civic life (Chambers 1983).

Whilst this approach to behaviour change appears predicated upon a much more 'social' model of health, it nonetheless retains elements common to the biomedical paradigm in its implicit assumption that if structural, physical or social obstacles are removed through 'empowerment' or communal efforts, and quality education and services provided, then individuals and/or social groups will (rationally) seek to follow (biomedically) defined lifestyles.

In practice it has proved difficult to mobilise sufficient political will or multi-sectoral collaboration to take PHC and health promotion to their logical conclusions. Interventions often remain rather piecemeal, slotting community participation or empowerment activities into biomedically defined top-down programmes (Heggenhouen 1984, Segall 1983). As such they rarely address fundamental political/economic 'obstacles' but rather aim to ameliorate their effects (e.g. setting up insurance schemes to help poor women cover medical fees rather than organising them to demand a minimum wage or healthier working conditions). Likewise, empowerment strategies often remain limited to the individual level (e.g. increasing access to information and skills) rather than addressing the social power relations through which individuals must act (Gish 1982, Rifkin & Walt 1986, 1988).

The role of anthropology within this paradigm is characterised by similar constraints as previously described, and has, therefore, remained largely descriptive and methodological rather than analytical, encompassing for example, the description of sexual/health behaviours or of the socio-economic organisation of targeted groups and the assessment of needs (e.g. Bentley et al 1992, Scrimshaw & Hurtado 1987, Scrimshaw et al 1995, Seeley et al 1992, Woelk 1992, Nichter 1984 & 1986).

Shifting Paradigms: Implications for Sexual Health

The description of the above paradigms - a biomedically driven, 'persuasive' health education and a socially aware 'enabling' health promotion, are, by necessity, rather simplified caricatures and, in reality, encompass much internal variation and energetic debate. With respect to AIDS however, whilst there have been successes, it has proved extraordinarily difficult to promote health or change behaviour and it has become increasingly clear that existing explanations of health-related behaviour as a guide for intervention and policy development are inadequate (Pollack et al 1992, Hornik 1989, King 1999, Shedlin at el 1992). Consequently, an unprecedented number of anthropologists and other social scientists have been employed in the HIV field in order to help shed light upon this problem. They have been using not only their discipline's methods, but are also turning to its theories, in particular, 'practice' theory, post-structuralism/post-modernism and phenomenology to try and develop more sophisticated understandings of human and social action[10].

Power, Knowledge and Practice

These theoretical approaches challenge the positivist view of an ultimate truth or reality that can be knowable through empirical research[11]. Indeed, the construction of knowledge through research is considered to be a social process involving relations of power constituted through discourse - "practices that systematically form the objects of which they speak" (Foucault 1972:49). Accordingly, knowledge is not viewed as 'objective fact', but rather as fragmentary, partial and provisional in nature. Knowledge, it is argued, is never fully unified or integrated in terms of an underlying cultural logic or system of classification but is seen to be embedded in

[10] A similar theoretical shift has been made by anthropologists working in mainstream 'development'. I believe their work is highly relevant but there has, as yet, been little crossover into the field of health (cf. Gardner & Lewis 1996, Nelson & Wright 1995, Scoones & Thompson 1994, Hobart 1993, Long & Long 1992, Pottier 1992, Mosse et al 1998).

[11] These approaches derive from an ongoing critique in the social sciences of the western positivist tradition (cf. Collingwood 1945, 1946, Quine 1953, Kuhn 1962, Foucault 1967, Feyerabend 1975, Rorty 1980).

practice, constructed by 'situated agents' (including medical scientists and health researchers) - seen as agents because they are actively engaged in the generation, acquisition and classification of knowledge, and as situated agents because this engagement occurs in particular cultural, economic, and socio-political contexts that are the products of both local and macro-level processes (Bebbington 1992:2, cf. Bourdieu 1977). This approach recognises the role of 'culture' or 'cultural difference' in mediating action, but suggests that the forms it takes are generated and transformed by what Bourdieu terms 'habitus' - particular social and historical conditions from which particular 'strategy generating principles' arise (Bourdieu 1977:72). Social practice is thus viewed not as directly related to static cultural/cognitive rules or schema but to 'generative principles' which define the realm of what is 'do-able' and 'think-able' (ibid:18). In this sense, knowledge is not merely an accumulation of 'facts' but involves a way of comprehending the world that is shaped by action in it, i.e. "knowledge is always in the making" (Scoones & Thompson 1992:4).

A view of knowledge as dynamic situated practice implies that a crucial arena for social/behavioural change comprises the interactions occurring between social actors in different contexts. And, as many interactions take place between people or groups of different social status, an understanding of the way that mechanisms of power shape practice and knowledge construction is essential. To use an oft-cited phrase of Foucault (1972:50): "the criteria of what constitutes knowledge, what is to be excluded and who is designated to know involves acts of power". According to this perspective however, power is seen as a property arising out of interaction rather than a static attribute of social status, thus where there is interaction, there is also dominance, negotiation, compromise and resistance (Foucault 1980).

What implications does this have for the study of sexual health? Firstly, if knowledge is considered to be socially constructed, then knowledge about sexual health is no exception. So far, the parameters of the 'sexual health' field have been largely defined by the practices of western health experts steeped in the traditions of biomedicine and health promotion. Although the knowledge and behaviour of 'others' is studied to increase understanding, it is ultimately interpreted within a western framework. However, if the meaning of sexual health for others is to be understood then attempts must be made to locate and interpret the significance of their practices within their own epistemological frameworks.

Secondly, if the relationship between knowledge and practice is considered to be inherently dialogical, emerging out of, and situated within, particular contexts and interactions, this has implications for the 'object' of study in sexual health, and for understandings of processes of

behaviour/social change. Above, it was pointed out that 'persuasive' and 'enabling' discourses appear to conceptualise behaviour change slightly differently – the former emphasising individual knowledge and volition, and the latter emphasising macro-level structural 'obstacles'. These differences can be related to a long-standing dichotomy in the social sciences between the role of individual action vis a vis social structure in processes of social/structural change and reproduction (Giddens 1984). In the field of sexual health, attempts have been made to circumvent this issue by suggesting that *both* individual and structural approaches are necessary for behaviour change and that they work in conjunction. This has intuitive appeal and does appear to yield some successes in practice, but there is a growing body of research that indicates that as a *theoretical explanation* for behaviour change, it is inadequate, as there are instances of 'risky' behaviour occurring in spite of knowledge and even where obstacles are few (for example, wealthy, well informed western men who persist in having unsafe sex with poor sex workers in developing countries). And, likewise, there are cases of successful negotiation of safer sex in extremely adverse circumstances (e.g. a poor and indebted sex worker refusing to have unsafe sex in spite of a client offering a large monetary incentive).

I have already noted that, though appearing different, persuasive and enabling discourses actually share some common paradigmatic assumptions. Both share a somewhat mechanistic, passive and 'rational' view of human action, where individuals are represented as acting rationally on the basis of objective knowledge about the world, and, as being passively manipulated by socio-economic, cultural or cognitive structures rather than as actively negotiating them. Both conceive of behaviour change as occurring as a result of *external* forces (expert medical knowledge or structural barriers) acting deterministically upon the individual. Change is thus conceptualised as occurring in a rather linear manner, largely dependent upon external intervention. Although enabling discourses stress the need for empowerment, participation and respect for local knowledge, this position is somewhat paradoxical as the parameters within which this should occur are still usually defined by outside experts within a discourse that holds that only biomedicine holds the key to 'true' knowledge[12]. In this way, knowledge and practice as creative, dynamic processes are denied and, instead, are turned into objectively measurable entities that are to be passively adopted by compliant populations. What is lacking therefore in both approaches is an acknowledgement of human agency. Indeed, this is reflected in the use of the term 'behaviour' with its deterministic overtones, as opposed to, for example, action, strategy, practice or praxis, used in post-positivist social science discourses to

[12] Anthropologists working more generally in the field of development have made similar points. For detailed discussions of the theoretical paradoxes of development concepts such as participation and empowerment, see Long & Long (1992), Scoones & Thompson (1994), Nelson & Wright (1995).

indicate that, though socially shaped and constrained in various ways, human action is purposeful and symbolically meaningful (Ortner 1984, Evans & Lambert 1997).

Social Actors, Life World and Agency

Long (1992) has argued that it is theoretically inadequate to base analyses of social change upon the concept of external determination alone:

> All forms of external intervention necessarily enters into the existing life worlds of the individuals and social groups affected and in this way are mediated by these same actors and structures (Long 1992:21).

The use of the concept of 'lifeworld' implies an explicit phenomenology whereby attention must be paid to the *meanings* of events and processes for particular individuals and groups that cannot be pre-defined (Schutz 1971).

Similarly, one can argue that the response to new knowledge or 'skills' imparted from 'outside' can only be understood when the meanings it takes on for individuals and groups in their own life worlds is analysed. The concept of life world however does not just imply analysis of 'meaning' from an individual's point of view thereby returning to an inherent individualism. It also recognises that such meanings will be shaped by the particular social, cultural and historical contexts in which they occur and are enacted. In this way there is no ontological differentiation between the individual and society, or macro-micro. Local practices include macro representations and are shaped by distant time/space arenas, and the macro-phenomena are only intelligible in situated contexts, grounded in the meanings accorded them through the on-going life experiences of individual men and women (Giddens 1984, Bourdieu 1977).

Crucial to the task of analysing social change (or, in this case, health related behaviour) from such a perspective are the concepts of 'social actor' and 'agency' (Long 1992:20). The social actor is conceived as an individual or social unit that has the capacity to act and make decisions, i.e. has 'agency'. Thus, actors are conceived as having an inherent creativity and decision making ability that will influence processes of social and behavioural change, but this is not the equivalent of volitional action as 'agency' can only be enacted through networks of social relations within particular social structures (Hindness 1986:115, Giddens 1984:1-16)[13]. In addition, forms of social action (such as decision making) require the use of implicit or explicit 'discursive means' (i.e. cultural constructions implied in expressing either verbally or through

[13] This is similar to the Marxian idea that humans "make their own history but in circumstances not of their own choosing".

social practice, points of view or value perspectives). Use of discursive means is quite different conceptually to ideas of human behaviour being based upon a supposedly neutral or value free 'knowledge'. Types of discourse are conceptualised as being part of a historically and culturally differentiated stock of knowledge and resources from which various types of strategies and cultural constructions become possible (Hindness 1986:117-19). And, since social life is never so unitary as to be built upon a single type of discourse, it follows that however restricted their choices, actors always face some alternative way of formulating their objectives, deploying specific modes of action and giving reasons for their behaviour. The recognition of alternative discourse use and availability to actors challenges, on the one hand, the notion that rationality is an intrinsic property of the individual actor, and, on the other, that it simply reflects the actor's structural location in society (ibid.). This implies that even seemingly self evident analytical concepts such as 'agency' must be located within indigenous discourses of personhood, action and capability, as cultural differences in the constitution of agency will profoundly affect the management of inter-personal relations and the expression of power within them (Strathern 1985:65). A consideration of cultural differences in the construction of 'agency' is important in the field of health and development for example, as differential conceptions of power, influence, knowledge and efficacy will influence the handling of personal and group relations and the kinds of control that actors can pursue vis a vis each other (Long 1992). This has particular relevance for understanding concepts such as 'participation' and 'empowerment', especially in situations where external and local ways of expressing 'agency' and of dealing with social hierarchies and power relations may be quite different. An important task for analysis is thus to:

> Identify and characterise differing actor strategies and rationales, the conditions under which they arise, their viability or effectiveness for solving specific problems, and their structural outcomes (Long 1992:27)[14].

This kind of analysis and a theoretical focus upon 'agency' also serves to challenge hegemonic representations of certain social groups, especially of the poor and marginalised (including sex workers) who, traditionally, have been portrayed as passive victims of circumstance. Use of such representations within, for example, the health and development field, lend themselves to an agenda that is imposed from the top-down. By contrast, acknowledging agency means acknowledging local knowledgeability and capability in all its diversity, and, in theory, necessitates allowing people to speak and think for themselves and to set their own agenda for change (as, indeed, is advocated by participatory discourses in development). Adopting such a

[14] In recent years, scholars of Medical Anthropology have been moving towards similar forms of analysis that seek to develop more integrated understandings of health practice (B.Good 1994:80, Singer 1995, Singer 1990:181, Singer et al 1988, Lock & Scheper-Hughes 1990, Frankenberg 1986).

perspective with respect to sex workers however appears to be particularly problematic. Kempadoo (1998a:9) has noted that:

> The idea of women's agency in prostitution is often vehemently rejected by feminists..[and]..sex workers remain relegated to the status of objects, seen to be violently manipulated and wrought into passivity and acquiescence. Prostitution appears to be one of the last sites of gender relations to be interrogated through a critical feminist lens that assumes that women are both active subjects and subjects of domination.

The heavy involvement of social scientists in sexual health research has, however, seen a shift in the way in which the 'object' of research is defined and in the way in which research is carried out. Increasingly, sex workers are themselves participating in research activities, or are represented as 'active subjects' (e.g. Lewis-Renuad 1997, Scambler & Scambler 1997, Kempadoo & Doezema 1998, Kielmann 1997, Nelson 1987). As described below, this trend, coupled with other 'post-positivist' research undertakings, has begun to challenge dominant representations of health and of the relationship between knowledge, individual behaviour and social structure.

Insights for Sexual Health Research

Focus on Context

The notion of situated practice has shifted the analytical focus of HIV-research away from the individual or social structures and onto the *context* of a particular 'behaviour' or event. Taking safer sex as an example, with the advent of AIDS it became evident that very little was known about sexuality and sexual behaviour - subjects that were traditionally taboo in most societies. Researchers that were commissioned to conduct research on sexual risk behaviour soon pointed out the limitations of applying normative models of human behaviour to this field. These might, for example, represent unsafe sex as a result of lack of knowledge or self-discipline or some other psychological deficiency. Or, unsafe sex might be explained with reference to various barriers that an individual faces in trying to practice safe sex (such as unequal power relations between sexual partners, or lack of condoms etc.). These perspectives focus upon the individual and assume that safe sex would be the rational choice (Davies 1992, Aggleton et al 1992). However, research has shown that to focus upon the individual when sexual behaviour is inherently interactive and usually involves a minimum of two people, is somewhat misplaced as only one side of the risk equation is considered. Alternative methodologies, therefore, have been developed in which the dynamics of a particular interaction and the context in which it occurs become the focus of investigation (Zeidenstein & Moore 1996, Brummelhuis & Herdt 1995, Parker & Gagnon 1995, Herdt & Lindenbaum 1992, Aggleton et al 1989, 1992, Aggleton

1994). This kind of research indicates that the outcome of sexual encounters depends upon a dynamic negotiation of power and identity that are differentially managed according to different social circumstances (Bloor et al 1993, McKeganey et al 1990). Whilst knowledge and attributes such as gender have an important part to play in this process, the contexts which allow for the enactment of different forms of knowledge or the expression of different masculinities, femininities and power configurations are viewed as equally important for social analysis (Hart 1995, Patton 1994, Ingham et al 1992, Schoepf et al 1991, Sibthorpe 1992, Holland et al 1990 a&b, 1992, Worth 1989).

Focus Meaning, Agency and Action

Likewise, much research has stressed that the meaning of the sexual encounter for those involved is crucial to understanding the outcome. These studies have reached the (rather common sense, but oft neglected) conclusion that sex is not merely a mechanical behaviour, rationally performed in line with current guidelines in pursuit of pleasure or material gain, but is an act full of emotional, social and symbolic meaning (Parker & Gagnon 1995, Caplan 1987). As previously noted, among sex workers for example, it is common for women to try and use condoms in their work, and, indeed, condoms may come to symbolise 'work-sex' and may be rejected within personal relationships (Day 1988). In the latter, sex may take on quite different meanings associated with a desire for trust and intimacy, or with gender role-fulfilment that is associated with an identification with the role of girlfriend or wife rather than with that of 'sex worker'. Identities and meanings associated with sexual behaviour may, therefore, be rather fluid. Moreover, if it is assumed that sex workers, are, (within the limits of their information and resources and the uncertainties they face), knowledgeable and capable (i.e. have agency), certain types of sexual behaviour, even unsafe sex can be viewed as an active strategy by which women attempt to manage their every day affairs in their own life worlds. It may thus be misleading to try and slot the meaning and purpose of sexual strategies into a western biomedical framework. Recognising women's agency however, does not imply that imbalances of power or other obstacles do not exist, simply that it is important to understand the ways in which these are negotiated from the perspective of the actors involved.

Focus on Performance

Focusing upon the particularities of the contexts of particular behaviours also highlights the shortcomings of positivist attempts to understand health practice by analysing behaviour post-hoc and trying to relate it to concrete cognitive, cultural or structural variables. Empirical

research on sexual behaviour usually inquires about the *outcome* of a sexual encounter, rather than the *process* (which tends to be viewed rather like the outcome of a rational plan - either premeditated individual intention, or the completion of an obstacle course). Thus, the outcome and the process are conceptually conflated which, research has shown, may be quite misleading. For, if social action is viewed as inherently meaningful and as occurring in response to ever changing exigencies and contexts of every day life, it has been suggested that the progress of a sexual encounter would be more appropriately conceptualised as *performative* (rather than planned or predetermined), and, as such, is inherently difficult to predict or model (Bourdieu 1977:73, Davies 1992:134). A similar point has been made by anthropologists working in other areas of 'development', and, I believe their conclusions may have much relevance for the study of health practice. In farming systems research for instance, empirical studies attempt to understand farmer's agricultural practices by analysing farming outcomes and by inferring a systematic logic to the methods and processes involved. Richards (1989:40) however has pointed out that:

> The crop mix [read health behaviour]...is not a design but a result, a completed performance. What transpired in the performance and why can only be interpreted by reconstructing the sequence of events in time. Each mixture is a historical record of what happened to a specific farmer on a specific piece of land in a specific year, not an attempt to implement a general theory of inter-species ecological complementarity...Researchers are looking for a combinatorial logic in inter-cropping where what matters to the....farmer is sequential adjustment to unpredictable conditions. It is important therefore not to confuse spatial with temporal logic and not to conflate plan with performance.

From Richards' (1989) perspective[15], it is acknowledged that farmers have culturally mediated views and 'knowledge' on crops and methods of farming, and that these are important for researchers to understand. Crucially however, it is recognised that these views are embedded in time and in place and have to be adjusted to changing conditions over which they may have only limited control. It is in this sense that knowledge becomes situated practice (cf. Bourdieu 1977). This is a radically different frame of reference to that of empirical research which seeks to develop models of behaviour that are replicable and comparable, timeless and context-free (Scoones & Thompson 1992:5). This is not a new insight in social theory, but is one that is yet to be fully elaborated with respect to health-related actions, understandings and interventions.

Focus on Intervention Processes

The ways in which external interventions, for example, sexual health projects, are understood and analysed are also changing. In development circles it is now well accepted that whilst research or interventions may be planned or modelled, their implementation does not

[15] See also the contributors to Scoones & Thompson (1994).

necessarily follow in a linear fashion from plan to result or outcome. The failures and unintended consequences of innumerable 'projects' bear ample testimony to the difficulties of trying to plan social change. Researchers of 'development' now increasingly conceptualise any kind of external innovation as necessarily entering the existing 'life worlds' of the individuals and social groups affected and thus come to form part of the resources and constraints of the social strategies they develop (Mosse 1995, 1996). In this way, so-called external factors become internalised and may come to mean quite different things to different interest groups or actors. Their response in turn mediates and transforms the nature of the intervention process itself (Long 1992b:20). Intervention is thus considered a dialectical process involving the encounter and negotiation of many different interest groups, value and knowledge systems. These encounters do not necessarily take place on equal terms however. Interventions may, in fact be characterised by conflict and struggles over meaning, power and resources. Indeed, Long conceptualises intervention in terms of a social interface which:

> Is a critical point of intersection between different social systems, fields or levels of social order where structural discontinuities based upon differences of normative value and social interest are likely to be found (Long 1989:3).

Thus if the social change that interventions are designed to bring about, are to be understood, it is necessary to include the intervention itself in the analysis.

A number of health and development agencies, including DFID have taken these kinds of analyses very seriously and projects are increasingly described as a 'process' involving negotiations between numerous interest groups (usually referred to as 'stake holders') and are continually reviewed and revised. Indeed, both the WBSHP and the SHIP are referred to as 'process projects'. In the sexual health field however, though targeted interventions are being advocated world-wide, there has, as yet, been little in-depth analysis of the ways in which these enter into the life-worlds of others and of the effects that they may have. This is a gap that needs to be filled.

Research and Sexual Health Practice

It is my view that, what may broadly be described as 'post-positivist' theories and research perspectives have, explicitly or implicitly, already had a significant impact in the sexual health field. This has perhaps occurred because of the unusually heavy social science involvement in AIDS research and also because vulnerability to AIDS is strongly associated with marginality. Interventions with marginal groups bring into sharp relief the importance of issues of difference,

identity, meaning and power that, in other circumstances, can be more easily glossed over. In addition, implementation of interventions with marginal groups often involves a great deal of advocacy work within and outside the target community, clearly revealing the contested nature of social practice, ideology and knowledge.

Thus, with respect to sex workers for example, policy documents and intervention guidelines increasingly stress the importance of understanding the context of sexual/health practices and of acknowledging the multiplicities of actors' lived experience (Gordon & Sleightholme 1996, WHO/Alexander 1993, NSWP 1997). Like wise, as noted above, 'best practice' manuals refer to the need to intervene at multiple levels (individual, community and society), to influence the overall 'milieu' of sexual health and behaviour, using participatory strategies that imply an acknowledgement of 'agency'. This represents an attempt to move away from restrictive individual/society dichotomies but is yet to be adequately theorised or investigated in practice.

Conclusion and Thesis Outline

In this chapter, I have described the complex constellation of factors that affect sex workers' potential vulnerability to HIV, and have traced the evolution and pros and cons of 'targeted intervention' strategies with this group. I noted that HIV has represented a challenge for sex workers but also an opportunity for them to make their voices heard, facilitated in part through community-based HIV initiatives that have acted as a platform for self-organisation. In addition, I have described how HIV has illuminated central problems in the understanding of health practices and processes of change which has resulted in increased opportunities for social science involvement in one of the world's most pressing public health problems. In examining the 'problem' of behaviour change I suggested that many popular theories or models are limited by their location within dominant, empirically based discourses of health, and proposed that concepts of social actor, agency and life world potentially open up fruitful avenues for alternative conceptualisations of sexual health practices and their change.

However, in spite of the progress that has been made, it is still a fact that much social science research in the sexual health field remains 'programme-driven' in the sense that it is applied work funded by agencies who want answers to specific problems, and within relatively short periods of time. Thus research is often focused upon a sharply defined range of issues and there have been few studies that have had the scope to look both at sex workers' life and work experiences and their responses to HIV and related intervention strategies, *and*, that have related these to theories of behaviour change and intervention (but see Lewis-Renuad 1997 &

Kielmann 1997). Having had the 'luxury' of time and funding for in-depth ethnographic research, the ensuing thesis is an attempt to develop a more integrated analysis. Thus, I aim firstly, to document and describe sex workers life experiences within a brothel based sex trade. Secondly, I aim to present and analyse sex workers' own discourses on HIV and sexual health, and, thirdly, to relate this to a context based situated analysis of processes of behaviour change and intervention strategies that includes a consideration of a sexual health project (the SHIP) and the ways in which it has entered into the life worlds of different actors and communities in Sett Bagan and Sonagachi, two of Calcutta's redlight areas.

The ensuing thesis is structured as follows. Chapter two details the study's methodology and the development of the research process. The next chapter provides an overview of the contemporary sex trade in India and goes on to introduce the two research communities in Calcutta, providing a detailed description of their structure and social organisation. In chapter four, the evolution of the Indian HIV epidemic and related policy development is traced and the SHIP and DMSC are introduced. Chapter five focuses upon women's experiences as sex workers in Calcutta and relates this to issues of identity, social exclusion and resistance – themes that run throughout the thesis and that affect the ways in which the SHIP has been interpreted and responded to by different actors, and that have implications for understanding processes of social change. The following three chapters comprise a situated exploration of sexual health, intervention processes and behaviour change. Chapter six describes the ways in which the SHIP was implemented and responded to in Sett Bagan and Sonagachi, and reveals the context dependent, strategic, meaningful and contested nature of the concepts of community, participation and empowerment, and also highlights the significance of different constructions of agency for the ways in which these concepts are expressed by different actors. Chapter seven examines sex workers' own (vis a vis biomedical) perceptions of sexual health and, drawing upon the SHIP as an example, analyses the representations, meanings and strategic uses of different kinds of 'knowledge' and its perceived role in behaviour change. Chapter eight looks at the varying meanings that sexual practices take on for sex workers in the context of their social and occupational position. It examines women's strategies around safer sex and uses this material to critique conventional theories of behaviour change, arguing for a perspective that acknowledges sex workers' agency yet recognizes the ways in which its expression is shaped and constrained by micro and macro level socio-cultural and economic forces. Chapter nine concludes the thesis by showing how in-depth ethnographic research on sex workers' lives combined with a contextually embedded analysis of the processes and meanings of an intervention yields important insights for understanding, developing and replicating effective HIV prevention initiatives among this group.

CHAPTER TWO

METHODOLOGY

Introduction

In this chapter I set out the methodological approach adopted for the research. I begin with a theoretical discussion on the way in which the research process was structured, and follow this with a detailed description of the research itself. I present a background to my personal involvement with the research communities and go on to describe the process of fieldwork by dividing it into three chronological periods. Here I discuss personal as well as methodological reflections on what transpired, and also give details of specific research activities that were undertaken.

Theoretical Reflections

The Production and Representation of Knowledge

In the previous chapter, I set out a theoretical framework for the present study in which the production of knowledge through research is seen as a situated social practice. According to this perspective, research cannot be considered neutral or objective as it involves processes of interpretation, translation and representation which are historically and culturally contingent (Scoones & Thompson 1992:7), and which are affected by the particular personal and inter-personal characteristics of the researcher.

As such, by contrast with empiricism, the aim of research is seen not as the pursuit of universal truths, but of "situated knowledge" (Mani 1990:25-6), where "the problem is to find ways of representing similarities and attaining solidarity whilst recognising the multiplicities of intersecting differences" (Wright & Nelson 1995:47-8). According to some commentators, the research process is conceptualised as "theoretically informed reflexivity" (de Vries 1992:80), described as a continuous movement from the researcher's personal experiences of social interactions in the field to a more distanced analysis of that experience drawing upon, and, in the process, critiquing, existing academic theories and discourses (Scholte 1974, Wright & Nelson1995, Marcus & Fisher 1986, Clifford 1988).

Such a perspective has given rise to debate on how the research findings or ethnographic 'text' are to be represented, with many taking the view that the final text should be seen as the outcome of a dialogue or interpretive performance which seeks to "give more equal representation to the voices of people involved in field research and to emphasise the process by which an exchange of information and ideas has produced a shared understanding" (Wright & Nelson 1995:48, see also Fabian 1983, Tedlock 1987). However, de Vries (1992: 80) comments that it is not sufficient to say that an ethnography "is simply the product of 'being there', whether through participant observation, dialogizing or through mutual negotiation of meanings". He notes that although experiences and understandings may be shared, this is only up to a point, after which researchers will process their experiences in different ways, that is, as *theoretically informed* representations of social life. Unlike their subjects, researchers have the luxury of detaching themselves from the everyday lives they are studying, and consciously reflecting upon and processing these. Thus, to some extent, they create their own representations of 'reality' (Bourdieu 1990), whilst at the same time trying to be as faithful as possible to the representations of the people with whom they work.

The role and practices of the researcher in the research process and in the production of the 'results' or 'text' should, therefore, be made explicit as a "positioned, interacting subject" (Wright & Nelson 1995:50). This includes considering the ways in which the research itself may have entered into the life worlds of the actors it purports to study, and how subsequent interactions may in turn shape the research process. In addition, the recognition of a multiplicity of 'realities' and 'knowledges' necessitates explicit attention to the thorny issue of *whose* interpretations are being represented and how. These are essentially political decisions, and, within research communities, often reflect existing social power structures that define both what is speakable and who is allowed to speak. These considerations are particularly pertinent when undertaking research with marginalised groups such as sex workers who may be in a weak position to resist others' representations. Throughout the ensuing text then I make an explicit effort to situate myself and my practices in relation to the research process and resulting interpretations. This is not always an easy or pleasant task. During the course of research, mistakes are inevitably made and painful or embarrassing incidents occur that we would normally like to forget or gloss over. There are times of lack of judgement and conceptual confusion as well as moments of true sharing and progress. Nonetheless, this is the stuff of which social research is made, and, however painful the process of introspection may be, I believe it is necessary in order to assist the reader to make their own judgements on the finished text.

Defining the Realm of Inquiry

The perspective of research as situated practice raises questions regarding how decisions are made in defining particular domains of study or research questions. If research seeks to try and investigate what particular issues (in this case, for example, 'sexual health' or the SHIP) mean to others in the context of their own epistemological frameworks, a major problem is how to start without having already apriori set the parameters of the investigation? This is essentially a problem of translatability between cultural/conceptual systems for which there is no easy solution (Tambiah 1990, B.Good 1994:chap.4). It is clearly not possible to begin research without having defined at least some areas for initial investigation. These should be kept as open as possible however, and in the course of research, should be subject to an iterative process of review and modification. Good (1994:chap.4) has suggested that the examination of interpretive practices formative of individual life worlds can only be understood and translated in the context of practical activities and engaged sense making, i.e. a comparison of the situated practices through which knowledge is produced and elaborated. Therefore, I proceeded by situating my inquiries on the meanings of sexual health for sex workers, processes of behaviour change and their relationship to the SHIP within two broad conceptual domains (outlined below). For the different topics within the domains I constructed initial checklists to guide my investigations that were then expanded and changed as the research progressed. For example, if I was exploring understandings of health and sickness, I might include in the checklist subjects such as: cultural constructions of illnesses (especially those relevant to biomedical definitions of STDs/HIV); perceptions of contagion; discourses & perceptions of 'risk'; perceptions of the SHIP's health education activities; perceptions and every day practices relating to the maintenance of health (here a large sub-topic might comprise all the issues around safer sex and condom use - the same topic would also, for example, be included in discussions on other topics such as sexuality, gender relations or work).

The first conceptual domain involved documenting and analysing every day life and practices. Here I tried to explore how specific understandings, values and discourses related to sexual health, behaviour change and the SHIP, were constituted and changed through every day practices that were performed by different actors in different contexts. This involved documenting the structure of the sex trade and generally observing the every day lives and interactions of sex workers. More specifically, it involved investigating strategies associated with health, the body, sickness, therapy, family and sexual relationships, work, and the SHIP. It also involved observing the every day practices and interactions of the SHIP.

The second conceptual domain of my inquiry was concerned with exploring the cultural premises on which action is based. This meant trying to explore fundamental issues such as: (a) different actors' understandings of health, the body, sickness (in particular STDs/HIV), therapy, sex, sexuality, work, gender relations, and the SHIP; (b) the social and cultural values underlying social, economic, occupational, family and community structures and practices; and (c) the contexts in which different discourses are embedded and differentially employed by different actors.

The Research: Strategies and Chronology

As noted in the Introduction, my association with women in the Calcutta sex trade dates back to 1993. At this time, at an annual book fair in Calcutta, my husband Jo came across a leaflet distributed by the Sett Bagan *Mahila Sangha* (MS), a sex workers' self-help group that had been formed in the eighties in response to severe harassment of sex workers by local gangs. The group and their remarkable history will be described in more detail in chapter six. Here, it will suffice to say that they had become involved with the SHIP in 1992, and had been encouraged to attend the book fair in order to raise public awareness about the problems faced by sex workers (MS 1993). In their leaflet, written jointly with SHIP staff, they called for practical help. Jo approached them and, in November 1993, began to run a small clinic on a voluntary basis in Sett Bagan on three afternoons per week.

After conducting research in Sett Bagan in 1994, I obtained further funding from the British Economic and Social Science Research Council to pursue a PhD. I became affiliated to the Department of Epidemiology of the All India Institute of Hygiene and Public Health (AIIHPH) who were running the SHIP and who kindly agreed to support the research process. Following a stay in the U.K., I returned to India in September 1995 and spent the next 6 months learning Bengali and organising the research, followed by 12 months of fieldwork in Sett Bagan and Sonagachi (Calcutta's largest redlight area), ending in March 1997.

For the sake of clarity, I have categorised the PhD fieldwork period into 3 phases.

Phase I: Preparation, Trials and Tribulations

This period represents the initial fieldwork phase from September 1995-March 1996 when I was learning Bengali and trying to organise the subsequent research. This was by far the most trying and difficult time of the PhD. I had returned to Calcutta with high hopes of picking up the

threads of the 1994 study, having planned to concentrate upon Sett Bagan, re-establish and deepen my relationship with its residents and conduct a more or less typical ethnographic study relying heavily upon participant observation and living in one of the brothels in which my husband and I had already rented a room in 1994. However, for reasons that I describe in detail in chapter six (on the evolution and response to the SHIP in the locality), I returned to find that local politics had changed dramatically. Hostilities had arisen between the powerful MS leader and the director of the SHIP, both of whose support I required to conduct my research. I was caught in the middle but was reluctant to give up on Sett Bagan and seek out another redlight area because of my long standing connections there. Other MS members and residents in the area had no objections to my presence and I felt I was in a privileged position having already spent many hours building up rapport and establishing relationships with the Sett Bagan sex workers. My introduction into the area had been made easy because of my husband. I was not sure that I could achieve a similar level of rapport and community involvement in a new redlight locality in a context where sex workers were extremely wary of outsiders. As I was supposed to be concentrating upon language learning during this time, I chose to wait and see what happened, having learnt from past experiences in Sett Bagan that community relations could change dramatically and quickly. I visited the area regularly and kept abreast of local developments but did not initiate any 'formal' research.

At the same time, as a contingency plan, I used my affiliation with the AIIHPH (and SHIP) to start visiting another redlight area in a locality called Tollygunge[1]. The SHIP was running a clinic there on 3 days per week and I would visit during this time and spend time with the project's peer educators on their field visits, trying to get to know local residents and introduce the idea of doing research there. However, I could see that full time research there might be difficult. The SHIP clinic, which served as a base for me, was only open on 3 mornings per week. In this area there were no bars or other public spaces in which a researcher would be able to hang out. In Sett Bagan by contrast, the MS had a club room, which also served as a central meeting point for sex workers in the area. I could spend time there as well as in my rented room to meet women if their rooms were in use. As predicted, the situation in Sett Bagan did eventually change radically in early 1996 when the MS leader was 'deposed' by the rest of the group and a new pro-SHIP leadership took over. As a result, the SHIP established a formal presence in the area through employing a large number of local women as peer educators and by using the MS club room as a base for its daily activities. The new MS leaders were supportive

[1] At that time I had not considered working in Sonagachi. This was because I had originally hoped to conduct an in-depth ethnography of a sex worker community that would require reasonable access to sex workers, an area of manageable size, and also a receptive environment. As it happened however, my research plans changed (see below).

of my proposed research and declared they would do all they could to help me. So, after much to-ing and fro-ing, I finally decided to risk being subject to the ebbs and flows of community politics and threw in my lot with the women there.

This episode illustrates how little influence a researcher may actually have over his or her planned research. I had made my plans in England but found myself entirely dependent upon external factors, largely of a political nature, that determined the extent to which I would be able to realise these plans. Although I knew that even the best made plans will be subject to some changes during the course of fieldwork research, it was nonetheless difficult to deal with feeling out of control and dependent upon the whims of others for the progress of my project. I worried whether I would be able to start, let alone complete, my study and felt frustrated that a lot of time had been wasted waiting for the situation in Sett Bagan to resolve. I had constant doubts about whether I was 'doing the right thing' or whether I should perhaps have adopted a different strategy. As will become evident from chapter six however, I now realise that far from representing 'lost' research time, the situation in Sett Bagan can actually be viewed as a fascinating illustration of the dynamics of project implementation at the community level, and although I had felt I was not making progress, I was in fact uniquely positioned to document this process.

As stated above, my original intention had been to conduct an ethnographic study of sex workers' lives and sexual health in just one particular redlight area. Though I knew at the time of planning the research that Sett Bagan was one the SHIP's 'fields' I had not anticipated what a profound influence the project would turn out to have upon the locality. It would have been impossible to continue research there and not to very explicitly include the SHIP as an important actor in local women's lives. Likewise, while the observations I was making regarding project implementation were of interest in terms of general anthropological debates, I felt that they would perhaps be of particular use and relevance to those working in HIV prevention. Hence, my research focus shifted somewhat towards an attempt to draw out the public health implications of the ethnographic material that I was gathering so that I began to consider more centrally, processes of intervention and social change vis a vis current HIV prevention discourse.

After spending the first six months of fieldwork exclusively in Sett Bagan operationalising this expanded focus, it became clear that one could not adequately study the SHIP without considering its activities in Sonagachi, its main centre of operations (Sett Bagan represented a satellite or peripheral project area). In addition, I felt that in order to examine processes of

behaviour change in relation to community and occupational structures and the SHIP, it would be useful and more comprehensive and representative to include more than one locality. Sett Bagan and Sonagachi were physically just next door to each other, but comprised entirely different types of sex markets, community relations and power dynamics. Thus, I decided to continue working in Sett Bagan and to use my relationships there to explore sex workers' lives and social worlds in a general way, but spent the last six months of fieldwork also working in Sonagachi looking more explicitly at project processes in relation to sexual health and behaviour change.

After these initial difficulties concerning the research location and focus, the search for an assistant was another point at which I felt my study was in danger of becoming unstuck. At the start of fieldwork, my Bengali was not yet up to mark and some sex workers from the North Indian States preferred to speak Hindi. I needed a tri-lingual interpreter who would also be able to undertake other small tasks. It proved extraordinarily difficult to find a suitable person who was also willing to work in a redlight area (the 1994 assistant was no longer available). After a number of frustrating false starts, I eventually found Jhuma, a young, married Bengali girl and a feminist, with a somewhat unconventional background as a dancer. She managed to establish an excellent relationship with the sex workers but was only available part-time. By this time, the wait for an assistant had meant that the substantive part of my research had become delayed, so that when I finally started working on a full time basis in Sett Bagan (but with an assistant who was only there half-time) I was already feeling somewhat jaded and concerned about whether I would ever manage to get anything done! Luckily, Jo was often available at odd hours and played a significant role in interpreting and assisting with the research.

Phase II: Research in Sett Bagan

After the MS 'coup' Jhuma and I spent the next six months going daily to Sett Bagan. Jhuma would be with me in the mornings and I would spend the rest of the time there alone, or with Jo who continued to run the local clinic. We began our research activities by holding two community meetings with MS and other community members. Here we took pains to explain that we would be spending time in the area and wanted to find out about women's lives and about the issues that affected their sexual health. We explained that there would be no direct benefit from our research but that we hoped that its findings would eventually contribute to a better understanding of sex workers problems and of their vulnerability to HIV so that appropriate action could be taken for sex workers in the future. We also stressed that complete confidentiality would always be maintained.

Although we always tried to explain our activities, the issue of informed consent and of "what was the research for?" was a constant dilemma. Women had little concept of academia or of what research was, and were far too concerned with getting through each day to have much time for abstract explanations. In spite of our efforts, I felt that many women never quite understood what I was doing. On a number of occasions I heard women telling each other things like: "she is the doctor's wife, she wants to know how we live"; or "she is doing studies on AIDS and has to go back and give an exam so we must help her as much as we can"; or even "she is coming here because she would be lonely all on her own at home"!

Whilst women displayed little interest in my research, I was often asked for practical help and advice - for jobs, help with child care, loans, etc. This contributed to a feeling that I should be doing something more immediately and practically relevant to the women's lives. I was concerned that I getting onto the 'AIDS bandwagon', and not giving anything in return. This is an issue that all researchers must face and resolve in their own way. Jo and I did what we could in a small personal way for particular individuals and for the community as a whole (such as raising money for an extension to the MS club room) but it never seemed enough and I frequently questioned the relevance of my work, particularly in the light of the SHIP which was making remarkable achievements in addressing sex workers' practical and political needs.

I have often been asked about whether it was difficult to gain access to a redlight area and whether it was possible to gain the trust of the women living there. These are important questions that relate to the status of the anthropologist as an 'outsider' and the impact that this 'difference' has upon interactions with, and acceptance in, a community, and, therefore, upon the final research outcomes.

Mine was a somewhat incongruous status. When I had first got to know the women in Sett Bagan, I was just "the doctor's wife" and was warmly welcomed. My husband was a well respected and trusted figure in the community and was respectfully referred as "*dada*" (meaning elder brother). Initially, my credibility and identity were established by virtue of my connection with him. Accordingly, I was referred to and treated as "*boudi*" (elder brother's wife). At that time, most sex workers' interactions with me were related to their health problems or to my conduct as a 'wife' (Evans 1996). When I reappeared in Sett Bagan but this time as a researcher, most people, understandably, simply slotted me back into my 'wifely' role as before, co-operating with my research activities but viewing them with a mixture of bafflement and curiosity. It proved difficult to create a separate identity for myself, and this was also hindered

by the need for Jo's help as interpreter until I became fluent enough in Bengali. Nonetheless, I tried to spend as much time in Sett Bagan as possible alone or with Jhuma and feel I was eventually successful in establishing myself in my own right. My affiliation with the SHIP was both a help and hindrance in this endeavour. Association with the project gave me additional credibility that I believe helped convince women that I was someone who could be trusted. On the other hand, being associated with the project also meant being viewed as politically aligned with it, and its supporters or employees at the community level. This affected my ability to form relationships with women in Sett Bagan who, for whatever reasons, were anti-SHIP or pro- the ousted MS leader.

On the whole however, the community seemed to accept our presence as we 'hung out' at the *chai* stall and club room, played with the children, observed proceedings in the clinic, took part in MS meetings, joined in with community festivals and sought interviews. In time I feel we came to be considered part of the community (albeit an unusual part). In Calcutta neighbourhoods, certain information or activities are considered the domain of insiders only, for the sake of maintaining the area's reputation or status. Sett Bagan was no exception and we were often told that a particular incident was strictly a '*para*' (neighbourhood) matter and should be kept to ourselves.

Nonetheless anthropologists can never escape their 'difference'. As a foreigner, a non-sex worker, a doctor's wife[2] and SHIP-affiliate I had to be aware of the possible effect this might have upon my research. As a foreigner, I was associated with wealth but also with a culture renowned for its 'promiscuity' and free ways. I was often asked how many husbands I had had and whether it was true that sex was a free for all in my country. This perception was possibly an advantage for my work, as I was perhaps not classified as a *'bhodromahila'* (a common Bengali term denoting a 'respectable' middle class woman) in quite the same way that a Bengali doctor's wife would have been. Women resented and ridiculed what they saw as middle class hypocrisy about sex workers yet also subscribed in part to middle class values about women's honour and therefore harboured deep feelings of inferiority and shame that would undoubtedly have affected the extent to which they would discuss matters of sexuality and work to outsiders. This was also an issue with respect to Jhuma. Our only solution for this was to display a genuinely non-judgemental attitude and hope that we would come to be seen as people with whom they could openly express their views. I think we were reasonably successful as, in time, women did seem to feel remarkably free and comfortable with us and our discussions often involved deeply personal matters.

My association with the SHIP might have inhibited discussion that was critical of the project or might have influenced informants to give me 'correct answers' (in the light of the SHIP's health education activities) rather discuss their actual thoughts or practices. It also inevitably meant that the majority of my interactions were with sex workers who were working for the SHIP as peer educators, or with their friends, or with women who were associated with the new pro-SHIP MS leadership. Nonetheless, I did my best to mix with all the residents of the locality and to obtain a range of actors' perspectives on different topics.

Much of the research relied on informal methods - just being there and participating in everyday activities and gossip and interacting with as many different people as possible to reflect the composition and social alignments in Sett Bagan[3]: sex workers; where possible, their clients, and boyfriends or husbands (locally referred to as *babus*); non-sex working women; ex-sex workers; peer educators; non-peer educators; MS members; and non-MS members. Here, our aims were manifold and included developing an understanding of the local community and its sex trade, and of different actor's perspectives of their involvement in them; gaining an understanding of sex workers' lives and concerns; building up a picture of how they constructed their social worlds; exploring sexual-health related matters; and, finally, exploring perspectives on, and responses to, the SHIP. As mentioned above, for each of these domains we had prepared checklists that comprised a range of questions that we wanted to explore. We committed these to memory and, where possible, would guide conversations onto these topics.

We also undertook more structured activities. Jhuma and I interviewed 61 different sex workers, frequently spread out over a number of sittings so that a lot of ground could be covered. Including the women I had interviewed for the 1994 study, this meant that I had had in-depth discussions with approximately 100 women in the locality. These interviews were loosely structured and aimed to elicit life history and reproductive health history narratives and also to obtain specific information on women's backgrounds, social networks, socio-economic circumstances and future plans or aspirations. They also covered sexual health related issues which, where possible, we tried to relate to women's personal relationships as well as to their

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[2] In India, doctors are accorded great respect and usually come from the upper-middle classes.

[3] Some socio-economic and demographic data on the community had been gathered in the course of the 1994 study. We were advised against a comprehensive household survey by community leaders who felt this might engender mistrust in the local population and compromise more central research activities. They also pointed out that, because of the SHIP, the community had come to associate surveys with 'projects' (and, therefore, jobs), and a survey without a resulting project might unfairly raise expectations. However we conducted a mapping exercise with a group of key informants in which each brothel and key features and characteristics of the community and its residents were detailed.

work. I took notes during the interview and expanded them immediately afterwards. Jhuma subsequently reviewed and corrected the draft interview transcripts.

We also spent many mornings on field outreach work with the SHIP peer educators, using them as an introduction to women we did not know well, and subsequently trying to build up relationships with them. We observed the peer educators in their work, looking closely at their interactions and health-related discussions with other sex workers. We also engaged in countless informal group discussions that spontaneously developed during our visits in the field, or that we convened with the peer educators, or with women who were spending time in the MS club room. At these times I did not openly take notes but wrote them up whenever possible during the course of the day. During this time, I also paid visits to other redlight areas in the city to gain a sense of comparison with Sett Bagan, and also visited other sex worker projects run by different organisations in and around Calcutta.

A question that was often raised in relation to my research and its methods was how I would ascertain whether sex workers were telling me the truth or not. Sex workers are understandably extremely wary of divulging personal details to outsiders, including friends and neighbours, having learnt from bitter experience that not everyone can be trusted[4]. Project staff in particular commented that sex workers often lied about their lives and expressed scepticism over my research methods which, some felt, were insufficiently stringent or structured to be able to catch sex workers out when they lied. One project associate in fact repeatedly offered to help me by doing role plays of mock-interviews with sex workers, where he would show me how to ask trick questions. I declined this offer. These concerns stem from a view of research as the empirical search for 'truth'. Of course, it was important that I should be able to obtain accurate data and indeed, I endeavoured to do so, but I felt it was also important to allow women to express *their* points of view and *their* interpretations of events so that I would understand how sex workers themselves constructed and represented their social worlds. In time I felt that I had developed a fairly accurate idea of what 'made sense' or not, and where there were inconsistencies, I would follow these up. The strategy of using different research methods, in different settings, with different actors also provided opportunities for triangulation and cross checking of information.

However people were right to express doubts about women's willingness to divulge personal information in the sense that sex workers were not used to 'formal' research methods and viewed

[4] There have been a number of incidents where journalists or social workers have disclosed a sex workers' identity, leading to ostracism from her social networks.

these with some suspicion. Understandably, women were most comfortable in situations in which they felt in control and which were familiar to them. I found there was an enormous difference in the nature of data obtained depending upon the different contexts of my work. In spite of knowing me well, women appeared anxious and wary when I requested a formal interview, even though they may have spent the entire previous afternoon with me in the club room recounting their life story. The presence of a notepad and pen only served to heighten the sense of formality and occasion (I did not have the time to tape and transcribe each of the sessions and the interviews were often so long and detailed that writing them up afterwards purely from memory was not an option). Sex workers found it hard to understand why I should want to just hear their views and stories and sometimes asked me whether they were saying the 'right' thing. I shared their discomfort in the sense that I also disliked the artificiality of the interview and felt bad at putting women into a situation that they were clearly not completely comfortable with. We did our best to put women at ease however and after a period of initial wariness, our informants usually warmed to the discussion. In spite of these constraints I pursued my interview strategy partly to gather systematic data on certain topics that would have been difficult to obtain opportunistically; partly to create an opportunity for one to one conversation that was also difficult to obtain under normal circumstances; and partly due to my own insecurities and feeling of having to conform to research convention. For the inexperienced researcher, a completed list of interviews is one way of reassuring yourself that something is being accomplished. It is also a way of convincing others who are unsympathetic to, or unfamiliar with, more unstructured anthropological methods that you are engaged in 'proper' research!

In the end Jo and I decided not to move into our room in the brothel, but rather, to use it as a base for daily research activities. We took this decision for a number of reasons. One was out of respect for women's feelings. We discovered that *seeking* to live in a brothel was something that the women in the locality simply could not understand. Many had been forced into, or had reluctantly entered the sex trade and it was simply inconceivable to them that any woman should *choose* to come and live there, and also that any 'decent' husband would allow his wife to do so. In their world view, being associated with the sex trade was one of the worst and most shameful things that could happen to a woman. We felt it would somehow be disrespectful to them and to the pain that they had endured as a result of being sex workers to ignore their views and move in all the same. In addition, both of us felt that it would be important to have some 'time out' from the community. The hot, overcrowded, noisy and bustling North Calcutta streets could be relentlessly intense at times and every day life in Sett Bagan was harsh and often upsetting. We gladly became involved in women's every day lives but this also meant taking on

their woes and witnessing their sufferings and often violence as well. Returning to a different home at the end of each day (often late at night) where we could talk through the day's events helped us gain some perspective and necessary distance on what we were experiencing.

Phase III: Research in Sonagachi

This phase refers to the last 6 months of field work, from September 1996 to March 1997. In Sonagachi, Jhuma and I accompanied the peer educators on their outreach work, initially covering the entire locality, and later concentrating upon 3 areas, which were representative of different sex workers, categorised on the basis of their earning power. These areas also included sex workers from the main ethnic groups found in Sonagachi, specifically, Hindu Bengalis, Muslim Bengalis (from West Bengal and Bangladesh), *Agrawalis* (a community originally from U.P.) and Nepalis.

During our field 'rounds', we would observe and participate in the peer educators' (PEs') discussions with sex workers and other actors (such as madams, pimps, servants, cooks, shop keepers, temple priests, clients, *babus* and house owners). In doing this, we had a number of different aims: firstly, to explore how the SHIP was operationalised at the community level and how its activities were perceived and responded to by different sex trade actors; secondly, to build up an understanding of the Sonagachi sex trade and of sex workers lives in it; and finally, to explore issues such as thoughts/understanding about HIV/STDs, sexual health-related practices and strategies, risk perception, condom use, and attitudes towards the SHIP.

I have estimated that we made contact with approximately 600 sex workers (non-PEs), 192 madams, 10 house owners, 15 babus, 50 customers, 25 local neighbourhood men and club members and 12 pimps including 3 of their leaders. Our conversations varied in depth from a courteous exchange of questions to lengthy narratives and discussions. Where possible we would try to encourage group discussions with the sex workers who shared one room. We did not openly take notes but wrote up our conversations/observations in between visits, joining in with the PEs to look less conspicuous as they busily wrote the field reports that they were required to complete in note books that they carried with them round the field.

Here our research faced different constraints compared with Sett Bagan. The SHIP had been running for 5 years and, in this time had received hundreds of outside visitors to view their work. The community was thus used to receiving strangers (and foreigners) and to being questioned by them. This meant that we were viewed with less suspicion than one might

otherwise have expected, also, because we were associated with the SHIP and, therefore, were endowed with some credibility. However, it also meant that people had, to some extent, learnt what kind of answers outsiders wanted. For example, the PEs would often tell women to make sure they knew the flip chart off by heart so that they would impress the visitors. PEs also, quite naturally, tended to take visitors (and us) to meet women with whom they were friendly and who they knew could speak well. This was unavoidable, but we tried to ensure that we met a more representative selection of residents by purposely going 'off the beaten track'. We instructed the PEs to leave us behind in particular houses and would then try to strike up conversations with women in rooms other than the one we had been taken to. Whenever possible, we would separate ourselves from the PEs and try to do our own thing. Without the PEs' help however, it would have been impossible to gain access into the area, and, in particular, to have been able to talk to other sex trade actors such as pimps.

Another issue to consider was that in the course of our visits, PEs might have making a special effort for our behalf, as they knew we were interested in the way they carried out their work. After some time however, I feel our presence became so 'everyday' that the PEs stopped making an effort and I believe we were able to observe their work as it was routinely carried out.

Nonetheless, because of this prevailing concern to conform to the 'Project Line' it was important to try and explore women's thoughts, understandings and practices around sexual health in a context that was, as far as possible, unrelated to the SHIP. My interactions and observations in Sett Bagan to some extent fulfilled this purpose but I also wanted to create a space where certain issues and questions could be discussed in depth in a group situation to allow for exchange and debate. I had read about an interesting methodology used by a researcher studying women's health in Bombay in which she had convened a series of group discussions but with the *same* group of women, to allow for an on-going dialogue and to try and facilitate a closeness in the group that would enable women to overcome their inhibitions (George 1992, George &Jaiswal 1995). I knew that most sex workers would have neither the time nor the inclination to participate in such an endeavour, so I enlisted a group of 9 PEs to meet together on one morning per week during their work time over 3 months. This was useful, as the women were happy to get out of having to traipse around the field in the heat, had no other chores to attend to, and were thus in a relaxed and expansive frame of mind. The SHIP was not mentioned at all, and the sessions started off with women drawing their pictures of a woman's body which were then used to develop particular themes about the body, sex, sexuality, work, relationships, health, illness and therapy. The groups turned out to be marvellous fora for mutual sharing and exchange of

knowledge, stories, songs, and experiences. These and other group discussions (see below) were taped and then translated and transcribed by Jhuma.

In relation to sexual health and behaviour change, an important issue is obviously condom use and safer sex. I felt that direct questions relating to these subjects were also likely to evoke a perceived 'correct' response rather than tap into women's own discourses. In addition, I was not only interested in whether sex workers used condoms or not. To explore processes of behaviour change meant exploring the *circumstances* of condom use or non-use. I was able to discuss this with women I knew well in Sett Bagan and with PEs but I felt it was also important to explore the strategies employed by non-PEs in the different sex trade environment of Sonagachi. To do this, I decided that rather than talk about safer sex in an abstract or hypothetical way (which is what often happened in the course of our visits), we should try to gather case studies where sex workers could talk about the dynamics of actual encounters with customers the day before. I felt that sex workers would be inhibited talking to me as a stranger, so enlisted a group of PEs who could write to collect these case studies in the course of informal conversations which were written up shortly afterwards. This strategy had mixed success, as, in spite of my efforts to train the PEs, the case studies were generally not as detailed as I had hoped (see chapter eight) but did nonetheless provide some useful insights.

During this research phase I took advantage of having become very close to the PEs who, between them, represented a cross section of Sonagachi and had immense knowledge and experience of the sex trade and of the process of project implementation over the years. I wanted to try and document their perspectives on the project, on its implementation, its components, its successes or failures, and on the community's response to it. I also wanted to find out what being a PE had meant for them personally and how they perceived their role. To this end, Jhuma and I conducted a series of 4 group discussions with different groups of PEs that were immensely rich and detailed and, usually, occasions of great hilarity and mutual teasing.

I also conducted a series of 3 group discussions with SHIP 'supervisors' (social workers who supervised the PEs' field work) and held interviews with other key project staff. These were again designed to explore different individuals' perspectives of the processes and implementation of the SHIP and to obtain their views of its activities and upon their differing roles within it. The interviews included the 3 project doctors in whose clinics I also spent some time observing. In addition, I conducted interviews with 3 local private practitioners to gain a sense of their views on the project and upon sex workers' sexual health. During this time, I also

became involved with the DMSC's work and regularly attended their meetings and public events.

Field work ended officially in March 1997. Around this time I began to inform women during specially arranged meetings in Sett Bagan and also in a number of DMSC/PE meetings that I would no longer be spending every day with them as in the past, but would have to concentrate now upon writing up. Because of my husband, I did not return to the UK immediately however, and, in the initial months of data analysis, I continued to meet my informants quite regularly during various meetings and visits to Sett Bagan to see old friends. Though I was in the UK from May 1997, my husband remained in Calcutta and was able to keep me up to date with events in the SHIP and in Sett Bagan. In November I returned again to Calcutta for a few months, and it was only after March 1998 when we both moved away from the city that I felt I had really 'left the field', though I have maintained contact with the MS, the DMSC and the SHIP director and research staff. For logistical reasons, not least being that work on the thesis became delayed following the birth of my son in 1997, I have not yet been able to share the analysis presented in this thesis with the SHIP staff and my sex worker informants, other than through informal discussions. However, copies of the finished thesis will be sent to the SHIP, the MS and the DMSC, and I plan to return to Calcutta in 2000 and hope then to be able to discuss my work at greater length with the relevant people. This process of feedback should of course ideally have taken place *before* completion of the thesis. Unfortunately this was not possible, but I am nonetheless firmly committed to incorporating any feedback into any subsequent publications or reports that might stem from my work, and to continue to develop this research in an iterative fashion through on-going contact with the women and project staff in Calcutta.

Data Analysis

Documentation

Field notes were expanded and written up using a Word Processor on a daily basis. Data files were constructed that covered different research activities, different topics or events, and different actors. Initial coding was done manually on an on-going basis, with codes recorded and cross referenced in a register to allow for easy retrieval of information on particular issues. These coding categories were changed and refined as the research progressed. I also kept a diary documenting my own activities and subjective reactions to the research process.

Analysis

The analysis comprised 3 stages. Firstly, I conducted a 'conventional' descriptive analysis of the different types of data using a basic classificatory and coding system with which to give the data some kind of initial order. Thus, for example, health practices were documented descriptively (e.g. listing indigenous names for, and ideas about, different illnesses) and common themes were identified. Secondly, after completion of this initial ordering, I re-examined the data and themes to try and tease out different meanings of informants' actions or statements. At the same time, the emerging themes and categories were 'situated' at the micro-level (i.e. I examined the different contexts in which different sorts of strategies/discourses were employed, analysed narratives to interpret their situated meanings in cultural, symbolic and individual terms, and considered the political-economic context and its implications for practice). Finally, I analysed my findings more broadly in relation to wider debates in anthropology, HIV prevention and international health.

Conclusion

In this chapter I have described the design and process of my research strategy. My experiences in Sett Bagan and Sonagachi are elaborated upon in chapter six. However, the description here shows how local events led me, through an iterative process of review and modification, to change the research strategy and focus over time to include the SHIP, intervention processes and also Sonagachi as more explicit research foci. As a result, my work became broader in scope, more specifically engaged with the theories and debates underlying public health strategies for tackling HIV in the developing world, and, I believe, more responsive to the real issues facing sex workers in the light of HIV.

CHAPTER THREE

THE SEX TRADE IN INDIA AND CALCUTTA

Introduction

This chapter begins by presenting a background to the sex industry as a whole in India, and goes on to introduce the city of Calcutta, its redlight areas and the two research sites, Sett Bagan and Sonagachi. The structural, socio-economic and political organisation of the sex trade in these two areas is described, providing essential contextual information on brothel based sex workers' lives and on the social context in which HIV prevention activities have taken place.

The Historical Development of the Sex Trade in India

Sex work has always existed in India and its practitioners have varied from courtesans skilled in the performing arts living in the harems of Hindu and Muslim rulers and noblemen, to dancing girls, to village 'free' women, and *devadasis*[1]. It has been proposed that up to the time of British rule, Indian society did not accord any particular moral attribution to prostitution and that the many different kinds of prostitutes that existed were socially recognised and occupied accepted (albeit restricted) positions in local feudal hierarchies (Joardar 1984, Talwar-Oldenburg 1991, Chatterjee 1992, Banerjee 1998:22). Historians argue that the arrival of British colonialism and the introduction of the capitalist economy in India radically changed the status of all prostitutes in India. The colonial system created a new cadre of sex workers specifically to service the British forces and passed a draconian Contagious Diseases Act (CDA) in 1868. Its aim was to protect colonial forces from sexually transmitted diseases but it had profound social consequences. The CDA meant that for the first time in India sex work was constructed as an appropriate object for regulation under the criminal justice and judicial system, and, under many circumstances, became a crime - codified under the institutionalised colonial mechanisms of control. Moreover, the women comprising the objects of the CDA were constructed as a homogeneous group. The myriad regional, class,

[1] *Devadasi* literally means 'servants of God'. These women form part of a religious tradition in India whereby young children are dedicated by their parents as part of a religious vow to the service of a particular God/Goddess in a temple. The duties of female *Devadasis* traditionally included completing certain rituals, dancing in the temple and, in some cases, providing sexual services to the temple priests or local influential men. This tradition continues in parts of India today, particularly in the Southern state of Karnataka and is now increasingly used as a means of procuring women for the sex industry (Gilada & Thakur 1989, Ramesh 1989, Marglin 1985, UNESCO 1995).

caste, and cultural differences, and performative traditions of practitioners of the trade were ignored and subsumed within a single category - the common prostitute. Chatterjee (1992) sees this as a great cultural violation in which the authorities were able to "push the Indian prostitutes out of history" (p.32). In addition, the CDA served to reinforce the influence of the Victorian moral purity movement within India by creating a moral stigma against sex work. Sex work has remained more or less criminalised and stigmatised ever since.

Sex Work in Contemporary India

The scale of the contemporary Indian sex industry is enormous. One report estimates that approximately one million women are presently involved in sex work with a daily average of approximately four million clients (NCW 1996). This report estimates that the economic activities associated with the sex trade total at least Rs.200 crore per year (over £36 million).

Available information indicates that India's sex industry is by and large a local trade - approximately 94% of sex workers are Indian nationals, 2.6% are from Nepal, 2.7% from Bangladesh and a tiny fraction from other countries (NCW 1996). A recent study (CSWB 1993) estimates that 36.5% are from scheduled castes and tribes, 24.2% from other backward classes and 39% from 'other' groups (figures were not disaggregated further). Many Indian sex workers are women who originally come from poor, underdeveloped rural communities whose economies are in transition following the introduction of capitalist modes of production. They share a common background of poverty and usually lack education and employment skills or opportunities. Many women are 'single' or female heads of households having been deserted, divorced or widowed or must, for other reasons (such as an alcoholic husband) become a family bread-winner. Another common feature is that, for various reasons, many of these women lack access to traditional forms of social support via family or kinship networks. Some women are kidnapped or misled into the trade, whereas for others it is a conscious decision - one of the only avenues open to them to earn sufficient money to support themselves (and often their immediate or more extended families). In certain areas and among certain social groups, sex work has become (or has always been) a customary occupation.

It is known that the women involved in sex work are extremely diverse, however this diversity is rarely reflected in research which has an urban and brothel-based bias[2],[3].

[2] This is in contrast to historical research which details the multiplicity of sex workers' lives in different periods (Bullough 1976, Henriques 1962, Sur 1973, Chatterjee 1992, Talwar-Oldenburg 1991, see also Raghuramaiah 1991).

Likewise, although the Indian sex trade often evokes images of seedy, mafia controlled redlight areas like those in cities such as Bombay (and also Calcutta), where women live and work in inhuman and exploitative conditions, perhaps the majority of India's sex workers do business in a less organised, less controlled and more informal manner (for instance in hotels, in scattered brothels, on the street, in massage parlours, along highways, at village markets and fairs, and, sometimes, in the home). In these instances, the sex trade is widely dispersed and diffuse. Some sex workers may operate relatively independently, but most must negotiate their work through complex and locally varied networks of power brokers who help to procure clients and may manage certain aspects of their work (such as providing a room and other services such as food, or handling relationships with police).

The sex trade forms part of India's unorganised economic sector, characterised by casual unprotected income and absence of employment rights. Even in the large redlight areas, the sex trade tends to operate as a conglomeration of many small-scale businesses or is run on an individual basis. Workers in the sex industry tend to be highly mobile, moving between different sex trade establishments and localities.

Regulation of the sex trade in India is by means of a 1986 'Immoral Traffic in Persons Prevention Act' (referred to as 'PITA'). This act represents the previously described 'toleration' approach to the sex industry. It is ostensibly designed to criminalise and prevent the exploitative activities associated with prostitution (keeping a brothel, procuring women, having sex with minors etc.) without interfering with a woman's right over her own body and, therefore, right to sell sex. Under India's 'PITA' a woman is allowed to sell sex as long as it takes place in private, away from any 'public' area (thereby maintaining a veneer of public morality). Soliciting on the streets therefore is illegal. However, the act also makes it illegal for any third parties (such as brokers or madams) to be involved in, or benefit from, commercial sex. This results in the rather bizarre situation where a woman can sell sex but finds it virtually impossible to legally engage in any activities to procure business. Even remitting money home is illegal (for those receiving the money). Inevitably sex workers must break the law and sex work is, in effect, criminalised. Clients are not offenders under the PITA although other trade-influencers are, and there are particularly strict penalties for trafficking or keeping minors. The criminalised nature of the sex trade results in women

[3] See for example, Sleightholme and Sinha 1996, CSWB 1992, NCW 1996, All Bengal Women's Union 1989, Pillai 1982, Punekar & Rao 1962, D'Cunha 1990, Bandyopadhyay 1983, Joardar 1984, Bhattacharya and Senepathi 1994, Dasgupta 1990, Choudhury 1989, AIIHPH 1992, Vivekananda Education Society 1994, CAN 1993, 1995, Kumaramangalam 1993, Gram Bharati Samiti 1994.

having to depend upon third parties for protection and becoming embroiled in a range of underworld activities and networks. Some clauses in the Act also effectively deny sex workers their fundamental rights - for example, the right to security of tenure. Clauses that make it illegal to rent a property for the purpose of sex work mean that sex workers can be evicted by a magistrate at short notice. Many sex workers are also denied official tenancy agreements by their landlords who do not want any documentary evidence of their collusion in the sex trade. They are therefore constantly at risk of rent increases and eviction.

Although the act was designed to protect sex workers from exploitative third parties, and does make provisions for the 'rescue' and 'rehabilitation' of women, especially minors, in practice it is differentially implemented. Studies in Bombay and Calcutta have shown that the vast majority of arrests are of sex workers rather than trade-controllers (D'Cunha 1990). An additional problem is that most arrests of sex workers are never made using PITA (which carries with it many administrative formalities and supposedly in-built protection of sex workers' rights) but are made using the 'public nuisance' clause of the Indian Penal Code. Whichever is used, the legal system can easily be manipulated (at a price) to return local sex networks to their status quo. In fact, police reportedly vie with each other for postings to areas where a lot of commercial sex takes place as these represent rich pickings in the form of bribes. The present ambiguous legal status of the sex trade also benefits local politicians and mafia dons who offer 'protection' in return for votes or other forms of support.

Most studies on Indian sex workers and publications from sex workers' rights organisations like the Calcutta DMSC, report that the most pressing concerns of sex workers revolve around their legal and social status, such as the lack of social and legal recognition of their profession; financial and occupational insecurity; social stigma; discriminatory treatment by the criminal justice and health care systems; and, lack of basic civil rights such as education for their children (until recently schools would refuse admission to children who could not give a father's name) - see GBS 1995, DMSC 1995a&b, 1996a&b, 1997, 1998.

Calcutta

Calcutta was established on the banks of the Hooghly river approximately three hundred years ago by the British East India company and subsequently became the Capital of British India . Today it is a city of almost 11 million, swelled by waves of migrant labour and refugees from West Bengal's rural hinterland, and also from Bangladesh following Partition and the 1971 war with Pakistan. The city has had a tumultuous history, and is best known for its extreme

poverty, its cultural and artistic heritage and also, for its politics (Chatterjee N 1990, Chatterjee P 1990, Bandyopadhyay 1990). Below, I briefly outline Calcutta's 'political culture' as it is of particular relevance subsequently for understanding the organisational structure and culture of the redlight areas, of the SHIP, and of the way in which Calcutta sex workers' became organised as a result of the SHIP's intervention.

Though Bengal has a long history of rural peasant uprisings and protest, organised politics developed in the State along with the nationalist movement of the Congress who, in the 1920s and 1930s, initiated new methods and structures of mass mobilisation by working through local newspapers, publishing houses, local athletic clubs, cultural organisations, schools, colleges, puja committees and social work organisations. The entwinement of everyday community structures with organised politics has remained a feature of West Bengal to the present day (Chatterjee P. 1990), and has a profound influence upon the nature of community power relations (which I will discuss further below in relation to the city's redlight areas). Since Independence in 1947, the political Left in West Bengal, supported by an educated middle class, became increasingly influential and developed new mechanisms of broad based protest such as mass demonstrations and general strikes. Following a brutally suppressed Maoist peasant uprising in the North of the State (in which many of Calcutta's students and intelligentsia participated), the Communist Party of India-Marxist (CPI-M) came to power as leader of a Left-Front Coalition in 1977 and has enjoyed a 23 year uninterrupted rule. Whilst the activities of the opposition Congress party have been hindered by factional in-fighting, the CPI-M party machinery has become thoroughly established throughout the State, particularly through its (elected) control of the majority of rural Panchayats and its policy of mass political consciousness raising (Mallick 1993, Beck 1994). Since Partition, West Bengal, unlike other states, has been relatively free of communal conflict, as also of inter-caste politics. Rather, as a result of the CPI-M's long influence, the dominant mode of protest and political mobilisation in the State has been conducted through the Marxist idiom of class oppression and pursuit of workers' rights (Chatterjee P. 1990).

Calcutta's Redlight Areas

In the eighteenth and nineteenth centuries, as Calcutta developed into an urban centre, a flourishing sex trade also sprang up around its main centres of trade and commerce, patronised by the city's large numbers of male migrants labourers, as well as the Bengali elite class (*bhodrolok*) for whom it was a matter of prestige to have one or more mistresses. Relatively little is known about the lives of sex workers prior to Indian Independence. Some

gained prominence and were able to publicly voice their views on sex work through their involvement in a theatre movement in the mid-19th century, but sex work was, as today, unorganised, and women lacked political representation or forms of collective organisation (Banerjee 1998). In the early 20th century there are some reports of sex workers trying to participate in mainstream life through engaging publicly in charitable activities to raise money for victims of natural disasters. Some also joined the Nationalist movement and placed themselves at personal risk by sheltering nationalists hunted by the British, but their efforts were generally not recognised by the upper class Indian elite - even Gandhi is said to have refused a meeting with one group of sex workers until they had 'reformed' themselves. There is one interesting report of courtesans forming a professional association which organised community pujas and a range of self-help measures (such as credit) but little else is known about their activities (Engels 1996:97).

As in other parts of India, the contemporary sex trade in Calcutta is extremely diverse. Most visible however are the city's redlight areas of which there are 18, including 3 that are located on the other side of the Hooghly river in the district of Howrah. These all come under the purview of the SHIP. Approximately 17,800 women are estimated in work in these areas, of which 12,800 actually live there whereas 5,000 commute on a daily basis – locally referred to as 'flyers' (AIIHPH 1993a).

Survey results (which are difficult to interpret as surveys were done in different places and are not necessarily representative of all sex workers) indicate that the majority (at least two thirds, probably more) of women in Calcutta's brothels are from West Bengal, and are mainly Hindus of lower and intermediate castes. The rest are from Nepal (approximately 1.4%), Bangladesh (approximately 11%) and other Indian states (Dasgupta 1990). The Nepali girls are mainly found in the larger redlight areas such as Sonagachi and they and Bangladeshi girls are often brought in through formal and informal procurement networks. One large group (estimated at 6.8%) from outside West Bengal are Hindu women originally from U.P. known as *Agrawalis* who are mainly found in Sonagachi.

Research conducted in the redlight areas by the AIIHPH (1992) found that there are significant differences in economic status between sex workers. They therefore categorised women into 3 different economic groups - A, B or C. This assessment was made according to amenities that women are able to afford and the fees able to be charged for a single sexual encounter, referred to locally as '*shot*' (which usually implies straightforward vaginal intercourse lasting perhaps 15 minutes). In 1992, 'A' category sex workers charged over

Rs.100 per *shot*, 'B' category sex workers charged between Rs.50-100, and 'C' category sex workers charged less than Rs.50. My own data suggest that charges have varied little in the intervening years. The high-charging sex workers are mainly found in Sonagachi, whereas the majority of women in other areas fall into the 'B' or 'C' category, - the latter, especially in the smaller areas where women are generally older and are reaching the end of their career-span.

The redlight areas are found in all parts of the city, but the largest and oldest conglomeration of these localities is in North Calcutta, around the city's oldest thoroughfare, Chitpur Road (also known as *Rabindra Sarani*). This is one of the busiest parts of Calcutta. Via the Hooghly bridge, this road connects major trade routes coming in from Howrah's industrial belt and other districts to Calcutta's largest wholesale market (*Burrabazaar*) and to other parts of the city and State. An immense variety of shops, temples, businesses, small scale factories and warehouses are found in the Chitpur area. Equally various are the different communities who have made their home here. Bengali Hindus, Muslims, Chinese, Tibetans, Armenians, Marwaris and families from Bihar and other North Indian States have traditionally, and still, rub shoulders in this area. The latter were previously migrants but many have now settled in the city. This is also one of the most chaotic parts of the city with an enormous amount of human and vehicular traffic trying to heave its way down the old and still cobbled Chitpur road on a daily basis. During the monsoon season when black sludgy water runs thigh-deep and when shoppers, workers, rickshaw pullers, trucks, cars, trams, cows and taxis all vie to get through the flooded streets somehow, the situation verges on the anarchic. The opportunities for casual labour that the area's trade and commerce offers attracts large numbers of migrant labour, and also some of Calcutta's poorest residents. There are many families living on the pavements or in dreadfully overcrowded conditions in the many slums or along the railway tracks.

Joining the Chitpur road is a labyrinth of much smaller, but equally old and crowded streets. Hundreds of tiny narrow lanes (locally called 'gullies') run east and west of this road, branch, and connect up with each other through even more tiny alleyways. These back streets are mainly lined by old multi-storied tenement buildings, some of which were clearly very grand in their day, but are now suffering from lack of upkeep. Many buildings have been more or less taken over by sitting tenants who are too poor to carry out any maintenance work. Any spare space along the streets has been taken over and turned into slum settlements. As a result, an aura of faded grandeur and contemporary decay pervades this part of the city.

It is in this area that Sonagachi and Sett Bagan, the two research sites, are located. The centrality of the area and its connection with trade, commerce, and, therefore, with mobile male populations makes it a logical site for the development of a sex market. Sonagachi is the city's oldest, largest and most famous redlight area and Sett Bagan, a dingy little lane that forms one of Sonagachi's off-shoots, lead directly off from the northern part of the Chitpur road and ultimately connect together through a tortuous network of gullies. Sonagachi is a thriving sex market representing the full gamut of different sex work systems, structures and actors. Sett Bagan by contrast is a small locality where sex workers tend to be older, poorer and more homogeneous in social background. The two areas are described below. First however, it is necessary to point out that the sex trade in Calcutta has its own *lingua franca* and it may be useful to describe briefly some of the main terms that crop up.

The word *babu* refers to a sex worker's lover/boyfriend and is also used to refer to the man a sex worker considers as her husband. The term originated in British India to describe a section of the Bengali *bhodrolok* (genteel/professional class) who aspired to emulate a decadent European life style. Part of this lifestyle involved patronising high class courtesans on whom they spent lavishly. The term *babu* has remained part of the sex trade patois with the specific meaning of someone who has a mistress there, although in every day usage in Bengal it refers generally to a respected male person. To have sex with a customer is often referred to as 'sitting', using the causative verb *boshano* i.e. "the customer sat with me" or, "I was made to sit ten men that day". Another way of describing sex (which is common all over India) is to refer to it as 'work' (*kaj*). Also common are various usages of the English word 'line' (as in being in a particular line of work). Women refer to themselves as *line-er meye* (girls of the line) and talk of themselves as doing 'line work', as being 'in the line', or as 'standing in the 'line' (when they are soliciting). Redlight areas are sometimes referred to as *line-para* ('line' neighbourhood) or as '*niseddho pulli*' – a prohibited place. It should also be noted that sex workers (regardless of age) are usually referred to (and refer to themselves as) '*meye*' (girls) and that this does not appear to be perceived as derogatory. Hence, I have also followed existing social convention and sometimes refer to sex workers as 'girls'.

Sonagachi

Sonagachi has approximately 4,000 resident sex workers and 1,500 'flyers' (AIIHPH 1997). Though research on the latter is lacking, these are often married women who live outside the redlight localities and commute into these areas to do sex work. Their families are often unaware of their involvement in the sex trade. The number of sex workers in Sonagachi is

subject to great seasonal variation however. In addition to sex workers, many other people live in the area, some of whom are directly associated with the sex industry (such as sex workers' families, ex-sex workers, madams and pimps) and some that are not – so called *grihastha* (family) households. The total population of the area is at least 20,000.

Sonagachi is a thriving sex market and has the atmosphere of a typical bazaar. Young girls and women line the streets gaudily made up and dressed in the latest fashions adopted from Hindi movies and MTV. Approximately 20,000 men come to the area as clients each day and throng the streets and numerous drinking outlets. Business is conducted at all hours and takes place side by side with other daily activities. It is a large and self-contained area consisting of 7 different streets and lanes[4]. The streets are lined with food and tea stalls and even fish, fruit and vegetable markets. There is a mosque and a highly popular *Sitala* temple.

The tenement buildings that line Sonagachi's streets are up to 5 storeys high with tiny, stiflingly hot make-shift rooms found even on the roof. Inside the houses, on each floor there are a number of rooms, each of which may be an independent brothel. Thus one house may contain many separate sex work establishments. Some buildings for example may contain at least 25 rooms that may be different brothels with over 100 sex workers and their associates living there. Other buildings may operate as a single brothel. The AIIHPH (1997) has estimated that there are 370 brothels in the locality. Living conditions vary considerably. In some houses as many as 13 sex workers are packed into one room, whereas in the more exclusive 'A' category houses, each sex worker has her own room. In rooms that are shared, there are usually a number of wooden cots that are partitioned off with curtains. Women take it in turns to use these cots and it is not uncommon to see queues of sex workers waiting with their customers for a cot to become free. At night, women share the cots and the floor with each other or with 'night customers'. Some rooms are barely larger than a cupboard and lack all amenities, whereas others, especially in the 'A' houses, can be spacious and may even have a fridge, telephone and air conditioner.

The buildings in Sonagachi and other redlight areas are owned by *bariwali* or *bariwala* (landladies/lords). These are sometimes referred to as *'Ma'* or *'Baba'* and are extremely powerful and well-connected people. In some cases they can exert tremendous influence over

[4] In the SHIP's work, they have included other smaller redlight areas located in the Chitpur area under the name 'Sonagachi'. They have thus categorised Sonagachi as comprising 11 different streets/areas. This includes Sett Bagan for instance, and other areas called Ram Bagan, Jora Bagan and some houses on Chitpur Road and Jatindra Mohan Avenue. However for the purpose of my research, I consider these other areas to be separate as they lie outside the main conglomeration of 7 streets that make up the central Sonagachi area, and they all have slightly different social and occupational structures.

their tenants, for example, even determining who they should vote for and what position they should take in local community disputes. House owners make huge profits from the sex trade. There is a shortage of rooms and rents are vastly inflated, varying from Rs.300 per month to above Rs.3,000[5]. In addition, upon taking up a room, tenants must also pay a large non-returnable deposit referred to as *salaami* which varies from Rs.30,000 to 100,000! Rooms are rented by individual, independently working sex workers or, more usually, by madams (*malkins*). Virtually all houses have access to electricity, the charges for which are set by the house owners, again at highly inflated rates.

The sex workers in Sonagachi are extremely heterogeneous. According to a study by AIIHPH (1993a) approximately 20% of sex workers fall into the 'A' category, approximately 45% are 'B' category and the remaining 35% are 'C' category (though overlap of categories often occurs, for example, a 'C' grade sex worker may occasionally receive a larger than usual fee for her services). Many 'A' category women adhere to a kind of *purdah* system and do not solicit on the streets. They thereby create a sense of exclusivity and are introduced to clients via pimps.

The majority of sex workers are Bengali Hindus, but women from almost every state in India can be found in Sonagachi's streets. Indeed, the main social differentiation made by sex workers themselves about each other is on the basis of ethnic/regional identity. A study of 400 sex workers by AIIHPH (1992) found that 12% were from Bangladesh. Two other groups predominate in the area – the Nepalis and Hindu women from U.P. – the so-called *Agrawalis*. Unfortunately there are no reliable figures as to the numbers of sex workers in these groups but they form a substantial minority. In the AIIHPH (1992) study 12% were Nepalis and 2% were *Agrawalis*. This latter figure is almost certainly likely to be an under-estimate however as another study by CSWB (1992) estimated at least 536 (13%) and I was told by SHIP supervisors that there are up to 1,000 women (25%) from this community.

There is considerable rivalry and, indeed, hostility, between the majority Bengalis (including the Bangladeshis) and the Nepalis and *Agrawalis* – and also the flyers. This has implications with respect to the response to, and acceptance of, activities of the SHIP whose staff and peer educators are overwhelmingly Bengali. This issue will be discussed in more detail later; however it should be noted that none of the studies conducted by the SHIP (for example on condom use) have disaggregated their figures along ethnic/community lines or according to

[5] That rents are highly inflated is obvious when one compares prices from non-redlight areas where it is possible to rent reasonable flats, let alone rooms in middle class neighbourhoods for the same amount (Rs.3,000/m).

whether the sex worker is residential or a flyer. It is therefore impossible to assess whether (and to what extent) differences in social, occupational and community structures might affect sexual health status. However, there is some evidence (anecdotal and from my research) to suggest that the dynamics of their vulnerability to HIV/STD are different.

There are a number of reasons for the rivalry that exists between the different groups in Sonagachi. The 'flyers' are resented as additional competition and they are sometimes referred to as *be-para meye* (girls from outside the neighbourhood). There is also bitterness as, in contrast to women living in the redlight areas, they are assumed to be able to live a supposed 'respectable' and 'normal' life in a 'respectable' neighbourhood and are believed not to be socially ostracised for being sex workers. There is also a feeling that 'flyers' undercut residential women and will "do anything with anyone for any price", thus undermining business generally. In reality though, flyers face similar economic and family difficulties that propel them into sex work. They must constantly deal with the stress of maintaining a façade of normality at home and live in fear of being found out. In addition, as they usually only work day time hours (not the peak time for sex work), it is difficult for them to earn well, hence they are forced to lower prices and provide services that are usually avoided (e.g. oral/anal sex).

The Nepalis are resented for similar reasons. Bengali sex workers describe them as 'dirty' – again, willing to 'do' anything, at less than normal market rates and without a condom. Their numbers are said to be increasing and there is a feeling that they present a considerable threat to business:

> These Nepalis stand outside all day, right from the early morning till late at night, and whatever the customer wants them to do, they do – if the customer say 'fly to the sky', they will do it. We Bengalis cannot do this. This is why business for the Bengalis is very bad these days (Bengali sex worker).

These observations are related to the conditions under which Nepali girls become involved in the Indian sex trade. Many are brought into Sonagachi through organised trafficking networks, where families may be complicitous. In some parts of Nepal for example, families reportedly enter into a contract with a broker who assures them of a fixed annual income from their daughter's earnings for a specified number of years. Girls are then sold into the sex trade and, after payment of the family (which is comparatively little) all profit from her earnings go to the broker, madam and others involved in the network. When the contract period is over, the girl usually decides to continue working to support her family. Nepali girls come under great pressure to earn because madams want to maximise their income during the contract

time. They are allowed little time off, and little autonomy in determining the nature of their sexual encounters. The pressure may also be self-imposed. In contrast to Bengali sex workers who tend to see themselves as more or less permanently ostracised from society, and who often spend their entire lives associated with the sex trade, Nepalis may see themselves more as temporary migrants, and therefore try to amass as much as possible in a short time to enable them to return home and resume their lives there.

Within the Calcutta sex trade therefore, Nepalis in particular but also flyers have a rather low status and are stigmatised in a manner that is characteristic of the experience of migrant workers in other contexts (Day 1993).

The *Agrawalis* are an extremely closed community whose female members practise sex work as a customary occupation. It is difficult to obtain any information about their social organisation. There are however widespread and well known stereotypes about the community which are recounted below but should be treated with caution. Some say that they are descendants of courtesans who migrated to Calcutta with the decline of the Moghul Empire and who accompanied various rulers and noblemen to Calcutta when they were exiled there by the British (Chatterjee 1992, D. Bose, pers comm). Other reports claim that *Agrawalis* hail from the *Beria* community of Agra who are said to be traditional traffickers.

Sex work within this community is organised through networks of relatives and it is common to find sisters and cousins as sex workers and aunts and mothers as madams and landladies. Local people say that the community puts their own daughters into the sex trade following an apprenticeship period. This practice is apparently changing now though as the girls are becoming reluctant to be sex workers and the community is said to be increasingly turning to trafficking to procure young girls from U.P. *Agrawali* sex workers speak Hindi and almost all are considered 'A' category. The girls are generally well educated, well dressed and their fair looks enables them to command high fees. In this community, sex work still has a performative dimension and dance shows for groups of men are common. *Agrawali* sex workers are apparently discouraged from keeping *babus* (much like traditional courtesans – see Talwar-Oldenburg 1991) who might pose a threat to the unity of the community and may siphon off their mistresses' earnings. Only those *babus* who pay their sex worker-mistresses large sums of money are allowed.

Agrawalis are now an exceedingly wealthy community in Sonagachi. Over time, many have become landlords/ladies and are thus highly influential in the area. The practice of keeping

sex work in the family enables earnings to be concentrated and re-invested into the sex trade and there are fears among the Bengalis that they are gradually taking over Sonagachi. They are therefore considered a threat and there is also envy at their wealth and earning power:

> For these *Agrawalis* money is their God – they are not like us – they have no love – they just make money and save it and buy houses. Even with *babus*, as long as they can give, they keep them but if they can't give, they let them go immediately. We Bengalis are different – we have more *maya* (compassion/affection). When we take a husband we keep him whether he gives or not – he is our husband. *Agrawalis* do not have this sort of *izzat* (honour). Their love is money – how else could they spoil their daughters by making them do this dirty work? (Bengali sex worker in Sonagachi)

Sonagachi's social divisions are spatially reflected to some extent. Two streets consist almost entirely of 'A' category houses. These streets are wider and the buildings much better maintained than in the 3 streets where mainly 'C' category women work. These are narrow, the buildings decrepit and the rooms small and dank. The remaining four streets comprise a mixture of sex worker categories and types of buildings. The Nepali and *Agrawali* communities are concentrated into particular houses and there is little mixing between social groups.

Sett Bagan

Sett Bagan comprises a narrow, dank 'gully', perhaps seven feet wide, lined on either side by crumbling tenement buildings with a rambling slum settlement area at the end of the lane. Though connected by small gullies to Sonagachi, it is considered a distinct neighbourhood (*para*). Sex workers stand or sit on little wooden stools along the Lane and at its entrance to Chitpur Road. In the Lane are also a *Shiv* temple, various food and *chai* stalls, liquor outlets, and some small-scale factories.

The neighbourhood is a 'mixed' area, comprising approximately 2,200 residents - sex workers, their children and *babus* and also other *grihastha* families. Some *grihastha* families are descendants of erstwhile sex workers but are no longer directly involved with sex work. Others are involved with the ancillary businesses that service the sex trade (e.g. selling liquor).

Rents for *grihastha* households are lower than for sex workers, though accommodation here generally is significantly cheaper than in Sonagachi. Rooms for sex workers vary between Rs.100-700 per month and *salaami* from Rs.5,000-20,000. As in Sonagachi, sex workers and *grihastha* live in single rooms. These are generally small, dingy and badly maintained but residents do their best to make them feel like home. They usually comprise a bed raised high

up from the ground, underneath which are kept a variety of household items such as cooking vessels, buckets, trunks etc. There may be a cupboard and a television or tape recorder. Shelves running around the tops of the rooms are crammed with personal possessions. The walls are usually adorned with garlanded and brightly coloured pictures of Hindu gods and goddesses, and with photos and other decorations. Cooking takes place in the rooms or outside on the landings. Each landing usually has a latrine, though there is often a small drain in the corner of the rooms in which people also urinate. Drinking water must be fetched from standpipes out in the Lane. Most houses have a secluded communal bath area where there may be a tap and water tank. This area is also used for washing clothes.

Due to the cramped living conditions, social life plays itself out in the lane which is a chaotic mix of children playing cricket, sex workers soliciting, drunk customers swaying home, vendors plying their wares and other families trying to go about their daily business. During the monsoon the Lane floods to become a knee-deep sea of murky water and sex workers stand bedraggled in the rain and the mud, huddled under umbrellas for protection.

In Sett Bagan there are approximately 230 sex workers, and 770 members of sex worker households. Some houses in the Lane are solely occupied by sex workers or *grihastha*, whereas others are mixed. Though they live side by side, there is relatively little close social interaction between the sex workers and *grihastha* families. With a few exceptions, the latter tend to look down upon the sex workers and see their own situation of having to live in a 'bad' (or 'dirty') area as highly unfortunate.

The majority of sex workers in Sett Bagan are in the 'C' category, are Hindu, come from West Bengal and are over 25 years old. Over two thirds of the sex workers have children and almost all are in a relationship with a *babu*.

The existence of the sex workers' organisation, the *Mahila Sangha* (MS), makes Sett Bagan rather unique in Calcutta. This group has been intimately involved with the SHIP's activities right from the SHIP's inception in 1992 and is now considered one of the SHIP's partner organisations (along with the more recent, but much larger DMSC). More details of the MS, its structure and activities, and the history of Sett Bagan are given in chapter six.

In the late 1980's a powerful faction in the Lane pushed through a decision banning anyone in Sett Bagan from keeping girls (this incident is described in more detail in chapter six). Thus, there are no 'madams' in Sett Bagan and all sex workers live and work relatively

independently. This means that there are fewer sex workers in Sett Bagan and, in theory therefore, less competition. However, it also means that the women there are older and are now beginning to reach the end stages of their 'careers'. With no young, fresh girls to attract customers, business is generally said to have become very poor in the area. For some sex workers in the Lane it is not uncommon for days to pass without having any customers. Some take their knitting outside with them to relieve the monotony of fruitless soliciting. Others take to 'grabbing' at any men who happen to pass by. Sett Bagan is now a redlight area in decline and some residents feel that it is only a matter of time before the entire neighbourhood becomes a *grihastha para.*

Sex Trade Actors, Systems and Structures

There are three main ways in which sex work is organised in Sonagachi and other redlight areas (though each area has minor variations): -(i) madam-controlled, (ii) independent, or (iii) madam and pimp controlled. In Sonagachi, approximately 90% of sex workers are estimated to work under madams (AIIHPH 1993a), whereas none do in Sett Bagan.

Madams and Sex Work

In madam-controlled sex work, there are 2 variations - *chukri* and *adhia*. *Chukri* refers to very young girls who are kept more or less as bonded labourers. A *chukri* is sold to a madam who retains all her earnings until she has paid off her purchasing price, after which the madam is then supposed to share the income. In practice this rarely happens and a girl may have repaid her debt several times over before she is able to move on. Many sex workers report having started their sex work careers as *chukri* and the *Agrawalis* in particular are said to keep *chukris*. It is not clear how many *chukris* work in Sonagachi. As many are under-age, madams are extremely secretive about these girls. *Chukris* have little personal autonomy - their movements are strictly monitored and they are dependent upon the madam for everything. Many sex workers report being mistreated during their time as *chukris* as this is the time when they must adjust to the sex trade and when they may try to protest or rebel. Madams treat them harshly, apparently with the intent to break their spirit and instil in them a sense of being irrevocably spoilt, as described below:

> On reaching the city I was sold to a madam in Sonagachi. I cried and refused to do work. She beat me terribly until I could tolerate it no more. I asked her 'why have you done this to me?' – she just said that you have been sold and now you have to make up the money I have spent on you'. My name was Renu but she said that 'from today onwards you will be called Durga'. I protested and swore that I would never give up my father's name, but she said 'you have become a prostitute, old names will not do'. She

> made me cut my hair so that it hung across the side – I could not think of showing myself in my village like this. I wept bitterly and all she said was 'you have become spoilt and once you are in the Line, even if you are washed in gold water you will always remain black" (Sonagachi *adhia*).

Chukris eventually move on to become *adhias* or independent workers. They may do this with the help of other sex workers who enlighten them about their options and may help them to put pressure on the madam to pay them their dues. Alternatively, they may get together with a *babu* or a kindly customer who may help them to find another room and escape.

Adhias form perhaps the largest group of sex workers. These are women who work for a particular madam who receives 50% of their earnings[6]. Some may have previously been *chukris* whereas others start off their career in this way. Some madams may keep just one *adhia* whereas others will keep many (depending upon the number of rooms they can afford to rent and upon their ability to manage large numbers of women).

The madam's role is various. In one sense, she acts as a business manager providing important support to a sex worker for dealing with customers and other local power brokers such as the police. She is usually older and highly experienced and can handle difficult situations with far more expertise than most ordinary sex workers. In times of trouble, such as sickness or when arrested, it is often the madam who takes control and provides assistance:

> I have to stand behind these girls. I have to deal with any problems – if there is trouble with the local boys or with the police or with a customer, I have to go and sort it out. If they get sick, I have to take them to the doctor (Sonagachi madam).

However, it is frequently the case that madams exploit their position and capitalise upon a sex workers' dependence to extract as much profit from her as possible.

> Madams, they know this is not my daughter so how does it matter what happens to her – they treat her as something detestable (peer educator).

In reality, madams usually call the shots, dictating everything from working hours to choice of medical treatment, and sex workers have few rights within the relationship. The only way *adhias* can object to an arrangement with a madam is to leave, but this is not always feasible as they may be indebted to the madam, or may be reluctant to face the insecurity of trying to find somewhere new, especially if they have children or fixed customers who will then not know where to find them. Only where madams are poor and are themselves dependent upon their *adhias* to survive do *adhias* have more control.

Independent Sex Work

Other sex workers (approximately 10% of Sonagachi girls and all those in Sett Bagan) rent their own rooms, work relatively independently and keep their own earnings. Most women aim to be able to work independently but, in order to do so, need to have saved enough for a *salaami* for a room. In addition, simply finding a room is difficult, and requires social connections in different redlight areas. In some cases, customers or *babus* assist women to become independent.

In Sonagachi, a 'contract' system also prevails in which rooms are sub-let to sex workers on a daily contract basis at very high rates (from Rs.60-100/day). These women can work independently but since they are not tenants, they are always vulnerable to eviction if they cannot pay the rent for more than a few days and live in a perpetual state of insecurity. Nevertheless, some sex workers say they prefer this to the restrictive life of an *adhia*, especially if they have a *babu*. Many disputes with madams arise over *babus* as the time a sex worker spends with him is time that is not spent earning and they are required to financially compensate their madams for this.

The Role of Pimps

In contrast to the European system where pimps often directly control the trade and particular women, in Sonagachi they are associated with the higher class ('A' grade) sex workers (especially *Agrawalis*) who, for prestige reasons, do not stand and solicit on the streets. There are no pimps in Sett Bagan.

Pimps are called *dalal* which literally means 'middleman'. They receive 25% of the agreed price and the remainder is split 50/50 between the sex worker and madam. In Sonagachi, approximately 300 pimps operate in well organised groups, each covering specific portions of the locality. The groups have a leader (*mukhiya*) and operate a *panchayat* system which sets trade rules, takes disciplinary action and may also provide welfare services for members.

Pimps are reportedly not particularly influential in local politics but can wield considerable influence over sex workers' business. If a sex worker has a dispute with a pimp or group of

[6] The term "*Adhia*" (which is a variation of the Bengali word 'half' - *adh*) is a derivation of an agricultural term denoting a share cropping arrangement in which half the produce is given to the leaseholder and half is retained by

pimps, they may be less inclined to bring her custom and can even decide to metaphorically 'lock' a sex workers' room or the entire house. They will no longer bring her (or the other girls) any customers until the dispute is sorted out which may require payment of a fine to the *panchayat*. Sex workers are therefore obliged to maintain good relations with the pimps.

Ancillary Actors and Services

Apart from the primary actors (sex workers, house owners, madams and pimps) and the primary economic relationships that their activities involve, the sex trade also involves many secondary actors and generates a vast indirect informal economy. This revolves around the ancillary services that primary actors rely upon to meet their day to day needs. For example, there are women (often ex-sex workers) who work as servants or cooks in the houses (called *masis*), or who look after children (*ayahs*). In Sonagachi, there are male servants called *chakor* who may work as cooks or as a 'doorman' providing security for the building and also monitoring the movements of sex workers. Both they and the *masis* may act as agents for madams and may also be involved with other illegal activities such as procuring new girls. Money lenders (some of whom are also madams) and dubious private investment companies provide financial services but at vastly inflated interest rates so that many sex workers become caught in a debt trap. If they have borrowed money from a madam, they effectively become bonded to her until it is repaid.

In all the redlight areas, the prices of all local goods and services are massively marked up. Related businesses have a monopoly however as most sex workers simply do not have the time to use services outside the redlight areas, and may feel inhibited from doing so (out of shame or embarrassment or because they are unfamiliar with the city or the language).

Local services include private doctors. Eleven doctors have practices in Sonagachi itself and I counted a further 41 in the area surrounding it and Sett Bagan (Evans & Lambert 1994). These are popular because they are nearby and sex workers complain of facing discrimination from other health services, but they charge high fees and are known to extract large sums through prescribing inappropriate investigations and treatments. Peer educators informed me that:

> They never give us correct medicines – for two or three months, keeping the disease in hand, they give us medicines and try to gobble money from us.

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the sharecropper (Beck 1994).

The police also profit from the redlight areas through extorting money from sex workers, madams and house owners and from all those involved in other illegal activities (such as those who run unlicensed liquor outlets). Extortion takes the form of regular protection payments or bribes following an arrest.

Many sex workers are involved with *babus* (discussed at greater length in chapters five and eight). These men have a reputation for deceit, betrayal and causing heartache. Indeed, *babus* are somewhat humorously referred to in sex trade slang as *khanevala* - literally, 'those who eat' (i.e. cheat and exploit), and *denevala* – 'those who give' (i.e. provide help and financial support). Sex workers lives are characterised by on and off relationships with different *babus* though most women aspire to a long term and stable relationship with a *denevala babu*. *Babus* who are in long term relationships are referred to as *bandha* ('fixed'). Although some pimps are *babus*, on the whole, *babus* are not usually directly involved in the sex trade, or in managing sex workers' business affairs. Many do directly benefit from a sex worker's earnings however though some *denevala babus* will encourage their mistress to stop working.

Procurement

Accurate studies on this (or on trafficking) are hard to come by. However, one study (Sleightholme and Sinha 1996) and my own impressions suggest that much procurement takes place on a small scale, unorganised, ad-hoc basis. For example, if a sex worker returns home to her village it is usually obvious from her clothes and the gifts she brings that she is doing well in the city. She may be asked to find a job for a local girl fallen upon hard times and may take her back with her and sell her into the trade (or, alternatively, keep her and earn from her herself). Nonetheless organised trafficking networks do exist (such as those employed by the *Agrawalis*) and these are particularly active in Nepal and Bangladesh.

Community-Based Social/Political Institutions and Local Power Relationships

Sonagachi, Sett Bagan and other redlight areas are characterised by highly complex power structures that are difficult to penetrate and are still poorly understood. Different political institutions play an important role in the social structure of redlight areas where sex workers are seen as a captive vote bank.

Sonagachi is dominated by the ruling Marxist CPI-M party. There are a number of grassroots party institutions in the locality such as a party office, branches of DYFI (Democratic Youth

Federation of India), SFI (Students Federation of India) and a CPI-M affiliated *Mahila Samity* (Women's Society). The CPI-M also runs a *Nagorik* (Citizen's) Committee that has a quasi-judicial function in settling local problems. In spite of its strong presence however, the CPI-M has never attempted to organise women as sex *workers* or to address labour issues within the sex trade. Sett Bagan by contrast, has always been considered a Congress stronghold and this party has given support to, and received it from, the MS, though the CPI-M is now beginning to gain influence there. There is considerable factionalism between and within the parties which sometimes spills over into violent confrontations. Bombs, shootings and politically motivated gang warfare are not uncommon in Sonagachi and Sett Bagan.

As noted above, these political institutions operate closely upon and within local power structures and community institutions. Most redlight (and, indeed, slum) neighbourhoods are under the influence of one or numerous 'leaders' (*para dada* - literally, "neighbourhood big brother") who form different factions and exert influence over groups of local men referred to as *para chele* (neighbourhood boys). The social life of these men (who are often unemployed and are themselves from poor socially marginalised backgrounds) are organised around community based youth or sports clubs, many of which are affiliated with a particular political party and many of whose members are simultaneously party cadres and enjoy considerable patronage from party leaders in return for procuring votes and doing other party work. These clubs, which are a common social institution all over Calcutta, ostensibly undertake community welfare and youth work but are often simply a place where young men gather to pass the time. Due to their political patronage, clubs yield extraordinary influence in Calcutta neighbourhoods and have come to occupy an extra-judicial role, promising 'protection' to *para* residents in return for support. They often take an active (but sometimes unwanted) role in settling local disputes and in controlling local economic activities. In the redlight areas their activities can be criminal in nature and spawn a mafia-like network of *para mastaans* (neighbourhood 'gangsters'). In many areas these clubs are the most visible and powerful community-based institution, and external interventions in neighbourhoods (such as by the SHIP) are only possible if they work with, or receive support from, these clubs. In Sonagachi there are twelve clubs of various political affiliations. The only club in Sett Bagan itself is the MS, though local men belong to clubs located nearby.

Sex workers and madams are bound up in complex patronage relationships with local *para cheles*, *mastaans* and the party institutions. Some women are themselves party members and, through their connections, are able to enhance their own position in their house or neighbourhood (by, for example, taking on the role of a power broker, mediating between

other sex workers and party officials). Indeed, establishing and utilising 'connections' with these groups or institutions is a crucial strategy through which sex workers have traditionally been able to secure access to protection and to various social and economic resources. Implicit in party political, club-based and other kinds of patronage however, is an obligation to return the favour. Sex workers and other residents are usually required to contribute substantially through their vote (or participation in illegal vote-rigging), and through financial contributions to various political, recreational and 'welfare' activities (as diverse as subsidising a night's boozing for the lads or a community puja). Whilst financial contributions to clubs are supposed to be voluntary, extortion of 'donations' is common (and, indeed prevalent all over the city). Sex workers are usually forced to oblige, out of fear of retribution and, importantly, in order to retain the protection of local men in times of trouble. The need to rely upon external individually-mediated patronage for help has undoubtedly contributed to the lack of collective organisation among sex workers in Sonagachi. Unlike in Sett Bagan (which is a special case, and where the MS was supported by local Congress cadres), there was no organisation of sex workers in Sonagachi prior to the formation of the DMSC in 1995. Sonagachi sex workers were thus dependent upon local power brokers:

> See, the main role played by the party or the boys of the *para* is in solving the problems amongst us. If there is a problem with a customer, or if a madam is not paying a girl, or if the girls fight with each other, immediately people will go to the party office or they will call the *para cheles*. They cannot solve these problems by calling upon more *malkins* or by calling more girls to come. Then the party does *vichar* (judgement) – they call everyone together and solve the problem. They will sort things out with the police. Of course, during election time we have to pay with votes otherwise we won't be allowed to stay in this area. The *para cheles*, they say that now we have helped you, we have solved your problem, now you have to give us donation. Even though most of us have *babus* we still have to run to someone for help now and then – what if my *babu* is not there and a customer is beating me? The *para cheles* will be called – we need them with us, and they help us because they want our help (Sonagachi sex worker).

Depending upon the locality, *mastaans* in particular are known for exploiting sex workers' dependent situation and also have a reputation for brutality. Sex workers who try to resist demands for money, sex or alcohol risk violent reprisal from a *mastaan* and his gang. It is not uncommon for sex workers to be beaten, tortured or gang raped. In Sonagachi, such incidents are quite rare due to the powerful influence of the CPI-M who reportedly tries to maintain strict discipline within the party ranks and disapproves of such abuse of power. In Sett Bagan such incidents used to be common and it was in response to this situation that the *Mahila Sangha* was formed in 1985 (see chapter six). Since then Sett Bagan is a relatively peaceful area, though other redlight localities in the city remain extremely violent.

Life and Work in the Sex Trade

In Sonagachi, Sett Bagan and other redlight areas, the sale of sex takes place at all hours, seven days a week. The women I knew rarely took time off except perhaps for the odd visit to a temple or to visit their families (if they were still in touch). They worked late and slept late into the morning. They then had to fit in myriad household and child care chores before starting the daily ritual of preparing to "stand in the line". Once dressed and made up, the rest of the day was spent outside soliciting. Only those exclusive women within the 'A' category could stay indoors.

Sex work in Calcutta operates in a free and highly competitive market. Charges for sexual services are not fixed and are set following a process of bargaining and negotiation with the customer. Sex workers tend to be highly competitive and also highly suspicious of each other. For this reason close friendships between them rarely develop. Women vie directly with each other for custom and frequently dabble with charms obtained from the local temple or even black magic (*totka*) to influence their own or another's business:

> See, here everybody is his own king. All day we stand and earn, standing next to another but not talking, just thinking about which one of us will catch the next customer (Sonagachi sex worker).

If business is not going well, women talk of their rooms as being metaphorically 'closed'. They sometimes offer special pujas to try and change this situation and may seek advice from a local priest.

Charges for sex are dependent upon the age and relative attractiveness of the sex worker, upon the 'status' of the area or house from which she is working, upon her bargaining skills, and upon the time and nature of sexual service required. All types of sexual service are available at a price, and although most women initially deny engaging in oral, anal or other 'alternative' sexual practices which are considered to be 'dirty work' (*nyongra kaj*), economic compulsions means that most will at times submit to a customer's wishes. However, vaginal intercourse is the most common and cheapest sexual service. In the sex trade, time is money and customers who overstay their time are expected to pay more, or are asked to leave even if they have not yet finished.

Most sexual encounters are quick and casual '*shots*' with unknown men, but many men pay to spend longer periods of time with sex workers in which they often drink, have food and chat. Many of my informants also drank and said it makes the work easier to cope with. Some

clients become regulars (also known as 'time' or 'fixed' customers) and may form friendships that can last for many years.

Minimum rates start at approximately Rs.20 per *shot* and a night long stay can cost between Rs.300 (for low income group sex workers) and Rs.5,000 or more for the high class sex workers. In Sonagachi, men who wish to 'break in' new and young girls may be charged anything up to or over Rs.20,000.

Clients come from all walks of life ranging from wealthy businessmen and professionals who visit the high class 'A' girls in Sonagachi to the working class men such as daily labourers, hawkers, rickshaw pullers, or small scale factory workers who make up the clientele of the 'C' sex workers in Sett Bagan (AIIHPH 1993b).

Business varies greatly on a daily and seasonal basis with high peaks during holidays and religious festivals. Sex workers entertain anywhere between 0-10 customers per day (some, especially new or young girls, even more). The average for the city though has been estimated at 3 per day (AIIHPH 1993a).

Violence in Sex Work

For sex workers in Calcutta (as elsewhere), their occupation carries with it a constant threat of violence from customers (as well as other sex trade actors, especially *babus*). Generally local people will intervene to help a sex worker who is being attacked by a client, but usually do not do so in the case of domestic violence. In the event of violence, it is not always possible for sex workers to raise the alarm however, as they are often alone in the room with a client and others may be unable to hear any calls for help. During my fieldwork, there were a number of brutal murders in Sonagachi – in one case the client had broken off the top of a beer bottle and had rammed it into the sex worker's vagina until she died of internal haemorrhaging. Clients are rarely brought to book, and sex workers do not even contemplate reporting the relatively common instance of rape. All my informants could recount at least one such experience and there was a prevalent feeling that "in this line our lives are in other people's hands".

Money Matters

Contrary to popular perception, few sex workers become rich although it is true that the opportunities for earning in the redlight areas far exceeds anything that most women (the majority of whom are illiterate and lack vocational skills) could ever hope to make in alternative sectors such as domestic service, stitching or as an agricultural labourer[7]. The previous sections of this chapter make clear however how the socio-economic organisation of the sex industry conspires to divest its workers of a substantial portion of their income. In addition to the very high costs of living, sex workers require expensive accessories such as glamorous saris, make up and jewellery. Women are frequently cheated, and, in addition, may need to support children, *khanewala babus* or impoverished members of their close or extended families. Those sex workers who still retain contact with their families are frequently asked for financial help, and many regularly remit money home. For these women it is difficult to amass any kind of savings. Medical bills constitute another large expense. As they get older, sex workers also spend large amounts on their children's weddings, often using all their savings in the process leaving little for old age. Contingencies are met with recourse to loans, and debt is a permanent feature of sex workers' lives. For a significant proportion of women who have become addicted to alcohol, much of their income goes to support this habit. Regarding this issue one of my Sett Bagan informants agreed that "although we earn so much money, none of it stays in our hand - our mind never has peace".

Career Trajectories and Old Age

Within the various occupational and social structures that exist, there are a number of possible career trajectories and paths of social mobility for sex workers. *Chukris* try to move on to become *adhias*. *Adhias* may remain as such until they become too old to work, or if possible, may move on to become independent workers.

As sex workers get older and earn less their income cannot keep pace with expenditures and their economic status usually deteriorates. If they are lucky, they may have a *babu* who contributes something each month. Many of the older sex workers in Sett Bagan for example, receive substantial assistance from their *babus* (often in the form of rent payments). Those who have children are sometimes able to live with and be supported by them. This is rarely

[7] Female domestic servants working in 4 houses may expect to earn perhaps Rs.1,000 per month. Young attractive *Adhias* in Sonagachi could earn upwards of Rs.5,000 per month, some much more. Even older 'C' category sex workers in Sett Bagan who had few customers were still earning between Rs.1,000-4,000 per month (including contributions from *denevala babus*).

possible though because children may be married into 'respectable' families (who do not know about the child's background) and hence cannot risk contact with their mothers. Also, quite often, children themselves are unsuccessful in life or marriage and may end up depending on their mothers' financial support. In Sett Bagan for example, a number of my informants were supporting unemployed grown up sons (and their wives and children) or daughters whose marriages had failed.

Older ex-sex workers can be found working as *masis* or *ayahs* in the brothels or elsewhere and the most unfortunate eventually become beggars living on the streets. Others who have managed to save may invest their money back into the redlight area by becoming a madam, or may buy property elsewhere, moving out to try and develop other livelihood strategies.

Children

The care of children presents sex workers with a continual problem. Having a child reduces time available to earn – a particular problem for *adhias*. An informal system of child care operates whereby older women look after children at Rs.10-30/day but this is a rate that not all can afford. Many older children therefore roam around relatively unsupervised and risk getting into trouble. For the care of younger children and babies mothers must rely on the goodwill of neighbours or keep them in the room (often hidden under the bed) during their work. Some women who still maintain contact with their families, make the difficult decision to leave their child behind with grandparents rather than have them grow up in the seedy environment of the sex trade. Others try to admit them into residential schools and orphanages. Mothers are keen to give their children a good education so that they can escape the deprivation associated with a life in the sex trade. Most children living in the redlight areas are admitted to school and also given private tuition. There is a high drop out rate however, which my informants partly attributed to financial problems and to the difficulties children of sex workers face in integrating with other pupils – described below by a sex workers' daughter:

> I am a 'line child'. I used to feel so ashamed. When I used to study everyone would ask me, 'where do you live'? I would reply 'somewhere in Calcutta'. 'What does your mother do'? I would say 'she works as a nurse'. 'And your father'? I would say 'he has married again and left us'. What could I say *didi* (sister)? People used to whisper about me. After some time I could bear it no more and I left after the half yearly exam. I used to say to my mother, 'when you gave birth to me, why couldn't you kill me'? I used to hate myself.

Clearly, the sex trade represents a complex social world. Women's experiences of living and working in this world are examined more closely in chapter five. However, below, I have

presented some brief life histories of women in Sonagachi and Sett Bagan in order to illustrate the situation of sex workers in a more concrete way and to reflect different aspects of the sex trade and of the relationships between different actors.

Case Studies

Anu – A 'Successful' Adhia in Sonagachi

Anu is a very attractive 22 year old sex worker who lives as an *adhia* in one of the smaller Sonagachi streets. Like many girls in Sonagachi, she is still relatively young and as yet, has no children, though she has had 3 abortions. She is in the B category of sex workers and is earning extremely well. She comes from a village in North-24-Parganas, a district north of Calcutta. There, she fell in love with a local boy but her parents wanted to marry her off to someone else. Thus, on the day of her wedding when she was already wearing all her jewellery, she ran off with her lover, but he sold her into a small redlight area in the same district and ran away with all her possessions. She was there for some time and fell in love again with a local man but he treated her badly and used to take her money. She eventually told him to go but he became very violent and she had to get help from the local *para cheles* who assisted her in running away to another redlight area. There again she had trouble with a man and eventually she came to Sonagachi. She considered herself lucky to have a 'good' madam whom she calls *didi* (older sister) and they seem to have a good relationship. She is taller and fairer than the other women in her street and says she has up to 25 customers a day. She buys about 8 saris each month and has 2 trunks full of clothes. She spends a fortune on cosmetics each month. She could in theory make more money by having a room of her own but there are no free rooms in the area and she also feels that she needs the madam's protection against trouble with the *para cheles*. Also, in spite of their 'good' relationship, the madam has told her that she will not allow her to take a room elsewhere in that street (she would then pose too much competition for the new *adhia* that the madam would take) so Anu would have to leave the area completely which she is reluctant to do as her present location is extremely good for picking up business. At the moment she does not have a *babu*.

Anu's good looks have made her popular among the local *para cheles* who sometimes pay her for sex. They also sometimes fix her up with their friends. From past experience Anu knows it can be risky to have such contact with local men but at the same time cannot refuse: "One time they brought a friend and he wanted to do 'sucking' – I told him I don't do this dirty

work but he made a lot of trouble and my *malkin* said that I had better just do this otherwise we will have trouble in the *para*.

Anu had few thoughts about her future "I will do this work as long as I can – there is no where else for me. I used to have my dreams – that I will marry and have children. Now where there were dreams there is just darkness. It is up to God what happens to me."

Shanti – A Madam in Sonagachi

Shanti is Anu's madam. She, her *babu* and daughter share the room with Anu. There is no space for Shanti to keep more than one *adhia*. She is presently saving for her daughter's wedding and cannot afford to pay a *salaami* for another room. In any case she feels: "I can run all right like this – with more girls there is more trouble." She is now about 45 and no longer does sex work. She relies on her *babu* and on Anu's earnings to live. Shanti was herself an *adhia* for a long time in until a previous *babu* helped her to pay for her own room.

Shanti was married young. Her husband migrated from their village to find work but never returned. She heard he had taken another wife. By this time Shanti was pregnant and had a baby girl. She went back temporarily to her parents' house but her brothers made it clear that they did not want to support her. She tried working as a domestic servant but had to leave when she was not allowed to take her infant daughter with her to work. One local girl told her about Sonagachi: "I said, no I can never do this kind of dirty work" but this girl said to me – see do you think we ever like this? We, who are from honourable families, can we enjoy work like this – but you have to eat – who else will look after you and your daughter? "Hearing this I realised that I had to come here and earn my own food".

Shanti is still in touch with her family and has somehow managed to keep her occupation secret: "of course I am always scared that one day they will find out about me. Truly, who can carry the weight of this sort of life? I have to take my own weight but yet I have to hide from this society."

Shanti feels she looks after her *adhia*, Anu: "In this place there is always trouble from the *para cheles* so I sit outside and make sure that nothing happens to her – she depends on me and if she listens to my words, then she will be safe. I am very well known here by everyone so nothing can happen to me. I have a connection with the *Nagorik Committee* (CPI-M citizens committee) and they help me if there are any problems. I am not one of those who

cheat the girls. This girl covers her own expenses, - only thing is I take Rs.20 for two meals each day. Actually I have helped her a lot."

Podda – An Independent Sex Worker from Sett Bagan

Like many of the women in Sett Bagan, I knew Podda well and she often talked to me about her life, especially the problems she had with her *babu*. We usually sat at the tea stall and, if she wasn't busy, she would sometimes invite me into her room. Podda is now almost 35 (but looks much older) and has few customers except for a few regulars. She is living with a *babu* in Sett Bagan but their relationship is a stormy one, as her *babu* frequently gets jealous. She feels that other women in her house are envious of her because she has a good *babu* and are deliberately spreading rumours about her to him to incite trouble. Her history is typically long and troubled. She comes from an extremely poor Hindu family from Bangladesh who migrated to India. Her father owned a cycle rickshaw. She was married at the age of 11 but: "he was not a good boy – he used to gamble a lot and he must have been in trouble for one day he hung himself. What misfortune, I had been married for only 2 months. My father had no money and one day he said we are going to Barasat (an Indian town that borders Bangladesh). After we came we had nothing and we started working in people's houses and the men used to eye us. One day the master's son spoilt me – he did it forcibly. I didn't tell anybody but I left that work. What could I do? Then there was trouble in my family because I had left work and one *masi* came to my parents and said that she will take me and find a job for me in Calcutta. She brought me to Sonagachi. When I saw everyone in petticoats I wondered what kind of place is this? The *masi* kept me in one room and then that night they brought a Punjabi to the room and locked the door. I couldn't escape. He too did it forcibly and afterwards they had to bring the doctor to give me stitches. When I was better the *masi* said I had to stand in the Line. I didn't want to but she would burn me with cigarette stubs. Out of fear I stood on the road and at that time there were many customers."

After some time, Podda fell in love and became pregnant with a *babu* who wanted her to leave the area and go and live with him: "I knew I wouldn't be allowed to go. The *para cheles* knew this *masi* and none of them would allow me out anywhere. But this man, he had a lot of connections because he used to do no.2 work (illegal work) and he got a group of friends together and they helped me escape. He kept me in a room and gave me food but did not put sindhur (i.e. did not marry her). There was a lot of trouble between us and when I was 9 months pregnant I got on a bus back to Barasat and went to my parents' place – at that time we were still living on the railway tracks. I had a little jewellery and told my parents that I

had married but that my husband had died. A week after the birth I started working in other people's houses again."

While Podda was at her parents' place her father was hit by a train and died. Her mother fell ill with the shock and Podda decided to come back to the sex trade. She left her baby son with her mother, and found a place as an *adhia* in Sett Bagan (at that time *adhias* were allowed there). She returned home every week with some money and a tin of baby milk. Eventually she got involved with a local *para chele* who used to mistreat her and take her money. She could not end the relationship for fear of reprisal from his friends in the neighbourhood. Sometimes this man beat her so badly that others in the house were worried that he might kill her: "all this trouble was bad for the house - many times the *bariwali* got the party people and they would call us and do *vichar* – my *babu* said that I had other *babus* – this is what the girls in the house would tell him. They were jealous of me because my *babu* was an influential man in the *para* and I used to have lots of customers. One day he was arrested and he is still in prison."

Now Podda has another *babu* who she feels is a 'good' man except that he drinks heavily. This man does not take her money – in fact he pays her rent and some living expenses. When a room became free in her house, this *babu* helped her pay the *salaami* for it so that she could be independent.

Podda is very proud of her son who is doing well at school and still lives with her mother in a small room that Podda helps them to rent but she is worried about their future: "I don't have anything now – no land, no savings in the bank – all my money has gone behind my mother, my sisters and my son. Everything has been 'eaten'. What to do? It is all written in our fate. In my mind you know there is no peace, only trouble (*osanti*). There is no happiness in my life."

Maya: An Independent Sex Worker from Sett Bagan

Maya is about 38. She is one of the few women I knew who, in spite of having to endure many problems, was philosophical about her life and did not regret having become a sex worker. She saw it as the best of a limited range of options. Her family of 3 brothers and 5 sisters were landless and extremely poor. Her father used to help out at a tea stall. All the women and girls of the family worked as servants in people's houses. They could not manage and eventually, through social connections, the family came to Calcutta where her

grandmother arranged for Maya's older sister to start working as a sex worker. Maya and her mother went to stay with this sister in Ram Bagan (a satellite of Sonagachi) and she supported them. Maya was eventually married to an uncle's step brother but they constantly fought and she returned to Ram Bagan and decided to enter the line. She says: "why should I spend my money on this husband? I would rather spend it on feeding my mother and sisters. My sister wanted me to marry again but I said no – in marriage there is no happiness, I will work like this and so I was spoiled in my own sister's house."

Eventually her sister helped her to find a room in Sett Bagan (very close by) where she did very well and had a son. After this she had many abortions and did not conceive again.

Maya says of her life: "see, my tragedy is different – when I entered the line I made so much money – I was making Rs.12,000 in one month. I bought 3 bighas of land in my *desh* (native village) but I was cheated out of this by my younger brother. I was earning so much, even more than my sister. I didn't go onto the road. People came into my room and I also got called to hotels. How can I tell you – it was like the Goddess Lokhi had come inside me. See, when I first joined the line I didn't know what love was and this was my first experience and I was enjoying every bit of it – the clothes, the jewellery, all the attention. I went to Bombay many times – there is good money to be made there. But when I was there, my mother used to write false letters saying that my son was sick and I had to send money – Rs.1,000, Rs.5,000. Like this I wasted all my money – it is only now I understand the value of money but I don't earn so much. Now I have no land, just a fixed deposit in my son's name."

During her time as a sex worker, Maya has had a number of *babus* but now has a *denevala babu* who actually lives in Delhi and owns a gold jewellery shop. He comes regularly to Calcutta on business: "he bears all my expenses, otherwise I couldn't manage – my son's tuition is Rs.600, and there are the college expenses – then rent and electricity. He is a good man. Now I have very few customers but there are still some fixed men who come and they also help me."

Maya is very religious and draws much strength from her faith. Of having become a sex worker, Maya says: "This is my life – it may not be much, but I can eat and I am not on the street – should I have spent my life as a beggar or as a whore to my husband? No, at least like this I have been able to look after my mother and make my son big."

Conclusion

The above case studies and the descriptions in this chapter of the structure and social organisation of the sex trade and sex work in India and Calcutta, illustrate how gender discrimination, poverty and migration shape women's options and lead some into selling sex as a survival strategy. The chapter also shows how the present social and legal context of the sex trade contributes to a market environment that, in many cases, is exploitative and that denies sex workers many of their fundamental rights. In Calcutta, political, occupational and community structures, especially in Sonagachi, push sex workers into dependent and unequal relationships with sex trade power brokers and hinder the development of any kind of solidarity or collective organisation between them. In Sett Bagan the situation is somewhat different because of the MS and because women work independently, but even here women live in an environment characterised by economic insecurity, lack of occupational rights, lack of social support, vulnerability to violence, exploitation by the police and dependence upon *para cheles*. This social context profoundly affects sex workers' ability to look after their health as will be described in later chapters. In addition, it poses a particularly difficult environment into which to introduce an external intervention.

CHAPTER FOUR

HIV AND SEX WORK IN INDA: DEVELOPMENT OF THE CALCUTTA STD/HIV INTERVENTION PROGRAMME (SHIP)

Introduction

In this chapter I give a brief background to the Indian HIV epidemic and related policies, and discuss how these have affected the country's sex workers. I then go on to introduce the Calcutta STD/HIV Intervention Project (SHIP) which was one of India's first targeted interventions among sex workers and whose activities and outcomes have significantly influenced national and international thinking on 'best practice'. As part of this discussion, I also introduce the SHIP's off-shoot, the sex workers' rights organisation - the *Durbar Mahila Samanwaya Committee* (DMSC).

HIV, Health Policy and the Sex Trade in India

The limited studies available, show that HIV prevalence is already high among sex workers in some urban areas of India. Prevalence rates amongst study samples in select cities are as follows: - Pune - 45% (Rodrigues et al 1995); Vasco Da Gama - 27% (NACO 1994); Delhi - 40% (Garret 1994); Bombay - 51% (NACO 1998); Madras - 15% (Asthana & Oostvogels 1996); Calcutta - 5% (AIIHPH 1998). With the exception of Madras, these studies have usually been conducted amongst brothel based sex workers. The extent to which HIV has spread among other women practising sex work is unknown, but existing figures provide sharp confirmation of sex workers' vulnerability to HIV and of the need to develop effective measures to help them to protect their health.

Within other population groups too, HIV prevalence is steadily rising and now poses a serious challenge to the health, welfare and economy of India as a whole. In the late 1980's when the epidemic first began in India, HIV was believed to be primarily an urban phenomenon that was confined to high risk groups such as sex workers. By 1998 however it is apparent that HIV has spread to all corners of the country, and that it is increasingly affecting rural areas and moving into supposedly low risk population groups such as married women (Gangakhedkar et al 1997, Solomon et al 1998). It is now estimated that approximately four

million people in India are infected with HIV, of whom a quarter are women. The main route of transmission in India is via sexual intercourse (NACO 1998).

During the early 1980's when HIV was first appearing in western countries, the official response in India was one of denial and complacency, characterised by a view that AIDS was associated with a decadence and immorality that would not be found within its borders (Asthana 1996). The response of a senior health official typifies the sentiment of the time:

> Our religious customs and god-fearing living habits are a shield of protection against many social evils. It will be difficult even for the HIV to penetrate this shield (Kerala State AIDS Programme Officer, quoted in ABVA 1991:48).

Given this attitude of moral self-righteousness, it was perhaps not surprising that when researchers first began to speculate about the possible presence of HIV in India, they chose to look for it among sex workers rather than any other population groups. Thus, India's first cases of HIV were detected in 1986 in a group of Tamil sex workers who had been 'rescued' from the brothels of Bombay and were being held in a State remand home in Madras (Panos 1990). This and subsequent events such as the death from AIDS of a sex worker in Bombay in 1987 shocked the country and generated enormous media publicity. There remained a general feeling however (reinforced by the media coverage) that the virus was a problem of marginal groups and foreigners only. Sex workers were publicly castigated as:

> The lousy lot who have AIDS....because they did not stop cohabiting with foreigners two years ago (Director General of the Indian Council for Medical Research & Head of the National AIDS Control Programme, quoted in ABVA 1990:14).

The government's initial response to HIV was to establish sero-surveillance activities to determine the extent of the epidemic. However, this was implemented in a somewhat ad hoc manner and, rather than monitor HIV prevalence across a representative sample of the population, initial screening concentrated upon groups that were pre-defined as 'at risk' (sex workers included). Some authors contend that this gave rise to a self-fulfilling prophecy (Asthana 1996).

The initial stages of the HIV epidemic therefore saw increased stigmatisation of sex workers. In addition, there have been human rights violations (though not restricted to sex workers) related to unethical testing, refusal of treatment, lack of confidentiality, breaches of anonymity, coercion and detainment (Nataraj 1990, Asthana 1996). For example, the above-mentioned Tamil sex workers were illegally detained at the remand home and were only released after local activists petitioned the Madras high court (Panos 1990, ABVA 1990). One

of the group committed suicide after she tested HIV positive and was exposed by the media. Such incidents continue to pose a threat to sex workers. In 1993 for example, a group of sex workers in Calcutta were forced to give blood for HIV testing when doctors from a government research institute entered the redlight areas with a police escort. In 1995 sex workers in Calcutta and Bombay were discovered to have been unwitting subjects of an illegal HIV vaccine trial (Talwar 1996).

The issue of human rights was also raised in response to another of the Government's initial AIDS policies. It had drafted a draconian AIDS Prevention Bill (1989) that would have provided sweeping powers to the authorities, including provisions for forcible testing, isolation of people with HIV and criminal penalties for the transmission of HIV. Sex workers would have been one of main targets of this legislation, especially as the proposed 'crimes' included promiscuous sex with foreigners. The Bill was widely criticised however and eventually thrown out.

Since these early days, in the face of both international and national pressure, India has moderated its stance (a condition of World Bank HIV-related loans) and has developed a highly comprehensive AIDS policy (Asthana 1996). Today, the country's AIDS-related strategies are shaped by a National AIDS Control Organisation (NACO) that was established in 1992. Its purpose is to facilitate the implementation of a National AIDS Control Programme (NACP) at the national and state level. The specific components of the NACP include: (1) strengthening programme management; (2) HIV/AIDS surveillance; (3) behavioural change through information, education and communication activities (IEC); (4) control of sexually transmitted diseases; (5) condom programming; (6) blood safety and; (7) reduction of impact. India's first AIDS Control Programme was completed from 1992-1997, and the second is underway. Individual States are being encouraged to form autonomous State AIDS Control Societies and are responsible for planning and implementing the NACP specific to their needs. Where possible an inter-sectoral approach is to be adopted, with HIV to be integrated with existing health programmes and programmes in education, youth affairs, women's issues, welfare, urban development and labour affairs (NACO 1995, Shreedhar & Colacao 1996).

The NACP makes a distinction between activities with the general population and targeted interventions (TIs). A proportion of State-level AIDS budgets is specifically allocated for the development of TIs for which sex workers (among others) form a major target group (NACO 1998). Faced with the task of implementing such a wide-ranging policy, NACO has explicitly

called for the collaboration of non-governmental organisations (NGOs) and for grass roots mobilisation (Asthana 1996:188). Grassroots approaches are suggested as being particularly relevant to the development of TIs in order to facilitate access to marginalised groups (NACO 1998).

Upon the request of the Indian Government, various international donor agencies have been providing technical and financial assistance to the NACP. The British Department for International Development (DFID) has been specifically concerned with supporting TIs and, in collaboration with State Governments, currently manages a 'Partnerships in Sexual Health' (PSH) project in 5 States, including West Bengal. In each State, agencies have been established to manage and provide support to TIs. In the early 1990's, the first such DFID-funded TI project was established on a pilot basis in West Bengal and is referred to as the 'West Bengal Sexual Health Project' (WBSHP). The British Council Division based in Calcutta was responsible for developing the preparatory phase of this project (1992-1994). The substantive project phase commenced in 1995, managed by a Project Management Unit (PMU) which has, from this time, been providing support to the SHIP.

The Calcutta STD/HIV Intervention Project (SHIP)

Prior to the recognition of HIV as a potential problem for Calcutta in the early 1990's, public concern about sex workers was sporadic. Five NGOs were (and still are) working in the redlight areas but their work is relatively small scale and has not succeeded in mobilising wide spread support or self-help initiatives amongst sex workers. The NGOs are mainly concerned with the welfare of sex workers' children. One (TAP) also provides health services and had previously been involved with the Sett Bagan MS, helping to place some children in a residential school, and had employed the MS leader, Durga, as a field worker. Another (Surya), is a feminist NGO that also runs counselling and legal advice centres for sex workers as well as homes for sex workers' children and for 'rescued' sex workers.

Research in Sonagachi: Precursor to the SHIP

The SHIP began as a research project in Sonagachi in mid-1992. It was conducted by the Department of Epidemiology of the 'All India Institute of Hygiene and Public Health' (AIIHPH), a reputed Central Government Institute based in North Calcutta. The Head of the Epidemiology Department, Dr.P, who became the SHIP Director, was approached by WHO urging him to conduct a study to determine STD/HIV prevalence among sex workers. He

describes how he was initially reluctant to get involved as he felt the sudden HIV-spurred interest in sex workers was distasteful and would ultimately add to their stigmatisation and marginalisation. As discussions continued however and the term 'sex worker' was used, Dr. P notes how he realised that; 'prostitutes can also be called workers – it was a revelation to me' (DMSC 1998:6). He eventually agreed to lead the research and a political-economic perspective, that vulnerability to HIV is primarily influenced by structural and gender-related inequality, has shaped the subsequent course of the SHIP which has taken the view that for sex workers, STDs/HIV are an *occupational* health problem (SHIP 1999:11).

The initial research took the form of a community based survey of STDs/HIV prevalence among a random sample of 450 sex workers, and also included some questions eliciting basic socio-demographic information. Results showed that 80.6% of 316 sex workers (who had consented to an internal examination) had a laboratory-diagnosed STD. Condom use was negligible. Only 1.1% claimed to 'always' use condoms and only 1.6% of sex workers said they 'often' used them (other, more accurate ways of assessing condom use were not used in this survey). Almost three-quarters of women sampled used no regular contraception and 46% had a history of abortion. Most women sought help from private medical practitioners who provided highly variable quality of care at high cost. HIV prevalence was low however at 1.1% (AIIHPH 1992). Given the scenario of high STD prevalence and low condom use sex workers were clearly vulnerable to HIV and to other consequences of multiple or chronic STDs. It was felt that, given the (still) low HIV prevalence, there existed a window of opportunity to prevent HIV from spreading any further.

Aims, Management, Structure and Scope of the SHIP

Following the survey, the AIIHPH was persuaded by WHO in collaboration with NACO to initiate an intervention project and the SHIP officially started in Sonagachi and 4 small outlying areas (including Sett Bagan) in September 1992. Funding was initially provided by NORAD and WHO but has since been taken over by DFID's WBSHP. The project was initially designed as a standard targeted intervention along a medical/epidemiological model of STD/HIV prevention. Its main objective was to reduce STD/HIV prevalence by means of the 3 core TI components: STD treatment and prevention, condom distribution and 'Behaviour Change Communication' (BCC). The main strategies included providing direct STD treatment facilities via a field-based clinic and using field outreach strategies including peer education (employing sex workers as health educators/community workers, supervised by 'supervisors'). The project's focus however has developed over time from a medical to

what it calls a more 'integrated approach' (described in the next section), and the SHIP's objectives have thus been slightly modified. In 1997 they were: - (1) To help modification of sexual behaviour of sex workers and their clients so as to make it safe; (2) To enable sex workers to sustain the changed sexual behaviour; (3) To develop an effective strategy and guidelines of an intervention programme which can be replicated in other areas (AIIHPH 1997:5).

At the SHIP's start in 1992, it was headed by Dr.P. of the AIIHPH, and the AIIHPH as an institution has been responsible for overall management of the project. Since then the SHIP has developed a rather complex and continually evolving management structure that reflects the project's move to a more integrated approach to service provision and also a concern with community participation. The SHIP initially had a 'conglomerate' management structure whereby the AIIHPH brought in three other NGOs under its umbrella who seconded their staff to work as field supervisors and made their services available to sex workers (e.g. de-addiction, research, community development, legal advice and human rights activism). In 1994, the SHIP took steps to formalise participation of the community in the project and the Sett Bagan *Mahila Sangha* and two local *para chele* clubs in Sonagachi (who provided space for project clinics) were included in the Conglomerate. Likewise, after its formation in 1995, the *Durbar Mahila Samanwaya Committee* (DMSC) was also included in the Conglomerate. The Conglomerate's operations were officially decided by two sub-committees formed from among its members – a Participating Council (containing representatives of all member organisations of the Conglomerate) and a Field Advisory Committee (comprising proportional representation from each level of field staff including the project director). Overall policy guidance and ratification of the Conglomerate's decisions were provided to the SHIP by a multi-agency Steering Committee on which all Conglomerate members had a permanent seat from 1995 onwards (before this they were invitees). In 1997, the management structure changed and a Society was formed to which the AIIHPH transferred overall responsibility of SHIP management (though Dr.P remained the SHIP director). In 1999, responsibility for the SHIP was devolved entirely down to the sex worker community and a sex workers' son (and ex-project supervisor) is now the Project Director, advised by various committees (SHIP 1999). Representatives of the SHIP, including from the two sex worker organisations, the MS and DMSC, are also included on the WBSHP's Steering Committee.

The project scaled up in 1994-5 and currently runs interventions directly in 12 redlight areas though smaller areas connected to these are also covered by project activities. In this way, the SHIP now covers almost all brothel-based sex workers in Calcutta and Howrah[1].

The SHIP has an office based in North Calcutta close to Sonagachi which it shares with the DMSC. There is a large staff body, a number of whom have previous experience of political organising and activism, and who also act as advisors to the DMSC. In addition to administrative office based staff, the SHIP employs a gender and research consultant (who, prior to this appointment, was actively involved with advising the DMSC). There are also 6 visiting doctors (male and female), 6 nurses, clinic attendants and administrators, 15 supervisors, 200 peer educators and a literacy programme co-ordinator. Most SHIP staff receive a monthly wage. However the peer educators (PEs) receive what is called a daily 'incentive' which is given only for those days worked. This is because PEs are sometimes quite irregular with their work, particularly at the beginning while they are still adjusting to unfamiliar routines and work schedules. Daily rates vary from Rs.25 for new recruits and gradually increase to Rs.40 for more senior PEs. The PEs are practising or ex-sex workers. They are usually older and have considerable experience of the sex trade. Some PEs have given up sex work since joining the SHIP as the SHIP's income, when supplemented from other sources (e.g. from a *babu*), is perceived to be sufficient to live on.

The project director, Dr.P, is a charismatic figure, who has been whole-heartedly committed to the SHIP making himself available to all levels of project workers and sex workers at any time of the day or night. There has been no 'middle management' layer within the SHIP, and Dr. P has, therefore, been directly involved in all aspects of project activities.

Project Implementation

The SHIP presently runs two clinics in the Sonagachi area (in different lanes). These are situated in two local *para chele* clubs (members of the Conglomerate) whose premises are made available to the project during its working hours. One clinic, located in a large club in the heart of Sonagachi, is open every morning from 10am to 1-2pm. The clinic is open to anyone and provides free general as well as STD-related health care[2]. Links have been formed with a 'reproductive health' NGO that provides a range of services (that cannot be directly

[1] Since 1998, the SHIP has expanded its services further to cover Calcutta's street working sex workers.
[2] 'General' ailments are treated but, for financial reasons, non-sex worker patients are subtly discouraged from using the clinic for non-STD purposes (e.g. they may be provided only with pain killers and asked to buy other medicines from outside).

handled by the clinic) ranging from certain types of contraceptive provision to medical termination of pregnancy. At the request of sex workers, child immunisation sessions are also organised at regular intervals. The STD strategy comprises investigation and treatment of existing infections, quarterly prophylactic screening for syphilis, and, where possible, partner notification. Sex workers receiving STD treatment are followed up in the field to encourage them to return to the clinic for a check up and to motivate them to complete the full course of treatment. On average 35-40 patients are treated at the clinic each day of whom approximately 70-80% are sex workers and their families. Approximately 30-35% of clinic attendees are estimated to have STDs (AIIHPH 1997:6). The other clinic was opened in 1993 and operates in the evenings (5 days/week) from 5:30-7:30pm. The main aim of this clinic is to cater to sex workers' clients and *babus*.

The main condom distribution and health education activities take place during field outreach. In the Sonagachi area, outreach is conducted by 6 field supervisors who are all female social workers and approximately 57 PEs, giving an approximate ratio of 1 PE to 96 sex workers (i.e. 1% of Sonagachi sex workers are PEs). This central Sonagachi area has been divided into 7 'fields' comprising different lanes, or even, sides of lanes depending upon the size of the houses and brothels concerned. Outlying areas such as Sett Bagan are covered by their own, different teams.

Field outreach takes place every morning during the clinic hours. The PEs gather for a roll-call and briefing outside the clinic club and then split up into 7 teams headed by a supervisor (if the supervisor is not present, a senior PE takes on the role of team leader). Each team takes a bag-full of condoms and a pictorial flip chart which contains basic information about HIV, STDs and condoms. The PEs wear green coats over their saris and the supervisors wear white ones, ostensibly to help local people identify them as project workers. The teams then move out into Sonagachi, each team covering one particular 'field' for approximately 6 months to allow time for rapport building. In conducting outreach work, the teams generally stay together and do not, for example, split up their work so as to cover an area more quickly.

Field work consists of contacting sex workers in the brothels, giving them condoms and going through the flip chart with them. It also involves motivating women to come for STD treatment and PEs accompany sex workers to the clinic. Another key aspect of field work is interaction with other sex trade stakeholders such as madams, landlords, pimps, *masis, babus* or clients. The teams carry small leaflets with them about HIV that can be distributed to clients. The SHIP places great emphasis upon building up rapport, trust and friendly relations

with sex workers. Where possible therefore, PEs and supervisors will sit and chat with sex workers and may, in time, take on the role of counsellor and confidant. The teams aim to regularly contact every sex worker and to keep track of movements in the trade so that new women are quickly identified and given condoms and advice. In Sonagachi which is quite large, the teams may meet individual sex workers about once a week though contact is more frequent in smaller areas. Most BCC or health education is given on a one-to-one basis but other BCC activities have included video screenings and street awareness meetings using a Talking Doll (ventriloquist), and group meetings with, for example, *babus* or pimps. In 1996, the DMSC established a cultural wing called *Komal Gandhar* which, among other activities, also performs dance dramas on various themes around HIV prevention (DMSC 1998b:42, SHIP 1999).

The project does not aim to fulfil the entire condom requirements of sex workers (at least 20,000/day). Rather it aims to instil a condom use habit and to promote broader social acceptance of condoms. Condoms are distributed free by the PEs. Since 1997 however, a condom social marketing strategy is also being implemented. A group of 60 sex workers called *Basanti Sena* has been formed that is responsible for direct marketing of condoms in Sonagachi as well as in 45 redlight areas across West Bengal (DMSC 1998:39).

After field work is over (about 1pm), PEs and supervisors reconvene at the clinic. PEs then attend non-formal education classes that have been organised by the SHIP upon the PE's request. These were initially conducted informally by supervisors, but since 1995 a systematic and specially designed Freirean education programme has been implemented (Bandyopadhyay 1996a,b, 1997). After classes, PEs return home, however supervisors work full time and go to the project office. Supervisors' other duties include organising meetings with sex trade stakeholders, conducting research, performing advocacy work with various groups (e.g. the police, private doctors or the media), and assisting with the project's other activities described below. Those PEs who are heavily involved with the DMSC often give up their time to attend meetings and to organise related activities which are co-ordinated with the help of SHIP staff from the project office. Meetings of PEs and of the DMSC members are held once a week in the project office.

Development of SHIP Philosophy and Integrated Approach

The SHIP's perspective and theorisation of sex work, behaviour change and its own strategies have evolved and become more explicitly elaborated over time. Below, I primarily draw upon

the project's most recent publication which includes a retrospective theoretical analysis of its work and philosophy (SHIP 1999). Project documentation refers to three principles which have underlain its work (SHIP 1999:11); respect (for sex workers), reliance (on their understanding and capability), and recognition (of sex workers' human rights and of sex work as a legitimate occupation).

As noted above, the project was initially formulated as a standard bio-medical targeted intervention. From the project's inception however, the SHIP director, Dr.P, felt that the initially formulated project goal and technical components could not be realised unless a much broader perspective on sex workers' health was taken.

> Even to realise the very basic programme objectives of controlling transmission of HIV and STD, it was crucial to view sex workers in their totality – as complete persons with a range of emotional and material needs and not merely in terms of sexual behaviour, as it was essential to address the range of issues that determine the quality of their lives and to locate these in the broader context within which they live (SHIP nd).

The SHIP subsequently adopted what it calls an 'integrated approach' that, it suggests, goes beyond conventional models of behaviour change (AIHPH 1997:9, SHIP 1999), and where the project's fundamental thrust is: "to address the structural issues that affect the health and lives of sex workers and to create an enabling environment for sex workers to affect significant change" (SHIP 1999:5). Rather than disease control alone, the aim of the project shifted towards attempting to support and sustain behaviour change by influencing the broader occupational and social power relations that create vulnerability to HIV, and by working to collectively organise and empower sex workers:

> In order to motivate the larger body of sex workers to change their behaviour and to enable and encourage them to participate in project activities and take best advantage of the services offered by it, the peer educators had to ensure that the entire body of sex workers in the locality developed a positive self-image, had self-esteem and self-confidence and had an increased access to power so that they can articulate their needs and have an interest in investing in and planning for their future.....given the asymmetrical power relations within the sex industry and their social exclusion, the only way the sex workers could gain greater control over their bodies, sexuality, income, health or life was through mutual support, collective bargaining and united action. It is not enough to design a technically sound and efficient intervention programme. What is crucial for the success of any such intervention is to contest the social structural power relations and ideologies that put communities in such a vulnerable position in the first place. Unless these structural obstacles are challenged at a much broader level, any micro intervention cannot hope to bring about behavioural changes which will result in disease prevention (SHIP nd).

As a result of this perspective, the SHIP has undertaken a variety of activities including: (1) addressing the felt needs of sex workers (e.g. help with child care, legal advice, counselling, de-addiction); (2) influencing the broader sex trade environment (e.g. including *all* sex trade actors in BCC activities, and conducting advocacy with these and other important groups such

as police, media, politicians and the city's intelligentsia); (3) challenging hegemonic discourses on gender and sexuality so that possibilities are created for sex workers to "negotiate and re-interpret the dominant discourses that frame them" (SHIP 1999:34 - e.g. by holding public debates and discussions on sex work); and, (4) attempting to collectively empower sex workers through community organising, capacity building and mobilisation (e.g. through support to the DMSC). In project documentation, sex workers' dis-empowerment is theorised in relation to their social exclusion resulting from "an intersection of their class, gender and sexuality and because of the moral stigmatisation experienced as a result of their profession" (SHIP 1999:34). This perspective has led the SHIP to think of empowerment primarily as a collective phenomenon, whereby:

> .....before an individual sex worker can be really empowered to protect herself, sex workers as a group will have to be enabled to break through the structural barriers that keep them excluded from access to resources as well as participation in society. Thus, building collective political strength is the only way of empowering sex workers' community as a whole (SHIP 1999:34.

In its philosophy therefore, the SHIP represents a clear departure from previous welfare-oriented work with sex workers in Calcutta, and also from traditional biomedically and individually oriented TIs.

Dr. P states that the key to implementing a more integrated approach lies in the way the project has developed and defined its peer education strategy, and, in particular, PEs' participation in the project. At the time the SHIP was started, the peer education approach had been successfully used in a number of countries, but was often conceived in an instrumental way – i.e. as a strategy for overcoming the difficulties of gaining access to, and building up rapport with, a 'hard to reach' population, and as an efficient means of implementing a project's technical components (Evans 1999, AIDSCAP.PE). However, Dr. P felt that, in addition to these functions, the peer educators could play a crucial role as community workers, mobilisers and advocates for sex workers' rights:

> Our initial peer education programme was designed not only for outreach activities but also for attainment of self-reliance, confidence and dignity and to transfer that image to influence other members of the community which actually facilitated the creation of a base whereby the sex workers could network among themselves and function as a group for collective bargaining....initially they started as health educators but they gradually got transformed and they fit themselves into the bigger canvas of society to act as a community leader, community mobiliser and as an agent of social change (AIIHPH 1997:9).

As a result of this perspective, the SHIP has focused upon educating and building up the capacity of its PEs. Its activities have included helping the PEs to form the above mentioned cultural group (*Komal Gandhar*) whose purpose is to "facilitate self-expression, identity and

cultural mobilisation of the community" as well as spread awareness about HIV (DMSC 1998b:42). In addition, the SHIP has organised the non-formal education programme as well as many workshops, exposure visits, trainings, street demonstrations against abuse of sex workers' rights, recreational events, public meetings and debates (with intellectuals, feminists, journalists, politicians and social workers), and conference visits. By participating in these activities, the PEs have been exposed to new ideas (many of which challenge traditional attitudes to prostitution) and have also had the opportunity to learn the idioms, means and methods of organised legitimate protest within Bengali society. Since 1995 the SHIP has increasingly been involving other non-PE sex workers in these activities by encouraging their participation in large workshops and in the DMSC's programmes.

The project also supported the PEs to form a Co-operative (Usha Multi-Purpose Co-operative Society Ltd) in 1995. The Co-operative was the first of its kind in Asia to be actually registered in the name of sex workers. The SHIP helped sex workers achieve a change in West Bengal Government laws that had previously stipulated that co-operative members must be of 'good' moral character whereby sex workers would have had to register as a generic 'women's group' or 'housewives group'. They successfully lobbied for this law to be changed and were able to register as a sex workers' group. The Co-operative now has approximately 1,000 members and aims to provide services to enhance sex workers' security, through providing savings and credit, group insurance schemes, a cost-price shop and vocational training and income generation schemes. The Co-operative also co-ordinates the SHIP's social marketing strategy.

The Durbar Mahila Samanwaya Committee (DMSC)

In 1995, the SHIP helped the PEs to form the DMSC and SHIP staff members have acted as key advisors to the group, especially in its initial years. The extent of the SHIP's involvement in the DMSC and its influence on the group's theoretical and political position on sex workers' rights vis a vis sex workers' 'own' voices or agency has been a matter of some controversy in Calcutta and will be discussed further in chapter six. Here, I will merely point out that, expectedly, the two organisations are intimately linked, and that the DMSC's policy/theoretical statements, some extracts of which are given below, were written with SHIP help.

The DMSC evolved out the PEs' desire to respond to requests for help made by sex workers they met during fieldwork. The organisation developed out of various PE-led committees that

had already been formed within the SHIP including an 'interlink' committee that was concerned with increasing networking between sex workers (and PEs in particular) in different areas, and an 'action' committee whose purpose was to take action regarding sex workers' problems. Eventually, the action committee was catalysed into becoming the DMSC following the revelation in 1995 that an illegal HIV vaccine was being tested on sex workers:

> First we had interlink committee and its rule was such that we would go around places doing meetings and talking to different girls, getting them together – the interlink women had many responsibilities. One day the girls decided that we cannot take all responsibilities, there are other girls as well – so we approached Dr.P and said that we should make another committee – the action committee. This committee's responsibility was to deal with all problems of the sex workers and the project. Meaning that all fights and everything would be resisted and solved by this committee. Then, this committee became the *Durbar Mahila Samanwaya Committee*. What happened was that we heard that some doctor was doing a vaccine trial on sex workers – But are not sex workers also human beings? Regarding this we brought out a rally – this was our first protest (interview with DMSC leader).

With the aid of the SHIP, the DMSC brought out a street demonstration against the vaccine trial and raised a lot of publicity in the media about the case. Since 1995, there have been a number of other incidents in response to which the DMSC has brought out large street protests, including an occasion when local *para mastaans* in Tollygunge were trying to extort large sums of money from the sex workers there. Other occasions were in Kidderpur when a sex worker was badly beaten up, and in other areas where sex workers were being threatened with eviction.

In addition to acting as a sex workers' 'watch dog' committee, the DMSC has long term political goals for the social recognition of sex work as a legitimate occupation and for the complete decriminalisation of adult sex work. It has organised two state conferences as well as India's first ever national conference of sex workers in 1997 around the key theme "sex work is valid work, we want workers' rights" (DMSC 1998a, 1998b, AIIHPH 1997). With respect to improving working conditions and controlling the abuses associated with the sex trade, the DMSC has proposed the establishment of locally-based self-regulatory boards along the lines of those of other professional bodies (of which, to date, three have been established in small redlight areas).

The DMSC has been undertaking networking and advocacy work on a national and international level and has been remarkably successful in mobilising support among other Indian sex workers. DMSC members have travelled all over West Bengal, visiting other redlight areas, telling women about the DMSC and SHIP, helping to set up local branches, and mobilising sex workers to attend DMSC events. With technical help from the SHIP, the DMSC regularly organises workshops for ordinary sex workers on subjects ranging from

legal rights to safer sex. Since 1995 therefore, there has been a concerted effort to bring more and more sex workers into contact with the SHIP/DMSC and to build up linkages and support at the grass roots level. The DMSC now has a State-wide membership of over 40,000 (including male and trans-sexual sex workers who requested to join) and has forged links with other sex worker groups and HIV NGOs across India. In addition, it is the Asian region co-ordinating body for the International Network of Sex Worker Projects. The DMSC has also been involved in HIV advocacy, participating in international conferences and, with the help of one of the Conglomerate NGOs, supporting local groups to set up their own HIV interventions in 20 redlight areas across West Bengal, and running an HIV/AIDS telephone hotline.

The DMSC is registered under the Indian Societies' Act and has a democratic management structure whereby its key office bearers are regularly elected. Its leadership is drawn almost entirely from among the PEs. The DMSC has a number of sub-committees and holds a weekly meeting which branch representatives are supposed to attend. The Sett Bagan *Mahila Sangha* has remained separate from the DMSC but participates in most of its activities. In 1999, a *babu's* collective called *Sathi Sangathan* (comprised of 30 PEs' *babus*) has been formed and is affiliated with the DMSC. Group members act as male PEs and lend general support to the DMSC's work (SHIP 1999).

Both the MS and the DMSC have, with help from the SHIP, spoken out to resist stigmatisation or exploitation of sex workers because of AIDS. As early as 1993 the SHIP supported the MS to publish a leaflet criticising their perceived exploitation in the name of AIDS:

> Nowadays, in response to the AIDS disease, lot and lots of organisations are jumping into the redlight areas and will not leave without 'serving' us. One says, I will serve you best, another says no, I will. We all got very scared.... We have heard that crores and crores of rupees are coming from this country and abroad....if anyone runs a business it does not really bother us...but if anyone runs it at your cost, by exploiting you, you will not like it (MS 1993).

The DMSC has also objected to the tendency to blame sex workers for the spread of HIV:

> In this society, as with all other issues, women are given the blame, and amongst all women, those who are the weakest, the sex workers, they are made to shoulder the burden of spreading AIDS.....this many know, that if sex workers want to do safe sex with their customers, this cannot happen if the customers do not agree. But these same customers are spreading the disease to their families and to society....The prevention of AIDS is only possible through everyone's united efforts. We want to make every person well informed about this disease. And it is not just our wish to speak big words about this matter. We want the social, economic and legal rights upon which the success of our endeavour depends.....Sex workers are also human. They also have self-respect and rights...come, stand by us, strengthen our hand (DMSC 1995).

Measuring Success: The SHIP as a Best Practice Model

In the HIV prevention field, the impacts of a TI are measured almost exclusively by attempting to measure changes in behaviour (usually changes in condom use and changes in health-seeking, e.g. relative utilisation of externally introduced STD treatment services vis a vis other treatment sources). In addition, there is often an attempt to measure changes in 'knowledge' about AIDS/STD and changes in personal risk assessment. Where possible, change in STD/HIV prevalence is also measured. These are highly specific and individually-oriented indicators of change and their measurement is usually carried out by means of quantitative surveys. The theoretical framework and methodologies for assessing broader social or community changes, in particular the operationalisation of concepts such as empowerment, participation or creating an 'enabling environment' are still being developed and are yet to be adequately elaborated with respect to the specific situation of sex work or sexual health (cf. Oakley et al 1998, Marsden et al 1994, UNAC 1996).

With regard to the SHIP, following the 1992 baseline survey, three subsequent quantitative surveys have been conducted to measure the above-mentioned outcome indicators (AIIHPH 1993c, 1995 and 1998). The broader social impacts of the project, or the impact of non-technical project activities upon the technical outcome indicators have not systematically been explored through research, monitoring or evaluation (but see DMSC 1998b), though a research project is now underway to assess "the role of community development approaches in ensuring the effectiveness and sustainability of interventions to reduce HIV transmission through commercial sex work"[3].

The methodologies used in the different surveys were not always consistent but some comparisons can be made[4]. Random samples of between 450-600 sex workers were selected to proportionately represent the 3 different economic categories of sex workers (A, B or C). 'Knowledge' of HIV is reported to have increased from 30.6% in 1992 to 96% in 1998. Condom use is also reported to have increased dramatically. It has been measured in two ways by the Project. One is by generic questioning about regularity of use, classified as 'never', 'always' or 'often'. This is acknowledged as being rather non-specific however and, since 1993, sex workers have been asked about percentage of condom use in their sexual encounters of the previous day. In 1992, only 1% of sex workers claimed to 'always' use

[3] This research is being conducted by the SHIP with financial and technical support from the Population Council, Horizons Operations Research Project.

condoms. This increased to 47% in 1993 and remains at 50.4% in 1998. By 1993, after only one year of the project 71.4% of sex acts the previous day were reportedly protected by condoms and this figure has increased to 78.5% in 1998. STD prevalence has also reduced – syphilis has decreased from 25.4% in 1992 to 11.9% in 1998[5], and HIV prevalence has remained extremely low in contrast with comparable populations in other Indian cities, rising only from 1%-5% by 1998.

These study results indicate that the SHIP appears to have made considerable progress towards achieving its technical objectives of safer sex behaviour change, STD reduction and curbing HIV transmission[6]. In 1995, an international external evaluation team stated that the SHIP is "perhaps one of the best interventions for sex workers in the world" (WBSHP 1996:1). In addition, it declared that:

> The Sonagachi project should be used a working model for the expansion of efforts to the West Bengal Sexual Health Project. The mechanisms of management, the involvement of the community and a large array of actors and the evident success of the project all argue for this (ibid:2).

The evaluation team attributed the SHIP's success not only to its technical strategies, but, crucially, *linked* this to its integrated and participatory approach. This, they felt, had brought about significant 'empowerment' of sex workers (especially the PEs), defined in terms of increased self-confidence and self-esteem and increased potential of the sex worker community to protect their own interests through mechanisms of "mutual support, collective bargaining and united action" (WBSHP 1996:19). The SHIP's philosophy of linking behaviour change to the need for structural change and community mobilisation thereby received international endorsement. Indeed, the SHIP is now held up internationally as a 'model' sex worker project and its replication is being encouraged across India and elsewhere. The director and other SHIP members are now seen as crucial resource people and are actively involved in national and international debates on policy and intervention initiatives in the HIV/sex worker field (UNAIDS Best Practice Book 1999, Gordon & Sleightholme 1996, NACO 1999). Later on in the thesis I will be examining more closely the ways in which the SHIP operationalised both its technical components and its participatory strategies, and will be considering what empowerment means in the Calcutta context, and to what extent a project can be constructed as a 'model'.

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[4] Further details on these surveys, including disaggregation of results according to 'category' of sex worker are discussed in the subsequent chapters.

[5] The syphilis blood test (VDRL) is able to detect *any* past history of syphilis infection. Active, current infection is defined as that which is detectable at dilutions of a 1:8 ratio or greater ratio.

[6] However, see chapters 7 & 8 for discussions on the potential problems with interpreting the SHIP's survey results.

Conclusion

Prior to HIV, Indian sex workers were a neglected and marginalised group. As in other countries, with the emergence of AIDS and its link to the sex trade, sex workers suddenly attracted unprecedented public attention – some of it unwelcome and stigmatising no doubt, but nonetheless, presenting an opportunity, if properly seized, for sex workers to make their own voices heard.

Sex worker TIs are now being implemented across India. A number of these projects (in addition to the SHIP) have, to some extent, realised this opportunity, and are playing an increasing role in publicising sex worker issues and in addressing sex workers' perceived needs. They stress women's social and medical *vulnerability* to HIV and call for a holistic approach to HIV prevention (Gram Bharati Samiti 1995, Jana & Bailey 1994, Jana & Singh 1995, AIIHPH 1997, Asthana & Oostvogels 1996, IHO 1992, 1993).

It is the SHIP in Calcutta however that has gone one step further and has actively facilitated the participation of sex workers themselves in mainstream discourses on HIV. As a result, sex workers in Calcutta have begun to challenge the status quo, and, indeed, are using AIDS as a platform for airing more general demands (Kumar 1997). Paradoxically then, with the DMSC now spearheading what has become a national movement for sex workers rights, AIDS and the SHIP have provided an opportunity for Indian sex workers to move from a position of near invisibility to being able to speak out against hegemonic discourses.

CHAPTER FIVE

NEGOTIATING MARGINALITY: SEX WORK, IDENTITY AND COMMUNITY

> We have not taken birth here. We were born in a *bhodro* (respectable) place. The *beshya* (prostitute) who has come here is someone's *meye* (daughter), someone's *bouma* (daughter in law), she is something other than only a *beshya* – she is someone's *masi* (maternal aunt), someone's *pisi* (paternal aunt), someone's *kakima* (paternal uncle's wife) – she is something of somebody's (Sonagachi peer educator).

Introduction

In this chapter I explore a dominant theme that emerged from my research, namely sex workers' search for, and construction of, an acceptable identity and sense of community. This is important as later chapters will show how issues of identity and community had profound implications for understanding the ways in which the SHIP was responded to, and for understanding behaviour change (especially, for example, sex workers ability to practise safer sex with their *babus*).

In chapter three, I described how, since British colonial times, sex work has been primarily a working class occupation and has been associated with poverty and with severe social stigma. In contemporary India this stigma is associated with dominant, Brahmanical constructions of female sexuality which lay great emphasis on pre-marital virginity and chastity within marriage in order to ensure the purity of the wife and thus of her children who continue the patriline within specific castes and communities. Thus the expression of female sexuality is expected to be confined to marriage, and then with the main purpose of procreation (Bennett 1983, Allen 1980, Wadley 1980, Jacobson & Wadley 1977). As women having non-procreative sex with many men outside marriage who may also be from different castes and communities, sex workers violate social norms and are set up against an image of the pure faithful wife. Research in India clearly shows that in reality men and women frequently break social norms and engage in various kinds of 'forbidden' sexual behaviours, and that in certain communities, pre/extra-marital sexual affairs are even tacitly accepted (Nag 1996, Jejeebhoy 1998). However, I believe it is true to say that at an ideological level most people in India will be aware of, *publicly* subscribe to, and will to some extent have internalised, the dominant discourse. This certainly seemed to be the case among my informants. Because they lived in redlight areas, they were publicly labelled *beshya* (prostitute). Reconciling this with their

other identities was often painful and full of contradiction (cf. Hart 1996, Lewis-Renuad 1997, Jaget 1980).

In the city, the stigma associated with the sex trade is experienced mainly in the form of harassment, discrimination and prejudicial treatment from public services (for example, hospitals, schools, the police and judiciary). Hence, when accessing these services, sex workers often lie about their identity, they may take *babus* with them to try and appear 'respectable' and they may seek the help of local power brokers to mediate on their behalf. In addition, sex workers are subject to disrespectful or unkind comments from local people who recognise them as they go about their daily business. For this reason, many sex workers dislike leaving the redlight area and try to fulfil all their requirements from the inside.

On a more personal level, as the next section describes, sex workers have to deal with a fractured self-image that, in Indian society, comes with the perceived loss of status from that of virtuous wife or pure virgin. The ways in which sex work affects women's relationships and status within their kin or other social networks are various and will also be described below.

This chapter is divided into 3 sections. The first discusses how women experience having become a sex worker. The second looks at the strategies sex workers employ to come to terms with their situation, including the ways in which women forge and use social relationships to retain a sense of personal identity and connection with wider society, and the final section discusses the different ways in which women perceive and resist their marginalised social status.

Falling into the Line: Identity Crisis

The social meaning of becoming a sex worker is indicated in Bengali by the use of the verb '*nama*', meaning to fall or to descend. Women most frequently describe their entry into the sex trade as having 'fallen into the line' (*line-e nemechi*). Some of my informants spoke of the first year following their 'descent' into the line as an unprecedented assault on their sense of identity. Some had entered into the sex trade when they were still teenagers and relatively naïve about the world. For those who migrated to Calcutta, it was often their first experience of a city and homesickness was acute. For those who were tricked or forced into the sex trade, unlike other migrant workers, they were unable to seek out support from village or kinship networks. Rather, they found themselves alone in a hostile environment, surrounded by

strangers of different castes, religions and ethnic groups. Women described the trauma of having to adjust to situations in which all normal social conventions and daily routines were turned upside down. Many talked of their first experiences of sex work as agonisingly painful – both physically, for obvious reasons, and also emotionally as their self-image as 'good' 'respectable' girls was shattered. Podda, a sex worker from Sonagachi described as follows the disorientation and emotional confusion that she experienced when she became a sex worker:

> When we used to stay in the *grihastha bari* (family house), when we lived with our *mababa* (parents) we knew what we are supposed to do and how our behaviour should be – what one has to do in the morning, what at night and what in the afternoon, we knew all this. But after coming here it all got mixed up – we had to forget everything we knew and learn how to behave in a different way. After falling into the line, that first year somehow my mind was broken – I wasn't right – all the time crying - didn't talk to anyone – just thinking about my *mababa* – what would they say if they knew I was spoilt? – didn't know what to do or where I could go. Then one day one of the *dalals* said to me it is no use crying, this is your fate, you must accept it. I said I can never accept this but he replied that see, now you have fallen into this line, you have lost your honour, you have become spoilt - you are like a white sari – if it gets stained, you can wash it but it will never get clean – now you are stained like this so accept your fate, stay here and make some money.

As the above example shows, some of my informants described how it is common for sex trade controllers to capitalise upon women's vulnerable mental state after their first few experiences with customers to make them give up any resistance to sex work. They do so by emphasising the dominant social discourses around female sexuality to stress that a girl who has sex before marriage, or a wife who has sex with men other than her husband has lost her honour, is immoral and is irrevocably 'spoilt'. I found that the feeling of being spoilt or of having become 'bad' is deeply internalised and very difficult to challenge even where women have consciously chosen sex work as a livelihood strategy. Sex workers would distinguish themselves in conversation as *kharap meye* (bad girls) as opposed to *bhalo meye* (good girls). When I tried explore alternative perceptions of sex work, the ideology of a woman's honour appeared all pervasive. According to my own personal view (and that put forward by SHIP staff), sex workers had made enormous personal sacrifices to assist their families, they were struggling commendably to somehow get by in life despite the challenges and difficulties that had come their way, and sex work was a job they did in order to survive. It proved extraordinarily difficult for my informants to see this perspective however. One sex worker, Komola, for example, replied that:

> What you say *boudi* is true. All my life I have worked and suffered for my family. I have made my children big and got them all married. For sure you are right that it is what is in a person's heart that matters, but in my heart I know I am bad – as long as I am here I can never feel that I am good.

On another occasion I was talking to Soma – a spirited and seemingly self-confident sex worker who had considerable influence in her locality and who was clearly well off. She had freely decided to join the 'line' after having worked in a *yatra* (street theatre) company and had done well, but had nonetheless been unable to come to terms with her identity:

> I do understand what are you are saying *didi* but for us line girls it is different. See, before I had nothing. After coming to this line I have all the gold ornaments I could desire. I have brass utensils, quilts and I could get whatever I wanted. I have known love, I have a man, we have a son and daughter, friends and relatives. My daughter has been married off. But amidst all this I feel so empty. My heart burns like a blazing fire. Amidst all this fullness is a vast empty space - as if nothing belongs to me. I close my eyes and I can see there is nothing. You see, you must realise one thing - you are from a good family, you are not spoilt. Whatever happens you will find some shelter in some place or the other. But it is not so for a line woman - we are the same as worms in the gutter.

Similar sentiments have been expressed by Bhadu, a sex worker who published her story in a DMSC journal:

> After joining the line it seemed I could jump over all hurdles in one go....stomach was filled, got new saris, sent clothes and money to my parents.....It is true that there is a lot of suffering in line work, but even before that life has been no less disgraceful and tortured. Now.....I think that line work has helped me eat and survive, taken care of my family needs. I have received a lot of love in this life but a strange sadness has always remained....To all, we are spoilt women....society has only that one thing to say – we are women of the line, we are bad. In this line we have our husband and yet we don't, there is no right to our own identity. This is why even after getting something (the little that we have) we feel we have nothing. A space amongst all will never be found. No wonder that though we are with all, yet we feel alone. If only we had that little identity that we are human being like others...our pain is that though we are living in society we are like outside beings – does anyone understand this? This suppressed pain is always looking for a way out. And nothing else do we want – just an identity, a social recognition – is that so difficult? (Das 1996)

Effects of Social Exclusion

It is my impression that the perception of social exclusion described above is a particularly acute problem for women living in the redlight area brothels in Calcutta. Not only do they personally feel 'spoilt' but, (unlike the flyers), their status is public knowledge through their residence in a 'bad' area. As one informant pointed out: "as long as I live in a place like this, I can never feel good". Sex workers, often with their *babus*, do sometimes try and move out to live in a respectable neighbourhood. However, it is not uncommon for the woman to be recognised, publicly labelled a whore and driven out of the locality.

Brothel based sex workers work and live in the same place, and are 'on duty' for virtually all their waking hours. The distinction between a personal and professional life (and identity) may eventually become very blurred. Socially, physically and geographically confined to the world of the sex trade, the sex trade becomes their world. For them, sex work becomes more than an occupation – it becomes a way of life. Over time, women adapt to the life, social rules

and political sub-cultures of this world and try to create their own space within it. However, as women get used to the culture of the sex trade, they may also find themselves increasingly uncomfortable with, and alienated from, the rules and culture of '*bhodro*' society. This may be one reason why attempts to socially 'rehabilitate' sex workers often seem to fail. In spite of being provided with numerous options, sex workers often return to the sex trade (Development Dialogue, Sanlaap, pers. comm.). A similar process of alienation has been noted by TAMPEP in its work among migrant sex workers in Europe:

> They are....continuously exposed to the context of the sex industry and work, in these cases [it] becomes a rather abnormal and strange life style characterised by severe isolation and marginalisation. For these groups it is extremely difficult to even think out and plan an independent excursion....outside the domain with which they are familiar. (TAMPEP1995:109)

While some women adapt well to life in the redlight areas and may become quite powerful within their own localities, the sex trade generally has little to offer in terms of finding a sense of belonging or community. In a society that is highly status conscious, it is usually considered inappropriate to air problems outside the family context. Thus, social interaction between women who are not part of one's own family rarely consists of sharing problems or garnering support. Rather, there is usually an attempt to gloss over any problems and to try and present oneself and one's family in a positive light. I found that this was the case even in Sett Bagan where a large number of sex workers had come together to form the *Mahila Sangha*[1]. Likewise, it is rarely possible for sex workers to establish 'fictive kin' relations within the redlight areas, a strategy that can sometimes be used in India for women to obtain family-like support from unrelated friends (often men who become fictive 'brothers'). The profession of sex work is seen to preclude the possibility of establishing a conventional brother/sister-like relationship, in which a brother would normally act to defend his sister's 'honour':

> We are women who sell our honour, so how can we ask someone to be our brother? If a customer is drunk and abuses us, he cannot come to our aid like a brother should, - in this place no-one can be a brother. One day you call them 'brother' and they next day they abuse you, and say - come, let's go to your room (Sett Bagan sex worker).

Thus, there has traditionally been little friendship or solidarity amongst sex workers, who, unlike other marginalised groups in India (such as Untouchables), share no common group-based (caste or kin) identity. The individualised sense of stigma associated with sex work that

[1] The MS had certainly fostered a greater sense of community in the area than was found in neighbouring Sonagachi but had also caused social divisions (see chapter 6).

stems from a discourse of female honour is a defining feature of sex workers' sense of identity. This, and the organisational structure of the sex trade appears, until recently, to have precluded the possibility of women finding solidarity through developing collective or alternative constructions of identity, such as the one proposed by the SHIP, on the basis of their shared identity as sex *workers*.

A common method employed by marginalised groups in India to protect or advance their interests is through establishing patronage relationships with powerful individuals (such as local politicians) or institutions (such as the church – cf. Mosse 1996). As noted in chapter three, individual sex workers do forge connections with patrons within the socio-political structures of the redlight areas, but this primarily occurs on an individualised basis, rather than to promote the interests of sex workers as a group. As such, these patronage relationships offer no possibility for re-definition of sex workers' group identity or re-negotiation of their social position. Thus, one of the only ways that sex workers have been able to gain emotional or practical support or retain a sense of personal identity or 'connection' with normal social life is through attempting to adhere to traditional family-like structures and relationships - keeping in touch with their own families where possible, or by constructing their own family units in the redlight areas by having relationships with *babus*, and by having children.

Making Connections

In the sections below, I describe the different meanings that family and personal relationships may have for sex workers, and how they try to construct and negotiate these relationships to maintain their own interests. The sections will respectively examine sex workers' relationships with their natal families, with their *babus* and with their children.

The Desh (Native Place)

The social ramifications of being a sex worker are perhaps most starkly visible through their effect on family relationships, which, unsurprisingly, are often characterised by ambivalence and role contradiction[2]. Sex workers' involvement with their family and kin networks vary tremendously. Some have lost touch altogether (perhaps having been secretly brought into the line from a distant place, having been disowned when their sex work was found out, or just

[2] The relationships between sex workers and their families, broader kin, caste and village communities requires further investigation however, ideally through fieldwork in sex workers' home communities. I found that without firsthand knowledge of the people and places involved, interviews with sex workers about their families and communities usually became extremely complicated, long and rather inconsistent. The analysis presented here, therefore, is at a rather general level.

having lost touch over time). Some are still in touch, but their families do not know about their involvement in the sex trade. Others retain close contact with their families of whom at least some members are aware of their occupation.

These different dimensions of 'connectedness' with family carry with them difficult issues which have to be negotiated. The first is how to cope with the sense of alienation and loneliness that may come from not having any contact at all with family or relatives. Sex workers who have lost all contact with their home are in many ways alone in the world. This is distressing for anyone, but in the Indian context where people generally define themselves through their community and kinship networks rather than through individual attributes (as in the West for example), and where there is no welfare state to fall back on, being alone is a particularly bitter fate.

The second issue is how to conceal one's involvement in the sex trade where families or village communities are unaware of a sex worker's occupation. Sex workers from rural areas describe how they must construct consistent stories about their lives and work in Calcutta, saying, for example, that they are working as domestic servants or in small-scale factories. They must be able to make excuses to discourage relatives who want to visit (usually blaming difficult landlords or citing lack of space). They live in constant fear of being discovered. The problem is particularly acute for women who were unmarried and childless when they left the village. If they return to the village with children in tow, they must develop a convincing story of a marriage and husband. They must also be able to produce a 'husband' to bring back with them to the village, especially in cases where women have attributed their ability to help out financially to a generous and 'good' husband. Sex workers often take their *babus* back to their natal homes and the couple say that they are married. Here, the transience of sex worker-*babu* relationships poses problems however. If the relationship breaks up and subsequently a new one develops, sex workers are in a difficult position regarding how to explain their new situation. They cannot return with a different man.

The third issue concerns a phenomenon that appears to be quite common among families who are aware of a sex workers' profession - the commercialisation of family relationships. Some sex workers I knew described how their families sometimes exerted tremendous pressure on them to remit money home. This is exacerbated if they have left a child with their family. It is not uncommon, for example, for relatives to fabricate stories of a child's illness and then to demand huge medical fees from its mother. Sex workers are often expected to make substantial contributions to relatives' weddings or funerals, or to buy land for their brothers.

Some of my informants reported rather bitterly that in spite of all that they had done for their families, they were themselves denied support or protection, or were merely used as long as they were earning well:

> I cannot return home without money, so I will have to look after my own future. It is true that with money people will even pick you up from the streets, but without money even your brothers will leave you there (Sett Bagan sex worker).

On the whole, my data indicate that the 'family' is rarely a place where brothel based sex workers can seek support yet, understandably, women cling on to their family connections out of a sense of duty and fear of otherwise being alone. In addition, if sex workers have children, they may feel obliged to retain contact with kin for the purpose of arranging their children's marriages in the future.

"Everyone Needs an Umbrella over their Head": Sex Workers and their Babus

Most of the sex workers that I knew were in relationships with *babus*. *Babus* are usually customers who begin to return to the same sex worker and develop a friendship with her. Over time the commercial nature of the relationship becomes blurred. For example, a *babu* may begin to buy the sex worker presents or help her out financially or, she may stop asking him for money for sex and, indeed, may start to give him money. This is common when a sex worker has fallen in love and a *babu* makes promises of building a common life together for which capital is required. As noted in chapter three however, it is also common for sex workers to be badly cheated and let down by these so-called *khanewala babus* and many of my informants (who were usually older sex workers) had experienced this:

> A man comes along and says he likes you...at first they think oh this man is so handsome and good looking.....he tells them things like – I will give my life for you – makes all these vows and so they start to trust them. This is what happens.....after some time these men realise that they can get money and *bidis* (local cigarettes) and alcohol and enjoy themselves – and they don't have to work, they can live there for free.....the *para cheles* are the worst – they think that if I can make a girl in the neighbourhood, then I can live off her, I don't have to work and earn, I can just 'eat' and become a 'big' person in the *para*. ....Me? I am a line woman, and this much I have learnt in my life – I may have my *babu* but I can never trust a man – no matter what he does he for me (Sett Bagan sex worker).

Sex worker-*babu* alliances are often casual and transient. However, sometimes they do formally marry in a temple, usually in a simple ceremony involving just the temple priest. The sex worker then wears *sindhur* (vermillion) and Bengali marriage bangles (*chaka-palla*). Even without marriage, when relationships with *babus* become long term, they may take on a conjugal shape in which sex workers and *babus* respectively behave more and more like wives and husbands, and may share a household and children. In such long term alliances, sex

workers sometimes refer to themselves as a second wife (*sothin*), if the *babu* is already married. Likewise, they refer to their *babus* in the same terms used to address husbands in Bengal: *kurta* (head of household), *swami/bor* (husband), *ghor-er lok* (man of the house).

Babus, like customers, are extremely various. Some are local men (*para cheles*), others live far away. Some men virtually live in the redlight area with their girlfriend (especially if they are migrant workers). Other men spend a few days each week there, and some simply visit but never stay over. Some are single, some are married. Some *babus*' families have no idea about his relationship. Others are aware of it, and some sex workers have even met their *babus*' parents or wives. These may not know that this 'other' woman is a sex worker however. In some cases, sex workers' children were even being looked after by their *babu's* first wives.

Sex workers' relationships with *babus* were often marked by ambivalence, and, as with the family, by role inversion. This is to some extent reflected in the language sex workers use to describe getting into a relationship with a *babu*. Women usually talk of 'making' (*kora*) or 'keeping' (*rakha*) a *babu*. These expressions imply that sex workers actively work to form their relationship. These terms are not normally used in Bengali, where love and marriage are usually described passively, as something that just 'happens' (*hoaya*) to someone[3]. Sex workers' linguistic expressions, therefore, already imply that their relationship is different from the norm – the world of love, marriage and romance does not just 'happen' for a sex worker – it is something she must actively seek to construct.

My informants explained that, especially when sex workers were still young, like anyone else they sought love and intimacy in their lives and hoped that a *babu* might fulfil their romantic expectations. Indeed, they indicated that in the context of the sex trade, where women cannot always rely upon their natal family, a sex workers' desire for love, nurturing and to have her *own* family is perhaps particularly strong:

> For a woman in the line, a *babu* is everything – more than your *mababa* (Sett Bagan sex worker).

However *babus* are not just romantic icons, but also play a crucial strategic, practical and functional role in sex workers' lives. In traditional Indian society women rarely live alone, and they are not used to having to manage affairs of the 'outside' world. Normally, they must always rely upon their husband or other male relatives to handle the public domain. Without a man to offer protection and guidance, sex workers feel extremely vulnerable (and, indeed, *are*

[3] The exception is love marriage which, in contrast to an arranged marriage, is also described as an active process.

extremely vulnerable). For their own well being therefore, it is important for sex workers to be able to access male support. In a context where they are generally unable to call upon their own male relatives, it is in their own interests to form a relationship with a *babu*. No matter how abusive or exploitative a *babu* might be, sex workers may still feel the situation is better than having no-one, and in this they are undoubtedly no different from millions of 'wives' in conventional marriages:

> Why do I keep a *babu*? See, *boudi*, everyone needs an umbrella over their head – I keep a *babu* so that there is someone over my head, someone who will look after me if I have trouble, someone who will bring me water when I am sick, someone to help running he family (Sett Bagan sex worker).

Many of my informants openly admitted the material or functional basis of their relationships with *babus*. They discussed how sex workers living in particularly violent neighbourhoods for example, might consciously try and make a *para chele* her *babu* so as to reduce the risk of being targeted by the local *mastaans*. Others were prepared to tolerate loveless and abusive relationships in return for a contribution a *babu* might be making to household expenses. Another reason why sex workers might tolerate a difficult relationship is that they have may have introduced their *babu* to their relatives as their husband and need the social status of 'wife' that a *babu* can confer in order to maintain contact with family and kin.

This practical husband-like function of a *babu* may also have a symbolic significance for sex workers. By keeping a *babu* and perhaps by having children by him, sex workers try to construct for themselves a 'family-like' unit in which they can take on the socially 'respectable' roles of wife and mother, and can feel that they are ordinary women and are part of 'normal' society. Also, by forming their own family, sex workers try to assure for themselves some kind of security for the future. If they have children, sex workers also value a *babu* in his role as a father and in providing a social identity to the child (as social identity in India is usually conferred through the patriline). Sex workers' children usually take their father's name and caste identity, and, where possible, their marriages will be organised through their father's community, though in reality, it is quite common for the relationship to have broken up by then.

Thus, *babus* play a crucial emotional, practical and symbolic role in sex workers' lives. They are however, inherently unequal relationships. Sex workers may be better off financially, but their dependence upon a *babu* in other aspects of their lives, and a tendency to adhere to conventional notions of wife-like (submissive) behaviour within the relationship generally leaves them in a weak position to assert their rights. Furthermore, the role ambiguity within a

sex worker-*babu* relationship means that these relationships are rarely harmonious. Indeed, they are all too often characterised by conflict and violence.

The sex worker-*babu* relationship is clearly an anomaly. Within a sex worker-*babu* relationship, the sex worker is not only often the main bread winner (unusual in the Indian context) but her work involves having sex with other men. Couples must reconcile themselves to this reality, and must also deal with differing expectations they may have of each other. For example, in some cases, a *denevala babu* may feel that he wants to 'rescue' his girlfriend or may dislike the idea of her seeing other men. Such *babus* may offer to pay money so that their girlfriend can stop sex work. Some sex workers are happy to agree to this and to create a relationship in which 'conventional' conjugal-like role expectations apply. Others are more cynical however, and feel they cannot put all their eggs in one basket, having learnt from experience that it is risky to trust *babus*:

> My *babu* says to come away from this place with him and stay outside but I am not going because I cannot leave everything in his hands. I have to earn and look after myself. I have mixed with five people and have heard what they say about men so I can't trust him that much (Sett Bagan sex worker).

Where *babus* are unhappy about their girlfriend continuing to do sex work, this can become a source of tension and conflict in the relationship. Relationships with so-called *khanevala babus* are also often characterised by conflict (often over money). In addition, although these men live off sex workers' earnings, they may also become jealous, especially if they suspect that their girlfriend is perhaps beginning to fall in love with someone else who may become a rival *babu*. In the redlight area environment, a girlfriend (perhaps a particularly beautiful girl) and the privileges that her money can buy lend status to men who may have little else in their lives with which to bolster self-esteem. Thus, although *khanewala babus* are renowned for treating their girlfriends with callous disregard, they may be exceedingly possessive and can become extremely violent if they suspect 'infidelity'. Rejected *babus* are dangerous. There are a significant number of sex workers sporting scars on their faces and necks where they have been slashed with a razor blade or burned by acid thrown by a spurned lover. Conversely, conflict in a relationship can also arise because of a sex worker's jealousy, especially if she knows that her *babu* has another family or another girlfriend in a different redlight area (which is not uncommon).

However, some women I knew were fortunate enough to be together with a 'good' *babu* and seemed highly appreciative of their situation. Indeed, my informants pointed out that when relationships are going well, a relationship with a *babu* is qualitatively different from that

with a husband, and some clearly treasured the love, intimacy and freedom that could be found with a *babu*:

> You know, the line girls love their *babus* more than a wife loves her husband. Why? Because a family girl has all the family around, there is no-where for just husband and wife. Here there are just the two of you. We can sit and eat and feed each other, drink and dance together and make love. You can't do this in a family house. They can't do anything during the day, only maybe at night. When the father comes home from work he goes to the child, not to you. To you he comes only at night. Here we can talk undisturbed (Sett Bagan sex worker).

The sex workers I knew tried to make a clear distinction between their relationships with *babus* and with customers, and this distinction was important to them in terms of creating some space in their lives that was away from commercial sex, where they could try and build up a sense of 'family', and where they could express their own desires and personality distinct from the imposed identity of 'prostitute'. Separating work from private life is not easy however in a context where women live and work in the same room and sleep with customers and lovers on the same bed. It is also not easy where relationships with *babus* are inevitably commercialised and based on explicit or implicit exchanges of money, 'protection', 'status' and sex. Indeed, the very distinction that sex workers themselves make between *babus* as *denevala* or *khanevala* is one based upon the flow of money. In some cases a sex worker-*babu* relationship simply represents an inversion of the customer relationship, whereby a sex worker seems almost to 'buy' a (*khanevala*) *babu* and the functions that he can provide in exchange for sex. In other cases, when, for example, sex workers have a *denevala babu* who pays them to stop sex work, the relationship may still be considered as a contractual exchange of sex for money, not dissimilar to sex work, (and also not dissimilar to conventional marriage in India in which sex is also often described by women in terms of 'work' – cf. Jeffery, Jeffery & Lyon 1989, Jeffery & Jeffery 1996, Kakar 1989, Khan et al 1996, Narayana 1996, George & Jaswal 1995, Seal 1999):

> If I stop giving him 'that' (sex) today, then tomorrow he will stop all my expenses and then where will I go? Going back to line work I would have to do the same thing – better I just do it with one (Sonagachi sex worker).

Many of my informants in Sett Bagan and Sonagachi however, tried to construct their relationship with their *babu* as different, as *theirs* and as special, by using a discourse of love, trust, sexual intimacy/pleasure and procreation. With customers, they stressed their professionalism and detachment, for example by using a different work name or by refusing to divulge any personal details to curious customers. They also emphasised the commercial and disembodied nature of their exchanges with clients – sex was 'just' work and did not involve any romantic feelings or emotional attachment, nor (usually) sexual enjoyment.

Women I talked to explained how they made a division between the body and the mind – they were using their body for work, but the customer could not buy their mind[4]. By contrast, sexual intimacy with a *babu* was described in terms of 'mental union' (*mon-er mil*) by which women allowed themselves to become emotionally and physically involved:

> All these many customers, they are false, as are we – what we do with them is false. We are acting for money. Emotional/mental union can be had only with one person and you have to satisfy your own urge to 'enjoy' only with him. Like you do with a husband. Like a *babu* – who is a *babu*? – The one you really love, with whom there is some mental union. You can do it only with him. It happens only with him (Sonagachi peer educator).

The distinction sex workers made between sex with or without 'mental union' or '*enjoyment*' (an English word used euphemistically to mean orgasm) was important, not just because it symbolised a 'special' relationship, but also because of a discourse in which only sex with love was considered procreative. For many of my informants, sex without 'mental union' was considered to be literally 'barren' as they believed that conception could only occur if both men and women achieved orgasm and if their respective 'semens' mixed[5]:

> Thousands of men are coming. Are you loving those thousands of men? No. Only when there is love there, then only can you have a child. '*Sex*' (orgasm) does not happen with everyone, it only happens with the one you love (Sett Bagan peer educator).

During fieldwork, sex workers often referred to their *babus* as the father of their children. At the time when these children would have been conceived (before the SHIP), condom and contraceptive use was extremely low, and I often wondered how women could be so sure about who the father was. It appears that some sex workers use this discourse of love and procreation not only as a way of establishing a 'special' relationship with a man, but also in order to establish a paternal identity for their children.

Sex workers admit however that there are times when they do feel attracted to customers. In these cases, they consciously try to exert 'mental control' so that 'nothing happens' and so that conception does not occur[6]. This strategy is, of course, not always successful in preventing conception during times when a sex worker is not in a relationship with a *babu*. The conception may then be attributed to a lapse in 'mental control' with a customer. Such children are referred to as *line-er baccha* (children of the line) and usually adopt their

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[4] Similar sentiments and strategies for creating some sense of separation between work and home and between a personal and professional identity have been described by sex workers in Europe (Day 1990, Delacoste & Alexander 1987, Jaget 1980).

[5] The same belief has been described by researchers in Bangladesh, South India and Sri Lanka (Nichter & Nichter 1989, McGilvray 1982, Maloney et al 1981).

[6] Some sex workers told me that they also used 'mental control' (i.e. avoidance of sexual desire/orgasm) with their *babus* as a birth control strategy.

mother's name and caste identity. Thus, in contrast to children where *babus* acknowledge paternity and are actively involved in the child's upbringing, *line-er baccha* are married from their mother's side. In such cases, it is quite common for the children to be married to other sex workers' children or, indeed, to have a love marriage.

The desired intimacy of a sex worker-*babu* relationship, and also the fact that longer-term relationships tend to take on a conjugal-like form, gives rise to a discourse of trust and 'fidelity' that tends to be common in any long term relationships (see chapter eight). This and the prevailing social/gender role expectations and power dynamics within sex worker-*babu* relationships have implications for sex workers' sexual health, in particular, for condom use. It has been reported that sex workers all over the world dislike using condoms with their lovers, as condoms often come to symbolise work-sex as opposed to personal, loving sex. Where condom use is desired, sex workers face the same difficulties as other women in trying to negotiate their use in a situation where partners are supposed to trust each other, and also where unequal power dynamics in a relationship prevent women from being able to insist upon, (or even communicate about), safer sex (Day 1988, NSWP 1997, Evans & Lambert 1994, Cohen & Alexander 1995, Baily et al 1992, Cohen et al 1992, WHO/Alexander 1993). This issue is elaborated in chapter eight.

In many ways, a *babu* is one of the key people in a sex worker's life, in a context where sex workers have few other sources of social support, material help or intimacy. Through their *babus*, sex workers can, to some extent, reclaim a meaningful identity by becoming a 'wife' and mother and by retaining contact with other kin. By having a *babu*, sex workers may also hope to secure their positions in the redlight areas and in the future. In reality though the sex worker-*babu* relationship is often exploitative and unequal, underlain by economic exchange and uncertainty about the future.

Motherhood

The previous sections have shown how sex workers strive to create or retain an identity for themselves that resists the powerful label of 'prostitute'. However, it is intrinsically difficult to reconcile their identities as wife, daughter or sister with that of prostitute, and, as a result, some of these relationships themselves become commercialised. Motherhood though is perhaps different, representing an intimate relationship that is usually (at least during childhood) untainted by commercial exchange. Moreover, in the Indian context motherhood is considered a crucial part of femininity, and represents the most respected, honoured and even

sacred status that a woman can achieve. In addition, a child represents a potential source of future security. For my informants, being a mother was an enormous source of pride and most women I knew deeply longed for children in spite of the difficulties of bringing them up in the redlight areas. By having a child, sex workers can claim the identity of 'mother' for themselves, and, in a child, can invest the love, hopes and dreams that they themselves have been denied[7]. It is a cruel twist of fate that a substantial number of sex workers end up infertile as a consequence of repeated abortions or repeated STDs. It is not uncommon in the redlight areas for such sex workers to adopt a child, or to take a special interest in a neighbour's child and help to "make it big".

My informants often complained that 'outsiders' do not understand the meaning of a child for them, and tend to take a highly judgmental attitude, suggesting that it is morally wrong and irresponsible for sex workers to bear children, and that it is in the best interests of these children to be separated from their mothers and raised in homes in a 'respectable' place. This attitude was deeply resented:

> You know, one day some visitors came to this project and they asked me, how could I, as a woman of the line, have brought children into this world. I said - why will I not? Because I am a line girl has the *maya* (love/affection) died in me? Yes, I am a woman of the line but the thing in me to be a mother, the thought of being a mother, that desire, has it all died? It is there – yes, even I, a woman of the line wish to have a child. Society has denied me an identity. Will you now even deny me that wish to be a mother? (Sett Bagan sex worker).

Re-definition and Resistance

Whilst the previous sections show how deep and all pervasive the ideology and stigma of the 'fallen woman' can be, this does not mean that sex workers unthinkingly accept their ascribed identity. Below I show how sex workers certainly resisted hegemonic discourses around sex work yet simultaneously subscribed to them, resulting in a painful ambiguity.

Subverting the Mainstream

One strategy employed by marginalised or minority groups to cope with, and resist, a dominant social order is to construct their own popular (sub) culture and social norms which are usually highly critical and subversive of 'mainstream' society. For such a sub-culture to develop however, there has to be some sense of 'community' and solidarity between group

[7] Sex workers in other countries similarly seem particularly to value their relationships with their children. In Jaget (1980:110-111) for example, a French sex worker writes that: "children are something really sacred. That's all they have left. Often they have only one real interest in life – having children.....In the world of prostitutes

members and this has traditionally been lacking among Calcutta sex workers. Thus, I found that although sex workers commonly mocked *bhodro* society and its values (especially the *bhodromahila*), they had no real counter culture to draw upon (cf. Scott 1985, 1990).

Occasionally however, I did come across examples of 'subversion' in which sex workers mocked the dominant morality and were not just scathing of society's hypocrisy, but cleverly played upon and inverted the cultural traditions that play a powerful role in conditioning social gender roles and moral norms. Using down to earth, ribald language, women's sentiments of rebellion and resistance were most commonly expressed through songs, in an idiom that was both sexually explicit and mocking[8] (cf. Goodwin-Raheja & Grodzins-Gold 1994). Religious/devotional songs seemed to be a particular target for such inversion and I was sometimes treated to magnificent performances of these in which the words had been outrageously changed! For example, a verse of an adapted *kirtan* (a devotional song to worship Lord Krishna in which 'love' in general, and in particular, of Radha and of the Gopis for Krishna is glorified) went something like this:

Rini-jhini-jhini I have never fucked
How does it feel to fuck?
Hori-bol
Brindaban trembles
and
Mathura foams
with
the force of fucking
like this give me a screw
Hori-bol

Another way in which sex workers dealt with their situation was through the subversive use of humour and by capitalising on the (albeit limited) power they themselves wielded in the redlight areas as sellers of something that was in demand. Women were expert at making crude jokes and innuendoes of which clients were, unsurprisingly, often at the receiving end. In the redlight areas sex workers did not have to conform to usual standards of feminine behaviour and I sometimes observed sex workers chasing drunken men down the street, grabbing at potential customers' *lungis* as they walked past, or laughing at, taunting and openly abusing their clients. In Sett Bagan, if customers tried to harass me sex workers would run after them with buckets of water or wielding a *boti*! At certain times when women were in a relaxed mood, they might exchange stories with much hilarity about different customers and

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children are the one thing nobody touches....even the husbands."

[8] Banerjee (1998:105-125) describes similar songs expressing similar sentiments employed by sex workers in 19th century Calcutta.

of the things they sometimes had to do – the same stories might evoke tears of despair on a different occasion, but humour was a crucial coping strategy in difficult circumstances.

Re-defining Morality: Necessity and Nature

My informants also tried to resist the stigma attached to their profession by interpreting the dominant morality to exonerate themselves from personal blame for having become sex workers[9]. It was common for women to draw upon a discourse of necessity (*obhab*) and nature (*shobhab*) to describe the character of women who become sex workers. Virtually all the brothel based sex workers I knew stressed that they had entered the line out of economic and circumstantial necessity. They would contrast themselves with 'other' women, in particular the flyers who, they said, were simply being greedy and were doing sex work to satisfy this greed. For these women, it was said that their 'nature' had led them into sex work and they were portrayed as 'bad' and 'immoral'.

Social Value of the Sex Trade

Though my data seem to indicate that many women feel that sex work on the whole is undesirable, they nonetheless constructed a professional identity for themselves by tapping into a widely held discourse that the sex trade is a social necessity and performs an invaluable social function in controlling male sexual 'needs'. Within this discourse, my informants tried to construct an image of themselves as performing a useful social service, that required a measure of professionalism and self-respect.

In the course of my fieldwork, I often heard the view that the sex trade performed a social function akin to a 'safety valve' – providing an outlet for male sexual desire pre-maritally, and also extra-maritally (for example in the case of migration, or when the wife is pregnant, or when the couple has grown up children, or when there is no privacy for sexual expression). In theory, though men are subject to similar social and 'sexual access' restrictions as women, there are parallel social discourses which tacitly accept that men's sexual needs are such that they *have* to be fulfilled. It is considered that men, by virtue of their socio-sexual physiology, may reach a point where they are unable to 'control' their urges, and that repression of sexual desire for too long may actually become physically harmful and lead to ill-health. In the latter case, 'desire' is discussed in terms of bodily (humoral) heat or 'tension' that accumulates in

[9] Cf. Mosse (1996) with reference to constructions of morality put forward by Untouchables in parts of Tamil Nadu.

the body and must be released through sex (Rao et al 1994, Sundaraman 1992, Boyce 1996, Carstairs 1957, McGilvray 1982).

Pushpa, a sex worker from Sett Bagan explained as follows:

> Yes, I do think that because of us line women, other women of society, the wives and sisters and friends can walk safe on the streets. If we were not there they would have trouble. The customer thinks that I don't want to have a *grihasthi* (housewife) because then my name might get spoilt and I might get beaten up, so better pay Rs.20 and come here. This is why we are needed.

Her view was mirrored by some customers: "see, without these girls society would not be able to function (*samaj colbe na*)". When I asked why, they said that: "well, the streets would be dangerous places wouldn't they? Lots of women and girls would be raped".[10]

Sex workers also noted how they performed a useful role in fulfilling male 'needs' for affection or friendship (if they were in a loveless marriage), for recreation and for 'alternative' sexual practices. Another way that some sex workers affirmed the perceived social value of the sex trade was to juxtapose themselves against other 'criminal' groups, stressing that they were different, in that their work was actually benefiting society[11]:

> We are not thieves, we are not *dacoits* (bandits), we do not murder – it is to kill the hunger in our own stomachs that we have come into this profession. We do not live on other's food. Everyday we endure torture upon our bodies so that our mothers and sisters can walk the streets in safety – in spite of this we are called bad (Sonagachi peer educator & DMSC leader).

What is the Difference between You and Me?

In spite of living the consequences of a social discourse that splits women into two categories – good and bad, madonna and whore, my informants frequently used the same discourse themselves when discussing the attributes of other women and would curse each other during fights as a "child of a whore". However, during discussions I had with peer educators, they did at times try to challenge this discourse by implicitly referring to the patriarchal system in which they perceived all women as subjugated by men, and as having to exchange sexual services in return for some kind of gain:

> What is the difference between you and me. You also sell your honour to your husband don't you? ....whether it is *khanki* (whore) or *grihastha bou* (housewife) women are mere toys in the hands of men.

[10] Similar views of male sexuality are reported by prostitutes and clients all over the world (cf. Hart 1995, Perrotta 1992, Leonard 1990, Scambler et al 1990, Nelson 1987).

[11] This is a common sentiment expressed by sex workers in many parts of the world (cf. Delacoste & Alexander 1987, Jaget 1980).

> The way they want us to move, we move accordingly. Some do it for money, others do it to keep their husbands in their room (Sonagachi peer educator).

I would sometimes take up this point that the institution and stigma of sex work was related to patriarchy and that all women were affected by this, in different ways. I explained that the term 'sex *worker'* was now being used precisely to challenge society's madonna/whore splitting of women, and represented an attempt to move away from the stigma attached to words such as prostitute or whore which centred upon a woman's social identity and moral character, rather than upon her work. By contrast, using the term sex worker implied that sex workers were women like any others, but that they happened to be engaged in the occupation of sex work. The peer educators were familiar with this argument through their interactions with the SHIP but many remained ambivalent. Indeed, though some PEs (usually the DMSC leaders) would make the same point themselves in their public speeches, it was always in the abstract. In their own lives bitter experience had shown them that they *were* regarded as different from all other women and they resented any suggestion that they should now be seen as the same. Such a suggestion, they felt, negated the pain and marginalisation that they had endured as a result of their difference:

> How can they [feminists/activists] say that we are all the same? Do police come and raid their house without a warrant? Are they arrested when they go out onto the street to buy some *paan*? We too are human beings but we have none of the rights that you all have. When the *bhodro* (respectable) people come secretly to our 'line' with their lovers and do their work in our rooms, are they called *khankis* (whores)? We are not the same. The stamp of a prostitute can never be erased. If we are the same, why don't they just call us *'workers'*? I'll tell you why - because we are whores (Sonagachi peer educator).

On the whole, my peer educator informants were rather cynical about attempts at political correctness and, as above, indicated that class, as well as gender was a defining feature of their experience. The PEs strongly felt that whatever term was used, there would always be a difference between them and 'respectable' women:

> See, *boudi*, it is all right to say *khanki* (whore), *beshya* (prostitute), *jouno kormi* (sex worker) in this area – 'see, a *jouno kormi* is walking down the road' – to say this here is fine. But when I go outside and meet 'good' girls, when I enter the room they will discuss among themselves and say what does she do – tell me, will I say I am a *jouno kormi*? Even thinking of it, my heart shrinks. It is like this – now that we have gained fame [because of the SHIP], there are many *bhodromahila* who come and see us, who want to rub shoulders with us. They talk to us and want to know our problems. But when they go away they still feel disgust for us – after all, we are women of the line (Sonagachi peer educator).

During my fieldwork, the SHIP/DMSC organised a number of meetings between sex workers and feminist/activist groups in Calcutta but these were often characterised by misunderstanding, suspicion and even hostility. The women's groups generally glossed over the vast differences in class and life experience between themselves and sex workers, and, instead, tried to express solidarity with the sex workers by stressing their 'sameness' – that all

women are oppressed. They generally took the view that the institution of prostitution was fundamentally wrong and all must work together to change or abolish it by challenging patriarchy. This was misunderstood by sex workers who became angry that their 'difference' was not acknowledged, and then even angrier at what they perceived was a lack of recognition of their profession. In my opinion, by failing to understand sex workers' class and gender based perceptions of stigma and difference, women's groups actually widened the gap between 'them and us'. Rather than using their knowledge of feminist/social theory to engage with, and address the contradictions in sex workers' lives, they simply reaffirmed sex workers' perceptions that *bhodromahila* and sex workers lived in irreconcilable worlds.

Given prevailing gender and class divisions, theorising the differences between sex work as social identity vis a vis sex work as an occupation is one of the DMSC's greatest conceptual challenges. Up until now, sex workers have primarily defined their work-related identity relationally through dominant constructions of gender - they are everything that a respectable woman is not. Re-defining this deeply internalised discourse by suggesting that all women are the same, and that *all* are oppressed will be extremely difficult in a context where a perceived difference has defined sex workers' entire lives. By contrast, re-conceptualising sex work through invoking a class and work-based discourse ("sex work is work, we want workers' rights") is far more likely to resonate with sex workers' experiences, especially in the political context of West Bengal where discourses of class oppression and workers' rights are part of mass political consciousness. Re-defining prostitutes as workers offers an immediate alternative identity that can co-exist with, (though perhaps in time will change), existing gender identities.

Conclusion

In this chapter I have described how women experience life in the sex trade, and how they try to negotiate their marginality and social exclusion. Most of the material presented came from sex workers that I knew well in Sett Bagan and from peer educators working in both Sett Bagan and Sonagachi. As such, I believe it is reasonably representative of the ways that older, experienced sex workers feel about their lives. Young girls in Sonagachi who have not yet experienced motherhood or *babu*-problems or who may be overwhelmed by the novelty of it all, may see things differently. Yet, as almost all my informants started off their sex work careers as *adhias* or *chukris*, I believe their views express a mature understanding of how one's experiences of the sex trade change over time.

In most societies sex workers and the sex trade are heavily stigmatised. This chapter indicates that the experience and effects of this stigma may be particularly strong for women who are confined to brothels in distinct redlight areas and who are thus very literally (physically and geographically), excluded and segregated from mainstream society. The consequences of this for women's self-esteem and sense of identity can be devastating. Nonetheless, as illustrated above, sex workers in Calcutta do try to resist their sense of exclusion and alienation by retaining connections with their families and by forging their own 'families' with *babus* and children. The sex workers who I knew are conscious of the dominant discourses on sex work and sexuality that hem them into a life of marginality, and do their best to resist these. However, due to a lack of community, solidarity and access to resources, sex workers in Calcutta have, until recently, been unable to develop a collective discourse or counter-culture with which to make sense of their experiences in an organised way. The process of re-defining sex work and sex workers' identities is already underway in Western countries where sex workers' groups have been working for many years to challenge social attitudes and re-negotiate their place in society (e.g. Delacoste and Alexander 1987, Jaget 1980, Kempadoo & Doezema 1998). Advisors to the DMSC note that in order to create their own discourse, applicable to the very different contexts of Indian society and of the Indian sex trade, Calcutta sex workers will need to de- and re-construct their own 'identities', and, indeed, facilitating this, is seen as one of the DMSC's fundamental roles:

> The institution of the DMSC symbolises a process of contestation over the meanings and definitions of prostitution and marks the beginning of a struggle by a marginalised and stigmatised group....to confront the material terms of their deprivation and question the discursive language of their social exclusion.....The process of struggle that the members of the DMSC is engaged in has only just begun. It has thrown up a whole host of issues about gender, poverty and sexuality that have to be debated, defined and re-defined....for a marginalised group to achieve the smallest of gains, it becomes imperative to challenge an all encompassing material and symbolic order that not only shapes the dominant discourses outside, but, perhaps, more importantly, historically conditions the way the participants negotiate their own locations (DMSC leaflet 1998, written by one of the group's advisors).

When HIV and the SHIP entered the social world of sex workers in Calcutta the spotlight of mainstream society suddenly turned upon the redlight areas and, somewhat ironically, opened up an opportunity for dialogue between sex workers and 'society'. Subsequent chapters show how, by being helped to take this opportunity, peer educators and, to a lesser extent, other sex workers, have been able to access the intellectual and material resources with which they can begin this process of contesting the dominant discourses and material deprivation that have shaped, stigmatised and confined their lives.

CHAPTER SIX

PARTICIPATION, POWER AND THE SHIP: MEANINGS AND PROCESSES OF TARGETED INTERVENTION

> We must admit that many of these developments 'happened' as part of a very complex social process. It was not just 'made' or 'done' (AIIHPH 1997:19).

Introduction

In chapter one I noted that an international consensus is now forming on 'best practices' in sexual health projects for sex workers (and, indeed, the SHIP is often cited as an example). However, while certain features and strategies of these projects (in particular, empowerment of sex workers, community participation/mobilisation or a focus upon fostering an enabling environment) are advocated as integral to their success (assessed, for example, in terms of behaviour change or sustainability), there has been little analysis of the *processes* by which these projects are working, the meanings of them for those involved and the implications of this for understandings of behaviour change and intervention.

In this chapter I attempt to explore some of these issues. The first section briefly describes the process of SHIP implementation in Sonagachi. My own field research did not directly cover this period and my understanding of this process therefore comes solely from second hand accounts of what happened based on information largely gleaned from project staff. The account is, therefore, slanted towards the SHIP's perspective on events. The next section however is a more detailed case study of the SHIP's implementation in Sett Bagan which is derived from my own field research and is more comprehensive. The case study focuses upon how the SHIP was interpreted and responded to by various interest groups there, and, in particular, the ways in which community participation was operationalised and understood. The third section comprises a combined analysis of the different (and changing) meanings that the project has taken on for various interest groups in both Sonagachi and Sett Bagan, and the strategic ways in which it has represented itself for different groups and for different purposes. I go on to relate this to the concepts of community participation and empowerment and consider how these have been operationalised and understood in the context of the SHIP.

The SHIP in Sonagachi

When the SHIP started work in Sonagachi, it had the advantage and disadvantage of being led by a Government institution (the AIIHPH). As a project coming from the Government, it carried some weight and power with it, but at the same time had to operate in a context where State institutions were not respected, and where, indeed, most interest groups were highly suspicious of, and hostile to, any Government personnel or initiatives. A key issue for the SHIP was how to work with these interest groups and gain access to sex workers. Local power brokers were reportedly concerned that the SHIP might threaten their own position and livelihoods. Supervisors and peer educators all report encountering hostility and suspicion from all groups of local people. The project director had to seek the help of the local municipal councillor and other influential people such as club secretaries who, after a period of lengthy explanations, assisted the project with making connections and smoothing the path. Without this local support, it would have been impossible to establish the SHIP at all. In addition, throughout its life, the project has used pre-existing connections to seek backing from members of the ruling CPI-M party and this has been given in the form of behind the scenes support, and also publicly through the attendance of senior party officials at strategic project functions, such as its opening day. Such support would obviously give any potential local project-opponents a clear message regarding what they would be taking on.

Negotiating the Social Structure

As one of the most powerful groups in Sonagachi, supervisors report how it was imperative to win the co-operation of the house owners:

> Most of them behaved atrociously with us. They thought we were bringing in a fresh lot of troubles. It was really tough. Each of the supervisors had to meet the landlords separately and that too over many days. Later on the landlords co-operated with us and actively participated in our programmes, but initially we had to face tremendous opposition from them (Supervisor).

Likewise, project staff had to deal with the local clubs and find a club from where they could run a clinic. In some of the redlight areas, club members have demanded something in return for allowing the project to function there, such as having a say in selecting peer educators, or giving one or two local men jobs as project helpers. In Sonagachi however, the clubs have not interfered directly with the project's work. Indeed, both clubs from which the clinics function have been helped by the SHIP to become legally registered bodies and are included in the SHIP's Conglomerate. This help and involvement has perhaps ensured their loyalty to the project to some extent:

> They viewed us with a lot of suspicion. They felt threatened. They are one of the trade controllers so they viewed us as another competitor. They feared that the girls may listen to us more than to them. They felt we should work through them. Then, the most difficult part was that there existed staunch inter-club rivalry. Though there is a single party, there are factions so if you go to one club then you are sure to displease the other club. We had to explain to them individually that we do not belong to any political group and that we have not come here under the umbrella of any political party and that we do not have any other motives. We tried to explain that we have come here to offer some good health services and to do social work. We also solicited their participation in our project and asked them to give us suggestions for further improvement – we were able to engage them in our work and now we are getting some kind of help from them (Supervisor).

It was apparently also difficult to establish rapport with the madams who are the key gatekeepers to all *adhia* and *chukri* sex workers:

> They used to hide the girls. They felt that these people are coming from government agencies to take the girls away or that we would inform the police – or they thought we were their competitors – may be we will take the girls in our hold. Some madams have now realised our motives, others have not and are still suspicious (Supervisor).

Sex workers too were initially hostile. Peer educators describe their initial attempts to make contact with other sex workers:

> At first, when we tried going to any girl's room we faced a lot of difficulty. They shut the door in our faces, they abused, scolded, some even threatened us and ran after us with *botis*. When we talked about condoms they got very angry – said oh yes, you give all this and want us to lose customers. Bearing much pain and hardship we explained to them. If we ever asked them – how are you? What are you doing to keep your body healthy? – they would shout back – why should we tell you? Whether I keep my body healthy or kill it – how does that matter to you? You go from here. Our work here didn't happen in a short time. We needed lots of time (Peer educator).

Project workers are agreed that the peer education strategy was key to the SHIP's ability to gain access to sex workers in such a suspicious and hostile environment. Peer educators were perceived as a bridge of communication between two different worlds:

> We had realised right from the very beginning that if we wished to work here we have to take the help of those who belong to this community otherwise we will not be able to get an entry here. They would not accept us and would always be suspicious of our motives (Supervisor).

Peer educators agreed:

> Yes, in our line we are dealing with so many kinds of men – using our knowledge of this, we can explain to the girls – the family girls cannot do this. When a family girl talks no-one pays any heed – they just think – what does she know? Only *beshya* can go to *beshya*. Only *beshya* can reach them. Only *beshya* can talk about the other *beshya's* thoughts, can understand her pain – so we were taken into the project (Peer educator).

As current or ex-sex workers however, peer educators were unable to command much respect from trade controllers. The supervisors were considered necessary to advocate and negotiate with other interest groups:

> There is a lot of scope for misunderstanding here created by the various groups – like, for example, the club boys – so the supervisors team up – the club boys have to be tackled by the supervisors because they will not listen to the peer educators. Even the *malkins* and the house owners – they will accept the supervisor more than the peer educators – we get more weightage than the peer educators. Also, it is necessary that the supervisors tackle the police – if there are any problems with them, we go to sort it out[1] (Supervisor).

In addition, supervisors note that although local people were suspicious of outside intervention, outsiders from 'respectable' society nonetheless command some authority by virtue of their perceived social status and connections. Supervisors felt that although some people may have resented interference from the project, others were impressed that outsiders, especially outside *bhodromahila*, were bothering with sex workers:

> See, their whole lives are spent under shadows of abhorrence, especially from respectable families. Even when they go out to see a puja they would be abused by the families near by. They are surprised that a girl or a wife from a 'family' is coming and talking normally to them (Supervisor).

The distinction between supervisors and peer educators as representatives of the sex trade vis a vis 'respectable society' is symbolised in the different colour coats worn over their saris during working hours. The uniform serves a pragmatic function in the sense of enabling local people to identify project workers, but it simultaneously reflects the project's own organisational hierarchy as well as a broader social hierarchy which, the supervisors feel, can be used to the project's advantage:

> The peer educators wear green coats and we wear white – to differentiate between those belonging to the community and those coming from outside. Now, we are well known in the community so now the colour of the coat hardly matters – but I have noticed that wearing a white coat gives us wider acceptance to the sex workers – they are so surprised that *didis* are coming to talk to them – they were quite awe struck at the way we used to sit with them and talk to them. They boast in front of their *babus* – see these *didis* are respectable – they have come from outside, from lovely places, they have come to do good for us – the white apron is given a lot of respect (Supervisor).

During the initial rapport-building project phase, project workers note how they interacted with various sex trade power brokers primarily to negotiate access to individual sex workers. This strategy changed over time however as the extent of these gatekeepers' influence over sex workers became clear, and it was decided that there was a need to focus upon building up sex workers' negotiation skills and to target the entire environment of the sex trade (referred

[1] As a rule, project staff did not involve the police in solving project-related problems, but they might for example advocate on behalf of sex workers to the police.

to in project publications as the "milieu of negotiation" – see Jana & Singh 1995:127). Groups were formed whose job was to tackle each of the interest groups through education, rapport building and advocacy, and there were also trouble shooting groups which would deal with any specific problems that may crop up. For example, if a pimp was threatening to 'close' a sex workers' room because she had refused to have sex without a condom and the client had complained to the pimp, a group of supervisors would try to intervene. Simultaneously, the SHIP also tried to target clients and *babus*.

Playing a Power Game

By the time I conducted field work, much of the initial resistance to the SHIP had died down and the project workers appeared (at least to an outsider) to be accepted as part of the daily routine of the locality and seemed to be on courteous terms with most interest groups. However, project staff note that the need to negotiate with the various interest groups is on-going as social and power dynamics change over time. They recall particular 'crises' which have threatened the stability of the project – such as when the secretary of the club where the main clinic is based was thrown out, and a different club faction gained control leading to a period of uncertainty over whether they would continue to support the project. Other examples are when there were police raids and rumours were spread that the SHIP was responsible, or when another NGO, in collaboration with a Government medical institution, forced sex workers to give blood for HIV testing with the help of the police, and where the SHIP was said to be involved, or when another NGO was allegedly using the name of the SHIP to gain access to sex workers for a study it was doing on child prostitution. More recently, when the DMSC was formed, they distributed a leaflet outlining its aims and objectives signed by peer educators who were the governing body members. Some of these women were already local party activists and this caused considerable trouble with some political leaders who felt that the project was interfering with their constituencies and support base. Some peer educators were threatened and they and the supervisors were temporarily prevented from carrying out their work. Supervisors report that some local leaders who were traditionally allies of the project now feel threatened by the DMSC and have withdrawn their support. Some have actively tried to undermine the project's work, for example by initiating rumours that the SHIP is behind police raids or that the SHIP is siphoning off money meant for sex workers. The project director has stated how all the various interest groups continuously:

> ...had to be pacified and brought under the folds of the project.....it was and still continues to be more of a power game where adjustments and re-orientations had to be made to keep all feathers unruffled (Jana and Singh 1995:127).

Sett Bagan, the *Mahila Sangha* and the SHIP

The material on Sett Bagan presented in this section illustrates how the nature of community participation or involvement in a project are heavily influenced by local, personal and intervention-related politics and by the ways in which an intervention and the actors associated with it come to be perceived. In addition, the material shows how this can have negative as well as positive consequences for different individuals, depending upon their community position. Communities' responses to, and participation in, projects is a subject of much interest among anthropologists working in development (e.g. Nelson & Wright 1995a), and some have noted a lack of "critical analyses of ethnographic contexts to see how the discourse and procedures of participation actually work in practice" (Nelson & Wright 1995b:1-2). Sett Bagan provides such an ethnographic context (albeit limited to the micro-level) and was my first experience of how a community might respond to outside help and intervention. It was not at all what I expected.

History of the Mahila Sangha

In order to understand the way things turned out in Sett Bagan following the introduction of the SHIP, it is first necessary to briefly describe the recent history of the locality and the formation of the *Mahila Sangha* (MS). This is a composite account based on interviews with MS and other local people.

In the 1980's, most influential people in Sett Bagan (house owners and *para cheles*) supported (and were supported by) the Congress party. At that time there was no MS. One group of *para cheles* was led by a local *mastaan* called Saju[2] who was also a house owner. Over time, he and his cronies exercised a reign of terror (*jhulum bhaji*) over the sex workers in Sett Bagan and are reported to have indulged in extortion, beatings, rape and torture. It was during this time that Durga, the *Mahila Sangha* leader came to the locality. She had been a sex worker but had married the son of one of the house owners in the area and gave up sex work. Saju and his gang also used to try and extort money from the other house owners, and one day, when Durga witnessed Saju viciously beating up someone she knew, she wanted to do something about it. By then some of the other house owners and local men were also

[2] A pseudonym.

unhappy about Saju's behaviour and his powerful position in the locality so they all got together and formed a *Santi* (Peace) Committee. This committee was tacitly supported by local Congress officials who were also concerned that Saju's behaviour was getting out of hand.

By virtue of her status in the locality and her powerful personality, Durga became the leader of the local sex workers, and she, together with a number of other powerful women (house owners) managed to organise the sex workers to fight back. Durga thus came into direct confrontation with Saju who viciously attacked her, leaving her with 9 stitches in her stomach and 15 in her head[3]. Durga interpreted this as a call to arms, and, once she had recovered, launched a full scale resistance movement.

Over the next few months, the sex workers fought back. Local men made bombs and tried to disrupt Saju's activities. They tried to blockade the Lane and the girls stood guard on the roofs and banged their cooking utensils as a warning to all that Saju and his gang were coming. There were a number of street fights and Saju was eventually caught, stripped naked, covered with tar and feathers and paraded around the locality before being handed over to the police who were forced to arrest him.

After this remarkable victory, the *Santi Committee* became the *Mahila Sangha* with a membership exclusive to women (sex workers and *grihasthi*) of the area. Its leaders were house owners and wives of influential local men, two of whom (Malati and Lokhi) were *Grihasthi*. Durga was the overall leader however. The MS was an unofficial organisation that was not registered under the Societies' Act until the SHIP helped them to do so. The MS represented women from most of the houses associated with sex work in the Lane except for three belonging to Saju and his friends. Sex workers are expected (and required) to show some sort of allegiance and loyalty to their landlords/ladies. The women living in these three houses therefore, were extremely hostile to the MS and never participated in any of its (or, later, the SHIP's) activities. Another reason for this hostility towards the MS was that, in contrast to many others in the Lane, these women became CPI-M supporters (probably as a result of Saju defecting to the CPI-M after his fall-out with the Congress).

[3] This illustrates the risk that individual sex workers take if they try and stick up for their rights. It is not surprising therefore that sex workers can rarely confront their oppressors. It also illustrates the need for more collective forms of resistance.

After a period in prison, Saju and others from his gang are now again living in Sett Bagan but have been divested of all power. The presence of the MS (with the support of a certain section of local men) has ensured that no other group has been able to gain power and, therefore, atrocities against sex workers and related activities such as extortion have stopped. Local women declare that since this time, there has been peace in the neighbourhood. The MS set itself up as a sex workers' self-help group and Durga managed to involve some small NGOs in providing services to local women (e.g. placing children in residential schools, non-formal education for children and stitching classes).

At some point in the late 1980's, the MS constituency began to split up into factions due to a number of petty disputes which also resulted in the loss of their traditional support from the *para cheles*. The three anti-MS houses exploited this situation and, with the support of the CPI-M, demanded the eviction of *adhias* in the Lane. Unlike other houses, they did not keep *adhias* (for reasons not clear to me) and the sex workers felt that they were facing unfair competition from younger girls. Many madams objected but because of splits in the MS and the absence of *para chele*-backing, there was no organised resistance to this move. Some informants state that by the time the SHIP began its research study in 1992, the MS had fizzled out to a large extent. In fact, by the early 1990's Durga was no longer even living in the Lane.

Projects and Promises: The SHIP's Entry into Sett Bagan

Durga had by then been employed as a field worker by one of the existing NGOs involved in the redlight areas that had also helped the AIIHPH with its initial research study. Durga was subsequently taken on by the SHIP, and is reported to have played a quite crucial role in helping establish the project. As a former sex worker who also had leadership and political experience, Durga knew how to make connections, how to talk, cajole and persuade – skills that were crucial in establishing connections among the key actors in Sonagachi. Durga claims (though this is unsubstantiated) that in return, she was promised help for the MS and jobs for the women in Sett Bagan. True or not, informants tell me that she returned to Sett Bagan one day full of talk of a project that had come and that would be providing jobs for many women. Durga saw this as an opportunity to help her friends and other women in Sett Bagan. In addition, as will be seen later, she probably also realised that by setting herself up as an intermediary between Sett Bagan women and the SHIP and by representing herself as the sole medium of access to the potential jobs and other benefits that the SHIP might offer,

she could use this position to regain considerable power and influence in the locality, and to revitalise the MS.

Through her influence 16 local women were employed as peer educators – including most of the MS leaders (even Malati and Lokhi, the two *grihasthi*) and other women who were connected with these leaders. They worked mainly in Sonagachi, coming to Sett Bagan only if they happened to be in the team that covered the Sett Bagan field area. By this time (1993) the economic condition of many Sett Bagan sex workers had begun to deteriorate, especially since there were no young *adhias* with which to attract custom or from whom to top up earnings. The local sex workers were, and still are, living in extreme financial insecurity and the possibility of steady employment with a Government project was extremely attractive.

Durga went around the locality making a list of women who were interested in work and promised that she would do what she could for them. Most sex workers, except for those in the three anti-MS houses, signed up, as did many *Grihasthi*[4]. In the meantime, in order to enhance women's chances of obtaining work Durga suggested that they attend classes at the MS club room in order to learn reading, writing, and how to explain the SHIP-flipchart so as to give them a head start over other aspiring peer educators from other areas. A relative of Durga's was roped in to provide these classes which were conducted through an unimaginative rote learning approach whereby women spent months copying out the same letters and words and, even after one to two years, appeared to have made virtually no progress at all.

After the employment of the initial group of peer educators from Sett Bagan, it proved less easy for Durga to place women. As the project expanded in Sonagachi, additional peer educators were employed but were mainly recruited from the central Sonagachi and other satellite areas. There was thus considerable competition over jobs and also over who could be seen to be providing them. In order to retain her influence in Sett Bagan, Durga had to continually prop up women's hopes that there *were* still jobs, or other benefits to be had from the project. At the same time, she had to engage in various strategic manoeuvres to try and get *her* women selected or find some alternative means of retaining her local standing.

[4] Given the social stigma that exists towards sex workers it is quite remarkable that *Grihasthi* wanted to work for a project in which they would have to pretend to be sex workers, and the fact that they did is indicative of their desperation for a job.

In 1993 until mid-1995 the MS club room was packed almost every afternoon because of the classes. Durga would also come there almost every day. Her status as MS leader was indicated by the fact that she sat on one of the few chairs, while everyone else was on the floor. Moreover, no-one actively involved in the MS was willing to take any decisions or action on any issues at all until Durga had first been consulted. These afternoon sessions used to remind me of someone holding court. Durga would melodramatically recount the latest project gossip and intrigue, always stressing that she was doing her utmost to further the interests of the Sett Bagan women but was hindered by various 'enemy' forces within the project (for example, other sex workers who were trying to get *their* friends jobs, or people who were jealous of her personally and were trying to bring her down, and sometimes she would blame the project director). She always promised that more projects and jobs were just around the corner and that, in time, she would prevail over the enemies. Through the afternoon discussions, various women did their best to curry favour with Durga or with the other influential MS leaders (now peer educators), openly praising them for their achievements and sacrifices, and readily agreeing to run errands and fulfil any other chores.

Durga's image as someone important and also as someone who was powerful within the SHIP itself (and thus able to influence it) was reinforced by the fact that she was indeed one of their star peer educators. She was intelligent and articulate which made her a natural choice as someone who should take the lead in developing the project's peer education and other activities. From the director's point of view too, she was the leader of the only community based organisation (CBO) of sex workers in the city, and he considered it important to lend her support and to strengthen the organisation (for example by helping to get it registered). In accordance with the director's participatory approach, the MS (represented by Durga) was given a place in the project Conglomerate and on its steering committee. At project events, it was Durga who was asked to speak on behalf of sex workers. She was interviewed by the press and appeared on television. She and Rekha (another Sett Bagan sex worker and close friend) were flown to Goa as resource people to help set up a sex workers' project there. Durga was eventually promoted to the role of supervisor and very proudly wore her white coat.

Somewhat cynically, Durga told me that she feels she was also valued because of her ability to mobilise women to go to various project functions, events and protests so that they were (or at least appeared to be) well attended. Indeed, during this time, many Sett Bagan women attended various project events. They were doing so however primarily to show their support for Durga (thus hoping to gain her favour in the next round of job allocations), or (at the

instigation of Durga), to show the SHIP director that the MS was committed to the SHIP's work (in the hope that it would be rewarded for its support), rather than because they supported or even understood the particular event they were going to. I would often ask Sett Bagan sex workers for example, about a particular protest meeting (e.g. against coerced HIV testing) they had attended, and many would have no idea of what it was all about or why it had been called. Yet, on the various occasions that outsiders attended these events, they were invariably greatly impressed with the strength of 'community spirit' and 'community participation' that they witnessed. This observation is not meant as a criticism of the SHIP, nor is it a new phenomenon (as anyone who has witnessed truck-loads of villagers being brought into Calcutta to attend political rallies, having been given promises of free food and a subsequent trip to the zoo, will attest!). Indeed, mobilisation of this sort is quite typical of the patron-client relations that characterise Indian political culture more generally. It does highlight however that, *initially* at least, in this context, people's participation relied upon the catalysing role of a particular leader and potential patron and was interpreted in the light of issues that were directly and personally relevant to them (namely employment) rather than around abstract ideals or principles.

The odd outside visitors who went to Sett Bagan were similarly treated to a seemingly remarkable display of local unity and involvement in the project (cf. Mosse 1994). Local women would be rallied and large community meetings held on the roof tops. For those who paid a one-off visit to the club room (as some journalists or other SHIP-visitors did), the scene of poor women, using precious time to improve themselves as part of a self-help group's activities, seemed highly impressive – an example of empowerment and community initiative. Though Durga and the MS' achievements *were* in many ways quite remarkable, and clearly showed that sex workers in the Lane had managed to develop considerable strength and also their own community mechanisms for promoting their interests, I was personally (perhaps naively) never quite comfortable with the manipulation of women's hopes and aspirations that was sometimes involved.

As an example, let me here introduce Jaya, an older sex worker nearing 40 who was at the end of her sex work career. Jaya was an affectionate and caring woman who, unlike many of her sisters, had not developed the hard shell and cynicism that years in the sex trade can induce. However, perhaps because of her nature, she was easily taken advantage of. During the period that I knew her (from 1993 onwards) Jaya was in dire straits financially. She had to support her elderly mother and a daughter and had recently been cheated by her brother out of some land. She had had numerous *khanevala babus* and was now together with a much

younger man who apparently cared for her but had no steady employment. He had contracted tuberculosis and Jaya devotedly cared for him and also helped to finance his medical treatment. Because of her age however it was extremely difficult for her to gain enough custom to make ends meet.

Jaya had jumped at the chance of a potential job. She faithfully attended classes and did whatever Durga asked of her. However as someone who was needy but not influential, she was passed over in the initial job allocations. She was very deeply disappointed but felt she had no choice but to continue attending classes and supporting Durga/the MS. She was in an unenviable, powerless position whereby she felt that her future well being and livelihood depended upon the whims of just one person and one project – neither of which she could control.

I will go back to Jaya's story in the course of narrating the subsequent course of events concerning the MS, Durga and the SHIP. During 1994, the SHIP stopped taking on new peer educators in Sonagachi but was expanding the project into other redlight areas in different parts of the city. It was thus looking to recruit local sex workers from these other areas as peer educators. Durga immediately arranged for a number of Sett Bagan women to go to these areas and temporarily work as *adhias* there so that they would be able to convince project staff that they were local. After many weeks of commuting every day to these other areas, five more Sett Bagan sex workers became employed with the SHIP. I do not know whether the SHIP was aware of what was happening (it must have been after the peer educators started working) but it was obviously politically expedient not to openly challenge Durga's behind the scenes manoeuvres. Because of her *babu's* illness, Jaya was unable to go and work in other areas so she again missed an opportunity to get a job. However, Durga promised her and others that there were still many more jobs and projects around the corner.

Research and Community Relations: Personal Involvement with the Mahila Sangha

At this point I will take another brief diversion to give a little background on my own and my husband's involvement and relationship with Durga and the MS during this time. As described in chapter two, my involvement with Sett Bagan began when my husband started a clinic there in 1993. At that time we knew that some of the MS women were connected to the SHIP, but we did not fully understand the nature of that connection. For a long time, we mistakenly thought of Sett Bagan and the MS as quite distinct from the SHIP. It took us many

months to realise the impact that the SHIP had already had upon the Lane, and the way in which this was enmeshed with the structure and processes of local politics.

In the Indian context where one's personal and working relationships are defined to a large extent through one's social connections and status, Jo was an anomaly. He had just 'turned up' in Sett Bagan with no-one's recommendation and no local connections. As such, (the women told us later), they had felt rather wary of him and had immediately sought the SHIP director's advice on how to respond to him. Had we understood the local situation better, Jo should perhaps have tried to work in Sett Bagan via an introduction and/or via the SHIP. The situation was exacerbated when I arrived, for now there was also a foreigner poking her nose around the locality and nobody quite knew who I was and what I was doing there!

Though I was interested in the possibility of doing research in the area, Jo and I also felt that we perhaps had something to offer the women of Sett Bagan by virtue of our outside knowledge and potential to facilitate access to outside resources. However, as it turned out, the MS saw things somewhat differently. The area surrounding Sett Bagan contained well over 40 private doctors and hospitals. In addition, the women there had access to the SHIP clinic. Health was not a conscious priority of the sex workers. Jo's clinic was well attended and seemed to be appreciated on an individual level but it did not appear to be valued in terms of something that was being done for the community. The MS leadership therefore did not see us as being particularly useful. Moreover, they had just had an experience with the SHIP whereby a 'project' had come and had provided significant employment opportunities for local women. We, on the other hand, had nothing concrete to offer. During chats with the MS leaders we sometimes suggested that they think about what they could do in the Lane or in broader terms to help the sex workers and their children (we were thinking along the lines of crèches, or vocational training for older women etc.). However, our ideas of self-help, facilitation or volunteerism seemed to have no contemporary relevance in Sett Bagan where women were clearly desperate for paid work, nor did our suggestions of going through lengthy proposal writing processes to try and apply for funds to develop a project or to support the MS. Our suggestions were not promises and this is what the MS leadership wanted! Without bringing money, jobs or any other immediately perceptible benefits, our role in the locality was (quite accurately) seen as benevolent but ultimately insignificant. If anything, we, quite appropriately took on the role of friends and counsellors – outside people with whom women could discuss their problems and ask for advice.

This role changed somewhat during 1994 when I carried out a six-month DFID-funded research study on health seeking strategies among sex workers and *Grihasthi* in the area (Evans and Lambert 1994), and was hoping to be able to extend this work into a community based study of sexual health for a PhD. The community was fully aware of my work (though it was not participatory as such) and I had had many discussions with the MS leadership about my findings and generally, how best to proceed. I felt quite indebted to the MS and the other women in the locality for allowing me to study their lives and for giving me their time, especially as they were receiving no tangible benefits from the study. I had gratefully acknowledged their help in the final research report but, in the interests of confidentiality, had not mentioned the names of Sett Bagan or of the MS. However, when I visited Sett Bagan again in 1995 after having given Durga a copy of the report, I found she was extremely upset and hurt that I had not acknowledged the MS. She felt that I should have mentioned its name so that "everyone in the world would know of its good work", and so that the prestige of the neighbourhood would be enhanced. The MS had helped me so much she said, how would they be able to help me again if I was not grateful for their efforts? Although we quickly resolved the problem (and I amended the acknowledgements page), this incident taught me a number of lessons. Firstly, that I should not make assumptions on relative issues such as ethics and should first have asked for the MS' opinions on the issue of acknowledgements. Secondly, I realised that as a foreigner and 'respectable' outsider, I had inadvertently denied the MS the one thing that I could offer it – not naïve suggestions for self-help, or unhelpful ethical concerns, but perhaps an increased name and status by virtue of its association with my research. This association was, at times, useful, as, in subsequent meetings with others, I sometimes saw Durga showing them the report as evidence that the MS was involved in international research and was thus an important and influential organisation. Finally, the incident also brought home to me how very dependent I was upon Durga's goodwill for doing any further work in the locality. The good relationships that I had built up with others in Sett Bagan would stand for nothing if Durga chose to label me as an 'enemy'. The fact that I was the MS doctor's wife would also not help me. Through his association with the MS, Jo had come into contact with the SHIP and, in 1994, had been offered employment as one of the project doctors, which he accepted but continued to give his services voluntarily to the MS clinic. To Durga and other MS leaders, his employment was interpreted in the same way as that of the peer educators'. They felt that *they* had helped to procure Jo a job and sometimes commented that he had done well only because of them. In their eyes then, although Jo was a 'respectable' doctor, he also had reason to be grateful to them.

Although most researchers are dependent upon the goodwill of community leaders to conduct their research, especially when the research is not associated with any concrete benefits for the community, I have rarely read accounts of how this relationship is managed. No matter how neutral, impartial or objective researchers wish to be, simply by having an interest in doing research, they become stake holders in community relations. This cannot be avoided but becomes potentially problematic in the event of conflicts arising in the community, as they did subsequently in Sett Bagan. By 1995 a serious rift was beginning to develop between Durga and the SHIP – a rift which affected everyone in Sett Bagan, including Jo and myself.

Community and Intervention Politics

In late 1994 and 1995 a number of factors came together to create a situation of considerable tension between Durga, the MS and the SHIP which ultimately resulted in Durga breaking away from the project and in the dissolution and subsequent reconstruction of the MS.

In late 1994 it was apparent to everybody that the SHIP had no more jobs to give. Many Sett Bagan women were disillusioned with Durga at her inability to deliver on her promises and had stopped attending classes. Only a faithful (and desperate) few, including Jaya still hung around in the afternoons, hoping to hear of some opportunities that might be on the horizon. The women who had been lucky enough to get employment with the SHIP, including the MS leaders now also had no reason to hang out at the MS club just to display their support. In fact, the other Sett Bagan peer educators no longer seemed very interested in local affairs at all. They were heavily involved in project work and were experiencing the full range of opportunities that the project could offer – in some ways then, Durga had a rival in the SHIP. To make matters worse, at this time the SHIP director was actively trying to bring other PEs into prominent leadership positions both within the SHIP (and also supporting them within their respective localities) as part of the SHIP's efforts to build up the PEs' capacity to establish, and form local branches of, the DMSC. Until then, Durga had been the unchallenged leader and representative of the Calcutta sex workers, and she and her organisation, the MS, had enjoyed much of the limelight that fell upon the project. She was, in effect, now being asked to move aside and share the stage with others. Durga had always publicly represented herself as fighting for sex workers' rights and had represented the MS as a sex workers' organisation. This proved to be a defining moment for her. Rather than subjugate her own position to the overall interests of sex workers' development however, she perceived the building up of other leaders and sex worker groups as a direct and personal threat. Durga focused her anger upon the project director. She had always had direct access to

him and had accorded him tremendous respect and, indeed, gratitude ("he is my guru"), but he had not previously interfered in what she perceived to be *her* territory. Through his support to the DMSC, Durga came to see him as a threat and a rival.

Thus, as the SHIP's ability to provide Durga with a sphere of influence in Sett Bagan was diminishing, and as Durga became increasingly insecure about her own position and suspicious of the SHIP, it became necessary for her to find other means of consolidating her support base and of keeping the MS functional. As it happened, this need coalesced with the interests of a number of other groups in the HIV field in Calcutta who had their own agendas to pursue, some of whom were hostile to the SHIP.

At this time Jo and I, who had previously enjoyed good relations with MS leaders, began to be noticeably sidelined. This was probably related to the fact that Jo was employed by the SHIP, and that I was now officially affiliated to the SHIP for my PhD research. They were thus unsure of our loyalties and we were excluded from various key MS meetings to which we had previously always been invited[5]. For this reason it came as a surprise to us and to the SHIP staff when it was suddenly announced that the MS had acquired land and was going to build a residential home for sex workers' children. Apparently a relative of Durga's had donated a small plot of land outside Calcutta to the MS and it had constructed a ramshackle building there. No-one had any idea where the money for this venture was coming from but Durga assured everyone that donations were flowing in. We and other 'dignitaries' were called to the opening of the school, which had managed to attract a number of children, though everyone was concerned at the complete lack of infra-structure and planning involved. With the opening of the home Durga could now claim that she and the MS were once again working hard for the welfare of sex workers. This incident was symbolic of the changed relationship between the MS and the SHIP as the home had been planned without the active involvement of the SHIP director. Prior to this, he had been consulted by the MS for *all* its activities – so much so that Jo and I sometimes found it frustrating that even the simplest decision could not be taken without first asking "Sir".

At around the same time, Durga made contact with START, an NGO in Calcutta that was offering reproductive health services to sex workers and other women living close to one of the other city redlight areas. START's director seemed extremely keen to forge links with the MS and to do something in Sett Bagan. He came to Sett Bagan where we were also introduced to him. He agreed to pay for some renovation work on the MS club room and left

the area dangling the carrot of a project. Some time later he returned in the company of an American representative of what we were told was a funding agency that was involved in health and family planning work. They toured the neighbourhood and said that they would seriously consider funding a project. No-one seemed concerned that there had been no discussion with the community about what sort of 'project' might be useful or suitable in the area – the conversation simply centred around an abstract idea of a 'project'. The Sett Bagan women were once again hoping that a project and thus jobs were coming, Durga was able to tell everyone that she was organising a project for them and START's director had his entry into the area without actually committing to anything. As an afterthought, as he was leaving, he told Jo and I to write a proposal for this 'project'. With everyone's eyes upon us we felt we could not simply refuse giving the reasons of lack of planning and consultation. This would not be understood. So we reluctantly agreed but said that we would need time to have proper discussion with him and the community. This also kept everyone happy. In consultation with Durga and other leaders, we subsequently wrote a proposal covering a range of community development activities. After the initial involvement in proposal writing we were no longer useful and were once again sidelined, and Durga handled all further negotiations with START herself. Ultimately no 'project' was ever undertaken in Sett Bagan. Although nothing concrete seemed to come out of this association with START, Durga was nonetheless able to give local women the impression that a project was coming and thus maintain her support base[6].

Again, at about the same time (winter 1994-spring 1995) Durga diversified her 'connections' further and forged links with Surya, the NGO that was working on women's and sex workers' rights issues, and ran some small projects in the redlight areas. Durga could make this connection easily as she had met many local NGOs in her capacity as representative of the SHIP's PEs. Surya had ideological differences with the SHIP and opposed their stance on sex workers' occupational rights. It also felt that the SHIP was manipulating sex workers and, because of its strong influence in the redlight areas, that it was blocking their own work (discussed in more detail later). Surya started to support Durga and fund the MS. Durga used this money to create five jobs for locally strategic people. Jaya was yet again passed over and tearfully petitioned Durga one afternoon in the club when we were also present. Her pitiful situation was making everyone uncomfortable so Durga announced in front of everyone that the *daktar babu* and *boudi* would give Jaya work – we had, after all, been in the

[5] Jo still ran the clinic however and we were both still on good terms with others in the locality.
[6] Many months later the press revealed that START had allegedly been involved in undertaking an illegal HIV vaccine trial among some sex workers from a different redlight area in collusion with some American researchers.

neighbourhood for so long and, after all the MS had done for us, we had not yet given even one person a job! Luckily, we knew Jaya well and were able to explain to her afterwards that we had no job to give. The five new positions were in effect sinecures as there was no work as such to do.

Many of the Sett Bagan women had now stopped attending the club room and MS meetings. Instead, Durga canvassed in a neighbouring redlight area –Ram Bagan (another of Sonagachi's satellites) - apparently trying to undermine the formation of a DMSC branch there. The Ram Bagan sex workers were factionalised and the PE leader who the SHIP was supporting to lead the DMSC in that area was opposed by other powerful sex workers and their supporters. Durga exploited these local divisions to foster discontent against the SHIP director and to win support for the MS. Indeed, a number of Ram Bagan sex workers started coming to the MS club in Sett Bagan for the usual routine of classes and speeches from Durga promising an imminent project. Durga was becoming increasingly hostile to the SHIP and often said how the SHIP had become what it was only because of her – it was she who had 'made' the SHIP and who had given the project director fame. If he opposed her, then she would go out into the redlight areas and tell everyone that there was no such thing as AIDS!

At this time there was also a dispute and something of a power struggle arising between the SHIP and another key actor in Calcutta's HIV scene from a local institute who I will call Hari (who had friendly links with Surya). Both Surya and Hari had connections to Durga and the MS who became caught in the middle. Dr. P was unhappy with the way things were turning out with Durga but still hoped that the MS could develop into an active sex workers' community organisation. Thus, he still supported the MS as an organisation and was interested in obtaining funding or technical assistance with which they develop their activities. Hari however was apparently telling Durga that Dr. P was blocking support to the MS and promised that instead, ***his*** institution would give a project. In this way he was apparently trying to bring about a split in the SHIP's sex worker constituency that would diminish the SHIP's credibility and reputation as a pro-sex worker organisation. This would also open up space for other actors to gain a stronger foothold in the redlight areas and thus in the HIV scene generally.

An example of their tussle over Durga's (the MS') loyalty came when a representative of an international sex workers' organisation came to Calcutta. She had apparently said she might be able to raise funds for the MS. Jo and I were hastily called by the SHIP director and once again told to put together a proposal for a 'project'. Durga however, categorically told us that

she did not want a project from the SHIP, saying that it would be yet another handle with which Dr.P could control the MS. In any case she said, Hari had promised that *he* would be giving the project. We did not therefore write a proposal. Two days later the SHIP director came to the MS and asked us for the proposal. We rather feebly said that that no agreement had been reached and it seemed the community didn't really know what it wanted right now. Durga flatly denied this and said that of course, she did want a project! We were then asked to write a proposal but again, there was no discussion about what should go into it! In the end, again no new project ever emerged but the idea of one was nonetheless powerfully used by various interest groups to enhance their position – in Dr.P & Hari's case, to try and win the MS' support, and in Durga's case, to maintain her local support base and to use the MS' support as a bargaining tool with Dr.P and Hari.

In addition to using the lure of projects to try and mobilise community support and engineer a split in the SHIP's ranks, various actors also used a current concern of the peer educators over their salaries for the same purpose. The MS and other peer educators had begun to raise questions of a salary raise. There had been some discussion on this issue and anti-SHIP actors were allegedly involved in spreading rumours that the SHIP director was blocking a salary rise for the peer educators (which was not in fact true). At this point, Durga and others were becoming increasingly militant and anti-SHIP. To make matters worse, the SHIP had also just helped to establish the sex workers' co-operative, and in order to get it going, were deducting Rs.100 at source from the peer educators' salaries that would go into their personal co-operative accounts. However this caused a lot of anger and resentment among the peer educators who did not yet fully understand the potential benefits of the co-operative and Durga capitalised upon their misgivings to spread rumours of financial misdeeds. Then Durga fell sick for a few weeks and Rekha, her friend, who was not as clever or strategically-minded, unilaterally led a stir against the docking of pay and spoke openly and unthinkingly about the SHIP director's 'plot' to block a pay rise and embezzle the peer educators' money. The matter went right up to the West Bengal health secretary who, upon making inquiries, was utterly shocked at *how much* they were already getting compared to community workers in the slums and flatly rejected any raise! Eventually a compromise was reached but the incident serves as an example of how the MS was, in some ways, unwittingly being used to further other actors' agendas.

During the spring and summer of 1995 I was in the UK preparing to start PhD fieldwork. I knew that the problems with the MS and the SHIP were escalating but, in terms of planning my research strategy, thought that I would wait and see how things turned out once I was

back in Calcutta in the autumn. With the present dispute between Durga and the SHIP, doing research in Sett Bagan would be difficult and I also did not relish the prospect of having to handle the resulting local politics and constantly have to re-negotiate my position depending upon current alignments. However, I had established such good relations with others in Sett Bagan that I was reluctant to give these up and start all over again somewhere else.

While I was still away, the DMSC was officially established and Durga, the SHIP's erstwhile star peer educator, had been completely excluded from the process (also from its precursor, the 'action committee'), but other Sett Bagan peer educators had been included. Although it was hardly surprising given her anti-SHIP activities, Durga took this as a direct snub and intensified her efforts to undermine the establishment of DMSC branches in other redlight areas, particularly in Ram Bagan where she had by now built up a measure of a support base. Moreover, Durga began a public campaign to destroy the SHIP's credibility. She made speeches about how the project director was now trying to destroy the MS – after all that they had done for him. She wrote letters to the press and to other important actors in the HIV field describing various misdeeds allegedly perpetrated by the SHIP. She seemed confident that others, especially the anti-SHIP actors, would publicly support her and this seems to be where she misjudged her importance. For no matter how hostile certain actors may have been to the SHIP or to its director, it was by now an internationally reputed intervention and the prestige of Calcutta's HIV prevention activities overall was connected to the success of the SHIP. No-one was willing to come out *openly* in support of Durga or to publicly denounce the SHIP. Moreover, by virtue of his social status the SHIP director was clearly at an advantage in being able to influence opinion. In fact, the SHIP complained about the MS' behaviour at a subsequent project steering committee meeting and it was agreed that they should (temporarily) be disqualified as a Conglomerate member and that their name should thus be removed from the placards hung above the various club rooms where the SHIP clinics are held.

Sett Bagan Coup d'Etat: Realignment of the Mahila Sangha

When I returned in August 1995 the situation in Sett Bagan was very tense. Durga was trying to rally local women to her cause, yet most of the Sett Bagan peer educators were not willing to support her against the SHIP (as they had no personal quarrel with the SHIP and it represented the source of their livelihood). There were charges that she was consequently making trouble for these women and had even instigated police raids against one. Those who would not support Durga and the MS were sidelined and even threatened. After much

persuasion and lobbying (along the lines that the project director was trying to destroy the MS, the organisation that they had all worked so hard to establish), Durga managed to regain the active support and involvement of Malati and other key MS leaders and they resigned on masse from the SHIP.

Those who resigned felt that they had been betrayed by the project director. Rekha told us that:

> See, Sir has done a lot for us, he is our guru, but he should not have taken down the boards with the MS name and should not have got others to talk badly about us – this is wrong.

Durga herself was aware that she owed a lot of her present status to her experiences with the SHIP and explained to us her perspective on the conflict:

> I cannot be someone else's slave. Sir is my guru, he will always be my guru, through working on this AIDS project I have learnt many things and it is only because of him – but he should not have done this – he has raised me to the throne, only now to bring me down.

In Sett Bagan generally Jo and I were treated with some suspicion and women had virtually stopped coming the MS clinic – where possible it seemed, people wanted to avoid having to deal with Durga or having to make a public statement of their political affiliation. One peer educator said she avoided all contact with others if possible. Her perspective was that:

> See, the MS women are saying to us that 'we have planted the tree and now you are reaping the fruit', but I don't agree. If it wasn't for Dr.P then Durga would have had no jobs to give anyway - isn't that true? so they shouldn't be making people feel bad like that.

In the present charged situation it would clearly be impossible for me to do research in the neighbourhood, and the project director had suggested that I start building up contacts elsewhere. I did in fact begin to visit another redlight area a few mornings each week but was still reluctant to give up on Sett Bagan completely. As it happened, events changed so that I was eventually able to work again in Sett Bagan, and under easier circumstances.

Following the resignations, Durga announced that the MS would be opening its own clinic in Ram Bagan and Jo arrived one day to run his clinic to find that all his equipment had all been transferred to this new clinic. I do not know who was backing the MS with this venture – possibly one of the NGOs with whom Durga had already established links. The new clinic employed a number of new peer educators in addition to the ex-SHIP women (but at lower salaries). These new women finally included Jaya.

It was now clear that Durga was a potential threat to the stability of the project and also to the DMSC. Nonetheless, the SHIP director did not confront her directly, but rather, used existing local factions and mechanisms to create a situation whereby others would tackle her. During project meetings and events she was publicly labelled a 'project enemy' and, through secret meetings with MS leaders, often late at night, the seeds of doubt and discontent were sown in the minds of Durga's followers in Sett Bagan. Three leaders, including Malati, were singled out and in this way, the director effectively engineered a coup d'etat. The table had turned and these three MS leaders were now convinced that Durga had in actual fact mislead them and was misusing MS funds. They agreed that Durga must go (their own jobs would be reinstated and they would take her place as the overall MS leaders). On the director's suggestion, they arranged for MS members to sign a petition against her which was to be brought up at an MS meeting, following which there would be a vote to depose her from her position of President of the MS. According to the Sett Bagan peer educators, Malati (the most prominent of the three) and the others virtually forced women to sign the petition, saying that the SHIP director had said that anyone who did not would lose their jobs. One of the PEs told us:

> We are not fools, we know that Sir will not sack us for this but still, it is our jobs and we don't want to have trouble. We don't like all this and we know that we are acting dishonourably towards Durga – after all, without her which one of us would ever have known Sir – she was the one who founded the MS and ran all over the place – she was the one who found us jobs, but she has made all this trouble with Sir so we have to sign this petition to remove her from the MS.

Using Durga's tactic, Malati was also telling women that 'Sir' had said that lots of projects and thus new jobs would be coming if the MS was revamped under new rule! Indeed Malati, a *Grihasthi*, was clearly looking forward to the prospect of increased power in Sett Bagan (even though, ironically, that involved being head of a sex workers' organisation) and also to the prospect of a 'special' relationship with the SHIP. She proudly told us that:

> Durga told us many bad words about Sir but when I learnt the truth I went back to him and now Lokhi and I are his most special people – every day we go there – I go to his house and he sits and talks to us – he said he will do whatever is required, however many projects we require, he will give. Once we have removed Durga I will be President.

There did indeed follow an MS meeting at which Durga was accused of financial irregularities and 'deposed'. The new office bearers were announced and the MS became once again a faithful partner organisation of the SHIP but now with a much more compliant leadership. At this point there was clearly a need for the SHIP to build bridges with the 'new' MS and for community relations generally in Sett Bagan to be strengthened. The SHIP director called a number of meetings and various sub-committees (health, child care, old age,

and so on) were formed headed by different peer educators, presumably in order to reduce opportunities for power to concentrate into the hands of a lone leader, and also to give other women experience and responsibility. It was important that the SHIP director was seen to be delivering upon the promises he was said to have made regarding new projects. One of the conglomerate NGOs (HIP) was asked to get involved in helping to revitalise the MS. This brought in new resources and possibilities, and the introduction of another actor into Sett Bagan was also useful in helping SHIP director appear (when expedient) to distance himself from direct involvement in local politics. As part of HIP's/the SHIP's/the MS' new activities, it was announced that women in Sett Bagan would start a crèche for sex workers' children (though this did not actually materialise until 1998). The 'old age' committee distributed blankets to the poor, and an educated local *para chele* was employed as a non-formal education teacher for the PEs. Jo's original MS clinic was formally brought under the SHIP's umbrella and Jo was requested to run a nurse training course for Sett Bagan PEs which he did, but this was never followed up with any mechanism for utilising the trained PEs, rendering it a largely symbolic exercise. Local PEs and sex workers were generally only notionally involved (through their attendance at MS meetings), in deciding upon the face of the 'new' MS. In fact it reverted rather quickly to its old structure with Malati as 'head' (though now much more clearly a deputy of the SHIP) proudly occupying the club room chair and announcing loudly to all the sacrifices and efforts she was making to 'get' projects and improve local women's situation.

Durga did not of course leave graciously. She again launched a publicity and letter writing campaign which was countered by the new MS leadership who we observed one day getting everyone in the Lane to sign/thumb print a letter against Durga that was to be widely sent out but whose contents no-one had any idea of. Durga also initiated a court case and managed to get an injunction placed on the MS. An ardent Congress supporter, she appeared to have defected and was spotted on a number of occasions hob-nobbing with local CPI-M *para cheles* and there were a number of street fights and bombing incidents in the locality. After some months however she appeared to give up. She was still associated with her clinic in Ram Bagan however and still seemed to be trying to establish some kind of support base through offering classes (run from her mother in law's house and attended by some sex workers from both Sett Bagan and Ram Bagan) and promising jobs there. On the whole though, Durga had lost her influence in Sett Bagan.

The SHIP as a Local Community Institution

After Jo's MS clinic in Sett Bagan had been brought under the SHIP's umbrella, HIP employed six new peer educators to work in it. This time Jaya was among the PEs and we were all delighted. During the time of the 'coup' she had also defected and had left Durga's Ram Bagan clinic, having been promised a job by Malati. She told us that:

> Malati said that lots of projects are coming – I am not interested in all this politics. All these big leaders are fighting among themselves. It doesn't make a difference to me. I have no bad feelings towards Durga but I have to go where the money is, that's all.

By officially providing a clinic in Sett Bagan (although the Sonagachi clinic was just 15 minutes walk away), the SHIP established a concrete community presence in the locality. The close links between the SHIP's leadership and that of the MS also meant that though the MS was still officially a separate organisation, it had, in effect, come much more directly under the SHIP's sphere of influence as Malati and the other leaders were not independent, creative and strategic thinkers like Durga. The SHIP director's attempt through the MS sub-committees to introduce different modes of leadership and organisational functioning failed completely, and after their initial token activities the sub-committees fizzled out. In fact there seemed to be a complete lack of interest or motivation in doing further community work. This was probably because there was no urgent perceived need around which the community could rally (no obvious threat like Saju), and also because the MS seemed no longer to be locally regarded as a community organisation but rather as a sub-organisation of the SHIP. The MS and the SHIP were viewed more or less synonymously and many of the PEs' loyalties had been transferred to the SHIP. Thus, they and their friends now looked to the SHIP for inspiration and leadership rather than to their own community organisation, which took on the function of an ordinary *para* club in the sense of mediating local disputes and providing limited assistance in the event of personal problems. Indeed, since this time, the SHIP director also seems to have given up on the MS' potential for community action – a function that has largely been taken over by the DMSC. At public events the MS is still introduced as a sex workers' CBO and is notionally involved in SHIP/DMSC activities (e.g. a crèche has now been opened in Sett Bagan) but in reality it is no longer a significant force within the project or within the sex workers' rights movement.

Nonetheless, after the initial 'coup' there was still potential for Durga to de-stabilise local and SHIP relations. It was important therefore for the SHIP to build up community support

(through delivering on its alleged promises) and a strong community presence through which events could quickly be known and reacted to.

Thus the SHIP employed another batch of peer educators. They were strategically chosen to include women from Durga's mother-in-law's house (to break her influence there) and also two women from two of the houses that had traditionally been anti-MS (or anti-Durga), in order to try and make in-roads there. By early 1996, a total of 44 women from Sett Bagan were employed as peer educators, almost one fifth of the sex workers in the locality. Subtracting those who worked in Sonagachi and other areas, there were 22 peer educators employed for just 230 sex workers in Sett Bagan (an approximate ratio of 1 peer educator to 10 sex workers). In Sonagachi the same ratio was 1:96 and in Ram Bagan it was 1:42. The SHIP's visibility in Sett Bagan was further reinforced by the fact that for a few months in early 1996, the MS club also served as a base for PEs from Ram Bagan, a number of whom had also been newly (and strategically) recruited. The Sett Bagan and Ram Bagan groups would congregate together at the MS club for roll call and post-field work classes. This wave of PE recruitment thus brought a number of rival groups under the SHIP's umbrella. A total of 50 'green coats' would try and squeeze into the small MS club room in the mornings and would spill out into the Lane. The Lane appeared to have been virtually taken over by SHIP staff during project hours and large numbers of peer educators wandered around the field with very little to do. About six months later there were a number of re-shuffles where PEs were allocated to other fields or to an afternoon shift.

Relationships with other women in the Lane were not good and I observed very little formal or informal health education taking place there. By 1996 however, Sett Bagan sex workers had already been exposed for almost four years to the SHIP's activities and, given the low local turnover, most women had probably heard the flip chart and AIDS-related discussions innumerable times, though this does not mean they necessarily 'knew' everything about AIDS or were consistently using condoms (something that will be discussed in the next chapter). Moreover, with so many local women employed by the SHIP, no-one could have failed to have heard about the project or its activities. The poor relationships between the peer educators and some of the other sex workers were unsurprising given the history of community relations in the area. In spite of having employed two sex workers from the anti-MS houses, this did not result in a mellowing of the remaining sex workers' attitudes to the MS and the peer educators were still unable to enter those houses at all. In addition, some of those women who had unsuccessfully put down their names for jobs with the project had become disillusioned and, naturally, somewhat envious and bitter at those who were lucky

enough to get employment. Many withdrew from the MS altogether and consequently also withdrew interest in the SHIP (as they equated the two). In a way, the SHIP/MS had become a kind of exclusive club and those who were not directly involved felt excluded. Thus, the non-peer educators in Sett Bagan were, in my view, largely indifferent to the SHIP/MS, and some were still attending Durga's classes in the hope of obtaining work in her clinic in Ram Bagan. Thus, whereas in Sonagachi, the peer educators were generally on good terms with sex trade actors (who they did not know particularly well however), in Sett Bagan where community politics, personal disputes, history and the project were much more closely entwined, women's relationships often seemed to be characterised by mistrust and lack of goodwill.

There was, therefore, never a dull moment in Sett Bagan, though I spent many days there feeling as though I was achieving nothing. As soon as Durga was 'deposed', Jo and I were once again welcome in the MS. My research position had changed overnight. At the height of the SHIP/MS dispute in autumn 1995 I was hardly going to Sett Bagan - just making the occasional appearance to catch up on events and to maintain contacts. Jo and I were treated with suspicion and some even avoided us. We were extremely uncomfortable with the situation, but because I was personally attached to some of the women there and was still undecided about my research strategy, I did not want to completely give up working in the area. Now that the MS was firmly aligned to the SHIP however, there was no more conflict of interest – in fact we were all seen to be on the same side. Thus, in some ways my affiliation with the AIIHPH was now a distinct advantage rather than the potential problem it had been before.

Community Participation, Empowerment and the SHIP

From the discussions above, it is clear that in order to operate, the SHIP has had to negotiate a myriad interest groups of differing status and power both within its own structure and within and outside the redlight areas. Clearly, cutting out a workable path that could weave between the different groups represented an enormous challenge. A notable feature of the project has been its participatory approach and this has been credited by the director and international experts alike as having catalysed the SHIP's community development and empowerment activities (Jana et al 1998, WBSHP 1996).

It was noted in chapter one that community participation and its corollary, empowerment have, as described by Nelson & Wright (1995b:2), become "warmly persuasive" concepts used by a variety of actors in the health, HIV and development field, who may however

imbue them with very different meanings. Definitions of community are contested and the purpose of participation has been described as varying from an instrumental "lubrication of the implementation process" (Baylies and Bujra 1995:203) to social transformation (Nelson & Wright 1995b, World Bank 1994). The possible relationships between the different stakeholders involved in a participatory process have been classified by Biggs (1989) along a 4-part typology as contractual, consultative, collaborative or collegiate. Nelson and Wright (1995b:16) add a fifth possible 'type', that of participation as a guise for co-option of protest. The relationships between interest groups, institutions or individuals in an intervention are essentially political as they may involve actors of widely varying social status/class, who have differential access to, and control over, resources, and, therefore, power. These relationships similarly may involve negotiation between diverse ideologies about how society should be organised and how it can be changed, though Nelson and Wright (1995b) point out that this ideological basis often becomes hidden as concepts come into widespread use.

Participation and empowerment are both 'active' concepts and in this sense hinge upon a notion of agency defined as a social actor's capability to act. However, definitions of who is capable and the parameters within which this 'capability' can be expressed, and which definitions or representations achieve predominance in given contexts, again involve relations of power. Both agency and power relations are expressed through socio-cultural norms and structures and may be constituted in very different ways (Hindness 1986, Giddens 1984, Strathern 1985, Hobart 1993b, Long & Long 1992). In the following analysis I look at the ways in which participation was operationalised and represented in different contexts, by different actors for different reasons, and at how different constructions of agency have affected the ways in which the SHIP functions and how empowerment is understood.

Defining and Constructing a Community

During my fieldwork the term 'community participation' was often used both by project staff and other groups (such as donor agencies or visitors to the project).
However, defining a community in the redlight areas is rather complex as there are various dimensions of commonality and also of division.

As noted in previous chapters, prior to the SHIP, there was little camaraderie or sense of community (especially in Sonagachi) among sex workers themselves, and many women had lost or loosened traditional community ties with kin and social networks. When I started fieldwork, brothel based women referred to themselves as 'line girls' and occasionally spoke

of sex workers as being one *'jat'* (caste), usually with reference to their common experience of stigma and marginalisation[7]. There had not been any collective mobilisation however around these common experiences with the exception of the MS whose activities, though remarkable, had, prior to the SHIP, remained confined to its own *para*. In this sense the MS community was defined largely through *para*-based relationships and I found more generally that local notions of community were strongly hinged to *para* affiliation, especially in the smaller redlight areas. In the absence of any larger institution or network of relationships to turn to, the *para* and, in particular, the *para cheles* or associated political parties, represented a key source of potential protection and support (but conversely also of exploitation and dependence) for sex workers. Sonagachi as a whole, because it was larger, was usually not referred to as a *para* but rather consisted of a number of sub-*paras* which served a similar community-defining function for some sex workers, especially Bengali women who had lived there for some time. However, for others, particularly the Nepalis and *Agrawalis*, their primary sense of association was forged through kin and ethnic linkages. Many sex workers in Sonagachi are transient and may spend only a few weeks or months there. For these women, possibilities to establish local affiliations were obviously limited. Another way in which local people (especially trade controllers) talked about common interests was with reference to their common business interests. In reality however, though everyone depends to some extent upon the sex trade for their livelihood, this is where points of commonality end (especially in Sonagachi whose population is mobile and heterogeneous). Within the business community, interests of the workers and the managers/brokers clearly often conflict.

Prior to the SHIP therefore, with a few exceptions, I suggest that sex work 'communities' were primarily geographically, *para*, and business based. From early on however, the SHIP has been clear that its main aim has been to work with, and empower, *sex workers*. The project has recently formulated its own definition of its target community as:

> .....sex workers, that is anyone who has ever practised sex work as a profession and identifies herself/himself or is identified as a sex worker; their children; and their *babus* or fixed clients (unpublished presentation notes, SHIP 1999)

Part of the SHIP's task therefore was to try and *construct* a greater sense of community among sex workers. In pursuing its goals however, the SHIP has simultaneously had to gain the acceptance of other, more powerful business/*para* stakeholders. The project therefore has had to work within existing power structures and create an impression that they have everyone's interests at heart. Yet, within the existing structures it has had to provide

[7] They would make similar general references to men and women as being of different *jats*.

opportunities for sex workers to develop some common ground and create a mechanism by which their interests can be represented. In order to explore how this may have occurred, it is important to investigate the different ways in which the SHIP has represented itself, the ways in which it has been perceived, and the ways in which it has operationalised community participation.

Representations: the SHIP vis a vis Local Communities

In this section I examine five different (though overlapping) ways in which the SHIP has represented itself, and, in turn, has been understood by different actors, and consider the implications of this with reference to community participation and empowerment. Unfortunately my discussion relies mainly on the perceptions of sex workers, peer educators and other SHIP staff. The analysis below would undoubtedly have benefited from greater interactions with other sex trade actors, especially in Sonagachi; however this was not possible in the research time frame.

SHIP as Service Provider

The first such representation of the project is as 'service provider' – an image that was particularly prevalent in Sonagachi and that was used particularly in the project's early days. Project supervisors told me that one way of negotiating with different groups during the initial phases of the project was to firmly position the SHIP as a neutral player by emphasising its bio-medical objectives and medical services. People were told that a new disease had come for which there was no cure and the government was concerned to prevent it spreading. For this, they were trying to promote condoms and were providing a clinic for sex workers and other local people (people's responses to being targeted in this way is discussed further in chapter seven). The project had to convince the business community that it would not affect their livelihood, and that it was in the long term interests of everyone to practice and promote safer sex. Project supervisors said they had explained to trade controllers as follows:

> See, if a girl sits without a cap (condom) it is quite likely that she will contract some disease. If, in this way 5 other girls also get infected by HIV the entire trade will be in jeopardy because word will soon spread that there is HIV here. As a result fear will spread and ultimately no customer will come here. This trade is the responsibility of all and it is imperative that the girl who is at the centre of it remains healthy. If she is healthy everyone will prosper while if she becomes ill, all will suffer (Supervisor).

Likewise PEs explained to sex workers that:

> Because this new disease has come, and because there is no cure, the government has started this project (peer educator).

At the time of my fieldwork, perhaps the majority of actors I spoke with in Sonagachi (though not in Sett Bagan) similarly viewed the SHIP as simply a provider of health/HIV prevention services:

> Rich people can afford treatment, but poor people like us cannot afford and we die – so it is for us that the project has come – the condom is our treatment (Sonagachi sex worker).
>
> The project has come because before for all the diseases there were medicines but for this disease there is no cure and then what will happen? This foreign disease will spread across the country – this is why the government has opened a clinic for us (Sonagachi sex worker).

People's experiences with, and views of, the project clinic varied:

> For poor people it is a good place, they give good medicines (Sonagachi sex worker)
>
> The doctor is good for sex diseases, but he did not cure my *gastric* so I went to another doctor (Sonagachi sex worker)
>
> Some girls feel if it free it is no good – they want to maintain a 'standard' so they won't go there (Peer educator)

Many whom I spoke to however, especially sex workers in Sonagachi, had no particular opinion on the SHIP or its services at all but simply talked of it in functional terms – "they have a clinic", "they give free medicines", or "girls come here and give condoms". Clearly many sex workers *were* accessing project services - using project condoms and attending the clinic - but other than using the project in this instrumental way, the SHIP did not seem to have made a great impression upon them. Similarly, many women I met in Sonagachi had not heard of the DMSC and were not aware of its activities, even during the time when it was hosting the first ever national conference of sex workers in India. At the time of my research, it seemed that many sex workers in Sonagachi saw the SHIP as it had represented itself - a service provider set up for them by the government - and felt no real personal stake in the project or the DMSC. This functional perspective may also have been related to the fact that the SHIP initially concentrated upon building up the skills of the peer educators as a core group of potential change agents/community workers. Many of the project activities were, for a long time, restricted to the peer educators in reach and operation and, it was only the PEs who had direct access to the resources that the project could offer. It was only in late 1996-7 that the DMSC/SHIP's capacity building and sensitisation work began to be expanded to cover a broader audience of sex workers, for example by organising residential workshops for several hundred sex workers at a time on AIDS and other topics. Since that time the peer educators have also increasingly taken on the role of community mobilisers as well as health

workers (for example, by broadening their discussion with sex workers to cover their problems and rights as well as HIV prevention), and the DMSC has its own cadre of community workers (many of whom however are simultaneously PEs).

The functional view of the project may also have been related to the nature and degree of interaction of sex workers with project staff in Sonagachi which varies considerably and is related to the structure of the sex trade in that area. One factor influencing this is the sheer number of girls and other stakeholders who have to be covered in Sonagachi, limiting the time available for in-depth interactions. In addition, mobility in the Sonagachi sex trade is extremely high, which again limits the possibilities for close relationships to develop. Another important factor is that project staff must work through gatekeepers such as madams. Where madams are hostile, interaction between PEs and other sex workers may be limited to a rapid distribution of condoms (if even this is permitted and in some cases it is not) with limited further discussion[8] [9]. Another significant factor is the heterogeneity of sex workers in Sonagachi. All but one of the SHIP's PEs in Sonagachi are Bengali and, by definition, their own sex work takes place in conditions of relative autonomy (otherwise they would not be able to devote time to being a PE) and some no longer work as sex workers. In addition, the vast majority of PEs are 'C' grade, and are thus working class and relatively low earners. As noted in chapter 3, there is some animosity between Bengali sex workers and the *Agrawalis* and Nepalis. During field visits, I observed, (and peer educators and project staff freely admitted), that the relationships between the PEs and these other groups was qualitatively different from those with the Bengali sex workers, due both to class/ethnicity-based suspicions and also to the fact that these groups tend to work in highly controlled environments. Peer educators were rarely able to chat at any length with Nepali/*Agrawali* women and their visits were usually short and cursory. With many (but not all) of the other sex workers and madams by contrast, the peer educators had clearly, over time, managed to establish courteous and friendly relations.

However, by representing itself as a functional service provider (especially in Sonagachi), the status quo between the different interest groups was not openly challenged. Had the SHIP confronted the more powerful lobbies, the project could not have functioned. By presenting itself as a government project local people in Sonagachi ascribed its agency to the State and saw themselves, at least initially, as relatively passive recipients of its services. At the same

[8] In smaller redlight areas the situation is different as the peer educators are more visible and have higher levels of contact with other sex workers who tend to work relatively independently.
[9] The role of madams in influencing the SHIP's work and sex workers' ability to protect their health is discussed in more detail in chapter eight.

time, the SHIP actually tried to involve powerful stakeholders in the project in order to gain not just their toleration but also support. The participation of local interest groups such as the Councillor, landlords or the club members was, therefore, pragmatic, and was largely kept to a contractual and consultative level. Although the two clubs through which the clinics operated were included in the Conglomerate structure they have not played a particularly active role in subsequent project activities and their inclusion is therefore somewhat tokenistic. As the SHIP has gained recognition, part of the limelight has also fallen upon the clubs and other SHIP supporters in Sonagachi, increasing their status and also their stake in the SHIP's success. The project director has talked of how even this process of consultative participation can, however, be riven with potential pitfalls. For example, the rife factionalism between and within the clubs, has meant that the project has had to tread carefully not to be seen to be associating with any one particular group, while at the same time, sometimes having to create an impression for particular groups that the project was actually 'on their side'. The project director has noted that:

> Actually we have learnt that we have to play a game with all these different actors – not too close and not too far – we have to play a game where all are involved but not altogether (AIIHPH 1997:20).

In the early years of the project, I observed that the *rhetoric* of community participation was frequently used at public meetings and in project publications but was not explicitly defined. In this way the SHIP could represent itself to local people in Sonagachi as a project that is doing something for the whole 'community' without having to spell out what this community is (cf. Jana & Bailey 1994). By leaving the definition open, different groups could interpret the SHIP's activities in their own way and there have been few serious or sustained attempts to undermine the SHIP from within Sonagachi itself.

SHIP as a Community Based Organisation and Employer

Another way in which the SHIP has represented itself, and has been perceived, is as a community-based organisation that is doing good for sex workers, and, therefore, for others in the business community. In order to convince people that the project had no interest in affecting the stability of the sex trade in general (i.e. no hidden agenda to rescue or rehabilitate sex workers) the project has been careful to have no connections with the police or with other state institutions. When a problem was encountered, staff note that it was usually resolved through negotiation internal to the sex trade. This is seen to have been important in gaining the trust of local groups and in establishing the credibility of the SHIP as a project that is working in a non-judgmental way for the welfare of local people, and that

genuinely puts their needs first. For this reason the suggestions of local people vis a vis the project have been solicited (consultative participation) and the SHIP has tried to respond (e.g. by providing child immunization services, or helping with placement of sex workers' children):

> The project has come from outside – they have come to work for us, to do good for us (Sonagachi sex worker)
>
> The project is for the line girls – to help us, to give us a chance (Sett Bagan sex worker)
>
> It is good – they are doing something for society – it is social work (Madam)
>
> They have given many girls jobs and have made them 'good' – this is a good thing (*Babu*)

In time therefore, the SHIP has managed to build up a strong community base in Sonagachi and even more so in Sett Bagan. The strategy of working through and (in Sett Bagan's case, co-opting) local clubs who have formally been made part of the project structure ensures that (at least some) local people feel a stake in the project.

The SHIP's community presence and potential influence is enhanced by the structure of its outreach work. During working hours, the project is extremely visible. Field outreach is conducted by groups (rather than by individuals). Such groups of 'green coats' pushing their way through crowded streets cannot be ignored nor can they be as easily fobbed off by hostile stakeholders as an individual could. The high levels of contact project workers have with local people also means that the project can serve as a central point of communication (and assistance) on matters internal and external to the sex trade and in this way it can act as a valuable community resource. I observed PEs and supervisors often being asked for help and advice from sex workers, and even from other groups such as pimps or madams. Thus, I suggest that the SHIP gradually became accepted as a benevolent community-based institution. However, I propose that through its outreach activities, it simultaneously served to build up the sex worker community, though this is difficult to assess directly. Prior to the SHIP, sex workers had had little contact with each other. With the start of peer education, sex workers were able to meet groups of PEs and were able to share ideas and experiences. This in itself presented an opportunity for developing a sense of commonality and building up a feeling of mutual support. The PEs were encouraged to develop friendships with other sex workers. They were told that this was as important as explaining the flip chart or handing out condoms and they spent 6 months in each field area. Much of the interaction that I observed in the field (especially in Sonagachi) was simply spent gossiping, often on topics that were seemingly irrelevant to safer sex. In this way they were able to try and build up good rapport

with many sex workers, especially the Bengali girls, among whom, in contrast to the initial hostility PEs report encountering, at the time of my fieldwork, the PEs were often welcomed, given *chai* and invited in to chat. Thus, I believe the PEs were able to convince these sex workers that they and the project genuinely had these women's interests at heart, and that the project represented an institution that sex workers could turn to in times of need. This was a message that was strongly backed up by project supervisors who often took on a counselling role during field visits. The message clearly hit home as PEs have cited the need to respond to the many requests for help that they were receiving as one of the main reasons for forming the various committees that were a precursor to the DMSC (see chapter four). Thus, while at the time of my fieldwork, many sex workers in Sonagachi did not appear to feel directly involved in the project itself and were not actively participating in it, a foundation for future community mobilisation was being laid through the relationships that the PEs were able to form with sex workers. This can be perhaps be gauged by the ability of the PEs later on to mobilise large numbers of sex workers to attend workshops and other project events once these were expanded in scope, and this is one measure of the success of community building that the SHIP is itself now examining.

In Sett Bagan by contrast, there was already a reasonably well developed sense of community (but also factionalism) among the women there. The case study showed that many sex workers seemed extremely eager to participate in the SHIP, but that their enthusiasm, at least initially, came primarily from its interpretation locally as a potential employer. Even during the first ever national sex workers conference in late 1997, when I asked Sett Bagan sex workers what they thought about it, I frequently received replies along the lines of:

> Well, I suppose this is all very good but there are not enough jobs here – I have put my name down but still haven't got anything – what is the use of all this if it doesn't do anything to help us girls? (Sett Bagan sex worker).

During the same conference a group of older sex workers from one of Sonagachi's satellites complained to me that: "we keep coming to all these meetings but there is still no job."

Thus, sex workers' more direct participation in project events, at least initially, appeared to be influenced by the perception that they might obtain concrete benefits from the SHIP, preferably in the form of employment (or through bringing in further 'projects' – as in Sett Bagan). In Sonagachi too, I observed that some of the women who appeared to be particularly friendly with the PEs, often asked them to try and find them jobs. The PEs themselves used this as a way of mobilising women to come to events. Once for example, an aged madam in

Sonagachi asked the group of PEs I was with for work, and was told: "see, first you come to all our meetings, then we will see if there is any job."

Other local people I spoke to in Sonagachi also made approving remarks that the SHIP had given so many girls jobs and was really helping them in this way.

The representation of the SHIP as a local community institution doing social work has also been reinforced by the widespread media publicity and national and international importance it has attracted over the years. Up to 300 outside visitors each year come to see the SHIP at work in Sonagachi and publicity has been encouraged through a public relations strategy that actively solicits attention to the SHIP's activities and to sex workers' rights[10]. This public visibility of the SHIP (and the DMSC), the tacit support of the ruling CPI-M and also the direct involvement of local stakeholders (clubs, sex workers employed as PEs) means that the SHIP is now in a relatively strong position to withstand any opposition. For example, the protests evoked by the establishment of the DMSC did not do the project any serious damage locally. Moreover, the project's status as employer perhaps also stifles any local detractors. Few people would want to be seen to be causing a large group of individuals to lose their jobs as this would turn public opinion against them.

The SHIP as Kin Group

In the course of my discussions with PEs, I found that for many of them the SHIP had assumed a deep and moving significance in their lives that can only be understood in the context of their social and financial insecurity, stigma and marginalisation. Certainly, as the Sett Bagan case study shows, the project is valued by PEs for the work and secure income it provides but for many it is also appreciated for the opportunity to have a 'respectable' job - one which they feel is 'social work' and of which they can feel proud, and through which they feel they can participate again in mainstream society as it gives them a 'respectable' social identity:

> No-one in my family knows I am a sex worker though they may suspect – by joining this project I can tell them I am working for the Hygiene Institute. I have not told them I am working in Sonagachi – but there again, in whatever place we work – it is WORK. If they question me, I show them my green coat and my identity card and this makes them silent. This work lends a sort of respectability to us. We girls have gained a lot of prestige since working for the project – we can be proud of our work. Also, we can

[10] See DMSC 1998a for a selection of press cuttings about the group and about the SHIP. During my stay in Calcutta, there were articles and press releases almost weekly in the (English language) papers about the project and about sex workers' rights – they are thus too numerous to list here.

> work for others – we are getting an opportunity to do social work, to stand by the girls in their hour of need. We can guide them and help them – for me this is a great source of joy (Peer educator).

In discussing their feelings about the project, many PEs emotionally describe their experiences as a journey moving from a state of darkness or imprisonment into light and freedom. They clearly feel that their guide in this journey has been Dr.P (rather than, for example, other project staff). Indeed, on many occasions during my research, Dr.P was described as the PEs' *guru* (teacher), and was talked of with almost religious reverence in outpourings of gratitude and loyalty:

> I felt I had been imprisoned in the darkness before I joined the project and that I had gained a new life. I felt as if I was released from a closed room and could see sunlight. I could never have imagined that I would associate with the people I do today nor meet the different visitors from various countries! All this has been possible because of Dr.P. He is like the almighty to us. Dr.P occupies the same position in my life as my parents. My parents have given birth to me while Dr.P has brought some light into my desolate life. My parents have not been able to do what he has done for me (Sonagachi PE, DMSC 1998:34).

> Because of the project I have been to many good places and have been able to interact with various types of people and came to know a lot. The project is like God to me as it has enabled me to face society with confidence. I had never imagined I would be able to emerge out of the dark alleys and venture into light. Before we were ignorant, we were dumb – our lives revolved around our rooms and our customers. Now we have become more vocal, more confident and we freely move around here and there. We know many things and discuss these with other girls of the line (peer educator).

As evident from the above quotes, a dominant metaphor used by the PEs to describe the meaning of the project for themselves was that of the family or of kin and this metaphor was also used by supervisors to express the project's function:

> It is true that most of these girls do not know who their parents are or where they are – they also do not have any guardians worth the name. Now that we have come here to work they have started taking us as their guardians (supervisor).

Another metaphor used by the PEs was of the project as a 'body' and in both cases Dr.P was represented as the metaphorical 'head' and they and other project staff as his limbs or children. In 1995 I attended one of the project's monthly meetings with the PEs and sat together with a researcher who had just been employed by the SHIP. During this meeting Dr.P discussed a rumour that had arisen that he was planning to leave the project and reassured the PEs that he was not planning to leave just yet but that one day he would go as the project was theirs and they must learn how to run it. This provoked a remarkable (and undoubtedly somewhat melodramatic) outcry with one PE after another standing up and drawing upon a variety of metaphors to pledge her loyalty to Dr.P and to plead with him not to leave:

> Yes we will run the project but do not leave Sir, without you we cannot do anything, Sir, you are our 'head' (*matha*) - whatever you say, we do.
>
> Yes, it is like when someone adopts a child and makes it big, they are the parent (*babama*) to that child – this is how we are – Sir you are *babama* to us.

After the meeting, the new researcher expressed her shock to me at what she perceived to be the 'gender-dependence' upon Dr.P within the project. Dr.P however attributed the response merely to a marginalised group's natural apprehension about their ability to take on responsibility for the project (and to some extent, for their destiny). Nonetheless, the perceived status of Dr.P as 'head' of a project family or body was a dominant metaphor even for other project workers such as supervisors and in my experience of the project I found a widespread reluctance among all levels of staff to take any decisions at all, no matter how trivial, until they had first consulted with Dr.P:

> Truly, everything comes through Dr.P (supervisor).

The absence of a middle management layer in the SHIP and Dr.P's direct involvement in, and evident commitment to, project and DMSC activities reinforced the image of him as a dedicated 'head' and leader of a kin group that could provide a much needed sense of belonging and identity for the PEs. This social construction of the project as family- or body-like with a strong leader resonates with predominant forms of social organisation in India, notably the family, and political organisations (Burghart 1993), and has implications both for the potential sustainability of the project (in the event of the director leaving), and for its replicability (in the absence of a similarly strong leader). These issues are discussed further in chapter nine.

The metaphor of the SHIP as kin-group can also be extended to the project's organisational structure. Having a connection with the SHIP offered even non-PE sex workers a means of forging and mobilising around a common social identity:

> The project has made possible unity of these workers under one banner and has given them the will to resist any form of oppression and exploitation, either individually or in a collective form. Thus a platform has been created where they can hope to network among themselves for integration and solidarity (AIIHPH 1997:18).

Through its community presence in almost all Calcutta redlight areas, the SHIP (and DMSC) now represent potential common linkage points that have not previously existed for sex workers who were more or less restricted to the world of their respective *paras* and who had only limited contact with each other. The extent to which different sex workers were

conscious of, reached by, or participated in, the potential opportunities offered by the SHIP or DMSC however was variable at the time of my research. As noted above, for a number of women, the SHIP appeared mainly to be perceived as a benign service provider and social worker or was valued primarily as an employer. Indeed, in Sett Bagan, those women who were not PEs, may in some ways have felt excluded from the metaphorical kin-group:

> When I see the PEs at these big big meetings, they are talking properly with good people, eating with them, standing with them. I feel that for these girls they are getting a chance – they are becoming 'good' through this work, but I cannot stand where they are standing (Sett Bagan sex worker).

However, this feeling of admiration and/or envy of the PEs may also have had positive effects (though this was not *explicitly* stated by my Sett Bagan informants). As positive role models, the PEs and their achievements as a result of SHIP/DMSC membership probably acted as a source of inspiration for other sex workers proving to them that sex workers *can be* worthy of respect and that they can interact effectively with mainstream society (and get results) given the right conditions and support. Seeing the changes in the PEs may thus have made women more receptive to participating in project and DMSC activities when these were expanded to include ordinary sex workers.

Those lucky enough to be PEs clearly felt increasingly united by their connection with the SHIP around which they were developing a stronger sense of community:

> We girls used to know each other by face but we did not mix and we never bothered to find out how others are keeping. After the project has come, not only in our area but in all the localities, we have come closer together. We meet regularly, we ask each other how they are, we feel more united. Even if the girls don't accept our condoms we still talk to them, find out their problems and they ask our advice. There is more unity among us, the fights and squabbles are reducing. Before, if I saw Podda, I would say to myself "earning a lot eh - so happy! Maybe I would call over "Hello Podda-di" but I will say to myself "common whore". But things have changed now. If I don't come to work for a day or two, they will come and visit me - it was not so earlier. We get to go about and meet people. All this while in darkness I couldn't talk to anyone. I couldn't even think of talking to people like you and I even didn't know how to talk to the other girls here. Now we sit and meet and discuss. It is good (Sett Bagan peer educator).

> Before I would sleep till 10 or 11am but now I get up early. I have a bath and cook and go off to work. I feel very good going to work. I go out and see everyone coming up to the club and we all shout and say how are you? And then we get together and talk about things. We never did this before. Each existed in her own world. We are learning so much. We are learning about laws. We used to be cheated so often and now our eyes are opening up. When we were indoors with just the four walls around us we didn't know the world. Before there was so much jealousy among us. This DMSC has been possible because Sir has got us together and we are all working together for something else (Sonagachi peer educator).

In order to construct or develop a community of sex workers brought together by the SHIP, it is necessary for them to be represented. Given the lack of pre-existing community and thus of community representation among sex workers (with the exception of the MS), the peer

educators employed by the SHIP (many of whom are themselves still working as sex workers) have been considered the voice of the sex workers. Similarly, they are supposed to convey the 'voice' of the project back to the field, serving an important dialogical function. This role of PEs as sex workers' representatives has generally been uncritically accepted. The peer educators (and thus many of the changes they have undergone and the views that they express) have, both in project documentation and in the media, been consistently equated with sex workers in general. Though they may have much in common with 'ordinary' sex workers, the material presented above shows that simply being a peer educator clearly sets them apart (especially after having worked for a number of years with the project), yet this difference is rarely acknowledged. In fact research is only now underway to assess the kinds of impacts that the project has had on 'ordinary' sex workers.

The assumption (or representation) that peer educators are representative of, and can be equated with, sex workers in general may also be problematic in another way, especially in Sonagachi where sex workers are extremely heterogeneous and where peer educators are in fact drawn only from *Bengali working class, brothel based* sex workers. The DMSC and the Usha Co-operative evolved out of PEs' association with the SHIP and their leadership is entirely drawn from among the PEs. These organisations and the PEs in general are however, usually portrayed as representing the entire sex worker 'community', glossing over any potential differences. Given that the PEs number over 200, meetings and other project events always appear well attended by the 'community' though this may not in actual fact be the case (as Durga pointed out with respect to Sett Bagan). In project documentation, group discussions with peer educators are often written up as: "the sex workers in Sonagachi feel that....." (see for example the project evaluation, WBSHP 1996). The occasional document notes that it might be important to investigate the implications of sex workers' 'difference' for various project components (e.g. condom use, or clinic attendance); however, to my knowledge this has never been followed up (Merten and Jana 1994).

In making these points, it is not my intention to criticise the SHIP. Given the social context of sex work where there was little collective strength or identity at all among sex workers, downplaying sex workers' differences can be an important strategy to build up a sense of solidarity and community among them. Project staff note how it would have been extremely difficult to persuade *Agrawali* or Nepali madams to allow their *adhias* some time to work as a PE. The other major group using Sonagachi, the 'flyers', were also excluded from the SHIP and were not specifically targeted until much later (1995-6) and then only in Ram Bagan and Sett Bagan. The exclusion of these groups among the PEs (to a large extent out of practical

necessity), may however, at the same time, have helped to contribute to the development of a greater sense of unity among the majority Bengali PEs, thereby preventing damaging internal divisiveness from emerging. Experiences from other sex worker projects have shown that differences between PEs and between different categories of sex workers has acted as a barrier to collective organisation (Asthana & Oostvogels 1996, Evans 1999). Moreover, representing the PEs as the voice of all sex workers allowed the SHIP/DMSC to develop a single coherent ideology on sex work with the attendant possibility of identity re-negotiation (as *workers*) that may otherwise have been internally contested. Thus, association with the SHIP and, particularly, the DMSC becomes akin to joining a social group that is able to provide a new and distinct social identity for its members.

SHIP as Patron

The representation of the PEs as speaking for a more or less united community of sex workers is also related to another way in which the SHIP has been perceived and operates - that of a sex workers' patron. This function is also crucially related to the understanding of sex workers' empowerment.

As described in chapter four, power within the redlight areas in Calcutta is structured through complex systems of patron-client relations. Traditionally, sex workers who needed help had to seek a suitable 'patron' (e.g. an influential madam or house owner, the party office or a local influential *para chele*) who would act on their behalf rather than attempting to take direct action[11]. With the formation of the SHIP and the DMSC, I suggest that these institutions represent alternative 'patrons' that, by acting in sex workers' interests, are subtly challenging the status quo simply through their existence as much as through direct action. This is an area that requires further exploration; however, it is possible that by robbing local power brokers and institutions of the chance to extend their patronage, the SHIP/DMSC also robs them of their claim to obligations or favours in the future, thereby breaking traditional ties of dependence. In addition, in the SHIP/DMSC, sex workers have found a patron who acts in *their* interests and who is willing to advocate on their behalf. A supervisor described to me how she felt that:

> The power structure of this area is slowly changing. The girls have a voice now and the power brokers realise that they can no longer carry on with their old ways. Today they discover their iron grip is being loosened and the sex workers are becoming more and more aware of their rights. Though these girls are not directly challenging the trade controllers, the latter realise that the previous power dynamics are

[11] This is why Durga's formation of the MS in Sett Bagan is rather an unusual achievement though it did receive tacit support from local men and the local Congress party office.

changing. The sex workers cannot be taken for granted anymore and cannot be exploited. *They have someone to speak for them.*

Most PEs too agreed that the power dynamics external and internal to the sex trade were beginning to shift:

> See, we have made our DMSC so that we can all go and stand next to a girl in trouble. Supposing a *para chele* likes a girl, he comes and the girl starts liking him, starts to sleep with him, he asks for money and she doesn't give. Then he beats her, hits her and finally slashed her. Why did he slash her? Because there is no-one to speak out for her, so he slashed her. And if she had someone to talk for her then perhaps the next man slashing her would have felt scared. After the DMSC has come, even the murderer feels scared. If I kill one girl today, I will have to answer to 2,000 girls tomorrow. Oppressing one girl, 2,000 will come demanding an answer – better that you leave the line girls alone. Yes we have even had a conference – we have proved that we line girls can call people from all over the country, we have shown that we have such power (peer educator).

The function of patron or sex workers' advocate is enhanced through the organisational structure of the SHIP and DMSC. Previously, sex workers' limited contact with mainstream society meant that their main sources of information about and communication with the outside world were clients and local power brokers and institutions. By having branches in most redlight areas, the project has opened up previously non-existent channels of communication among sex workers. This has enhanced sex workers' access to information and also means that few local events now go unnoticed. For example, those who go against the SHIP's safer sex message (e.g. a pimp threatening to close a room because a sex worker refuses to have unsafe sex) are 'reported' and immediately find themselves cornered by a trouble shooting gang of white-coated supervisors! Since the DMSC is an integral part of the SHIP, it similarly has access to local knowledge and events, and atrocities against sex workers are no longer invisible or unchallenged.

> Only after entering this project have we come to know what is happening where, what are the problems of the girls. This knowledge has brought about a change. Before this project we were totally ignorant – how would we have known what was happening in other places? (peer educator).

The SHIP and now, increasingly, the DMSC, appear in some ways to have taken on a kind of 'big-brother' surveillance role in the redlight areas that seems to have been instrumental in changing power dynamics in local areas by acting as a check against abuses against sex workers. The structure of patronage relations however necessitates a strong leader and also a sense of unity among the support base.

From the SHIP's early days, the project director has been conceptually clear regarding whose side he and, thus, the project are on. My observations and the subsequent course of the project indicate that he has very successfully managed to facilitate a common vision, identity and

clarity of purpose among the highly diverse group of actors involved in the SHIP. I found that the fundamental ideological conviction that sex workers deserve respect and recognition was shared by most project staff (at least in public). The perspective and ideology around sex workers' rights propagated by the project was systematically conveyed to its PEs in the form of group discussions and even coaching sessions (especially prior to public meetings), so much so that PEs would tend to give almost identical answers to questions that were asked. Within the project there was an unstated expectation of organisational loyalty. Anyone who radically or publicly did not conform to the project's line was visibly sidelined (for example, transferred from his/her normal working location to an unfamiliar locality where they could not cause trouble) or, in extreme cases (as with Durga), labelled an 'enemy'. In addition, in potentially difficult localities (such as Sett Bagan but also others), the SHIP has dispensed patronage (reminiscent of the methods of political parties in India) in the form of providing jobs to ensure loyalty, and has used the strategic employment of potential 'enemies' as PEs as a way of dividing any opposition and building a broader community base. Thus, maintaining a united and cohesive identity under a strong leadership and stressing sex workers' commonalities rather than differences has, I believe, contributed to the SHIP's and DMSC's ability to present themselves as legitimate advocates of a sex worker 'community'.

SHIP as Movement

Since 1997 the project director has referred to the SHIP as a movement and clearly perceives this in positive terms:

> Truly speaking, Sonagachi is no more a project but a movement – the project has instigated a chain reaction (project director writing in DMSC 1998b:31)

It is important to note however, that the SHIP's ideology, its consciousness raising methods, its strategies and idioms of organised protest (via the DMSC), and its own and the DMSC's organisational structure (having groups of loyal workers operating at the grass roots through inter-connected local branches but reporting to a central leadership), mean that the 'chain reaction' instigated by the project has followed well established patterns of political mobilisation in West Bengal. This has implications for the current practice of constructing best practice 'models' to be replicated in very different socio-political contexts and will be discussed further in chapter nine.

The SHIP currently enjoys considerable support in the international HIV field as a best practice model whose hall mark has been its ability to extend the boundaries of sexual/public

health into social activism that is perceived to challenge the structures that create vulnerability to HIV (Gordon & Sleightholme 1996, WBSHP 1996, NSWP 1997, Scambler & Scambler 1997, Kempadoo & Doezema 1998). However, at the local level the SHIP's catalysing role in the formation of the DMSC and their very close subsequent linkages has led to considerable opposition to its work from certain quarters. From its inception, the SHIP has had to face criticism from other public health/HIV experts in Calcutta who have disagreed with its participatory approach, advocating alternatives such as mass screening and HIV testing among sex workers and use of coercive measures to implement such policies. These voices have proved powerful detractors of the project and several attempts have been made to undermine the project's work. Likewise, there has been considerable opposition from women's groups, public health workers, social activists and other influential groups to the SHIP's ideological position on sex work. Hostility has been heightened due to recognition of the SHIP's 'big brother'-like position in the redlight areas, creating a perception that the SHIP has established a kind of monopoly over Calcutta's sex workers leaving little room for others with alternative perspectives to manoeuvre. This has caused resentment, especially among Calcutta's feminist NGOs and, in particular, Surya, who disagree with the DMSC's ideology on sex workers' rights and who feel that the project director has used the PEs to push his own political agenda:

> The project has used these women as a mouthpiece for 'certain people' to express their political ideology (feminist NGO member)

In handling these kind of criticisms, the SHIP's participatory approach has proved to be strategically as well as operationally useful. In dealing with any potentially controversial affairs, the SHIP has often employed the strategy of distancing itself from the fray, and, instead, has brought in one of its Conglomerate organisations or other project supporters to take whatever action is required. Increasingly, the DMSC has taken over all activist activities (such as demonstrations or protests) leaving the SHIP's detractors with mere suspicions about the SHIP's role behind a particular protest for example, but unable to do anything about it.

Likewise, where questions have been raised about the SHIP's approach, especially that of sex workers' empowerment and promoting sex workers' rights, the SHIP has been able to draw upon the 'warm persuasiveness' of participation to justify the direction in which it has moved. The SHIP director has always pushed for PEs themselves to be invited to participate in project related meetings and public events concerned with the sex trade. This is very important in the obvious sense of actually allowing PEs' voices to be heard and it has also contributed to capacity building among the PEs who learn how to speak in public, how to follow 'proper'

decorum and how mainstream institutions function. However, it simultaneously has a powerful effect in countering protest and I observed a number of occasions where it seemed that PEs had been taken along to meetings primarily for this strategic reason. The director would co-opt the popular (but often non-specific) support for a 'participatory approach' by describing how participatory the SHIP was, and would then ask the PEs, as representatives of sex workers, to express their opinion. Those opposing the SHIP were then placed in a situation where continued opposition was effectively seen to be opposition to participation and opposition to what *all* sex workers' themselves want and feel. It is hard even for powerful interest groups to tell a PE to her face that her opinions and needs are wrong. What some claim however (especially some of the women's groups) is that the PEs have been manipulated and have merely become a mouthpiece for the project director. This raises interesting questions about agency as those who support this view imply that PEs do not just not represent all sex workers, but do not even represent themselves, having instead been brainwashed.

Participation and Agency

Kempadoo (1998:9) has noted that in debates on sex workers' rights, denial of sex workers' agency, especially by feminists, is nothing new (cf. Barry 1979, 1995):

> Sex workers who fight for changes within sex industries and not for its abolition, are often charged by feminists....with acting with a 'false consciousness', or as handmaidens to patriarchal capitalism. Clearly, the 'good girls' are privileged in much feminist theorising, while sex workers remain relegated to the status of objects, seen to be violently manipulated and wrought into passivity and acquiescence.

On first glance, the research data I have presented might in some ways support the false consciousness or manipulation argument. A large-scale sex workers' movement emerged only after outside resources and thus ideologies were introduced to the PEs via the SHIP. The relationships between sex workers and 'leaders' be it Durga and MS members or Dr.P and the PEs certainly seemed to be somewhat dependent. PEs even metaphorically referred to themselves as Dr.P's 'limbs' or 'children'. They stated that they would do whatever he might say, and were extremely reluctant to act without his consent. Moreover, there was a remarkable uniformity in the project staff's and PE's vision and opinion on sex workers' rights and HIV that could perhaps be interpreted as indicating an uncritical acceptance of Dr.P's views. Indeed, any serious dissent was co-opted (as in Sett Bagan for example, by giving the detractor a job) or ultimately quashed (as in Durga's case) in the interests of maintaining a seemingly united sex worker constituency.

If however, one insists that the starting point for any analysis is the "respectful attribution of agency" (Scambler & Scambler 1997b:xv), a different picture emerges. In Western discourses agency is often constructed as an 'active' attribute, associated with the intrinsic ability of an individual person to exert their own will, based on rational and empirical knowledge. In other cultures by contrast, agency and, indeed, its relationship to types of knowledge may be constructed and enacted differently (cf., Strathern 1985, Hobart 1990). Moreover even within the same culture, the ways in which agency is expressed are contextually dependent. What is of interest with respect to the SHIP, is how agency may be expressed and conceptualised within organisations and between leaders and their constituencies. Burghart (1993), with reference to a traditional Hindu polity, has provided an ideal-type description (though clearly an over-generalised stereotype) of how agency may be constructed within a Hindu society:

> In Hindu society a lord possesses a domain and commands the people who derive their livelihood from that domain. The people whom the lord commands are instruments of his will. There is a dual movement in the relation of agent and instruments. On the one hand, the lord subjectifies the entire polity in the notion of the body politic, incorporating ruler and ruled. On the other hand, the lord objectifies the polity by casting his instruments as his physical body – the organs of perception and action – while reserving for himself the commanding function of mind. *Agency is expressed in passivity* [my emph.]. The lord speaks softly and briefly issuing commands to his subjects – likened to limbs – who enact the instructions. The position of agent and instrument are relative; a man may be lord of his household, but an instrument of his landlord's will....In brief, there is a hierarchy of lordship which is structured by relations of ....'source and force'...which are seen to stem ultimately from the political centre of the realm.....The polity is also a moral society...the subjects are in some sense dependent upon their lord for their livelihood and well being. The lord is duty bound to protect his subjects.....As for the dependants, they are expected to serve their lord with faith and devotion. Since the lord is the mind of the polity and the subject its limbs, there is no place for criticism, for that would imply that some other mind is at work. Rather, subjects should praise their lord in speech, thereby magnifying his...'name and fame'. (Burghart 1993:83-83)

When I first read this excerpt, I was struck by how well it seemed to describe the relationships between SHIP staff, particularly the PEs, and the SHIP director. Indeed, as my data shows, the PEs drew upon the same metaphor of the body politic on a macro-level and on a micro-level family structure to describe the way they perceived their position within the project. In this cultural context therefore, agency appeared to imply *active deference* to another's will and willingness to be an 'instrument'. Within the traditional Hindu polity the lord holds court. If he is benevolent he encourages opinions to be freely expressed and indeed actively solicits his subjects' views. Only he however is imbued with the authority to take final decisions. But this does not imply that subjects cannot or do not think or act for themselves. The other dominant metaphor referred to by the PEs was of a guru-disciple relationship which implies similar requirements of respect and deference, at least initially, though it also more explicitly implies the possibility of one day moving on and developing one's own 'mind'. In my view, it was through these kinds of constructions of inter-personal relations that participation was, at least initially, operationalised within the SHIP. Like India itself, the SHIP was highly

democratic in structure, but the way this democracy played itself out was through active deference to the 'mind' of its leader who was treated as a patron and head of the PE/sex worker 'kin-group'.

Within the redlight areas, the SHIP was essentially an external institution representing 'outside' knowledge, status, power, and, for the PEs, a previously unimagined opportunity to access these. The director, and, therefore, the SHIP, were also unrivalled in the sense that their power and political influence extended beyond, and were not *directly* involved with, the localities in which they worked. Thus the SHIP could, to a certain extent, choose whether and how to make connections with local power brokers. The DMSC likewise evolved from the SHIP's position of power. The MS by contrast, was a rather different organisation that had emerged out of the existing local political system of patron-client relations connected into Calcutta's larger political arena where the relationship between a 'leader' and his/her subjects was distant and mediated through many 'middlemen' who had scope to gain considerable power for themselves. Initially, Durga and other MS members embraced the SHIP but for Durga, the opportunities it offered were interpreted within the local political culture as a means of increasing her status and power. Ironically however, this could only be accomplished by becoming an intermediary of the SHIP, and, therefore, by positioning herself as an instrument or deputy of its director. Though she never liked her dependence upon the SHIP for status ("I don't want to be someone else's slave") her situation nonetheless enabled her to be 'Lord' of her own locality, and her initial role as spokesperson of Calcutta sex workers offered prospects for expansion of her power base. As the SHIP expanded however, and more and more 'deputies' emerged from among the sex workers, Durga's influence waned, threatening her local position. Durga's only option then was to malign the director and find other patrons to support her. For local MS members and PEs however, the SHIP clearly had more to offer them than the MS/Durga and their loyalties had largely been transferred. Her perceived rebellion was represented by the SHIP director as the action of a "project enemy" and was stopped in what were perceived to be the larger interests of the organisation. Though the SHIP director subsequently tried to bring about change in the MS' structure and functioning, this failed. The organisation was too deeply embedded in local political structures and, clearly, had come to be seen by the community as an 'instrument' of the SHIP and as subject to the SHIP's command. Thus, through their relative *inaction* and lack of involvement in the revamped organisational structure of the MS, the Sett Bagan PEs themselves made clear the terms on which they wanted to 'participate' in the SHIP – i.e. as instruments.

Representing the PEs as the SHIP director's 'mouthpiece' not only implies that PEs lack agency but also that they lack judicious intellectual capacity, in the sense of being unable to evaluate for themselves the ideas that they were being exposed to through the SHIP. It also fails to acknowledge the way in which ideology underpins 'participation' and raises broader questions about the mechanisms and power dynamics of participation within a project.

Participation in the collaborative or collegiate sense ideally implies a two way dialogical process between equals. In reality however, this can almost never be the case. Though 'community participation' and 'partnership' are often pronounced as a project ideal within the field of sexual health[12], the issue of how groups of people who are severely stigmatised and socially marginalised can begin to constructively engage with projects that are initiated from within mainstream institutions, systems and discourses has rarely been examined. This observation is perhaps especially pertinent in the context of a bio-medical intervention given the high degree of specialised technical knowledge that is required to understand project components and processes, and also given the high degree of respect (verging upon awe) accorded to doctors in many countries, including India. When the beneficiaries are primarily female, processes of participation also have a gender dimension as most poor women in India are unlikely to be familiar (or comfortable) with interactions in a formal public sphere (Mosse 1994:512). Thus, for women who feel themselves inferior, ignorant and unworthy, the very concept of equal participation with (in their words) a "big person" (*boro lok*) and a government project is one that would have to be learnt and, therefore, *taught*.

Participation and Ideology

This latter point is, in my view, quite crucial in understanding the development of the SHIP and of the sex workers' movement. In order to function and participate more effectively in the project, the peer educators themselves requested, and clearly required, education, training and skill building (referred to in development-jargon as "capacity building"). The ways in which these were organised and their content quite naturally reflected the particular perspective or ideology of the SHIP director and other staff. When the PEs first came into contact with the SHIP, they reflected the sentiments about themselves and society described in chapter five. Some may have resisted dominant discourses about prostitution but sex workers on the whole lacked access to alternative or effective ways of formulating such resistance. Hence, they

[12] Indeed, the DFID programme under which the SHIP is funded is called the "Partnerships in Sexual Health Programme".

lacked both an ideological framework within which to structure their views and also a forum to make themselves heard. The SHIP provided them with both.

The SHIP's ideology did not resonate equally among all peer educators or ordinary sex workers. Some of the latter were not at all interested in participating in any project-related activities. Some PEs (such as Jaya in Sett Bagan) and other sex workers who did join in project events were not interested in the politics of the sex trade but were mainly concerned with keeping their jobs (or getting a job) or being able to access the various resources and services that the project/DMSC could offer. Such women however had no problem with supporting the project's and the DMSC's work, and, indeed, felt it was in their best interests (for long term employment, or protection and support) to do so. Among other peer educators (and now clearly, other ordinary sex workers too) however, the project's and DMSC's human/workers' rights perspective resonated deeply. Some of the PEs were already local CPI-M activists and were thus familiar with a Marxist discourse. What was new for them was the extension of this discourse to include sex workers. These women and other locally powerful PEs were the most articulate about their anger and hurt at what they perceived as society's hypocrisy and betrayal of sex workers. They clearly stood out as potential leaders and were encouraged to play a key role in the development of the DMSC. One day I was speaking to Lila, one of the DMSC leaders. She was a woman who made a conscious decision to enter the sex trade after having fallen on hard times. I told her that some people were saying that they were all being manipulated by the project and that the DMSC etc. was all the director's idea. She become very angry and gave the following reply:

> To these people I will say – you tell me, the first day when I came into this line, then who was it who put their cock into my cunt – you tell me? They will say I do not know. So I say to them, what makes you think that somebody else has given us the *buddhi* (intelligence) to form the DMSC? We have formed this out of our own *buddhi* – do you not think we have any brains of our own? Yes, we were once idiots – we were stupid when we had not yet gone out of our room in the brothel, when we were locked in there. But after joining the project we have gained so much of *buddhi* – we have roamed around and seen and learnt many things. Like this we have also thought of having our own DMSC.

What the women's groups and other project-critics were failing to acknowledge was the well accepted fact (in political, gender and development theories) that most empowerment processes among highly oppressed groups *require* external facilitation and, also, help with accessing external resources. As noted by Batliwala (1994:131):

> The demand for change does not usually begin spontaneously from the condition of subjugation. Rather, empowerment must be externally induced by forces working with an altered consciousness.

It is not surprising therefore that the SHIP's empowerment strategies *required* the project (at least initially) to position itself as a powerful sex workers' patron. Likewise, its strategies *required* consciousness raising in one way or another (e.g. commissioning the Freirean adult education programme or supporting workshops on occupational and legal rights). However, to say that this instilled a *false* consciousness is both insulting to the PEs (and now 40,000 DMSC members) and also ignores the reality that all social practices (including health projects) have an ideological basis. What the SHIP's critics were actually objecting to was the way in which the SHIP has successfully enabled one representation of sex workers' rights and HIV prevention (with which many sex workers, for whatever reason, are clearly happy to agree) to prevail over others, including their own.

Perceptions of Empowerment and Agency

In chapter one I noted that empowerment has been conceived as a process taking place at individual, community and societal levels, but that a medical, disease-oriented discourse tends to privilege the individual level. For instance, success of a project is measured in terms of *individual* behaviour change and definitions of empowerment are often pre-determined in line with the standard three TI components (for example, in terms of an individual's ability to use condoms). Interestingly, though safer-sex related behaviour change certainly seems to have occurred among sex workers in Calcutta, these kind of technically-oriented individual-level changes hardly feature in my informants' own discussions of the benefits of the SHIP.

As previously described, many non-PE sex workers who were not directly involved in the SHIP, accessed its services but appeared to take a rather functional (but usually positive or neutral) view of the project. In discussing this with project supervisors and PEs, they felt that changes had taken place that may not have been consciously reflected upon by the women concerned. For example, the supervisors felt that self-esteem had improved, reflected in the fact that sex workers appeared more confident in talking to project staff and other outsiders, and that they made more effort with their appearance. They felt that women had developed more self-respect, reflected in improved health seeking behaviour, condom use and greater motivation to look after themselves. In addition, both PEs and supervisors felt that, because of the project and the DMSC, sex workers felt less insecure, and now knew that there was someone who they could turn to for help and who would stand by them:

> Earlier they lived in constant fear, I think this has reduced a lot now, they know that we are there to help them, say, if the dalal closes their room. There is now a greater feeling of co-operation. The DMSC has promised to stand by SWs in distress. Now SWs ask us for advice on how to change rooms, whether

> there is a vacancy under a good malkin. They ask us about money matters and we advise them (Supervisor).

These kind of changes are difficult to assess (and research is currently underway to investigate the SHIP's broader impacts on non-PE sex workers). However, it is interesting to note that increased solidarity, unity and collective strength as a result of the SHIP and DMSC were the themes that were most consistently emphasised throughout all my discussions with PEs, supervisors and other project staff on the potential impacts of the project. At the time of my research these were most evident among the PEs (as expressed in some of the quotes above). While there were certainly personal benefits in terms of relatively secure employment and raised social status for the PEs, what many tended to emphasise most were the possibilities for increased social integration that the project had brought for them. This was described both in terms of their enhanced ability to mix with relatives and other 'outside' people by virtue of having a 'respectable' job, but they also talked in terms of an increased sense of community and belonging among themselves. As such, they were articulating a collective model of empowerment that is congruent with traditional power structures and power relations in the redlight areas. PEs did not talk about having gained individual strength to act against exploitation. Their discussions about enhanced self-confidence focused on how this enabled them to come together and fight collectively:

> This project is giving us great medical benefits but there is another side to it also. We girls have become united. We were so ignorant before. We were dumb. Our lives revolved around our rooms and our customers. But now we have become more vocal, confident and we can freely move around here and there, know many things and discuss with many people. We girls of the line can interact with many kinds of people. This has been a great opportunity. Moreover after joining this DMSC we have this great feeling of elation – a sense of freedom has been instilled in us – we have no barriers. There are thousands of girls with us so it gives us great joy and happiness. This is a good feeling (Peer educator).

During my research, shortly after attending the meeting with the researcher who was shocked at the dependence of the PEs on the SHIP director, I had a conversation with a senior figure in the HIV field in India. We discussed empowerment and the SHIP. He felt that sex workers should by now be individually empowered enough to be able to challenge their madams and to negotiate condom use with their *babus*. Moreover, he proposed that building up autonomous sex worker organisations in different redlight areas, or involving different NGOs in running the SHIP in these areas, would be beneficial so as to avoid dependence on the SHIP and over-centralisation. Just as I felt the researcher had, in some ways, misinterpreted what she had seen, so I felt that this perspective in some ways missed the realities of power structures and relations in the redlight areas. He was articulating an individualist perspective of empowerment which sought changes in individual (rather than group) behaviour. Though he undoubtedly realised the very severe structural constraints that limited the scope of

individual action, empowerment was nonetheless understood as an individual's own ability to overcome these (helped by the project), rather than as an environmental shift that opened up a space for individual action, but that was brought about by a powerful backer. Furthermore, in my view, he failed to appreciate just how important it was at that time to keep the SHIP's activities under one umbrella so that it could represent itself as a united and influential patron of sex workers' interests. This centralisation of power was a source of irritation to others, especially the NGO Surya, which charged the SHIP with having established a monopoly over sex workers.

As with participation, a key issue in understanding empowerment concerns how agency is constructed and, in the redlight areas, I suggest that it was constructed in a collective rather than individual sense, with some women willing to defer their 'agency' to the authority of powerful leaders.

The difference between an individual and collective construction of agency can be illustrated by a minor incident that I observed during field work. We were sitting in a room in Sonagachi talking with some sex workers. A woman carrying a note pad and pen suddenly walked in and, without introduction, started to ask the girls their names and other personal details. The girls were worried and confused, especially when, upon questioning by me, the woman did not have an ID card and was reluctant to state her identity, saying rather unconvincingly that she was a sales representative. We told her to leave. One of the PEs who was with me brought this incident up at the next DMSC meeting, asking those present what should be done if something like this happened again. Personally, I felt that the PEs could go round and inform individual sex workers of their rights to confidentiality and suggest some ways in which they could deal with such situations (e.g. asking for an ID card, or simply refusing to speak to them). Interestingly, the SHIP director and the PEs looked at it from a rather different perspective, coming to an agreement that sex workers should be told that anyone asking questions like that should be referred to the local DMSC branch for checking out and permission to talk with the other girls. Whereas my own response had been individualistic, centred around individual rights, action and, therefore, agency, the DMSC/SHIP staff took a collective view that attributed the DMSC with the agency to make decisions for all sex workers it purported to represent. In this sense, collective empowerment does not mean just strength (for the individual) in numbers, but an empowered collective notion of agency based on a greater sense of community.

Where projects are introduced by 'outsiders' to a community (as is usually the case with sexual health projects), even when the ultimate goal is empowerment, it is inevitable that:

> No matter how firm the commitment to good intentions, the notion of the powerful outsiders helping powerless insiders constantly slips in. This is of course the central paradox of planning and designing the means for social change in the first place. It is not removed by stressing 'participatory' and 'empowerment' goals (Long 1992b:275)

When the SHIP was first started, it was designed as a typical TI to act as a way *in* for health workers to reach a previously socially excluded group - sex workers. However, as the project has progressed and as the participation of PEs has become increasingly institutionalised and effective, its function has become increasingly inverted so that it has now come to represent a way *out* of social exclusion, acting as a gateway and opportunity for PEs (and increasingly other sex workers) to start a dialogue with, and even re-enter, mainstream society.

The role of the SHIP as a gateway between sex workers and mainstream society has meant that Dr.P, as the SHIP's director, has been in a position to exert some control over the nature of that contact on both sides. Where this contact by-passed the SHIP and threatened the interests of the project (as with the MS), he could try to block it or re-channel that contact back through the SHIP. Retaining this strategic control was clearly important at the beginning of the project in order to negotiate effectively with different interest groups and to establish the project as a platform for community-building and sex workers' collective organisation. However, as long as an outsider retains control of an intervention, the nature of participation or empowerment of a community unavoidably takes place on someone else's terms. For this reason, the recent move by the SHIP director to give up his position and hand over the entire control of the intervention to the sex worker community represents a rare achievement of the final goal of participation - that of greater autonomy and power for communities to shape the course of social change, and of the potential sustainability of that change through continued action/ intervention[13].

[13] The SHIP has defined sustainability as occurring when: ".....the target community.....gain control over production and distribution of services and assets of the intervention programme" (unpublished SHIP presentation notes, 1999).

Conclusion

By the end of my fieldwork, the DMSC was firmly established. It was organising events which increasing numbers of sex workers were attending and had begun to mobilise women in other redlight areas (though not yet Sonagachi) to form their own branches and fight against exploitation. Sex workers, especially from the smaller redlight areas where occupational controls are not so severe, were increasingly using and representing the DMSC as their own community-based forum (such as the protests against *para chele* harassment in Tollygunge). My own research however took place at a time when the community building process in Sonagachi was still in its preliminary stages. The material I have presented indicates the various ways in which the SHIP represented itself to, and manoeuvred with, different sex trade interest groups to create a space in which this process could take place. It also illustrates the importance of peer education in this endeavour in three ways. First, it comprises a direct strategy for community building in the sense that the PEs became, to some extent, a ready made community (or even family) by virtue of their association with the project, and could be represented as speaking for all sex workers. Secondly, through the structure of their work they were able to transcend many of the physical and social barriers that had previously divided sex workers and create opportunities for mutual sharing and support. Thirdly, their status as employees and as being associated with a project through which they could potentially facilitate access for others to concrete benefits, made them role models (whether admired or envied) and able to mobilise women to access project services, and, later, to participate in project events.

In Sett Bagan by contrast, a community was already identifiable to some extent. My material shows however that even where this is the case, community *participation* is perhaps not always what it seems. At the time of my research, most sex workers in Sett Bagan, for example, were, on the whole, not mobilising around a common (community) desire to prevent AIDS or even to advocate for sex workers rights, but were interested in what they could personally gain from being associated with the SHIP. This is a primary and understandable motivation, and I believe, only slowly changed (and not in everyone) as PEs were increasingly exposed to the problems of other sex workers through their work, and to the ideology of the SHIP director and staff through their participation in the project. Participation is thus an on-going process whose nature and meanings develop over time.

In the literature, community participation is often considered in terms of the extent to which local people become involved in an outside intervention. However Long (1992:21) has pointed out that:

> All forms of intervention necessarily enter into the existing life worlds of the individual and social groups affected and in this way are mediated by these same actors and structures.

The material on Sonagachi and Sett Bagan in particular, shows how involvement indeed goes both ways, with the SHIP itself becoming deeply entwined within community structures and also within individual 'life worlds'. The examples described in this chapter clearly reveal how the SHIP took on quite different meanings for different individuals and how these meanings were also affected by the social groups and structures within which individuals were located. From 'guru' to 'disciple', from suspicious *para* clubs, to hostile madams, to desperate Sett Bagan sex workers, to employment seeking *Grihasthi*, to disapproving 'Surya', to politically ambitious Durga – all these viewed, interacted and engaged with the SHIP in different ways which in turn affected the SHIP's own strategies and activities.

Another way of thinking about an intervention proposed by Long (1989:3) is as an interface which:

> .... is a critical point of intersection between different social systems, fields or levels of social order where structural discontinuities based upon differences of normative value and social interest are likely to be found.

As such, the conflicts and manipulations that occurred during the SHIP implementation were unsurprising. The self-described 'game' played by the SHIP director to deal with different interest groups is difficult to capture with a discourse of 'community participation' or 'involvement of stakeholders'. Within the sex trade it involved a shrewd understanding of local structures, relations and political mechanisms, and the ability to work within these rather than to confront them. Outside the sex trade it involved the careful managing of relationships and representations of these relationships to win support for itself. However, the Sett Bagan case study and other material also shows how a failure to understand the nature of power in the redlight areas and also culturally variant expressions of agency, may lead to misinterpretations about the ways in which participation and empowerment may manifest themselves and how local power structures can best be tackled. Indeed, the denial of agency to marginalised groups was one of the most serious obstacles faced by the SHIP in its advocacy work with various stakeholders in Calcutta.

From the data presented in this chapter, it is quite clear that the SHIP did not stick to a pre-planned design but rather, comprised a *process* of interaction and negotiation with individuals and groups within which there was some room for change, adjustment, re-evaluation and strategy modification. The shape that the strategies and re-adjustments took however were circumscribed by individual, community and macro-level social, political and ideological considerations. Moreover, a process cannot take place in the absence of certain guiding *principles* (ideology). Some aspects of the project may simply have 'happened' in an event-response manner (as suggested by the SHIP director in this chapter's opening quote), but the SHIP was very clearly also a social actor in the sense of being directed by a particular ideology, having a strong leader, making decisions, formulating strategies, playing a political 'game', and manoeuvring to achieve its goals.

CHAPTER SEVEN

SEXUAL HEALTH KNOWLEDGE(S) AND HEALTH EDUCATION

Introduction

In chapter one, I noted that there is now a considerable consensus within the public/sexual health field that knowledge of relevant medical 'facts' alone will not lead automatically to behaviour change. However, while the link between 'correct' medical knowledge and behaviour change is now acknowledged to be indirect, it is still usually regarded as a *pre-requisite* for effective public health interventions and all sexual health TIs accord an important place to health education or 'persuasive' approaches. As such, the measurement of changes in 'knowledge' presently constitutes a key method of evaluating the relative 'success' of an intervention.

The survey in Sonagachi in 1992 (AIIHPH 1992) reported that 31% of sex workers said they had some 'knowledge' of AIDS but that regular condom use was only 1%. Just a year later, in 1993, reported knowledge of AIDS had jumped to 86% and condom use by clients in the previous day's sexual encounters had reportedly also jumped dramatically to 71% (AIIHPH 1994). In 1995 (AIIHPH 1995), 96% of sex workers said they had 'knowledge' of HIV/AIDS and condom use by the previous day's clients was reported to be 76%. These figures have shown only small changes since then. The 1998 (AIIHPH 1998) survey showed that 96% of sex workers said they had 'knowledge' of AIDS and that the previous day's condom use was reported to be 79%. Knowledge of generic STDs has always been high – 69% in 1992, increasing to 99% by 1998.

These results appear impressive, though it is not clear to what extent they directly relate to the impact of the SHIP. Since 1992 when the SHIP started the Government has also launched numerous mass AIDS awareness campaigns and there has been considerable general publicity and reports in the media about HIV/AIDS. The SHIP's efforts have therefore coincided with (or may have been reinforced by) AIDS education campaigns targeted at the 'general population'.

In addition, it is notoriously difficult to measure knowledge or condom use in surveys (Pickering 1994), and after 7 years of constant exposure to the SHIP's health education activities, the likelihood of women giving the 'right' response to avoid embarrassment or censure, and simply because they knew what the answer *should* be, seems quite high, particularly since it is the PEs and supervisors who conduct the survey (though this potential source of bias would be difficult to eliminate). Indeed, I sometimes witnessed peer educators coaching sex workers to answer correctly – in this case, in order to impress visitors to the project:

> We test them to see if they can remember the answers – we tell them see, visitors might come and will you say you don't know? (Sonagachi peer educator)

These biases notwithstanding, it does appear that some level of behaviour change *has* occurred, reflected also in lower levels of STDs (the complexities of interpreting survey results will be further elaborated in the next chapter with reference to condom use). Thus, the findings above, though interpreted with caution, appear to lend weight to the proposition that knowledge alone does not lead to behaviour change (as the figures for knowledge are significantly higher than those of condom use). The figures could also be taken to support the contention that correct knowledge is a necessary condition for behaviour change. In this chapter I argue that whilst this contention may be correct in certain circumstances or with certain groups of people, its universal applicability should not be assumed.

One of the proposed reasons for the tenuous correlation between knowledge of medical 'facts' and behaviour change is that the new facts may conflict with cultural beliefs and practices and may not, therefore, be acted upon. As a result, a key task of medical anthropologists working in international health has been to identify relevant local knowledge or cultural beliefs. Their role has been to give advice regarding the cultural acceptability of new information, and how to translate medical facts into locally comprehensible idioms. Behind this work lies an assumption that for new knowledge to be effectively transmitted (and acted upon) it must be culturally appropriate in the sense of being superficially adapted so as to fit in with local knowledge and practices. Once this is so, it is assumed that behaviour change is more likely. A critique of this assumption has already been given in chapter one and is related firstly, to its representation of culture as an objective 'variable' of health behaviour; secondly, to its empiricist representation of knowledge as a set of isolated facts or belief systems; and thirdly, to its neglect of the influence of political economy on social action (cf. Singer 1990, 1995, Lock & Scheper-Hughes 1990, Farmer 1997).

Below, using the SHIP as an example, I draw upon this critique to examine sex workers' sexual health practices in relation to the *process* as well as the content of health education. In doing so, I look particularly at underlying epistemological pre-suppositions that shape what is understood by, or thought to constitute, 'knowledge' of health and how this understanding may relate to practice. In particular I focus upon Bourdieu's (1977) and Giddens' (1984) distinctions between practical and discursive consciousness (or 'logic'). I then consider the processes through which medical knowledge may be transmitted, i.e. the processes of teaching and learning that took place within the SHIP and also the meanings and interpretations that both this knowledge and its form of transmission took on for different actors. I go on to argue that, survey results notwithstanding, bio-medical knowledge of HIV/AIDS/STDs (taken as in-depth understanding or knowledge of 'correct' facts) was, in fact, rather poor in Sonagachi and Sett Bagan, leading me to ponder the opposite question to most health behaviour researchers – namely, why significant behaviour change *has* occurred *in spite of* apparently rather scant bio-medical knowledge.

For the sake of simplicity, in this chapter I have focused solely upon examining the potential link between health education and knowledge on behavioural change among sex workers. I must stress that this is only *one* part of the picture however. Sex workers' health-related actions must be negotiated in the complex environment of the sex trade, and involve interactions with various stakeholders. The ways in which the sex trade structure and sex workers' relationships with different actors affect their potential to practise safer sex, and the ways in which the SHIP may have influenced this broader 'milieu of condom use' are addressed in chapters eight and nine.

Investigating Sexual Health

Representations of Knowledgeability and Knowledge

Among my informants there was no term that could translate directly as STDs. The Bengali equivalent, *jouno rog* ("sex disease"), was not part of the sex trade lingua franca. Rather, in discussing ill health in relation to sex work, women talked of "diseases of the line" (*line-er rog*) indicating an underlying attribution of these conditions to their environmental and occupational circumstances (these are elaborated in the next section). Knowledge about line diseases varied considerably. Generally, older and more experienced sex workers were usually able to elaborate some ideas on the nature of line problems whereas younger girls

were far less articulate. Indeed, there was an expectation that young girls knew nothing, and that knowledge only grew with age and experience:

> These girls who come from the village, especially the young girls, they don't understand anything. How will they know? – especially those who were not married before. Once they are in this line for 5 years, when they have had children and *babus* and have had to run after many doctors, then they begin to understand (Sett Bagan sex worker).

Sex workers were often perplexed at our requests to listen to their ideas about health, saying that "we know nothing", or "you know all these things, we are ignorant, why are you asking us? What do we know – you tell *us* the answers to all these things" In doing so, they publicly represented themselves as ignorant with respect to bio-medicine (a system which we were perceived to represent). Many peer educators stated that prior to the SHIP, they had lived in metaphoric darkness:

> Before we joined this project we knew nothing of disease, we just took money, sat men and forgot. After joining we were given training we learnt what was *bhairas* (virus) what is AIDS, what is syphilis and gonorrhoea – everything was taught – only after this training could we explain to others – before we didn't know anything so how could we explain? (Sonagachi peer educator)

On other occasions however, usually when we were not interviewing but were simply observers to group discussions, some sex workers implicitly challenged this representation and indicated that they were both knowledgeable and quite capable of looking after themselves. These varying representations of knowledge are illustrated below in my material investigating women's knowledge about STDs and condom use prior to the SHIP.

Graduates of Experience: Knowledge and Condom Use Prior to the SHIP

Knowledge and practice regarding condoms and STDs prior to the SHIP appeared to have varied considerably among my informants. During informal discussions some of the older women, including peer educators, asserted that STDs had never been a real problem. Problems that did occur were said to have been not serious and easily treated by indigenous therapies (described later) or a visit to the doctor. However, somewhat inconsistently, on other occasions the same PEs would recount to SHIP visitors how badly they had suffered from STDs and from poor medical treatment prior to the project (thus implying that the SHP was providing a valuable service).

In contrast to STDs, AIDS *was* perceived as serious because it was incurable, and it was this aspect of HIV that was often emphasised by the PEs to other sex workers in the course of

their work (elaborated below). In addition, they noted that they had previously been (and still were) careful to check the customer for any outward sign of disease and, if identified, they would not have sex with him:

> I never used all these caps before. There never used to be all these diseases. We used to keep ourselves clean – nowadays the girls don't keep themselves clean. (Sett Bagan peer educator)

> There was no disease like AIDS before so I didn't use condoms. If we got syphilis or gonorrhoea we just went to the doctor & got an injection & it was done with. At that time we were very smart. We didn't get diseases. We would check the customer & if there was a disease we would send them off. (Sett Bagan peer educator)

During informal discussions, some of these peer educators were scathing about the SHIP's attempts to teach them about condoms and self-protection, focusing their ire particularly upon the supervisors, who, they laughingly implied, as 'respectable' women (some of whom were not even married), could hardly be in a position to teach them about anything:

> What can these good good girls tell us whores about condoms? These things are best left up to us (Sett Bagan peer educator)

As noted above, these older informants explained that knowledge of how to look after oneself was gained only through experience. They described how it was common to contract a STD shortly after entering the line, after which women learnt to be more careful:

> When a girl first comes, she doesn't know anything. She and the madam are only interested in making money – she takes a lot of customers, doesn't bother to check them, gets drunk all the time. Then she will get a problem, maybe a big ulcer will come and she has to have an injection. Then her madam or other girls in the room will explain to be careful – to check the customer. Now of course we are there and we teach her about AIDS and explain all about condoms. (Sonagachi peer educator)

Likewise, on one occasion when I was trying to explain my research to the MS, and had said that I hoped it would help people to understand their situation better, Durga replied:

> Yes, yes, that's all very good – they will read about this in your book and you will pass your exam – but remember it is *we* who are graduates of experience.

With respect to condom use, before the SHIP started, women stated that condom use was rare, and entirely customer-led. Some older women claimed to have known all about condoms and their link with STDs, having learnt this through experience with customers who had brought them, whereas others admitted to having known nothing.

> Some customers used to bring their own Nirodh. Now everyone knows about them. People from good, rich families used to bring Nirodh because they were scared of catching any disease. These good customers would even tell us girls to use them and that condoms will prevent disease (Sett Bagan sex worker)

> Before the girls [PEs] started coming round, I didn't know anything – I had never seen a condom before in my life. (Sonagachi sex worker)

Prior to the HIV epidemic in India, condoms were primarily marketed as a family planning, rather than a disease prevention method, and research confirms that the general public mainly associated condoms with contraception (Mane & Maitra 1992:93-115). This also appeared to be the case among my informants:

> If I wanted to use condoms, I could have stayed at home and done it with my wife. With you I want to have fun (customer of a Sett Bagan sex worker)[1].

> I only knew about Nirodh as a way to stop a baby entering the stomach. My husband had used it with me (Sett Bagan sex worker)

However, as indicated by one of the quotes above, research has found that their protective function was understood by some (mainly educated) men, and that this was especially associated with commercial sex, though on the whole, condom use in commercial encounters was extremely low (ibid).

This example shows how sex workers represented their knowledge primarily as *experiential.* Furthermore, though some women represented themselves as ignorant of a formal knowledge system – biomedicine - some nonetheless felt that their own experience-based knowledge was, in certain contexts, quite adequate or even superior. This example also shows the limitations of such experience based knowledge however. In spite of some women's assertions that STDs had never been a big problem, the 1992 SHIP survey found a STD prevalence of 81% among a range of sex workers (diagnosed in a laboratory, AIIHPH 1992). Though some women had been taught by customers that condoms could prevent certain diseases, a feeling that line diseases were anyway curable, and the resistance to condoms by other customers, meant that the protective function of condoms was not taken seriously, and their use was, on the whole, not part of local sex work practice. Knowledge about them therefore, was generally not passed on internal to the sex trade, but was ad hoc, coming only from outside from a minority of customers.

[1] Another barrier to condom use was the fact that prior to the HIV epidemic, condom quality in India was extremely poor (thick rubber was used and they were un- or inadequately lubricated). Condom use was thus uncomfortable and unerotic for both partners (Mane & Maitra 1992). Since this time however, super-thin and well lubricated varieties have been introduced and are widely available.

Conceptualising Sexual Health

The PEs' varying representations of their relative knowledge and ignorance, and, for example, their inconsistent assertions about the problem of STDs prior to the SHIP also shows how 'knowledge' is not absolute, but rather, is structured according to the prevailing situation or audience. As such, the task of analysing 'local knowledge' of sexual health is inherently difficult (and also raises serious questions about the validity and utility of surveys that try to measure knowledge). Taking this problem on board, in my research I tried to cover a range of different contextual settings (such as formal interview, observation of PE-sex worker and doctor-patient interactions, and informal chats and group discussions), as well as a range of different social actors.

Somewhat predictably, my research revealed no clear cut categories of line diseases. Different informants would attribute widely varying conditions to their work, or would not consider particular conditions to be related to their work at all (whereas others might). Furthermore, as elaborated below, women's explanations of line diseases drew upon a wide variety of different theories and ideas that formed part of a larger medical domain that structured health practices. Characteristic of India more generally, this domain was pluralistic, encompassing a range of medical traditions and practices (including bio-medicine, ayurveda and regionally-specific folk traditions), and was not clearly systematised (Lambert 1996, Nichter 1989). As some of the material below will show, when I talked to sex workers about their health problems, I rarely got a clear cut answer. Replies were often highly personalised and women were reluctant to generalise to others. Common refrains were: "I can't speak for others, but my mind tells me it is like this", or, "I can only talk from my experience whether it is right or not I do not know". Usually, my queries invoked long narratives that placed the problem at hand within a specific time and social and moral context. This was sometimes frustrating for me as a researcher (before I fully realised the value of narrative responses). For example, I remember feeling quite impatient with Shanti, a sex worker in Sett Bagan who was complaining of vaginal discharge, when my question as to what she felt had caused it, resulted in a reply that took up the entire afternoon and involved an elaborate description of life events going right back to her childhood in the village (where, she eventually explained, her problems may have started because of too much sexual desire as an adolescent). In contrast to the certainty of bio-medical science, illness aetiology and treatment were areas of considerable uncertainty and ambiguity creating a lot of room for doubt, debate and consideration of a wide range of possibilities, and cause was often attributed retrospectively depending upon the ultimate outcome of the disease and its treatment (cf. Good 1994). In a

discussion with Podda, for example, about her menstrual disorders, she described seeking treatment from at least eight different practitioners representing biomedicine, homeopathy, folk specialists in the village and temple priests. She had various theories about what could be causing her problems, including high blood pressure or an excess of bodily humoral heat (see below). Only after a visit to a particular priest however did she feel her that problem improved, and she finally decided it must have been caused by witchcraft that had required an especially powerful priest for its cure.

Whilst acknowledging the contingent, pluralistic and variously represented nature of sex workers' knowledge, below I have tried to draw out and summarise some of the most prevalent concepts of line-related ill health upon which sex workers drew. For ease of analysis, I have classified these into three groups, but these are by no means mutually exclusive. I relate these to local assimilations of biomedicine as well as to formal biomedical understanding of STDs as it is this that is of particular importance when considering women's responses to the SHIP's health education.

Humorally-Based Understandings

There were a number of conditions which sex workers described that are related to India's humoral healing traditions and their associated understanding of the body (though my informants did not themselves make this connection). In formal ayurveda and folk concepts that are related to it, there is an holistic view of health as a continually fluctuating state of balance both within the body and between the body and the environment (Zimmerman 1987). Bodily conditions are described in terms of wet/dry or hot/cold, affected by factors such as individual constitution, diet (where foods are classified along the hot/cold, wet/dry continuum), climate and the general condition of the physical and social environment. Any imbalance in these conditions is thought to lead to problems. Sexual desire and sexual activity is also interpreted according to a similar humoral schema relating to Hindu metaphysical physiology which has usually only been elaborated with regard to men and the tradition of *brahmacharya* (the sublimation of sexuality into spirituality through sexual/mental control), but that appears to have a counterpart among women too (Bottero 1991, Kakar 1989, Carstairs 1957, McGilvray 1982, Boyce 1996, Ford Foundation 1994, George & Jaswal 1995:54, Lambert 1998, Osella & Osella 1997).

Put simply, semen (or, in a woman's case vaginal/sexual fluid) is thought to represent *virya* (spiritual/physical energy) and is stored in the brain in a subtle form known as *ojas*. During

sexual activity, the 'heat' of desire causes *ojas* to move down the spinal cord and is emitted as semen. This loss of semen is conceptualised as a loss of life giving energy and can only be replaced through consumption of high energy (and expensive) foods (such as meat or eggs) which are thought to undergo a lengthy process of transformation within the body (blood-flesh-fat-bone-marrow-semen) fuelled by humoral digestive fires. Sexual activity is said to be characterised by some ambivalence as satisfaction of bodily desire must be balanced with denial to prevent a harmful loss of energy (Kakar 1989, Carstairs 1957).

These underlying schema structured the way in which many sex workers interpreted bodily symptoms and guided their strategies to maintain health. For example, vaginal/urethral discharge, genital ulcer (traditionally called *garmi* – heat) or burning urine were often attributed to a bodily accumulation of 'heat'. The imbalance was usually related to an excess of heating foods (or alcohol), to hard work and heating activities (e.g. having to deal with many rough customers), or to an excess of sexual 'heat'. Remedies concentrated upon cooling the body with cooling food and drinks, losing the 'heat' of desire through orgasm and release of sexual fluids, or exerting mental and bodily 'control' of desire. Allopathic treatment however was often concurrently sought out. Control of desire through physical or mental 'switching off' was considered a crucial health-maintaining strategy as excess orgasm (excess loss of sexual fluids) was thought to lead to weakness and eventually to ill health. Below, a Sonagachi sex worker describes how she tried to stay healthy:

> I use condoms, I try to eat well when I can afford to. These good good foods are very expensive here – a glass of *mousumbi* juice [considered very 'cooling'] is Rs.15. I have vitamins and fish and meat and sometimes I will have a glass of milk. Then, with the customers I have to control myself. [I asked why?] Well, when we are doing this work we have to keep our body under control so that too much 'sex' doesn't happen – how would we be able to do this work if 'sex' happened all the time? It would be impossible – you wouldn't be able to get up from bed. See, sex is a kind of *shakti* (power) of the body – if that goes out of one's body everyday at least once/twice then a person can't survive – too much sex makes the body weak – there must be a limit.

This discourse of sexual control was also related to a very prevalent discourse relating to conception in which conception was only thought possible if there was a mixing of sexual fluids from the man and the woman[2]. Thus 'control' was sometimes used as a form of birth control.

[2] The same belief has been described by researchers in Bangladesh, South India and Sri Lanka (Nichter & Nichter 1989, McGilvray 1982, Maloney et al 1981).

The association of sexual body fluids with strength meant that vaginal discharge was viewed with particular concern by sex workers as it was thought to represent a loss of vital energy, but doctors I interviewed noted that this concern was often generalised to *all* discharge, which it made it very difficult for them to know whether a sex workers' complaint was related to bio-medical pathology or to her own interpretations of what a doctor would consider normal discharge (cf. Lambert 1998). Sex workers also sometimes related prolonged vaginal discharge to genital ulcer and (in an interesting interpretation of bio-medicine) to cervical cancer – women described how, if one spot was continually being dripped upon - wouldn't a groove or ulcer eventually form? And if this was left untreated it would undoubtedly turn into cancer.

Sex workers attached strong symbolic meaning to 'blood' which was also thought to embody bodily strength. They were extremely concerned about its loss (for example through prolonged menstruation, or even by taking just 5mls for a blood test). For this reason the blood tests promoted by the SHIP were viewed with great concern and were avoided where possible. If someone was already feeling off colour or weak, the suggestion to take their blood (i.e. even more of their strength) was often unacceptable. At the same time however, they were also intrigued with a doctor's ability to diagnose illness from examining the blood. There existed a prevalent feeling that looking at the blood gave the doctor a picture of one's overall medical condition and would show him/her *all* the various diseases 'hiding' in the body. There was thus some confusion over the value of the VDRL blood test for syphilis being offered by the project. Many sex workers eventually came to accept it (having initially been very sceptical) but saw it as a generic kind of health check up rather than as a test for a specific disease. Thus a positive result was often referred to simply as "the doctor said I had bad blood". Thus one day I heard a PE encouraging a sex worker to attend the project clinic:

> You should come to our clinic and get your blood tested. In our clinic they will test you for this gonorrhoea, syphilis, vaginal discharge, jaundice and hepatitis – all this the doctor will see and will tell you if you need treatment.

Humoral understandings of bodily fluids also affected the way in which PEs interpreted the transmission of AIDS. They had been taught that AIDS was a disease of the blood and that there were two kinds of blood cells, red and white, AIDS only being found in the latter. One of the PEs explained to me her interpretation of this: -

> There are two types of blood – that when I cut myself and I bleed, this is red blood and that which men make when their sex comes out and where AIDS is, that is white blood/cells (*sett konika*).

If they had followed this interpretation right through, the PEs might have questioned why, if AIDS was only in 'white cells' (meaning semen), it could be transmitted through 'red' blood too as they are taught to explain in the flip chart, but I never heard this raised as an issue.

In addition to humoral explanations for (normal/abnormal) vaginal discharge and genital ulcers (the main visible initial symptoms of gonorrhoea and syphilis respectively, though these diseases are actually often asymptomatic in women), sex workers frequently used the bio-medical terms 'syphilis' and 'gonorrhoea' which had become part of every day illness parlance. However these were used as a gloss for a range of genital symptoms and could rarely be exactly specified. They were however also related to the sex trade environment. Chobi, a non-PE in Sett Bagan explained to me as follows:-

> Chobi: When I first came to the line I used to get syphilis-gonorrhoea a lot.
> Catrin: Can you tell me what is syphilis and what is gonorrhoea? – how they are caused?
> Chobi: When it's itching itching, burning burning – the doctor told me I had these diseases – he examined my blood and saw them there. These are common problems among us line girls. We have to take an injection and then we are cured. Some people used to call this *garmi* but now we say syphilis-gonorrhoea.
> Catrin: And how are they caused?
> Chobi: Well, I am not a doctor, but my mind tells me that living in this dirty bad place, having to do work like this – won't some disease happen? I feel it doesn't suit me. I'll tell you something, I have only started getting these diseases after coming to the line. Before my body and looks were very good but here we are like a rubbish tip – whatever people put upon us we are forced to take it.

Even after years of training, many PEs still showed some confusion about syphilis and gonorrhoea and their relation to local knowledge. I asked a group of experienced Sonagachi PEs in what ways people could develop vaginal discharge (*sada srav*) or genital ulcer (*gha*): -

> - Sometimes you can get it from the customer if he has *sada srav*.
> - No no, customers don't have *sada srav*, they have gonorrhoea.
> - All girls have *sada srav*, some more then others – you don't get *sada srav* from customers gonorrhoea maybe. Sometimes if the body gets hot you get *sada srav*.
> Catrin: Well, how do you get a *gha*?
> - If you have too much *sada srav* you will have a *gha*.

Whilst humorally-related explanations of health problems were common, many sex workers also implicitly related the local political economy to their ability to maintain correct bodily balance through regulation of the diet. Good foods were expensive and were a luxury that many could not afford. Envious remarks were often made about the *Agrawali* community who are generally better off and who, unlike their Bengali counterparts, were said to be able to afford cooling and strengthening foods as required. Moreover, some PEs seemed to recognise how the controls within their work environment prevented them from being able to exert autonomy over their bodies:

> From the very beginning we had felt that that right (*adhikar*) over our own body we don't have that – that I will think that after having my bath I should have a good *tiffin* (snack/breakfast) in the morning to remain healthy – all this was not within our rights – why? Because in the morning after waking up normally one has tea but for us we are forced to hold the drinking glass – in the afternoon after bathing one normally has rice but we probably haven't had a bath or eaten rice – the whole day it was only drinking (Sonagachi peer educator).

In addition, some of the PEs who had been taught about immunity (*protirodh komota* - "preventive strength") in relation to AIDS interpreted this to mean an underlying bodily strength/power that could only be achieved if this balance was maintained, and, as above, some of them explicitly related one's ability to do so to one's social and economic circumstances:

> How does a disease enter our body? As long as our blood has the power to resist, no disease can enter our body. When we have a running nose and cold we lose our taste for food – this makes our body weak, we will not feel well. Gradually we will develop fever and then headaches and then because we are weak, other diseases will come. The main thing is having food. Our body is like an engine – if enough oil, water and food are given to it and if it is cleaned properly, no disease will happen. But tell me *boudi*, how is this possible for poor people like us, living in a place like this? This is why we get all these diseases.....It is like this, suppose a poor man has a few valuables in his hutment. The inhabitants of the hutment are very weak and soft because they are poor and cannot eat good food. The dacoits will not fear them and enter the hut and take away everything. If the inhabitants were strong, the dacoits would not have been successful. Our body is like that. Truly, p*rotirodh komota* (preventive strength) is our body's *shakti* (strength/power) – like when we eat rice and become strong, this is our body's *shakti* –the *shakti* that is in our blood. (Sonagachi peer educator)

Anatomical/Mechanical Understandings

Another way in which women described various health problems was in relation to their understanding of the anatomical or mechanical structure of the body. Though women's ideas on internal structure varied widely, there was nonetheless a common notion (also found in classical Ayurveda) that the body was made up various tubes, channels and 'pouches' through which vital substances flow. Ill health was sometimes perceived as resulting from a misalignment or blockage of internal structures and treatment consisted of re-alignment and removal of the blockage. For example, menstrual patterns comprised a common health concern among sex workers related to the humoral conception that blood embodies vital strength and energy but that excess should be released every month to cleanse the body and maintain a correct balance. Painful periods were often attributed to an incomplete flow or internal blockage, as were scanty periods which were perceived as a serious problem as the excess 'dirt' in, and heat of, the blood was thought to accumulate progressively inside leading to many different health problems. Again, biomedical discourse had been incorporated into these local concerns, in this case – the concept of 'blood pressure'. For example, one sex worker I knew whose periods had stopped following a hysterectomy regularly donated blood

to release the 'pressure' as a result of blood accumulating inside. Homeopathy and traditional herbal remedies were also popular for menstrual disorders.

Another highly prevalent complaint among sex workers that they related to mechanical disturbances was lower abdominal pain. Here, pain was very often related to a shift in the position of the *nari* – a structure perceived to lie underneath the umbilicus at the centre of the body. Shifts in this structure were attributed to any sudden jolting movement or bodily strain such as a fall, lifting a heavy bucket or, in the case of sex workers, as a result of particularly forceful intercourse. Treatment consisted of abdominal massage and vacuum cupping over the umbilicus to try and restore bodily alignment[3]. If pain was severe or if local treatments did not work however, sex workers would combine these therapies with visits to allopathic doctors who would give strong pain killing injections and antibiotics.

Doctors I interviewed felt that what sex workers perceived to be a *nari*-shift was often Pelvic Inflammatory Disease (PID). This is a chronic inflammatory condition of the upper reproductive tract that can be caused by a variety of STD pathogens (often chlamydia and gonorrhoea) and can cause extreme lower abdominal pain (sometimes with fever), infertility and ectopic pregnancy, and, is suspected to be a contributing cause of cervical cancer. Many STDs in women are asymptomatic and may not be detected until symptoms of PID occur. PID is also associated with under-treatment of symptomatic STDs which then progress up the reproductive tract. Treatment involves taking a complete and intensive course of numerous antibiotics, and, in its later stages, may require surgery. However, in my experience, sex workers never explicitly associated their abdominal pain with diseases that could be contracted from a customer or that could prevented by a condom. Rather, where possible, women took care to prevent mechanical injury during intercourse. As the quotes in the earlier section indicate, some older sex workers would confidently assert that they had previously had no need for condoms and that they had never suffered from STDs. A number of these informants however were suffering from on-going bouts of lower abdominal pain, indicative of PID, but they did not associate this with STDs.

Swollen inguinal lymph nodes (also indicative of some STDs) were also related to shifts and blockages in internal structures.

[3] Similar beliefs and therapeutic strategies have been observed throughout North India (Lambert 1996).

Cosmological Understandings

Women often related the cause of particular problems to underlying cosmological and cultural understandings structuring human and group relationships within Hindu society. Sex workers made an association that is found throughout India whereby direct or even indirect contact with another person's body fluids is generally considered to be impure or polluting and can lead to ill health (Nichter 1989, Khare 1962, Bean 1981). Some health problems were thus referred to as *chuachui* (literally 'touching-touching' where the touching relates to association with something impure). For example, women often said that if they borrowed the petticoat of someone who had *sada srav* (vaginal discharge) then they would also get it. Another common belief was that urinating in a spot where someone else with genital symptoms had just urinated might lead them to contract the other person's disease (cf. Nichter 1989). Likewise stepping on or over someone's spittle was sometimes thought to be a possible cause of skin lesions characteristic of secondary syphilis. Proper ritual 'hygiene' (daily clothes washing, daily bath and immediate cleansing following contact) was considered crucial to maintain health. A Sonagachi sex worker told me that: -

> We try to keep clean. We get up and have a bath every day, we wash and change our clothes every day and we wash ourselves in hot water after doing customers.

Interestingly, none of the problems that sex workers classified as *chuachui* were said to be spread directly through sexual intercourse, though these would correspond to biomedically defined STD symptoms. Below is a dialogue I had with a group of experienced PEs that illustrates their varied perceptions about the issue:-

> - *Sada srav* is *chuachui* – if you wear the petticoat of a person with this disease you will have it.
> - Yes, suppose someone has problems of menstruation. Now if they urinate and do not clean the blood and urine and if I go and urinate in that place, I will get this disease – it is unclean and if I see this blood the disease will come into my body.
> Catrin: But how can you catch a disease like this?
> - Yes, it is surprising – it is here-say – that is what people say in the village.
> - It is our experience
> - Doctors say that it is not *chuachui* but we feel it is.
> - Can I speak? In my mind I don't believe any disease is *chuachui* there is no such thing. It is all inevitable, part of the karmic laws. If I have a disease – will you have it? No. It depends upon our karma.
> Catrin: Well what of those diseases which are not *chuachui*, are there any other diseases which if I have it and we have contact, you might get it?
> - No there are no such diseases.
> Catrin: Well, what if a man has a *gha* (ulcer) on his penis and a girl has sex with him – will she get it?
> - Yes – if she does it without Nirodh
> - If she uses Nirodh she will not get it.
> Catrin: So is this *gha* not passed from him to her?
> - It is not a *chuachui* disease – if you prevent it you won't have it. If I have it and sit you without condoms you will have it – it is direct contact but if you use a condom it will not spread. It is not *chuachui* – if you have it and I am near you I cannot have it – like AIDS.
> Catrin: Can syphilis and gonorrhoea be spread from one person to another?

- A lot of women have ulcers inside their bodies called syphilis and gonorrhoea – the skin there is delicate, if there is constant rubbing some disease will happen there.
- Yes, but it often happens that people have diseases and do it with a girl who is healthy and she does not get infected, but maybe all of a sudden she has it – it is a matter of luck.

The sex workers in the above discussion provide a good illustration of the lack of systematicity in, and varied nature of, women's knowledge. They seemed to be articulating a notion of *chuachui* which suggested that certain genital problems could be caused by *indirect* (as well as direct) contact with, or proximity to, polluting bodily fluids and which would not be preventable by condom use. Some of the above informants suggested that only diseases caused by direct contact could be prevented by condoms, though other informants also gave an alternative friction-related explanation of genital disease, and two appeared to question the extent to which any disease could realistically be prevented given one's inherent fate (or, conversely, the extent to which it is possible to formulate a universal theory of disease).

The notion of *chuachui*, though based on entirely different premises, corresponds to some extent with biomedical understandings of contagion in which a disease can be transmitted (e.g. through droplet infection) even without direct 'touching' contact. Understanding of the mechanisms of disease transmission is important for AIDS prevention (given many misperceptions that exist about its contagiousness by mere proximity). I wanted to explore this issue further. During my many discussions about health problems with sex workers, not once did they spontaneously refer to a germ theory of disease. However, the SHIP flip chart depicts AIDS as being caused by a 'germ' (*jibano*), represented pictorially as a monstrous insect-like creature. I was interested see how this would be interpreted. Surprisingly, once I brought the subject up, sex workers usually agreed that all diseases were caused by *jibano* or *poka* (literally means 'bug', insect or small worm). The two terms were used interchangeably. When I asked why no-one had talked about this before, I was told that I had not asked but that definitely each disease had its own *jibano*. When I tried to probe how *jibano* might cause disease however, most sex workers were unable to answer or gave extremely contradictory replies so that no common pattern emerged at all. Most simply said that *poka* were everywhere – inside and outside the body. Nichter (1989) has noted a similar germ-related discourse amongst South Indian informants which also coexisted with various other attributions of aetiology and was rarely made explicit. He has theorised a system of multi-level causality such that other causes (such as transference of impurity) may be perceived to be the 'efficient' cause whereas germs are considered the 'instrumental' cause of disease. He notes that this is an area that requires further exploration.

Ill health was also sometimes conceived of in relation to cosmological beliefs such as spirit/ghost attack, black magic or evil eye. Bad business and unexplained health problems were often attributed to an enemy having done black magic against you or being envious. For example, skin lesions characteristic of secondary syphilis (which may appear years after an initial infection) were sometimes perceived to be the result of having been poisoned with mercury (*para*) by one's enemies. I heard examples of sudden and prolonged bleeding or women inexplicably 'drying up' as a result of blood or fire spells having been put upon them (*rokto* or *agni baan*). In addition, crossing paths with a malevolent spirit (*hawa*) or ghost (*bhut*) could lead it to enter your body and cause terrible sickness which only a priest could cure. Sex workers consulted with the priests of the local temples for all such problems and would carefully follow the prescribed course of action. However they might also simultaneously consult with an allopathic doctor or modify their diet as they felt they could never be entirely certain of the cause of a disease. One PE explained this with respect to secondary syphilis:

> See, we don't understand all these things but we feel that if you go to the temple they can predict whether you have had *para* or not and what kind of *para*. But one strange thing – even when we are certain that no-one has given us anything, these eruptions can still occur so how can this be due to *para*? Actually it is the heat of the body. Some say that even if you have been fed *para* a long time ago, when the body becomes hot, then it can come out. We have to take cooling foods and take injections from the doctor.

(Sexual) Health-Seeking Strategies and Use of Bio-Medicine

In spite of sex workers' health related understandings being predicated upon an eclectic knowledge base whose presuppositions are in many ways entirely different to that of bio-medicine, my research found that allopathy was by far the most common form of treatment sought out by sex workers for sexual/reproductive health problems. Home remedies, dietary adjustments or visits to a priest were nonetheless often pursued, sometimes prior to, or simultaneously with, allopathy but the latter remained the major treatment form, especially as the urban environment offered an enormous range of allopathic services that were easily accessible to sex workers (Evans & Lambert 1997)[4]. Thus women's beliefs or 'knowledge' did not relate deterministically to their actions. Rather, their treatment choices were overwhelmingly pragmatic. In a context where time is short, where sex workers are pressurised to earn and are allowed few days off to rest and where some (especially *adhias*) have little autonomy to determine their own treatment modalities, allopathy was generally

[4] The same point has been noted in a number of different studies where accessibility of bio-medical services per se is not a problem (cf. CINI 1994, Kanani et al 1991, Mull & Mull 1994, Young 1981, Kloos et al 1987, Ho et al 1984).

viewed as the quickest and most effective therapy. My informants' main concern when sick was less how they could return to some abstract culturally defined state of 'balance' but rather, how they could quickly return to work and re-attain functional competence. Sex workers often described illnesses in terms of how they could not work or how they were unable to perform household duties rather than how sick they felt. For this reason, traditional remedies such as ayurveda were generally rejected for being too slow to achieve a 'cure' and also, for requiring changes in life style that sex workers could not effect or afford within the confines of the sex trade. By contrast, there was a common perception that allopathic medicines were strong and powerful. They were also believed to be heating and thus potentially damaging to the body, and were therefore viewed with some trepidation, but were nonetheless considered to be the only treatment powerful enough to combat quickly the 'diseases of the line': -

> Living in a place like this with all our drinking and smoking do you think [remedies from 'traditional' healing traditions] would catch it [our disease]? The *vaidya* (ayurvedic practitioner) said to stop taking allopathic medicines, to give up sour foods and to eat a lot of cooling food. But I couldn't keep up that diet for a whole year....there was a time when these foods were cheap and we could eat them every day but we can't afford this any more. It will take too long to get relief. Allopathy is quick so we don't mind spending money on medicines. If you take the medicine at night by the next morning you are better.

Allopathic medicines tended to be viewed as a powerful quick fix (Nichter & Nordstrom 1989). This perception, combined with economic hardship and a lack of understanding about the nature of allopathic therapeutics, meant that from a bio-medical perspective, they were widely misused and all doctors I interviewed complained about this. For example, sex workers might self-treat with powerful antibiotics, taking just one or two when a full week's course should have been taken; they might take strong painkillers for years to be able to keep on working when they actually required surgery that they could not afford; they might pick and chose from doctor's prescriptions according to what they could afford at the time; they might not take medicines for the full course because it was too expensive or because they feared side effects; and they might switch doctors and medicines on a daily basis looking for the 'right' cure. Because allopathic medicines were considered so powerful, women felt that prolonged use would damage the body. They would, therefore, sometimes reduce the prescribed dose out of fear of side effects or might be concerned about multiple drug therapy which was thought to have magnified side effects. They would omit medicines on those days where their work meant that they had to take a lot of heating foods or alcohol so as to minimise bodily harm. Likewise, they might not take a medicine at all because they could not afford the cooling or strengthening foods that were felt to be required to mitigate its damaging effects. This was particularly the case with the oral contraceptive pill which was viewed as a medicine like any other that required constant cooling measures to avoid permanent harm to

the body and uterus. For this reason most women who started taking the pill soon stopped or used it only erratically (Evans & Lambert 1997).

Thus, the pragmatic need for a quick cure and the perceived relevance of that cure to the exigencies of sex workers' lives largely determined sex workers' choice of formal treatment (as opposed to their 'local knowledge' or 'beliefs'). Where sex workers' own understandings of, and orientations towards, health *were* drawn upon, however, was in the interpretation of the action of allopathic medicines and in their subsequent use in a way that was calculated to minimise disruption to, or enhance, bodily balance and functional health, even if this went against doctor's orders.

A good example of the local 'logic' of health seeking was illustrated in a case described to me by Podda, one of the PEs, concerning her *babu* who had developed urethral discharge and a penile ulcer. He was frequently visiting other sex workers as she was pregnant:

> I think what happened is that he urinated in a place where someone else had just urinated and it must have splashed him and he got this sore and discharge. I made him go to the doctor at the clinic and he said it was syphilis and gonorrhoea. Too much heat has accumulated in his body – he keeps drinking and eating meat and then going to all these girls. I told him he must use condoms next time because I don't want any of these diseases. The doctor gave him an injection and some tablets. The tablets made him so weak that he couldn't get up from his bed so I advised him to stop and I asked one *didi* [another sex worker] who gave him a bit of Horlicks that she had – what could we do? He has to work.

Here Podda is simultaneously drawing upon a bio-medical explanation (of condoms preventing disease transmission) as well as a notion of humoral imbalance and impurity. She took her *babu* to a bio-medical doctor but interpreted the prescribed therapeutic action in terms of its functional and humoral effects.

Sex workers choice of medical services was similarly pragmatic and primarily influenced by convenience. For this reason most women sought treatment from the private medical sector[5] as this was perceived to be quick, non-judgemental and high quality (unlike the Government hospitals), though the SHIP's clinics were also popular as they were located in the redlight area itself, were perceived to give 'good' medicines and were free. In Sonagachi, only the *Agrawalis* and Nepalis rarely used the SHIP clinic. In the former case, for status reasons, they were said to look down upon a free service and preferred to utilise their 'own' popular private doctor. The SHIP clinic was always crowded and consultations took some time. For this reason too, the Agrawalis avoided it as any customer they might miss in the mean time

[5] This sector consisted of MBBS (or higher) qualified medical doctors, non-registered practitioners and practitioners from ayurvedic or homeopathic systems of medicines.

represented substantial lost earnings (unlike Bengali 'B' and 'C' grade workers who had less to lose). I was told that Nepalis were primarily prevented from coming by their madams, again out of fear of lost earnings during the waiting and consultation times.

The Nature of Sexual Health Knowledge(s)

The material presented above shows that whilst sex workers sometimes found it difficult to articulate their theories of sexual health knowledge – that is to reflect discursively upon their practice, especially in relating this practice to *illness* aetiology - they all had very clear and relatively consistent ideas about what constituted appropriate *health*-related practice and I could also observe this directly in my day to day interactions with them (rather than having to ask questions in an artificially constructed interview situation). For my informants, eating the right kinds of food, maintaining sexual control, and keeping ritually clean were unselfconscious and taken for granted practices perceived as essential strategies to maintain functional health. As such, they can be considered examples of what Bourdieu has called 'practical logic' (Bourdieu 1990:61). By this, it is suggested that much of practice is organised in a manner devoid of conscious deliberation or reflexive control but that it is not entirely without its purpose or practical intent. Williams (1995:582) notes that the source of practice is seen to be located within an individual's own experience of reality rather than, for example, being related to second-order analytical models that social scientists or behaviour change researchers may wish to construct in order to explain or predict that practice (cf. Jenkins 1992).

Taking this perspective, a key question is that if much of health-related behaviour is a relatively routinised feature of everyday life (and work) which is guided by an implicit or practical logic, how are new ideas or new practices transmitted, interpreted and acted upon? And what implications does this have for pre-existing practice or knowledge and people's confidence in them? I will explore these questions in the next section in relation to the introduction of new knowledge (about the new disease AIDS and other bio-medically labelled STDs) and a new (though not entirely unfamiliar) practice (use a condom).

Learning Sexual Health 'Knowledge'

Medical Knowledge: The Flip Chart and Representations of AIDS and STDs

As described in the previous chapter, the SHIP's main health education activities took place during field outreach work prior to which groups of peer educators were trained by supervisors or senior PEs to teach other sex workers about AIDS. They were trained to do this using a pictorial teaching aid – a flip chart which formed the focus of most teaching sessions. The PEs were supposed to go through the flip chart with sex workers (and other sex trade actors) on a regular basis to ensure that it was properly understood and that the new knowledge it imparted was regularly reinforced. At the start of the SHIP a black and white flip chart was developed and used for four years, after which it was replaced by a colour flip chart that was produced generically for sex workers and also sex trade gate keepers in India by NACO. The data in this chapter are based on the SHIP's first flip chart which was the one in use during my research. This flip chart is reproduced in Appendix one. In Appendix two is a typical narrative given by one of the SHIP's most articulate and experienced PEs that accompanied the pictures, and that was recorded verbatim.

The flip chart represents an entirely bio-medical model of health and constructs its message about AIDS using the germ theory of disease. Thus, in the second picture AIDS is shown as a monster representing a terrible new 'virus' (*bhairas*) that is threatening the world. Using the sex trade as the background context, subsequent pictures go on to describe how this germ may enter the body. Drawing upon a military metaphor that is typical of bio-medicine (Sontag 1988), the immune system is represented as the body's army fighting whatever germs may enter its territory. AIDS however is shown as a super-bug, able to overpower and defeat the body's defences slowly leading to illness and death. Means of transmission are represented according to the epidemiological concept of core groups, and are described by an example of a customer who spreads AIDS to a number of sex workers and then also to his wife and she, in turn, to her unborn child. Likewise, the sex workers are then depicted as unwittingly passing the virus on to other men. There is a picture that describes how to use a condom properly and condom use is stressed as the main way to avoid AIDS, although use of tested blood and clean syringes are also encouraged. There is also a sequence of pictures that shows how AIDS does *not* spread, stressing that it is not a contagious disease. There follow pictures that show a madam teaching her girls to use condoms, and that exhort sex workers to go the SHIP clinic and, in particular, to get their blood tested regularly. The last pictures show many people getting together with various weapons to kill the AIDS virus and stresses that united

action by all is required to overcome the disease. There is then one final reinforcing picture that prescribes four types of preventative action – "use a clean syringe and tested blood", "get your own blood tested regularly" (though the SHIP tests for syphilis not for HIV), "detect symptoms of and prevent STDs", specifically syphilis and gonorrhoea (shows a picture of infected men's penises), and "use a condom".

In spite of the SHIP's integrated approach to sexual health, the flip chart did not seem to reflect this orientation. The flip chart focused upon AIDS (rather than STDs) and was concerned with teaching women how to prevent AIDS rather than how to promote 'sexual health' in any broader sense. The flip chart presented 'facts' and, therefore, appeared authoritative, leaving no room for doubt or discussion in spite of the fact that the majority of sex workers had no personal experience with AIDS. Moreover the flip chart was entirely disease- rather than sex worker-centred and did give not give any weight to sex workers' own discourses, idioms, concerns or practices, especially relating to health as maintenance of functional balance. STDs were barely mentioned, whereas these (in the sense of their related symptoms and preventive strategies) were prominent in women's discourses. Where STDs were mentioned, it was to describe briefly how they might be identified in a man. There was no information on the nature of STDs in women, nor, importantly, that they could be asymptomatic. The flip chart thus missed some crucial areas where some input might have been useful, specifically regarding women's (mis)perceptions of PID, and that pregnancy could be prevented through sexual 'control', their concerns about vaginal discharge, their concerns about the oral contraceptive pill and around medicine use in general. Neither did it draw upon women's own recognition of structural and occupational barriers to health as a talking point for broader community action.

Dr.P and some of the other project doctors with whom I spoke, recognised the discrepancies between sex workers' own understandings and that of bio-medicine. Interestingly, they themselves did not, however, appear to consider the knowledge-transmission part of the project's work as specifically important (in spite of evaluations in 1994 and 1996 pointing out that there existed some confusion among sex workers' about STD/health-related matters – Mertens et al 1994, WBSHP 1996). They were apparently not particularly concerned to address or build upon sex workers' own understandings. Rather, a perspective was taken that the structural barriers to health were so great that any knowledge, bio-medical or otherwise, was somewhat inconsequential. This perspective was illustrated during a discussion I had with one of the project doctors regarding the potential value of health education to improve treatment compliance. He explained that:

> What good will health education do? – even we educated people often don't take medicine for more than two days so how can one expect others to? See, you must understand, these girls, in places like Sonagachi, they live in a totally abnormal environment –if the customer or madam tells them to do something they have to do it. Even if they understand, they cannot act. This is the problem.

The project's own answer to sex workers' knowledge and need for education was to develop a Freirean education programme through which sex workers could themselves begin to analyse their social situation (Bandyopadhyay 1996, 1997). Nonetheless, perhaps because of the emphasis placed by donor agencies in project evaluations on changes in knowledge as an indicator of project effectiveness, use of the flip chart and attempts to transmit its' 'knowledge' continued to be an integral part of field work and PEs were required to learn it. In addition, the flip chart would also have been useful in symbolically supporting the SHIP's initial self-representation as a medical project.

In contrast to Dr.P's attitude on the importance of medical knowledge, the PEs and project supervisors placed tremendous emphasis upon learning the flip chart and upon the PEs' ability to say it correctly. For many of the PEs especially, use of the flip chart appeared to be understood as the primary task of field work and for them, its symbolism of formal medical knowledge was highly meaningful as described below.

Learning the Flip Chart

Once a sex worker had been chosen to be a PE, her first task was to undergo training to 'learn the flip chart' and generally to understand something about the project and her own role within it. Following this training she was given an exam by the project director or other senior project staff. By the time I started my research, most PEs in Sett Bagan and Sonagachi had already been through this training. However I was able to observe the training of the new recruits in Sett Bagan following Durga's departure and also in Tollygunge, another redlight area where the SHIP had recently opened a clinic and where the PEs were still very new to their work. I had spent 3 mornings a week there for 3 months during the time of political turmoil in Sett Bagan in order to try and build up contacts with another locality should I have been forced to withdraw from Sett Bagan.

Most PEs were illiterate or semi-literate. Those who had attended school for a few years when young had often forgotten what they had learnt by the time they were adults. Thus, many PEs had little experience of 'formal' learning. For such women, most of their learning about life would have been in the form of stories, songs, myths, observation and, lastly (as described by

sex workers themselves with reference to their sexual health related knowledge), by practice or experience - what Jordan (1988) has called the apprenticeship or experiential mode of learning. Within traditional forms of learning and perhaps especially among poor women (cf. Mosse 1994), verbalisation does not play a prominent part. Learning is largely by watching, doing and experiencing and thus enshrines a measure of uncertainty. Likewise performance is judged on the basis of practical results rather than on ability to give a verbal explanation for what has occurred (Jordan 1988, Lave 1987, Chaiklin & Lave 1990, Bloch 1991). Knowledge acquisition is usually driven by contextual practical requirements, hence knowledge about health is learnt in the process of having to obtain treatment for, and care for, someone who is sick, rather than being driven by abstract pedagogical interests. As proposed by Young (1981), much knowledge therefore is practical (knowledge in response to something) rather than representational (knowledge of something). Furthermore, to the extent that learning and knowledge are embedded in everyday life and practice they may not be consciously reflected upon (Bourdieu 1977).

Learning the flip chart by contrast took place in a de-contextualised didactic manner in which there was a strong emphasis on verbalisation. Each page had a number of associated points that were supposed to be described. However, in keeping with the pedagogic approach in India generally, during teaching and learning, the emphasis was largely upon remembering exactly a specific narrative for each page, rather than on developing an understanding of the points so that the flip chart's narration could be flexible, improvisational and, therefore, modifiable to specific contexts. Project staff (specifically some of the supervisors) stressed the importance of the post-training exam, sometimes hinting that women would lose their jobs if they failed. PEs viewed the exam with great trepidation. In Sett Bagan they would gather in the club room and listen to a more experienced PE relating all the pages of the flip chart. Then each one in turn would be asked to repeat off by heart the specific narrative that had accompanied each different page. Success in learning was judged by a PE's ability to recount each narrative correctly, word for word. Any slight deviations were pointed out. I hardly ever witnessed any discussion reflecting a desire for greater *understanding* of its contents. This did not appear relevant. PEs, fearing the exam, were pre-occupied with remembering the correct *words* rather than *concepts*. I remember helping one PE 'learn' how to talk about one page in which the body's still healthy immune system (warriors) is shown successfully fighting a variety of germs (monsters). The narrative that this PE had been taught goes like this: (referring to the pictures of monsters) "these are small diseases, cough, colds, syphilis, gonorrhoea, they have got inside our body and our body is fighting them". I tried to get her to

think about the picture and to explain it to me in a different way but it proved impossible, she was so worried about remembering the correct names of the 'small diseases': -

> These are monsters, coughs, cold, fever – no, not fever – coughs, cold, um, er, these are small diseases in our body like coughs, cold, - what were the other two *boudi* I can't remember – with a brain like mine will anything go in?

Where this PE did display her intuitive understanding and improvised by adding 'fever', she immediately corrected and scolded herself.

In addition to the unfamiliarity of the rote learning approach, it was also unsuitable in other ways. For many sex workers, their lives were full of worries and stress from which they found it difficult to switch off and concentrate. I often heard comments like "my mind is so full of worries, how can anything more go in?" or "as soon as I go back to my room my worries come back and everything I learnt goes out of my head". Some of the PEs I knew in Sett Bagan and Sonagachi who had been working for at least three years still skipped certain pages of the flip chart or tried to avoid having to recount it at all because they were not confident about being able to remember the page-specific narratives. Others however, had in time become experts in 'saying' the flip chart. Interestingly, this involved the development of the confidence to improvise a bit – i.e. to make it more story-like and to bring in contextual details. These women were often relied upon by the others to hide their weaknesses.

In Tollygunge, the PEs were taught by one of the project supervisors who placed great emphasis on rote learning of the flip chart and also on knowledge of the English names of the various STDs/HIV/AIDS and related diagnostic tests. Thus, although these PEs were new recruits, they did not receive any in-depth training to help them *understand* all about STDs – knowing their names was considered sufficient knowledge as this is what was going to be tested in the exam. I witnessed many teaching sessions in which PEs got hopelessly confused. Below is a typical example:

> Supervisor: what is the full name of HIV?
> PE: *heuman eeemuno bhairus*
> Supervisor: what does it mean?
> PE: *syphilis* and *gonorrhoea*
> Supervisor: no, I mean what is HIV?
> PE: you have to do an *eelisa* test and then *westaarn blot*
> Supervisor: that is how you detect HIV but what is HIV?
> PE: you get it in blood and fiom mother to baby
> Supervisor: yes, but what is HIV?
> PE: it is a *jibano*
> Supervisor: it is a virus
> PE: it is a *bhairus*

Supervisor: what is AIDS?
PE: AIDS is a disease
Supervisor: what does AIDS mean?
PE: HIV
Supervisor: No, I mean what is the full name of AIDS?
PE: *heuman dafienci*.....
Supervisor: no – all right tell me 5 types of STD (*jouno rog*)
PE: *syphilis, gonorrhoea, hepatitis*, um, ah
Supervisor: what about AIDS – isn't that a STD, a line disease?
PE: yes, AIDS, *sada srav*
Supervisor: No, leave out *sada srav* – tell me what are infectious diseases (*chuachui rog*)?
PE: um, ah, *syphilis, gonorrhoea*?
Supervisor: is AIDS infectious?
PE: no
Supervisor: what is the name of the test for syphilis?
PE: um, ah, oh I don't know – all these names don't stay in my head.

The above dialogues showed that these PEs had actually understood some of the basic concepts around HIV/AIDS but it was not this knowledge that was being tested. Moreover, words which potentially had quite different meanings for sex workers (STD, line disease & infectious, *chuachui*, disease) were confusingly being used interchangeably by the supervisor.

The project supervisors who were directly responsible for the PEs' work were understandably concerned that the PEs should know how to do their job properly. They therefore stressed the need for tough training and an exam so that the PEs would develop a sense of responsibility towards their work, and so that they did actually learn the necessary facts to be able to recount the flip chart accurately. Following the initial training, the PEs were actually encouraged to give 'mouth explanations' about AIDS i.e. – to explain it in their own words - but many I witnessed trying to do this simply repeated what they had memorised from the flip chart. Others however were able to do this quite well but usually only after years of working experience. Many PEs did eventually manage to learn how to 'say' everything correctly. It cost them a great deal of effort and they were extremely proud of their new 'knowledge'.

The Meaning of Biomedical Knowledge

The PEs described the new knowledge that they had learnt as *daktari biggaen* (medical science), about which (as previously noted), they stated that they had known nothing prior to the SHIP. PEs understood that, in contrast to biomedicine, their own knowledge was not respected or authoritative in 'mainstream' society. As described in the previous chapter, one the greatest benefits that PEs felt from working with the project was a renewed connection with 'respectable', mainstream society. Indeed, they valued their new knowledge tremendously as it provided them to some extent with a language in which they could converse with the *bhodrolok* ('respectable' people) from this society as equals. Indeed, in

relation to learning the flip chart or indeed, other matters (such as the nature of the DMSC's demands), PEs often stressed to each other that they must be able to learn it and to say it correctly, so that when visitors came, they would be able to answer their questions and talk to them. In this sense their new knowledge and ability to 'talk' about it was highly valued for its implications for social mobility, as much as for itself.

Moreover, having command of, and access to, this knowledge (as well as having a job with a government project) symbolically raised the status of the PEs among their peers. That they became acknowledged and respected by many Bengali girls as specialist (biomedical) health workers was reflected in the fact that they were frequently consulted about general health complaints (I observed this many times during fieldwork). PEs derived tremendous pride and pleasure from this status and acutely felt their lack of biomedical knowledge in other areas. They were keen to improve their skills further and often requested further training in health-related matters:

> We feel so good when visitors come and we can discuss all these things with them. We have learnt so much. But there is one matter – in the field the girls are asking us for help, they ask us many questions – what to do about *sada srav*? what is jaundice, what is *nari tumours*? Now we tell them, we will have to consult with a higher authority (*upor mahal*) and tell you, or you come to our clinic. It would be good if we could know more about these things. We want to have lessons on all this. (Sonagachi peer educator)

Through their training, the PEs had understood that, as project workers, they were supposed to be spreading *biomedical* knowledge. However, they did draw upon their own knowledge and experiences when questions were raised that were not covered by the flip chart. They appeared to see their two kinds of knowledges as quite separate (but not incommensurable) – one, related to their personal experience and in which they were agents (but made no or only uncertain claims to authoritativeness), and one - biomedicine, a powerful and authoritative outside discourse which they were learning, but in which they were 'patients' and had little understanding of, or control over. Thus, when PEs taught the flip chart, I rarely witnessed any discussion at all – it was simply recounted and recipients were expected to accept it at face value. By contrast, when PEs shared their less formal knowledge, it was usually in the form of debate and dialogue where numerous options were deliberated over. When I was present on such occasions though, the PEs were keen to stress to me that "this is not *daktari biggaen*, this is what we know from experience but it is not *daktari biggaen* – we don't usually tell the girls all this, only if they ask".

Sex Workers' Knowledge of AIDS

In spite of many years of exposure to the SHIP's health education messages, I found sex workers' medical 'knowledge' of AIDS to be highly variable, even within the same locality. Some differences may be attributable to differences in the inter-personal relations that PEs were able to develop with the sex workers, however, even a good relationship did not necessarily correspond to 'good' knowledge.

I spent considerable time going around the field with the PEs in Sett Bagan and Sonagachi, asking sex workers what they had learnt from the PEs and what they knew about AIDS. Some sex workers clearly had developed a good understanding of the main issues. During a conversation with two *adhias* they described to me what they knew: -

> What do these girls talk to you about?
> These *didis* come and tell us about diseases, they explain about condoms and tell us to look after our body.
> Can you tell me what you have learnt?
> We have learnt about AIDS – it is a new disease, a disease of the blood. Who has it cannot be seen from the outside.
> How does it spread?
> It spreads in blood, when you use a dirty syringe or take untested blood and also if a man who has it sits with a woman without using Nirodh.

Others however were not so clear about the 'facts'. I asked some *adhias* in another house what they learnt from the PEs: -

> We have learnt about AIDS, about diseases, not to sit anyone without a condom.
> Do you know how AIDS spreads?
> Um, no.
> Do you use condoms.
> I try to with everyone.
> Why do you try to use condoms?
> Because of AIDS.

Another *adhia* gave the following reply to the same questions: -

> Do you use condoms?
> Yes.
> Why?
> Because of all this AIDS.
> What do you know about AIDS?
> It is very serious and you will get a big *gha* (ulcer) and die.
> Are there any other disease you can prevent by using condoms?
> That I can't say.

On another occasion in Sett Bagan, I talked to a sex worker who had been exposed to the SHIP's health education activities for 4 years: -

What do you know about AIDS?
I have seen the pictures, they have a book that they show us.
Can you tell me what you know about AIDS?
Well, um, ah [thinking back to the pictures in the flip chart], there's deep kiss – you shouldn't do this, and then, um, there are syphilis, gonorrhoea.
Do you remember anything about AIDS?
It is a serious disease.
Do you know how it spreads?
No, I can't remember all that but I have seen the pictures.
Do you use condoms?
Yes.
Why?
Because of all these diseases, after all we are girls of the line.

The three sex workers quoted above were not entirely knowledgeable about the medical facts of AIDS and its transmission but did have a basic *understanding* that AIDS was a dangerous disease that could be avoided through condom use.

Knowledge Overlaps and Understanding

In spite of the differences in sex workers' informal and bio-medicine's formal 'knowledge' around sexual health, they do contain areas of overlap though these are based upon different premises. Many of the most important points contained within the flip chart fall within these areas of overlap (for example, sexual contact may lead to disease, condoms may protect against such disease, bodily 'strength' is crucial to health, one of the causes of disease may be *jibano*, some diseases emerge from within the body and are not necessarily visible to others, diseased or 'bad' blood potentially has a dramatic effect upon bodily health and strength, and, allopathy is a suitable treatment for many 'line' diseases/STDs). Thus, although biomedical discourse on the whole was quite foreign to PEs/sex workers, and led to great difficulties in learning and being able to verbalise *details*, certain concepts resonated with women's own understandings. Indeed, there was no real contradiction at all. Thus, sex workers were not being asked to learn something completely alien to their own understanding, they were merely being provided with a different (aetiological) rationale. They found it difficult to fully understand and verbalise the biomedical *rationale*, but the basic *message* about what had to be done (use a condom, see a doctor for STDs) was not inconsistent with their own knowledge.

I have emphasised the words 'rationale' and 'message' above, because they symbolise a difference between theoretical/discursive and practical knowledge (cf. Giddens 1984, Bourdieu 1977). For the purposes of every day life, it may not be important or necessary to know the rationale behind the way some things work. It is sufficient to know that they work in particular ways, and indeed, what one has to do to cause something to work in a particular

way – this can be learnt from practice as much as from theory. My material suggests that sex workers' discourses about health and the body were primarily grounded in this practical knowledge. In their particular social context (which did not emphasise formal learning and, indeed, did not provide any reward, motivation or use for it), it was not relevant to know exactly 'why'. Far more relevant was knowing what *to do* to survive in difficult circumstances. It is for this reason that I believe sex workers had difficulty remembering the aetiological and pathological information about AIDS provided by the flip chart, but they generally had no difficulty remembering and also understanding the prescriptions for *action* contained within it, particularly condom use. Condom use was promoted in the context of women's *work* and was not challenging any deeply held personal beliefs or sensitive cultural roles or norms (unlike some health education programmes for example, that try to change dietary practices, child care habits or otherwise try to alter firmly entrenched life styles).

As such, even though medical knowledge may have been sketchy, a perception that sex workers *were* at risk of AIDS appeared to be have been internalised. This is elaborated below.

The Transmission of, and Response to, Formal Medical Knowledge

Representations of Biomedicine and Perceptions of Risk

One of the characteristics of HIV infection is that it may be asymptomatic for many years. In addition, when the SHIP started, there had been only a few cases of AIDS in Calcutta. As a disease which few had had any experience of, health educators faced a particularly difficult task. Indeed, for AIDS to be taken seriously, a certain amount of trust in the medical establishment would be required. Studies of health education campaigns elsewhere have shown how the public actively interprets and evaluates the information it receives in terms of existing lay 'common knowledge', life circumstances, cultural values and, importantly, in terms of the source and nature of the messages that are presented (Lambert & Rose 1993, Kielmann 1997). Thus, for example, in India, the introduction of unfamiliar medical directives such as the small-pox vaccine at first faced widespread resistance, partly because local people did not trust the colonial institution of European medicine or the British authorities who were promoting it, and partly because small pox was attributed to the anger of the goddess Sitala and was not considered part of medicine's legitimate domain (Marglin 1990). In western countries, biomedicine's representation as an authoritative science is increasingly being questioned by alternative health movements and counter-culture groups. It is also questioned because the nature of its advice may be evaluated as inconsistent (e.g.

frequently changing advice on healthy lifestyles), or as too simplistic in the face of complex realities (Davison et al 1991, 1992). In these cases (research has shown) that the general public may lose faith in the source and trustworthiness of the advice and may be more likely to reject it or modify it.

To give an example, in chapter one I described a tension between the group based TI approach based upon epidemiological conceptions of the role of core groups in STD transmission, and an understanding that risk is associated with behaviours which are in turn associated with risky settings that may have little to do with particular group identities. Sex worker groups in some parts of the world, particularly western countries, have criticised the group-based approach, claiming that it is stigmatising and have rejected the notion that sex workers are inherently any more at risk of having HIV than anyone else. This perception has led some of the more radical groups to fundamentally question the validity of biomedical knowledge on HIV and its representations of HIV risk[6]. My material however suggests that sex workers in Sett Bagan and Sonagachi generally accepted the medical and epidemiological representations of HIV presented in the flipchart. Many appeared to perceive themselves as individually at risk and were concerned to protect themselves:

> If I want to keep this life I must use condoms so that this disease doesn't enter me. I have children and if something happens to me, who will look after them? (Sonagachi sex worker)
>
> I use condoms with everyone – I'm not going to stay here all my life no? I want to go home and get married so I must look after my body. (Sonagachi sex worker)
>
> This much I have understood. If we are to survive, we should guard against all these diseases. Using condoms has become a habit for me now. I feel disgusted if I do this work without a condom. (Sonagachi sex worker)
>
> [Viewing the flip chart for the first time] Oh *baba*, after seeing this a great tension has happened in me. I didn't know about this disease before. Now I am afraid for my life.

Some however, especially older women were rather indifferent about HIV:

> I'm going to die anyway. (Sonagachi sex worker)
>
> In all my years I have never had a *gha* (ulcer) or any injections – now you are telling me about a new disease (laughed) so what if I die – at least I'll be reborn quickly and come back. (Sonagachi sex worker)

The peer educators I spoke to more or less agreed that the sex trade plays a role in spreading HIV and other diseases:

[6] In 1993 for example, the English Collective of Prostitutes published a book (ECP 1993) that challenged the representation of sex workers as high risk, and indeed, challenged biomedicine's understanding of HIV, supporting instead various alternative and conspiracy theories that question whether HIV is linked to AIDS at all.

> The reason that the project is here is because....see, one man comes and gives it to me but then how many am I giving it to? That day I have 10 men coming to me – I give all those 10, and the next day 15 come and I give those 15, but it was only one man who gave it to me. This is how it spreads. (Sonagachi peer educator)

They did not however perceive themselves to be responsible for this situation – rather they blamed their clients and were scathing but pragmatic about what was perceived as society's hypocrisy in focusing interventions mainly upon sex workers:

> The project started here to inform us girls about AIDS – but until now all AIDS patients have been found only in family houses – though they think they are learned they are worse than idiots – yes, they think they will stay with their wife and nothing will happen to them. Why do you think the project was opened here? Because it is the men of the *grihastha para* who come here. It is men who play a big role in spreading this disease – especially those who refuse to use condoms. If they use condoms the disease will not spread. It is spreading mainly because of men – we the line girls are not going out into society spreading it – they are coming here and then they are taking it from one girl to another. (Sett Bagan peer educator)

> Yes, you cannot just go into a *grihastha para* and make a project – there will be a lot of problems – they will not listen – do you think any of the men tell their wives that after office they come to Sonagachi? – the wife doesn't come here but she cannot trust her husband. There are many misunderstandings in *grihastha* families about AIDS but here it is different – we know and the customers who come to us they learn from us and they are made aware. This could not be done in the *grihastha para* but that is where the AIDS cases are more. If you go out into society to look for our customers they will scream back and say – what! you think I go to the *line paras* – you think I go to fuck – what nonsense! Don't I have a wife and children! Even those women from *grihastha* families who are coming here to do line work – you can't go to their houses and say that hey you, you go to the line – if we did that we would get slapped – don't you know that? (Sonagachi peer educator)

Other sex workers I spoke to about this were not as articulate as the PEs but similarly indicated an attitude that they were at risk, but that others should also take responsibility:

> All these people coming round telling us to use condoms. We try to use – but let me ask you something – do they use condoms? (Sonagachi sex worker)

A feeling of slight resentment was sometimes also made evident when sex workers would mischievously counter my own and other SHIP visitors' questions on condom use with their own question – "well, you tell us - do *you* use condoms?"

Trust and Credibility

In India today biomedicine generally holds an exalted position and its practitioners are treated with great respect. My informants frequently spoke of doctors as being akin to *mababa* (parents). Nonetheless, as described in chapter six, when the SHIP first started it faced considerable hostility (for various reasons) and staff had to work hard to present it as a neutral biomedical service provider, and also as an institution that cared about sex workers' well

being. Much of its initial work focused upon establishing credibility in the redlight areas. Still, various sex workers described to me how they were initially sceptical of the information on the 'new' AIDS disease, but gradually came to accept (trust) that it must be true. One reason they gave for this was because of reinforcement from other sources:

> At first I didn't believe it but after some time I understood – it was in the TV and radio too. All these visitors like you *didi* keep on coming to find out about AIDS here – so my mind tells me AIDS must be here. (Sonagachi sex worker)

> When I first heard I couldn't believe about AIDS, but after the *didis* kept coming and everyone was saying about it, and I saw all these pictures and writing about it, then I believed it. (Sonagachi sex worker)

Some women I talked to still seemed to be rather sceptical but nonetheless had decided to try and use condoms:

> We don't know if all this AIDS talk is really true. How can we know? We haven't seen any AIDS here. [Do you use condoms with your customers?] Yes I try to (Sonagachi sex worker).

Other women however described how it was only after a personal experience of suffering with STDs and being treated by the SHIP that they finally listened to the PEs' exhortations to use condoms:

> I never used to use condoms unless customers brought them. The girls had come and told me about all these diseases but I didn't listen. Then one time I got an ulcer and the girls told me to go the clinic. The doctor said I had syphilis and had to have an injection. I tell you *didi*, this injection nearly killed me – I had head spins and couldn't get up from my bed. After this I still didn't use condoms, I had so many customers, how could I explain to all of them? Then I got another ulcer and I didn't tell the girls because I was scared of the injection but it became very bad and I got worried so I went again to the clinic and had to take another injection. Since that time I have always used condoms. In fact it has become a habit with me now (Sonagachi *adhia*).

Some of the local men I talked with seemed less convinced but their suspicions centred mainly upon the political intentions of those supporting the SHIP:

> Projects like this are started so that the British can take over us again – they can't own you directly so they make you dependent by giving you projects and jobs (regular customer)

> This is all a ploy to stop people from having children – the government is putting medicine in the condoms (Sonagachi bootlegger)

The development of trust in the SHIP's information was also related by some women to its perseverance:

> I didn't take any heed of them – I would think, oh they have come again, now they'll talk and talk and waste my time. Then I would say no, I don't want to hear, come some other time. One day I thought

> these *didis* come everyday and I turn them off. I am making them go round and round for 3 days come later come later come later – today let me hear what they have to say. So I told them to come tomorrow. They sat in my room and said that there is this dangerous disease which has come out – you see this book and you will understand everything. Then they opened the book and started explaining – this disease is a foreign disease, it is not a disease of our country. So that it doesn't spread around our country, follow these 4 rules – use a condom and your body will stay healthy, you will have customers and at the same time will not have any disease. I did not know about AIDS before but I thought these girls are coming around every day in this heat to teach us about this new disease – will they do this if not to help us? So I listened and slowly I understood. Now I use condoms with everyone. (Sonagachi sex worker)

Perseverance and Persuasion

The health education component of the SHIP has been unusual in the duration and intensity of its campaign and has been highly time and labour intensive. Unlike some projects which have opted to provide one-off or occasional health education events (be they trainings, workshops or individual counselling sessions), the SHIP has persevered with one–to-one interactions day in and day out for 7 years:

> Before we didn't know anything about diseases or condoms, we didn't know how to talk to customers. I never used condoms. But then the girls kept coming – every week they came and explained to me, showed me that book and told me to use condoms. Finally it went into my head. (Sonagachi sex worker)

One-off activities are perhaps not sufficient to build up faith in (or recall of) new information, to allow for doubts to be cleared, or to allow for reinforcement after personal experiences of problems or sickness. PEs told me that:

> The girls forget – we will explain one day and they understand. The next time they come they have forgotten everything. So we sit down again and explain it – we tell them you must try and remember all this – how will you convince your customers otherwise? (Sonagachi peer educator)

As some of the sex workers above noted, if an intervention is active day in and day out, people may begin to feel there is something to it. Moreover, by visiting the sex workers so regularly, PEs were able to build up trust among them in spite of the constraints posed by social organisation of the sex trade. On a practical level too, daily contact ensured that women had access to a constant free supply of condoms.

Interestingly, the few evaluations that have been done of health education work in other sex worker projects have shown that *any* kind of health education activities (especially when combined with facilitated access to condoms and medical services) *are* usually followed by a reported significant and relatively immediate increase in medical knowledge and condom use (Fox et al 1993, Asamoah-Adu 1994, Visrutaratna et al 1995). This was also the case with the SHIP, and probably reflects the extent of unmet need for health services among sex workers

generally. However, the evaluations which have been done also indicate that reported increases in 'knowledge' or condom use tend to drop off over time after exposure to health education activities (ibid). According to the SHIP survey results however, changes in safer sex behaviour have not only been improved upon, but, importantly, appear to have been sustained, indicating that a significant shift in social norms around safer sex has taken place.

The Role of Peer Education

This shift in social norms, and also more generally, the development of trust in, and acceptance of, the SHIP's information may have been related to its peer education strategy. As described in chapter six, PEs were clear that sex workers would not be receptive to advice from outsiders, and, indeed, they themselves were sceptical about, for example, the supervisors' suitability to teach them. This is difficult to assess directly but my observations on the PE's own responses to being taught perhaps illuminates the issue. During my fieldwork I attended various workshops given by outsiders with the PEs. Often they could not remember or understand all that they had been taught (if the workshop was on STDs for example). During other workshops on, for example, negotiation of safer sex and condom use, the PEs were sometimes offended at the way in which it was presented (particularly if it involved explicit discussion about sexual practices), or they were rather scathing of the facilitator's ability to teach them about sex work. On one occasion however, a representative of a sex worker project from abroad came to visit the SHIP and spent an afternoon with the PEs. The atmosphere was electric and the PEs listened raptly throughout. They were impressed with her demonstration of different ways of putting a condom on a customer. Later, they could all remember her talk and many commented that "yes, she is one of us, she is one of our *jat*".

In addition to building up trust and credibility (i.e. enhancing access to a group), another purpose of peer education is to enable health education messages among a peer group to be delivered in a way that is meaningful, comprehensible and acceptable (AIDSCAP.PE, Williams 1996). Interestingly, within the SHIP however, the health education message itself, though delivered by 'insiders', was very much presented as an authoritative 'outside' discourse. Peer educators were used to deliver the project's message but there was little scope for their participation in developing the content or presentation of this health message and little room for them to build upon their own knowledge or impart this to other sex workers in their own familiar idioms in a way that one might expect from *peer* education. Instead, their health-education activities consisted mainly of reciting the flip chart off by heart. There was rarely any discussion or questions. At most, some more experienced PEs would embellish the

narratives with a few contextual or life-like details, but would never tamper with the 'facts'. Thus, health-related communication was generally uni-directional - from the SHIP to the sex workers. Where PEs did talk about their own opinions, experiences or skills, they were quick to point out that this was not 'medical' (*daktari*) knowledge.

As noted above, anthropologists involved in public health argue usually strongly for respect for, and incorporation of, local knowledge within health campaigns and cite its lack as a potential reason for lack of behaviour change (Scrimshaw & Hurtado 1987, Coreil & Mull 1990). Counter-intuitively, I contend here that the project's way of using peer education may actually have enhanced *acceptance* (but not necessarily *understanding*) of the flip chart and of the project's message, and that, in this case, mere acceptance was sufficient to achieve the programme's desired results. Although the facts were rather alien and presented in a user-unfriendly manner, they were presented as part of the discourse of biomedicine, whose institutions and practitioners have considerable power and authority in India. The SHIP was (at least initially) mainly represented and introduced as a medical project. The flip chart was effectively its prescription – the doctor's orders. Developing a more culturally appropriate idiom may actually have reduced its authority and thus credibility to some extent, at least initially. As noted previously, the sex trade controllers have little respect for sex workers and, I suspect, would have paid little attention to the PE's activities and health education had they presented this as sex workers' own knowledge. Like wise among the sex workers. In a context of severe competition where they had little respect for each other, ironically, the PEs had to be made to appear 'different' (though not too different) and had to be seen to have some authority behind them. This was achieved through giving them employment with a government project (which in India carries a high status). In addition, the PEs wore a project uniform (a green coat) thus symbolising their authority as project- and health workers, and they were constantly backed up by a (white-coated) supervisor. This way of working is in contrast to some other sex workers projects for example, that have recruited volunteers who work informally, alone and in an unstructured way among their peers. Hence, the PEs came to be seen as authoritative health workers employed by the SHIP rather than simply 'peers'.

In addition, to carrying the weight of biomedicine behind them, the structure of PEs' work may have been significant, though this again is difficult to assess directly. The PEs carried out their work together in large highly visible groups, rather than, for example, on an individual basis as in some other projects (Evans 1999). During field visits sex workers were gently drilled on what they knew about AIDS and condoms, and they were constantly questioned by PEs and also supervisors about their condom use. Answers to these questions were written

down by the PEs in notebooks, ostensibly to keep a track of condom use for project monitoring purposes, but it must also have created an impression that sex workers were themselves being personally monitored by SHIP staff. I suggest that the peer pressure put upon sex workers to use condoms was greatly magnified through this group based approach. During field visits for example, if women admitted to non-use, they were counselled and sometimes gently scolded by large groups of PEs and the importance of trying again was reinforced:

> It's OK – if you want to die then do so – but if in doing so you spread this disease around the line, then other girls will die. People will say there is AIDS in Sonagachi and our business will get cut (Sonagachi peer educator).

In addition, these kind of group-based intensive interactions probably also helped in the community building process (described in chapter six) as sex workers were clearly and repeatedly told by the SHIP/PEs that they were part of a sex worker group and that they had responsibilities towards that group to protect themselves:

> See this you must understand, unless we all become one we cannot solve our problems. All of us living in our own little rooms, can we do anything? No, but if 5 girls come together we will be strong. We have to fight this disease together, only then can it be overcome (peer educator talking to an *adhia*).

In addition to field outreach work, the condom use norm was again reinforced if sex workers attended the SHIP clinics. I suggest that in these ways the SHIP very persuasively promoted a feeling that condom use *should* be the norm in sex work and that it was sex workers' *collective* responsibility to use condoms. Deviations from this norm were looked upon negatively (albeit sympathetically). Group discussions with PEs (and later, various DMSC events), represented spaces which previously did not exist where sex workers could come together and discuss their problems and in which they were taught about the importance of collective solidarity. These mechanisms may have enabled health education processes to operate at the group as much as at the individual level, in helping firstly to create a sense of group affiliation, and secondly by creating a context in which group-linked previously taken for granted behaviour could be collectively re-negotiated (cf. Campbell 1997).

It is my view that that the social relationships forged by the peers combined with the respect accorded to their status as 'respectable' health workers, together with biomedicine's authoritativeness, all helped to enhance acceptance of the safer sex message. Put together with an intensive and on-going interactive peer health education strategy that created space for community building, it is likely (though cannot be directly determined) that the SHIP contributed to a change in social norms around condom use from that of an unknown or

customer-led strategy to one that was associated with a sense of collective responsibility and that was widely understood and, indeed, considered socially desirable.

Conclusion

At the beginning of this chapter I identified two assumptions underlying health education approaches, namely that knowledge of medical 'facts' is a pre-requisite for behaviour change, and that such knowledge should be culturally appropriate and build upon 'local knowledge'.

In this chapter I have raised questions about these assumptions. Firstly, in spite of survey figures indicating very high levels of medical knowledge, by exploring the different ways in which sex workers interpreted the information being presented to them by the SHIP, I showed that sex workers' assimilations of biomedicine were quite often factually inaccurate. This notwithstanding, they did however, appear to have understood the main points as to what constitutes appropriate preventative *action* and also appeared to have understood the nature of their HIV risk (though this was tinged with some resentment towards their customers and society more generally). Detailed knowledge of medical facts did *not* therefore appear to be crucial in this particular context of health education. Rather, constantly reinforced messages of what to *do* was more important. This raises questions about what kind of knowledge is being measured in surveys and for what purpose. Asking people to state whether they have heard of AIDS, or to recall the names of some STDs for example, gives no indication of their *understanding* of these conditions or of what people actually do in relation to them. If it remains of perceived importance for project evaluation purposes to measure 'knowledge' (though the utility of this seems questionable), methods need to be developed to assess practical knowledge. This in itself however is a theoretical and methodological minefield! In this chapter, sex workers represented their own knowledge differently according to different contexts, and their representations were influenced by the different meanings in terms of social status that were attached to different kinds of knowledges and audiences – in this case, local knowledge (sex workers) vis a vis medical knowledge ('respectable' people). A single survey cannot capture these complex nuances of meaning and representation, nor can the rapid assessment procedures increasingly employed by medical anthropologists in their attempts to delineate 'local knowledge' (cf. Scrimshaw & Hurtado 1987, Gove & Pelto 1994, Scrimshaw et al 1991).

This point brings me to the second assumption outlined above. The material in this chapter shows that the representation (within certain branches of medical anthropology) of local

knowledge or culture as 'out there' to be identified and re-worked to incorporate a similarly unitary, meaningless and context-free medical knowledge is clearly problematic (Lambert 1998). My material on women's health seeking and therapeutic strategies also indicates that so-called cultural beliefs, even if they could be satisfactorily identified, do not in any case appear to relate deterministically to what people actually do. Rather, women's health-strategies appeared to be more closely related to general conceptions of the nature of health under particular material conditions than to ethno-medical illness classifications or aetiologies (Evans & Lambert 1997). Where cultural context *does* seem to be of crucial importance however is in the suitability of the *process* of health education (rather than its content) to local conditions (using groups of peer educators and supervisors to do long term, highly intensive field work in order to penetrate and become part of the social structure of the sex trade), and of the sensitivity of this process to prevailing cultural concerns (in this case) around social status (capitalising upon the authority and 'respectable' status accorded to biomedicine in India and to those associated with it).

Another point regarding the importance of the meaning of 'knowledge' that emerged from my material was that, particularly in a context where people do not have any personal experience of a new disease (or new technology, in this instance, condoms), such messages must be perceived to be credible – i.e. their source must be trustworthy. The SHIP represented biomedicine (a respected institution) but it also represented the government which was viewed with suspicion. Either way, it represented outside society and had to develop a credible image in the redlight areas. In particular, the strategy of peer education appears to have been a crucial mechanism for making acceptable outside and unfamiliar (but respected) biomedical knowledge, in being delivered by influential insiders to whom sex workers could relate.

Thus, a key criticism of the two assumptions underlying much HIV-related health education work is that they over-simplify the nature of knowledge and neglect its social and symbolic meanings and, thereby also neglect social actors' agency in representing, responding to, or making use of, different kinds of knowledge. Perhaps only when this is acknowledged can the debate on the link between 'knowledge(s)' to social change fruitfully move on.

Returning to the SHIP, (though again, its impact cannot be directly determined) it seems that the way in which its health education and PE strategy has been implemented (in particular, the project's group-based, empathic and strongly persuasive approach), has played a key role in developing an *understanding* among sex workers of what they should do to protect their

health. In addition, it appears to have contributed significantly to building, as well as shifting, community norms sufficiently so that condom use has become a desired social norm among sex workers, whether or not this is actually followed in practice.

CHAPTER EIGHT

SAFER SEX STRATEGIES, BEHAVIOUR CHANGE AND THE MILIEU OF NEGOTIATION

Introduction: Methodological Issues in Exploring Safer Sex

As with 'knowledge', measurement of changes in reported safer sex behaviour (usually equated with condom use) is considered a key indicator of a TI's success, and continued donor agency support for a TI is usually dependent upon improvements in this indicator. In this chapter I explore the complex and interlinked factors that influence sex workers' strategies around safer sex and relate these to the SHIP's intervention strategies and to theories of behaviour change.

I would like to start however with a methodological note. As I used to do my 'rounds' in Sonagachi with the PEs, our conversations tended to be dominated by condoms, condoms and more condoms. Likewise, the many visitors who came to see the SHIP's work in Sonagachi seemed similarly entirely condom-focused. Even when I tried to shift the discussion onto other things, both sex workers and PEs often used to reorient the conversation back onto condoms. PEs would sometimes ask me with a hint of impatience, "why are you talking about all of this? Just ask her - here, I will ask her for you – do you use condoms?" However, these kind of conversations tended to remain extremely superficial and generalised and therefore of limited use. In other areas of health research, for example, health seeking behaviour, it has been argued that it is insufficient to explore only hypothetical or abstract scenarios[1]. The question "what do you do if you get sick?" will yield a very different kind and level of response than the question, "what did you do 3 days ago when you had fever?" Collecting narratives of responses to specific health-related situations is now considered increasingly important (Good 1994, Evans & Lambert 1997, Lambert 1998). Curiously, this same insight is only rarely applied to the field of sexual health research (except in the West where studies among gay men for example have made extensive use of narratives and other context-specific methods such as diary keeping, cf. Parker & Gagnon 1995). This is in spite of a growing body of criticism (described in chapter one) of behaviour change models which analyse and attempt

[1] This has been a criticism of the rapid anthropological research alluded to in the previous chapter which often includes abstract methods such as pile sorting or free listing in an attempt to construct models of local knowledge.

to predict behaviour primarily in terms of individual intentions or outcomes of sexual encounters and tend not to consider in depth either the process, or broader social context.

To elicit details of people's sexual encounters is of course a sensitive and difficult undertaking. In my own work I found that PEs would share this narrative style contextual information with relative ease, especially if it emerged as part of a general conversation, rather than from direct questioning in an interview. This was probably related to their familiarity with me and to my association with the SHIP. Even here though, PEs seemed reluctant to talk about specific examples of *unsuccessful* condom use, but were quite happy to recount stories of successful negotiations. However, other sex workers were generally reluctant to talk about the specific details of their sexual encounters at all. This was probably a reflection of the fact that my time in Sonagachi was limited, it was a much larger area than Sett Bagan and, therefore, opportunities to build close or trusting relationships were also limited. For this reason, I enlisted the help of the PEs, who spent a few days trying to obtain such narratives from girls they met in the field. Interestingly, even they found it difficult to obtain the kind of contextual detail that I wanted. Sex workers were suspicious of their intentions and considered it bad luck to talk in such detail about their business. The timing of this particular part of my research was also unfortunate. Shortly beforehand, there had been a controversy over an NGO who was conducting research on prostitution and who had gone about it in a rather unethical way. Some sex workers had shared their concerns with the PEs and the SHIP/DMSC had taken the decision to recommend to sex workers not to co-operate with the research. Then when a few days later the PEs themselves turned up requesting highly personal information for a foreign woman's research, some sex workers' understandably pointed out the contradiction:

> Weren't you the people who taught us not to tell about our private details to other people? That was only a few days ago and now you yourselves are asking us all these details! Why should we say these? (PEs' reports of sex workers' queries to them).

The PEs' own accounts however and those that we did manage to obtain from other sex workers proved invaluable in providing the required insights to develop a more complete understanding of the influences on safer sex practices and of their meanings for the women involved. I analysed sex workers' narratives in two ways. Firstly, by examining the micro-level processes, factors and strategies involved in negotiating safer sex during the immediate sexual encounter with casual customers, regulars or *babus*. Secondly, by situating these sexual encounters within the broader social organisation of the sex trade, and by exploring the

ways in which the overall macro-level structure of the sex industry shaped and constrained women's ability to negotiate and practise safer sex.

At the time of my fieldwork (1995-97), condom use among sex workers was primarily assessed by the SHIP by means of a periodic quantitative survey. Usage was measured in two ways; by a question giving 'always', 'often' or 'never' answer options, and by asking about usage during the previous day's sexual encounters with customers (considered to be more accurate). In 1992, the combined results for the 'always' and 'often' answer categories yielded a total of 2.7% of sex workers saying they 'sometimes' used condoms (the other form of measurement was not undertaken in this survey). By 1993, only a year after the project had started, the average condom use during the previous day's sexual acts was reportedly 71.4%, a clearly impressive result. However, since then, this has only increased slightly to 78.5% in 1998.

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Clearly, some behaviour change *has* occurred, though if the survey results are to be believed, the most dramatic change, somewhat surprisingly, came in the first year of the project. As noted in chapter seven, though the SHIP survey results appear impressive, one should, nonetheless, be cautious about drawing conclusions from them that link behaviour change directly to its intervention activities. The surveys only asked about condom use on the previous day and made no attempts to explore the circumstances under which it occurred. By the time of my fieldwork many sex workers I spoke to however noted that practising safer sex was becoming much easier and also more common because customers themselves were now bringing and requesting condoms. Lila, a PE explained:

> Now, two out of three customers *want* to use condoms. Many men themselves ask for Nirodh – nowadays they have understood. There is no need any more to make them understand, they themselves ask for it.

It is impossible to know to what extent the SHIP's activities have influenced customers' behaviour through increasing sex workers' insistence on safer sex and to what extent customers may themselves have been changing behaviour or attitudes due to other AIDS campaigns and heightened public concern since 1992. The SHIP evaluations and other studies in the HIV TI field have generally not explored how and by whom condom use is initiated though such a study may yield some useful insights into this issue (cf. Plumridge et al 1997).

During field outreach PEs made a note of sex workers' condom use on the previous day, and this information was again elicited from women attending the SHIP clinics. The latter two

data sources however, have, to my knowledge, never been systematically analysed. Though an 'average' condom use figure is an extremely useful general indicator of behaviour change, it cannot (and is not expected to) capture the dynamics and variations of condom use among different types of sex workers in different sexual encounters. On one of the days I spent observing in the Sonagachi clinic, I analysed the condom use data collected from 17 sex workers who were treated for various ailments. They reported a total of 77 sexual acts of which only 32 were said to be protected, yielding a protection rate of only 41.5%, considerably less than the evaluation. Clearly no conclusions can be drawn from this snap-shot, non-random, biased statistic[2], but it does indicate that it might be worth exploring ways to triangulate measurement of condom use, and that survey results cannot necessarily be taken at face value. Also of interest in the data I obtained that day was the wide variation in reported condom use. The 41.5% statistic consisted both of sex workers who said they had used condoms with everyone, and those who said they had used them with no-one. As part of my research I also analysed the condom use statistics obtained by my husband at the MS clinic in Sett Bagan from January to July 1996. During that time 148 sex workers presented for treatment (but only 38.5% of them with ailments that may have indicated some STD or reproductive tract problem). Of these women only 118 had had customers the previous day. Of these 118, the overall protection rate was 72%, a figure that matches more closely with the 1995 evaluation results. However, again, this figure comprised 16 women who said they had not used condoms at all, 16 who reported having used them less than 50% and 65 who reported having used them 100% of the time. Again, no conclusions as such can be drawn from these data except that they back up my impressions during field work that condom use was still highly variable in Sett Bagan and Sonagachi and that some women remained extremely vulnerable to HIV/STDs.

Since 1993, the average percentage of reported condom use in the previous day's sexual encounters has remained in the seventy to eighty percent range[3]. In this chapter, I explore the possible reasons for why it may be difficult to increase this figure further and also explore some of the possible reasons for variation in condom use by examining the dynamics, context and performance of sexual encounters.

[2] Those less likely to be using condoms are more likely to experience symptoms requiring medical attention.

Safer Sex Negotiation and the Immediate Sexual Encounter

Risk, Trust and Safer Sex

Research in other sex trade settings has indicated that perceptions of risk and the practise of safer sex are closely related to the nature of relationships sex workers form with customers and other men. As a rule, though there are always exceptions, it seems that the closer and more meaningful the relationship becomes, the more difficult it is for women to negotiate safer sex (Hart 1996, Lewis-Renuad 1997, Day 1988). I discuss this issue here with reference to casual customers, regulars and *babus*.

The previous chapter showed that many sex workers did seem to have internalised the notion that they might be at risk of contracting AIDS or other STDs. Exploring this issue further, I found that this sense of risk was mostly identified with their casual customers, with whom many women said that they tried to use condoms (whether or not they ultimately succeeded – an issue which is discussed further below):

> What sort of person do you think is most likely to have AIDS?
> That we can't understand *didi* – we can't tell from looking at someone from the outside who might have AIDS or not – this disease can't be seen from the outside. This is why we now use condoms with everyone. I tell all my girls to use condoms and some have such fear they use double (Sonagachi madam).
>
> How do you know if someone has AIDS?
> Just by looking you don't know – of course there are some who take *ganga* (marijuana), they are dirty and you worry that they may have a disease – but even then there are people who may be white on the outside but black on the inside (Sonagachi *adhia*).
>
> Who is most likely to have AIDS?
> We have no idea –we haven't seen AIDS here, we don't know what is inside us – those men who come who are very drunk or who are very dirty, these very thin bad looking men, these we try to avoid, but how can we say who might have AIDS? This is why we use condoms (Sonagachi *adhia*).

With regular customers however, women were more ambivalent. Within some of these relationships there was an explicit or implicit expectation of trust. Some customers expected women to believe that they were the only sex workers they visited and that they were somehow special. Such customers would also on occasion help the sex worker financially or in practical ways. Some women I spoke with appeared to trust their regulars and didn't see the need for condom use in these relationships:

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[3] In the latest survey (1998) 'C' category sex workers reported 83% of protected sex acts the previous day. The figure for 'B' category sex workers was 72% and 75% for 'A' category women, yielding an average of 78%.

> I use with all these men from the street, but with my fixed customers – that trust has to be there no? I know these two only come to me – they have been coming for years (Sett Bagan sex worker)

Others however were more uncertain about these customers' trustworthiness. They noted though how it was extremely difficult to broach the subject of condom use with these regulars, and that the men tended to become offended at the implied lack of trust, and might threaten to go elsewhere. Women were reluctant to openly challenge them as they did not want to lose this regular source of income (and also a back up source of emergency help):

> My regular customers say that we have been to you alone for so long we haven't got any disease, we don't go anywhere else – these are the fixed men. Actually, we know from experience that men cannot be trusted. With new customers I fight and tell them you go all over places, but I feel why should I break the faith of my old customers? You need to keep some men in your hand (Sonagachi sex worker).

In Jaya's case (who I introduced in chapter six), she had actually managed to persuade most of her regulars to use condoms, but was unable to do so with one 'special' man upon whom she relied for help:

> *Boudi*, you know I have one daughter who has all these (health) problems. I am trying to make her study so that in future she can give tuitions and in this way make a living. I have one customer who has been coming to me for years but he won't use condoms. What can I do *boudi*? My other regular customers I have convinced but they still come to me because of my good behaviour. Recently I told him all about my daughter and he must have felt '*maya*' (pity) for me because he said OK, what you must do is find some land and build a small house where your daughter can live safely. I said how can I buy land? I only just now have enough to eat *dal* and *bhaat*. He said don't you worry, you find some land and I will see to it. In my sister's *desh* is some land and I fixed up to buy 2 *kattahs* – it is all in my name and he gave me money for this. Then when I talked to him about condoms his face went all sad and he hung his head like this. If I insist I will lose this man – he won't come any more. So what could I do?

With *babus* the issue of safer sex was even more thorny. I found that only very few sex workers ever used condoms with their *babus*[4]. However, from what women told me, it seemed that a significant proportion of sex workers' *babus* engaged in multi-partner sex, not only with wives who they may have had at home, but also with other sex workers. A number of PEs who I knew very well and who said that they used condoms with 100% of customers, continued to get infected with various STDs. They themselves attributed these infections to their *babus*. Rekha for example repeatedly tested positive to syphilis and complained to me one day:

> He keeps giving me this disease. He goes to all these women in Sonagachi and then I fight with him, but he just says what are you bothered about? Don't I give you everything you want?

[4] Similar findings regarding condom use in personal relationships have been reported in studies with sex workers all over the world (Campbell 1993, Waddell 1996, Day 1990, Morgan-Thomas 1990, Albert et al 1995, Berer 1993).

As reported in other studies in other parts of the world therefore, in situations where sex workers practise safer sex with all or most of their clients, their personal relationships may pose a greater risk to their health than their commercial encounters. During discussions with SHIP staff and sex workers on this subject however, both felt that it would be almost impossible for women to use condoms with their *babus*. Indeed, safer sex with *babus* was not explicitly covered by the flip chart. The SHIP does however encourage *babus* to attend project functions and, if present during fieldwork, supervisors usually try and talk with them about AIDS. In time some *babus* have become supportive of the SHIP and in 1999 a *babu* support group was formed which employs 30 *babus* (of PEs) as peer educators, specifically to work with men.

Rekha's example above indicates that some women were quite aware of the potential risk posed to them by their *babus*. In many of these cases however, women indicated that a *babu's* role in meeting social, practical, financial and emotional needs (see chapter five) took precedence over safer sex. Women relied upon *babus* and were reluctant to jeopardise their relationships by making a fuss about condom use:

> My *ghor-er lok* (man of the house) will never use condoms, even if it causes AIDS and death. Just last month my blood test was bad and it is because of him. He tells me a man can't eat dal and rice every day – some variety is required. What to do? I am getting old and hardly have customers these days. If this man goes who will be there to look out for me? Everyone needs an umbrella over their head. Can a girl survive alone in a place like this? (Sett Bagan sex worker)

In some cases, the PEs I knew had given up sex work and were financially dependent upon their *babus*. Shanta explained her situation like this:

> If I stop giving him 'that' today, then tomorrow he will stop all my expenses and where will I go? Going back to the line I would have to do the same thing. Better I do it just with one. *Babus* using condoms? No never!

Sex workers reported that, like regular customers, *babus* might draw upon a discourse of trust to resist requests for condom use:

> He tells me, what, suddenly you are talking about condoms. Now do you not trust me? Why are you so suddenly so suspicious? (Sett Bagan peer educator)

Other women however indicated that for them too, trust was a very important part of their relationship with their *babus* and that they did not see the need to use condoms with their *babus*:

> I have been with this man all these years. That feeling of trust should be there no?

Others again were more ambivalent. Malini for example, a sex worker in Sett Bagan expressed the view that as a 'wife', it was her duty to conform to her *babu's* sexual wishes and that this was a strategy for trying to ensure monogamy within the relationship:

> See, *babus* are like husbands. We have to do 'work' when they want it. I can't say no to my *babu* if he won't use condoms because then there will be trouble...No, even when you don't want to, you have to make yourself because otherwise he might go his way and leave me to go my way, or maybe he will go to other women.

For some of my informants non-condom use had come to represent a means of expressing intimacy and distinguishing between commercial and non-commercial relationships:

> See, with other men I am doing business, trading, but that one in my room who I love - with him I want to have fun (*maasti*) – why should I use a condom? (Sonagachi peer educator)
>
> If I talk about condoms with my *babu* – he says, oh, so now you are treating me like a customer? (Sett Bagan peer educator)

In the case of *babus* therefore, a variety of discourses associated with trust, intimacy and normative conjugal behaviour, combined with women's very practical concerns to retain the material and social benefits and protection a *babu* could confer, worked against the possibility (or even 'thinkability') of safer sex within these relationships. However, some spirited PEs I knew did occasionally manage to negotiate a compromise. Shobha, a PE from Sonagachi for example, said that she tried where possible to persuade her *babu* to use condoms as she knew he frequently went elsewhere. She told her *babu* that this was for family planning purposes and that if he did not use condoms, she would be unable to enjoy herself as she would be having to exert such mental and physical control to prevent a conception! Kamala, a PE from Sett Bagan told me about a time when she refused sex altogether to her errant *babu*:

> He has got pus coming out of there. I made him come to the clinic. I know it is not from me because I don't do customers any more and I have had my blood tested and it was OK – so it must be from him. He is of the driver *jat* and I know they go places when they are out. I told him to use a condom but he wouldn't so I said OK, I won't sit with you at all.

These examples show that even in sex workers' supposedly non-commercial relationships, sex was implicitly or explicitly conceived of as "a resource with symbolic and material value" (de Zalduondo & Bernard 1995:157). The meanings that sex took on in their relationships and the ways in which sex was linked into other discourses of gender/conjugal roles and contractual relations (e.g. sex in exchange for protection) therefore circumscribed sex workers' understandings and actions around safer sex in this domain.

Customers' Attitudes to Risk of AIDS/STDS

As noted in the previous chapter, prior to AIDS, some men associated condom use with prevention of STDs but the majority perhaps did not (Mane & Maitra 1992). Sex workers said that they had initially faced considerable resistance to condom use from customers. By the time of my fieldwork however, as mentioned above, sex workers were reporting a significant shift in customers' attitudes. The reasons why this may have occurred are unclear. The few customers I spoke with knew about AIDS but felt that it was not yet a problem in Calcutta. Some said it was a foreign disease and speculated that it might be greater among the Nepali sex workers. Another, who admitted to not using condoms with his regular 'A' category sex worker, refused to discuss the issue further but simply said that he knew how to look after himself.

Sex workers themselves noted that (in addition to regulars) it was mainly their poor and uneducated customers who remained resistant to condom use. These men are often migrant workers from neighbouring states and live difficult, socially marginalised lives in Calcutta. One might speculate that their poverty and social dislocation contributes to a 'here and now' philosophy, where precious (and rare) leisure time is conceived to provide fun, not to be dampened by thoughts of disease or the hassle of donning a condom (cf. Maticka-Tyndale et al 1997, Campbell 1997):

> It is these *tela-wallahs*, *mutia-wallahs* and *rickshaw-wallahs* who won't use. I explain and explain until my head breaks. All these Hindustani types – they come here drunk and they won't use condoms – they say, 'we won't have fun'. These kind of customers we don't like (Sett Bagan sex worker)

Those men who were still resistant to condom use drew upon a variety of rationales to try and justify unsafe sex. Similar rationales have been given by men all over the world (Berer 1993, Leonard 1990, Perotta 1992, Kinnell 1989, Hart 1994, Bond et al 1996, Maticka-Tyndale et al 1997, MacQueen et al 1997). The most common examples of these reported by sex workers in Calcutta, were as follows:

- We don't get fun.
- If I have to use condoms, I might as well do the work with my wife.
- You don't get the same 'taste' with condoms.
- It takes too long.
- I have never used one before.
- I am clean, I have no disease.
- I go only to you.
- The thing (semen) won't 'fall' if I use a cap (condom).

Thus, some customers represented condom use as interfering with sexual pleasure, while others represented themselves as 'clean', thereby claiming not to pose any risk for the sex worker.

Negotiating Power and Safer Sex in the Customer-Sex Worker Relationship

This section examines the strategies sex workers employed to negotiate with their customers. Here I am primarily restricting my analysis to examples where a sex worker expressed an initial intention or desire to use condoms and where a customer was resistant. Cases where both sex workers and customers agree on safer sex or where both are not interested are also important to document but shed less analytical light upon the interactions that must take place and the issues that must be resolved during processes of behaviour change. Successful negotiation in the face of resistance can be conceptualised as success in exerting control and, therefore, power over the commercial encounter (Hart 1996). Unsuccessful negotiation usually ended in one of two ways; either by the sex worker refusing to have sex with the particular customer (i.e. breaking the contract but still retaining control over the situation albeit at a personal financial loss), or by having unsafe sex and hence giving up a measure of control.

For the vast majority of sex workers I spoke to, safe sex equalled condom use. Though most sex workers would agree to providing 'alternative' sexual services if the price was right, there seemed to be a general disdain for any sexual practice other than peno-vaginal intercourse. I sometimes asked why they did not try to eroticise non-penetrative forms of sex but was consistently told that men would never agree to this, and also that they themselves found vaginal penetrative intercourse to be quickest and easiest, physically and emotionally:

> See, when a man comes he has paid for 'that' – he will not agree to anything less. Anyway, like this [vaginal intercourse] we don't even have to see 'it' and it is finished quickly. All this feeling and holding or doing it here and there makes us feel disgusted (Sonagachi *adhia*).

Sex workers have always had a range of strategies in which they attempt to exert some control over their relationships with customers - for example, in order to protect their health (by checking the customer as described in the previous chapter), to avoid being cheated or to build up their business. These strategies have also been effectively adapted to negotiate safer sex.

One such strategy concerns the mechanism of payment. Almost all sex workers said that they tried where possible to obtain the customer's money up front before he entered their room. In this way they felt they had "some power in our hands". They rationalised that having already paid, customers would be more likely to comply with safe sex demands, and if a customer refused, many sex workers would retain at least half of the fee (for time already spent) and ask the customer to leave. Thus loss of a customer because of non-condom use was not a complete financial loss for the sex worker concerned, making it easier for her also to insist upon safer sex. This strategy was almost always followed with 'new' customers whose trustworthiness could not be predicted, and similar strategies have been reported from studies in the UK that show that taking advance payment is an important handle with which to influence customers (McKeganey et al 1990). An exception to this general rule however sometimes occurred in the more exclusive 'A' category houses where payment was given after the sexual act:

> See, these girls on the road, they take the money first – some steal and cheat but here the environment is different, here there is a high class environment (*bhodro poribesh*). Here a customer is brought [by a pimp], the price is fixed and you go to the room. After the work is done the customer gives what was agreed and if he likes you he gives a tip. Customers come here for the environment and for the girls' good behaviour (Sonagachi *adhia*).

Where payment is not taken first however, sex workers are in a much weaker position to bargain for safer sex. Onima, a 'C' category Sonagachi *adhia* described an experience of hers the previous day where poor judgement (and perhaps lack of experience in this matter) had led to an incident of unsafe sex:

> Normally I always use condoms. But yesterday a young chap came and said will you go? He looked like a real gentleman, not one of these rowdy types so I was stupid and didn't take the money first. I didn't think he would make trouble. We both took off our clothes and I got out the Nirodh and he refused to use it. As I didn't have the money I couldn't throw him out so I just checked him and sat him without.

Payment was not always as clear cut in the case of regular customers. In these cases where, as previously described, there was supposed to be a relationship of trust, sex workers were sometimes reluctant to openly challenge this by demanding payment first. In addition, rates might not be explicitly discussed at all. Sex workers would simply hope or assume that a particular sum would be given (usually what had been paid on a previous occasion). If they were lucky, the customer might give more but they would also accept less, hoping that the customer would pay more another time when he had more money. Smaller fees were also accepted because regular customers sometimes gave generous presents or helped out in times of acute financial need. Because they came regularly, an occasional discount rate was seen as acceptable.

A study among female street sex workers in England (McKeganey et al 1990) noted that sex workers' assertive managerial stance towards their customers at the time of negotiation helped them to take control of the encounter. Interestingly, in Calcutta, though negotiations on the street were relatively explicit about price, some sex workers described how they deliberately avoided any discussions about safer sex or sometimes even about the kind of sexual services that were to be provided:

> Basically I say yes to whatever the customer says at the gate – what to do? Otherwise I wouldn't get anyone. Then once they are in my room I try and explain and I refuse to do dirty things like sucking or from behind – if they don't like it I tell them to get out – don't you have any shame I say – do your wife and daughters know what you are doing? One man had given me Rs.250 – he wanted to do it without a condom but I drove him out – he wanted the money back but I said no way. (Sett Bagan sex worker)

Because of sex workers' practice of retaining half the fees even if a customer leaves without having sex, avoidance of open discussion until they are both in the room and she has the money is one way of trying to establish control over the situation.

Another strategy centred on the sex workers' 'behaviour' (*byabohar*) with the customer and was also related to their general business strategies. Some sex workers went to great efforts to 'behave' well with their customers – to appear honest, sweet, submissive and to be responsive to the customer's needs in order to try and build up a relationship of trust. These women rationalised that this strategy would ensure that the customer would return time and again and would become a 'regular', maybe even bringing friends. They also rationalised that establishing a good relationship with the customer facilitated open communication on issues such as condom use and would perhaps help to ensure greater respect for the sex workers' explanations and wishes. Rebha, a Sett Bagan PE recounted how she had recently successfully negotiated with a customer:

> I fixed up with him for Rs.50 and brought him to the room. There he refused to use condoms. I did not get angry. I sat calmly on the bed with him. Told him to have some water. Spoke to him about the new disease that has come. I explained that condoms are to keep everyone well. He has a wife at home? Yes. Then it is his duty to protect her and his children. What will happen if she gets a disease? Then everyone will start bad mouthing her even though she is not at fault. Better to use a condom and have no worries. Like this I calmly explained – I didn't shout or use bad bad words. He was impressed and said you have spoken very well. OK I will use this Nirodh.

Such sex workers were extremely disparaging about other sex workers who tended to treat customers with disrespect and who tried to cheat them or extort money from them. The latter were often reported to steal or would refuse to have sex at all and simply throw the customer out, or demand more money than was initially agreed upon once the customer was alone with

them in the room. These sex workers operated on a system of short term gain and were keen to extract as much as possible from present customers, rather than build up a good reputation for themselves or establish a regular clientele who could be relied upon in the future to help withstand some of the vagaries of the market. The PEs explained that such sex workers were more likely to have problems with ensuring condom use:

> Some don't bother to take time and explain – they just lift their skirt and say do it, do it quickly – they won't even open their dress. This is not the way to behave. A man has paid for something – he should get it. Also, if the girls don't give time and don't make the man's heat come, she will not be able to convince him – if she touches him and strokes him it will stand and then he will have no sense. You have to give time – you can't just say here use a condom – he will get angry – you have to speak nicely, explain properly – you have to make him understand, then he will use. (Sonagachi peer educator)

In addition to these general business strategies, which, PEs informed me, were usually learned through experience, sex workers described a number of more directly persuasive strategies that they employed with reluctant customers to try and convince them to use condoms. One of the most effective appeared to be engaging the customer in an explicit discussion about AIDS and line diseases in which, as above, they tried to get the customer to feel a personal sense of risk and responsibility, and in which they were clearly drawing upon their understandings of the SHIP's health education messages. Malati, a sex worker from Sett Bagan told me her experience with a customer the previous day:

> I fixed up the price and took him to the room. I took the money from him. The moment I showed him the condom he did not want to use it. I gave him half the money back and told him to go but he said no, he wanted to do it with me. I tried to explain – I said see, I am in the Line and lots of men come to me – I might have a disease. I asked him if he was married and he said yes, his wife was in the *desh*. Then I said so why are you coming to the Line like this? And when you come you won't use anything so that you won't get a disease? So I explained – I told him that after he's been with me, one day he'll go back to the *desh* and that day he won't use condoms with his wife and whatever diseases he got from me, he'll go and give to her – is that fair? So I told him, not only with me but with any girl, you must use a condom. Then he said, yes, you have said the correct thing so I will use.

Anjali, also sex worker in Sett Bagan recounted a similar but less successful experience she had had with a customer:

> This customer, I fixed him up for Rs.30 in the garden. He didn't say anything – we don't say outside because the customer might leave then and there. In the room this man said I won't use, I won't get any pleasure so I started explaining. I explained for half an hour – I showed him the books, I told him a dangerous disease has come and its not just AIDS, there are other diseases too like syphilis and TB. You tell me I don't have a disease but how do I know? Those with diseases say the same thing so how can I trust you? This customer went off and I let him go because I had already had two customers that day so at least I had some money, but tell me *didi*, can I refuse a customer if he is the first? I will have to think will other men come? And if not, how will I eat on this day?

Anjali referred to showing the customer 'books'. By this she meant small printed leaflets that were distributed by the SHIP that PEs gave to customers during their rounds, and that many

sex workers also requested to help them convince customers of the truth of what they were saying. Having some kind of official concrete evidence to draw upon appeared to be an important way of influencing customers, though in Anjali's case it was unsuccessful. Rita, a Sonagachi *adhia*, told me that:

> Now I use condoms with everyone. I show them all these leaflets we have and if they don't listen then I tell them to go.

It is difficult to assess the different ways in which the SHIP may have influenced women's negotiation strategies; however Kamala, a PE, described how her own interactions with the project had helped her by helping her to know what to talk about:

> Before when customers used to come they would get angry if we talked about condoms – even now they say why should we use? But I just tell them, wear it and see, why do you want to buy this disease by paying money? Before I couldn't talk about it – I didn't know anything. Now since working with this project I can discuss with the customer.

Other forms of persuasion described by sex workers included trying to eroticise condom use. Mina, an experienced PE from Sonagachi explained her perspective on this:

> What I tell the girls is this - you must be nice to them and you must run your hand over their head and be gentle. Call them terms of endearment and explain to them why they should use a condom and that you want them to use a condom. Also you must get them to a state (of arousal) where they will definitely use a condom. At that point he only wants to discharge, he can't think of anything else. The *sala*, (term of abuse), once he's come into my room won't leave until he's used a condom. Arouse him to a point where he can't do anything and then he won't go, he'll have to use a condom. One customer came to me and was making trouble over condoms, I told him that, listen, now that we know all these diseases might be there, if you wear a condom both you and I are free from fear, there are no mental obstacles so I can also enjoy freely – if you do not wear a condom there will be fear in my heart and I cannot enjoy – eventually he agreed.

Other sex workers said that they just kept at it and tried to instil a condom use 'habit' into their customers:

> Some customers say it won't rise with a condom, so I say just put your mind to it – it is all a matter of the mind and then I put it on and after a few times like this they get used to it – it becomes a habit (Sett Bagan sex worker).

To some extent, women's personal characteristics and ability to be assertive with clients also played a part in their ability to negotiate safer sex. As previously noted, PEs said that becoming street wise was largely learned from experience and this appears to be backed up by SHIP survey results (AIIHPH 1995, 1998). For example, in the 1995 evaluation, reported condom use with customers in the previous day was 48% among those who had been in the sex trade for less than 2 months, 56% at 3 months and 63% at 6 months. In 1998, the figures

were 19%, 32% and 56% respectively. The SHIP claims that its empathic approach and counselling work with sex workers has helped not just to teach women about AIDS and negotiate condom use, but has also helped to build up women's self esteem so that they are more interested in taking care of themselves and feel that they deserve respect from their clients (AIIHPH 1997). These kind of changes are extremely difficult to assess. Certainly, I observed SHIP supervisors on a number of occasions challenging sex workers' negative self-perceptions, trying to convince them that they were not 'bad' but were just doing a job. They spent considerable time with women listening to their problems and offering advice. This seemed to be appreciated but it is impossible to say to what extent such counselling translated into increased self-esteem and resultant behaviour change (especially within just one year of the project). However, assertiveness and good judgement was, on occasion, crucial for dealing with difficult clients. For example, the ability to turn a client away in spite of protest required a measure of confidence in being able to deal with the situation. Kabita, a sex worker in Sett Bagan recounted how she had recently dealt with an uncooperative customer:

> I fixed a price with him and then I brought him to the room and told him to wear a cap, but he refused to wear a cap - he said taking money and putting on plastic you're going to make me do work? I explained to him and told him that he must use a condom and he agreed so I went to take off my clothes and when I came back I saw that he had ripped and torn the condom off. I looked at his *lingo* (penis) and I saw that the condom was present at the root but at the front there was no condom so I held it and I realised that he had torn it off. Then I told him again to wear a condom and he refused - then he started shouting and I also started shouting - he would not listen so I just pushed him out of the room – but I kept the money.

Kali, another Sett Bagan sex worker I knew however, was far less assertive in her relationships. She claimed she tried to use condoms but generally acquiesced to the customers' wishes:

> Yesterday a Hindustani *pandit* came and I had him in the room and we opened our clothes and touched. I said use a condom but he said what's this? I won't use this, so I had to sit him – what to do? If I don't, it's a loss for me.

Financial considerations as mentioned by Kali are clearly important (and will be discussed in more detail below); however, as my material shows, some sex workers like Kabita had developed ways of handling such a situation so that a customer's resistance did not always mean a financial loss.

Skills like this are particularly important for handling potentially violent situations. Indeed, I found that fear of violence was a powerful factor that influenced how far a sex worker would go in pushing safer sex. Some, especially the older and more experienced women, were sometimes able to handle a potentially violent situation, for example (like Kabita), by getting

aggressive themselves and thus taking control of the situation, but all sex workers I knew reported being victims of violent attacks. Two Sett Bagan PEs, Malati and Podda (respectively), described to me recent potentially violent situations that they had encountered in their work:

> One man came and said will you go. We fixed a price for Rs.35 and I took him to my room. It was late in the night and he was quite drunk. I don't normally take customers like this but no-one else had come the whole evening. I opened my dress and took out a cap. When he saw it he became very angry and started shouting. He said that he had paid for sex and that was what he wanted – without a condom. I tried to explain softly to him and make him understand but he just kept shouting – said a lot of bad things. I began to feel scared that he would hit me. Then I got angry and I said to him you son of a whore, you go to all these places and get diseases and now you want to sit without a condom? I said listen, you can go or you can sit properly and if you try to touch me I will chop you into little pieces. Listening to this, he said "to which 'Kali' have I come tonight?" and, using Nirodh, he sat and left.

> Some days before a customer came – one of these Hindustani types – they are bad people. In the room he wanted to drink so I got *masi* to get some *madh* (liquor) and he had a bottle. Then he was ready to sit and I got out the cap. He said to me I have never used one of these and I will not use. Many customers say this so I started to explain but then I saw he had put a razor blade into his mouth – I saw it glinting in the corner of his cheek. I said nothing more, just lay there and let him finish the work. Like this, our lives are in God's hands.

The examples above show how some sex workers have developed a range of negotiation skills with which they attempt to exert control within their relationships with customers with varying degrees of success. These strategies are only one part of the story however and the next section illustrates the ways in which sex workers' strategies are shaped and constrained by their position in, and the social organisation of, of the Calcutta sex industry.

Safer Sex and the Social Organisation of the Sex Industry

Though women's individual negotiation strategies were important, at the time of my research the most significant and obvious structural and contextual dimensions that affected safer sex practices were sex workers' occupational position within the sex trade structure (for example, whether working independently, being on contract, working as a flyer, or working under madams with or without pimps as an *adhia* or *chukri*); their socio-economic position and security (categorised by the SHIP in terms of A, B, or C grade sex workers); and, their relationships with third parties (e.g. *para cheles*). None of these dimensions operated in isolation. Rather, women's past and present, personal and occupational circumstances (including their negotiation skills and strategies) combined to create specific but dynamic situations that shaped the practice of safer sex. For this reason it would be misleading to make definitive generalisations about the differential impacts of the three dimensions listed above. Nonetheless I suggest that some general trends can be observed whether or not they

ultimately affect safer sex practice in a specific case. These general trends are described below.

Position in the Sex Trade Occupational Structure

The biggest distinction sex workers themselves made with regard to possibilities for safer sex concerned the extent to which a madam or pimp was able to influence a sex worker's practice. In situations, as in Sonagachi, where the majority of sex workers work under madams or pimps, negotiation of the sexual encounter is handled directly or indirectly by up to four persons (sex worker, madam, pimp, customer). The relationships between these persons has an important influence on safer sex.

Madams

PEs and SHIP project supervisors described how their biggest challenge in fieldwork lay in convincing the madams to allow them access to sex workers and to support safer sex. They did this through regular meetings with madams, usually conducted by the 'higher status' supervisors and through intensive 'trouble shooting' (where groups of supervisors would pay a visit to a particular madam) if they came to hear about specific situations in which a madam was being un-supportive of safer sex. In late 1996 the attitude of madams was still said to pose a problem in some field areas, though many were said to have now accepted the need for condom use. Indeed, some of the madams I met appeared openly supportive of safer sex and said that they instructed their girls to use condoms:

> I tell both my girls to use. OK, so I might lose a bit of money today, but if they get sick tomorrow, how much will I have to put behind them for doctors expenses (Sonagachi madam).
>
> This disease can't be seen from the outside. This is why we use condoms with everyone now. I tell both my girls to use (Sonagachi madam).
>
> Yes, these *didis* have come and told us about this new disease. Now I send my girls to the project clinic if they are sick and they all use condoms (Sonagachi madam).

An *adhia* of such a supportive madam recounted to me one occasion where her madams' help had been instrumental in negotiating with the customer:

> One customer came and said he will not use Nirodh. I explained and explained but he would not use and then he asked me to do sucking – I lost my temper – I thought if I have to do sucking then I will tear it up off with my teeth! I made an excuse saying I wanted to go to the bathroom and I just sat there. When the time was up I came back and said I was going – he was angry and screamed at my *malkin* - what kind of girl have you given me – she doesn't know how to behave. But *masi* said that I told you that if you want to sit with girls here you have to use a cap and she sent him off.

Other madams were not as supportive however. PEs explained that madams' main interest was business and with a ready supply of girls, pleas to preserve their health for the sake of their long term business prospects were not always convincing[5]. For this reason, even where madams did not appear to openly oppose the project or condom use, they still might not *actively* promote safe sex. During my field visits to Sonagachi I met approximately six sex workers who were either new to the trade or to the area and who had not yet had any contact with the SHIP. Interestingly, none of them had heard about AIDS, none were using condoms and none had received any information about safer sex from their madams. This implies that for an intervention such as the SHIP to be sustainable, some kind of on-going external HIV awareness effort may be necessary, as safe sex information may not necessarily be passed on internally, at least initially, within the context of a madam-controlled sex trade even after many years of intervention activity.

There are various ways in which a madam may influence the practise of safer sex, and their influence appears to be particularly strong upon the 'A' category girls (especially the *Agrawali* girls), the Nepali girls and upon those sex workers who are heavily indebted to them. PEs explained that even where madams were ostensibly supportive of condom use, they would rarely push the issue:

> See, this you have to understand - the *malkins'* interest is profit so they advise the girls – if the customer does not want, don't insist - why make trouble? (Sonagachi peer educator)

PEs also pointed out that negotiating safer sex with customers takes time. In addition, sex with a condom sometimes takes longer. In the sex trade, any time at all spent with a customer is time that must be accounted for. Thus a major problem faced by some *adhias* was that their madams would not allow them the extra time to use condoms with their customers, and if practising safer sex took extra time, the sex workers themselves would be made to pay for it. Pinky, a PE who was also a madam of a 'C' category girl explained it like this:

> Many girls are *adhias*. Now if you have to convince a customer and make him wear a condom it takes time. Now I am the *malkin* and I have a girl in my room. If the girl takes time to convince the customer I will understand that since I am doing this job. But these *malkins* and girls whom we have taught don't remember so much. When we are around they remember but when we come away they forget easily. When the girl takes the time the *malkin* says what were you doing in the room for such a long time? You must have sat twice. You have kept the money of one sitting for yourself and paid me only for one, so I won't give you the share of your one sitting. Many *malkins* say this and many girls tell us this story. The

[5] If a sex worker becomes seriously ill, a madam may tell her to go home rather than have to support her, and she may replace her in the mean time.

> girls say *didi*, how can we make customers use condoms? If we do it without a condom it only takes 15 minutes but using a condom takes half an hour. The *malkin* will not give us half an hour.

I was initially puzzled at this attitude of madams given that the average number of customers per sex worker per day was only 3-5. I asked Pinky why madams were so concerned about how long an encounter took when most sex workers anyway spent most of the day on the street simply waiting for custom? She replied that:

> *Boudi*, it is not a question of the room being empty. It does not matter if the room is empty for a whole day if one is alone in the room. But even if one customer enters for 2 minutes, the girl has to pay the malkin for those 2 minutes.

In addition, some madams kept anything up to 12 sex workers in a room and some popular rooms were busy all day, so much so that girls with their customers would be queuing up outside waiting for it to become free. In such a context, time spent negotiating safer sex would be time spent blocking that room from other customers.

Another example of madams' indirect influence over their girls' safe sex practices is that of sex workers who were also indebted to their madam. This occurred in situations of bonded labour where a *chukri* had been bought by her madam and the madam was recouping her outlay and trying to maximise profits (particularly common among Nepali girls and *Agrawalis*). It also occurred in situations where a sex worker got into debt by being loaned money by her madam at exorbitant rates of interest. As the debt mounted these sex workers became more or less tied to their madams. A PE explained the potential impact of such debt-bondage situations upon safer sex:

> There is not usually direct pressure from *malkins* not to use condoms – it is like this. If I have a Rs.2,000 loan from my *malkin* and if I cannot even earn Rs.200 per day then I cannot give Rs.100 – from the Rs.100 that is left I have to deduct Rs.40 as boarding charges, then Rs.60 will go towards loan repayment. So naturally this is a kind of pressure which will compel me to allow people to do the job without a condom. But it is not direct pressure. Some girls like that are indebted for Rs. 20,000-30,000. These girls cannot force the *malkin* to do anything. They always have to listen to their *malkin* – do you understand? If any *malkin* says to me, don't make trouble, do it without condoms, I won't listen, I will go to another good *malkin* – there are many after all in Sonagachi – or I can get a room on contract. But those who are in debt cannot speak back to their *malkin* – maybe 25 out of 100 girls are like this (Sonagachi peer educator).

Some sex workers and PEs however also reported instances of direct interference from madams. PEs recounted how some madams were rather disingenuous, appearing compliant when talking with the PEs, but actually making trouble for their girls over condom use. One madam I talked to told me emphatically that she supported all her girls in using condoms, but when she later left the room the sex workers confided that she had actually threatened to throw them out if they made a fuss over condom use. Others had to secretly meet the PEs and

hide stocks of condoms out of their madam's sight. Thus, even where madams were unsupportive, some sex workers still did their best to protect themselves. For example, Thumpa, an 'A' category *adhia* in Sonagachi with a very controlling madam who is openly disapproving of the PEs (sarcastically calling them the *Nirodh-walis*), related her experience to me of the previous day:

> I had five customers yesterday. Three came to the room and I used with all of them. Two of them didn't make any trouble. The other one did not want to use. He said I will not be able to discharge. I was worried my madam might hear him protesting so very quietly I spoke to him and rubbed him and showed that see, just try it and you will definitely discharge. I thought he would make trouble. Usually, if a man is taking too long my madam starts to blame me and says that I have sat twice so if he takes a long time I take the condom off. With this customer I convinced him and he discharged quickly so there was no trouble.....Then in the night I was called to another house in this area and those customers didn't want to use. There were two of them and another girl was there as well. They were quite drunk and we didn't want any trouble so we did it without. I was afraid to go back to my *malkin* without any money.

In the first case Thumpa successfully managed to convince a reluctant customer in spite of the constraints of her situation, but in the latter case, she was influenced by fear of her madam but also (in spite of being together with another sex worker), because she felt less able to exert control in the relationship with these customers because they were drunk. Thus, even in situations where sex workers' lives seem more severely constrained, as with *adhias* with un-supportive madams, the outcome of sexual encounters are nonetheless somewhat unpredictable and, to some extent, contingent upon the dynamics of the moment.

Dalals (Pimps)

Having a good relationship with pimps is crucial for those 'A' grade sex workers and their madams who are dependent upon these men to bring them custom. The relationship is symbiotic to the extent that a pimp's income is dependent upon the sex worker seeing customers, but a pimp does wield some power over the sex worker as he always has the option of taking the customer elsewhere. In the event of a dispute therefore a sex worker usually comes out the loser, especially if pimps resort to the strategy of 'closing' her room or the whole house.

Pimps approach customers on the street and ask them what they are looking for. They will then take the customer to a woman who they know will provide the required service and, if selected, the price is negotiated in front of the pimp who goes off, coming later to collect his cut (if the customer does not like the first choice, he is taken to see other women). In the event of any dispute between the customer and sex worker, the customer may complain to the pimp,

request his mediation, or demand his money back (or, if he has not yet paid, he may refuse to do so). As with madams, the pimp's main interest therefore lies in keeping the customer happy. If a customer does not wish to use condoms and complains to the pimp, it is the pimp's response that has a strong influence on the ultimate outcome depending upon whether he supports the customer or the sex worker.

PEs described how sex workers in *dalal baris* (houses where customers are brought by pimps) may be more constrained in their actions than other sex workers. Shobha, an independent sex worker PE explained that:

> Girls from the *dalal bari* rarely misbehave. If I sit in a room I know that if I behave badly nobody would come to me. The girls there are bound to do all kinds of sex – anal, oral. They rarely can protest or behave badly. For us it is different. If I bring a customer I can make him use a condom or drive him away – I can do that – they cannot do that.

Kumari, another PE elaborated and gave a personal anecdote:

> Yes girls from the road can do anything, they are free. Like me - I didn't have a customer for a few days. I was standing on the road. I was saying I am ready to do anything even sucking but I must get a customer. Now a customer heard that and he came. I took him to our room. He was trying to do something else. I told him why don't you just sit properly? He said aren't you going to do sucking? I said No, why should I? He said you were saying on the road. I said, what I said, I said on the road but I said nothing to you – so now you do what you do at the price I've said and go. Now had there been a *dalal* then he would have forced me to do sucking.

Again, the PEs and supervisors informed me that pimps were initially very reluctant to support condom use as they were concerned about its impact on their business but suggested that a significant shift in attitude had since taken place so that they now much more likely to be supportive of safer sex. A great deal of advocacy and trouble shooting work with groups of pimps and their leaders, the *mukhias*, has been conducted by project staff and they appear to have established good relations with these men. In fact, during my research, the supervisors reported that the pimps were now beginning to approach the project for help with various problems (particularly police raids), and were said to be demanding changes to the structure of their own *panchayat* to make it more democratic. The supervisors attributed this to the positive spin off from their meetings in which a wide range of topics were discussed, including sex workers' rights.

I met with groups of pimps a number of times but our conversations tended to remain rather superficial, as would be expected given my status as an outsider in Sonagachi. During these meetings pimps gave the impression that they knew all about AIDS but (similar to customers) asserted that it was not a problem in Calcutta:

> Yes we know all about AIDS – these *didis* come and sit with us and show us the book. Before we didn't about AIDS – other diseases we knew like syphilis and gonorrhoea but not this AIDS – this is new.
>
> There is no AIDS here, it is not a big problem – no, we are not afraid of this disease.

It is difficult to assess though to what extent their statements represented their actual views or just what they thought I should hear. Likewise, the pimps I spoke with all said that nowadays they supported condom use and would tell customers (and even each other) to use condoms:

> Yes we do tell customers, we tell them to use condoms and you will be safe.
>
> Now we tell customers that you must use condoms, we tell them the girls won't sit without condoms – sometimes the customer comes and complains to us but we say that you never said that you wanted to sit without condoms – you should use them for your own health. Now we even tell people in our own committee to use condoms.

Assuming that there has been at least some shift in attitude, the PEs offered an interesting explanation for this which illustrates how inter-linked processes of behaviour change may be:

> Suppose a *dalal* brings a customer and there's trouble over condoms. The same dalal may have brought five men, four who use condoms and one who doesn't want to and makes trouble. Then what happens is that he has to go and try and find someone else to sit without a condom, or what often happens is by that time the man has lost interest and he will just say I'm going - in that case the dalal loses his entire commission – obviously he does not want this (Sonagachi peer educator in a group discussion).

What I think this peer educator and others who agreed with her were trying to say is that condom use was becoming the norm - a general culture of condom use was developing, so that the majority of men now did *not* cause trouble (rather than the other way round). The PEs noted that it was becoming increasingly difficult to find girls who will not use condoms in which case, it starts to become in the *dalals'* personal financial interest (rather than out of any particular concern for a sex workers' health) to persuade the man to use condoms too, so that there is no trouble and so that he gets his commission. Nonetheless, as indicated by the PEs' other comments above on how sex workers' were still being pressured to practise unsafe sex, evidence of this attitude shift is somewhat contradictory. In addition, as described below, my material seems to indicate that 'A' category girls (who mainly rely on pimps) were in fact *more likely* to agree to unsafe sex than other women for financial reasons as much as out of fear of pimps.

Socio-economic Position

According to my informants, the structure of the high class sex trade in Sonagachi created situations in which 'A' grade sex workers seemed to have less autonomy than the others. A sex worker's potential earning power also affected possibilities for safer sex in other ways.

My observations indicated that the poorer, 'C' category sex workers appeared more likely and more able to negotiate safer sex than did the 'A' category women. This would seem counter-intuitive at first as it is normally assumed that poorer women will be more likely to have unsafe sex out of financial need, and that more well off women will have sufficient financial security to be able to refuse the odd customer. However, none of the 'A' category girls that I spoke to said that they would insist upon safe sex at any cost, whereas many 'C' category girls (who were also *adhias*) related anecdotes of throwing customers out or refusing them if they did not comply with condom use.

Some of the 'A' girls and their madams who I spoke to explained this finding in terms of an economic logic. As their rates were much higher than other girls, each customer lost represented a substantial loss as opposed to the 'C' category girls who might lose only Rs.30 (or, if they kept the half the money, they would lose only Rs.15). In addition, women who solicited on the street were perceived to be more likely to get another customer to make up for the loss, whereas *dalal bari* girls could not be sure of this as soliciting was not under their control. Two 'A' category *adhias* explained their perspective to me:

> See, here it is not like in these other places where girls do men for Rs. 15, or Rs. 20. Our rates are much higher and if they stay longer then it is much more so we naturally do not want to turn anyone away – it is a big loss for us and if we have opened our clothes already then naturally we don't want to give the money back.
>
> If the customer doesn't want to use then I look and sit him. What can I do? If I don't sit him he will go to another girl and it will be a big loss for me. We are not one in this house [i.e. there was no unity among these sex workers].

The PEs agreed with this interpretation adding that where large sums of money were involved, the madams and pimps would also be more concerned to see that the transaction was completed:

> These 'C' grade girls can throw customers out. They can do this because they have '*shot*' customers, so many customers, if one is lost it doesn't matter, another will come. But the 'A' girls, their customers are worth a lot of money and they can't stand on the street. If she makes trouble with a customer then he will go and complain to the *dalal* and the *malkin* and they put a lot of pressure on her and she has to sit without (Sonagachi peer educator).

Thus, their potentially high earning capacity meant that 'A' category *adhias'* actions were closely supervised by third parties (this was especially so among the *Agrawalis*). This supervision or control was not just confined to sexual practices, but to their movements more generally. Thus, as mentioned in chapter seven, they might not be allowed even to attend the SHIP clinic in case a customer should come in the meantime.

The reluctance of 'A' category girls to insist on condom use might also have been a reflection of PE-sex worker relationships where, as previously described, the PEs had managed to establish better relationships with the mainly Bengali 'C' category girls than with other groups. In spite of the difficulties reported by 'A' category girls in attempting to enforce condom use however, according to SHIP statistics usage was still surprisingly high. PEs and supervisors explained this by pointing out that 'A' category customers are anyway more likely to be using condoms themselves or are more likely to be amenable to condom use. Thus, instances where a customer flatly refuses to use condoms may actually be quite rare.

In explaining the differences between 'A', 'B' and 'C' category girls, PEs also mentioned that 'C' category *adhias* may have relatively more freedom from their madams when the madam herself was not well off (and was therefore unable to provide loans to create a debt-bondage situation or to buy a new girl) and where she relied heavily on her *adhias'* day to day income. In such cases, I was told the madam was not in a position to interfere with her *adhia*. In the event of a dispute, the *adhia* could simply go elsewhere.

However, though some 'C' category sex workers (especially independent workers) may have more occupational autonomy, their insecure financial situation may lead them to agree to unsafe sex in certain circumstances. Indeed, coping with financial insecurity and an unpredictable sex market was a prominent and consistent theme in relation to safer sex that emerged from discussions with sex workers, especially among older 'C' grade sex workers (such as those in Sett Bagan) who generally had less custom, and among those women who had a lot of family responsibilities:

> See, it is all right to let the customer go if it is just you, but if you have a child and a family then how can you do that? It becomes a matter of the stomach (Sett Bagan sex worker).
>
> When I have not had a customer for two days and a man comes but will not use a condom, what should I do? If I tell him to go how will I run my household? Who will pay for my expenses? (Sett Bagan sex worker)

Such sex workers very clearly depicted their decisions around safer sex in times of dire need in terms of a cost benefit analysis – which was worse, hungry children today or a disease that would manifest itself in ten years time? Women's economic logic and practice however was very much framed on the basis of *day to day* need as well as reflecting general hardship. Sex workers took loans, paid off debt instalments and managed their household expenses on a day to day basis, and safer sex practices also seemed also to be influenced by these day to day circumstances, and were swayed by constantly changing market conditions. Thus for example, when sex workers began soliciting for the day they had in mind a particular sum that

they knew they would have to earn in order to cover the expenses of the moment – this was the priority for poor sex workers. When times were tight, making a profit was an added bonus. Padmini, a Sett Bagan PE who had two children to care for described her predicament:

> Usually *boudi* I use (condoms) with everyone but business has been so bad lately. School is starting next week and my son keeps pestering me for books and uniform. Yesterday I got so mad at him, I whacked him over the head. The other people in the house scolded me and there was a big fight. Then two customers came and I did them without condoms – what to do? I am so tired. With my children and household, all these expenses on my head. It will be better if I get AIDS and die.

Maya, a sex worker in Sett Bagan who had three children and no savings (having recently given a substantial sum to her family in the *desh* for a younger sister's wedding), explained to me how she made decisions around safer sex referring to the previous day:-

> Yesterday I had four customers. I sat with three of them and fourth I sent away. With the first man I did not use a condom. I had been waiting at the gate the whole day and he came and we fixed a price for Rs.30. He didn't say anything so it was only in the room that I said about using a condom. We don't say it outside because then the customer might leave. This man said no, I won't have any pleasure, so I started explaining – I explained for half an hour but he still refused. I got really angry and I would have thrown him out but he was my first customer. I had no money in my house. I thought I don't know if any other men will come today and if they don't then how will I feed my children? So I sat him without a condom. After that another two customers came and they did not make any trouble – one of them asked me at the gate if I have Nirodh in the room. I had another customer much later and he also did not want to use a cap so I kept half the money and sent him off. I could send him away because I had already had three customers so I had a little money in my hand. In this way God looks after me.

Although Maya's socio-economic position was clearly related to her condom use on this day, this example is a good illustration of how many different factors may combine in complex ways to influence condom use outcomes. In this case for example condom use was influenced by Maya's and her customers' knowledge/understanding and motivation, by Maya's status as an independent sex worker where she could make safe sex decisions for herself, by her child care responsibilities, and also highly variable contextual factors such as the time of day, the perceived likelihood of getting another customer, and simply, her bad luck that it was the first customer who came who didn't want to use condoms. The outcome of Maya's sexual encounters on this particular day was thus contingent on a whole constellation of factors that were both predictable and unpredictable.

The material in this section indicates that indebtedness, economic status and economic insecurity are clearly significant factors that influence a sex workers' ability to practise safer sex (even though many women are nonetheless able to overcome these constraints)[6].

[6] In 1995, in order to address this economic dimension of unsafe sex the SHIP helped the PEs to form the Usha Co-operative Society which, among other things, provides soft loans and saving facilities, and which, in 1999, has a membership of 1,000 sex workers.

Relations of Protection and Control

Sex workers' actions around safer sex and security more generally were also framed by the relationships of patronage, protection and control that exist in the redlight areas. In Sett Bagan for example, prior to the establishment of the MS, women described how they lived according to the whims of the local gangs and *para cheles* and how it would have been unthinkable to ask a *para chele* or one of his friends to use a condom against their will if they had come to them as a customer.

In Sonagachi, as far as I know, the situation is not as extreme as it used to be in Sett Bagan (though abuses of power still take place in other some of the other redlight areas)[7]. Sex workers told me that the strong influence of the CPI(M) in Sonagachi provides a potential check on any excesses committed by local men/*goondas*. However, even where relationships with local men or institutions (such as a political party) do not appear openly exploitative, sex workers still described their relationships with these actors in terms of dependency. They had to rely upon these men for protection and help and did not want to jeopardise their relationships with them. I heard a number of anecdotes where sex workers did not use condoms with local *para cheles*, their friends or party workers because of fear of upsetting the status quo and creating trouble for themselves. In such cases madams would also encourage the sex worker to give in and not to push the safer sex issue:

> I don't use condoms if the customer makes a fuss – like with those who threaten to beat me or call the *para cheles* I don't use. My madam tells me not to create trouble. What to do *didi*? – I need to eat [has four children] (Sonagachi *adhia*).
>
> One of the *para cheles* fixed up his friend to come to me. He didn't want to use. I explained and explained but he said no, I won't have fun – I have come to you for pleasure not to wear a condom. I didn't want to make trouble so finally I checked him and sat without. The next day I went straight to the clinic and asked the doctor to give me an injection. I am very frightened of all these diseases (Sonagachi *adhia*)

Sex workers said that *para cheles* and other actors rarely interfered directly in their sex work (though many also had a stake in the smooth running of the sex trade through their involvement in ancillary businesses such as sale of liquor). Rather, they were seen as wielders of street justice and mediators of potential disputes. Thus customers or even other sex workers might sometimes go and complain to local men about a sex worker's behaviour, or a sex worker herself might seek help with a difficult customer from local boys. It was important therefore for sex workers to try and keep local men on their side. I met some sex workers in

7 In one case a sex worker in a different redlight area was slashed in the face because she had tried to use condoms with a local *mastaan*.

one particular field in Sonagachi who would not push safer sex with difficult customers because they did not want the *para cheles* to get involved:

> If the customer starts making trouble, I will sit him without. After all I have to stand out there on the road where all the *para cheles* are (Sonagachi *adhia*).

The SHIP has conducted advocacy and awareness work with local men through group discussions and large gatherings such as video shows. In addition, by working through local clubs and employing some local men as helpers, it has directly involved a number of *para cheles* in the project. Some sex workers I spoke to seemed to suggest that the *para cheles* were becoming more supportive of safer sex:

> Before if customers made trouble they would go to the *para cheles* and get them to pressure us but now even the *para cheles* support us. Everyone has heard about AIDS now (Sonagachi madam).

As described in chapter six, there was feeling among the PEs and other SHIP staff that the power wielded by these local groups over sex workers was beginning to diminish. This is difficult to assess. In other redlight areas (though not in Sonagachi) the DMSC has directly confronted these groups by organising protests against instances of exploitation and abuse of sex workers. However, PEs described how, this notwithstanding, they should be careful not to alienate the *para cheles* as they still served a potentially important protective role:

> We need the *para cheles*. Though most of us have *babus* yet we have to have someone for help every now and then. And they help us because they want our help – during the elections they take our votes, we have to give them *chanda* [donations]. Just because there is an MS or because we have made the DMSC doesn't mean we don't need the *para cheles* any more. Here [in Sonagachi] we are many girls, we have some strength, but in other places where there are only a few – in time of trouble what can they do? They must keep up good relations with the *para cheles*. If a *para chele* wants to sit without a condom, you tell me – is she going to force him? (Sonagachi peer educator)

> Yes, what happens if there is trouble with a customer late at night – this happened just a few days ago – a night customer took away the ornaments from 4 girls and stabbed the servant – now at that moment it is not possible to run to the DMSC – but we can go and get the *para cheles* and they will help us – it is no use leaving the *para cheles*. (Sonagachi peer educator)

In the above quotes, the PEs astutely recognise that in spite of now having their own forum, the DMSC, it is still in their own interests to maintain good relationships with local power brokers. The difference brought about by the DMSC is that they now are in a better position to define the nature of these relationships, as they are no longer in a situation of total dependence.

Re-visiting Behaviour Change

The material presented above illustrates how sexual practices in the redlight areas held different meanings for different individuals with different sexual partners and was influenced by an extremely wide range of individual, social and occupational factors that were in turn strongly shaped (but not determined) by structural forces operating at the macro and micro-levels. In the light of these ethnographic findings, below, I would like to briefly re-visit the theories of behaviour change that were outlined in chapter one (p.24-29), in order to examine their applicability for understanding safer sex practices in this particular context. These have been broadly grouped (as in chapter one) into individually-oriented cognitive or social psychological models and structural models.

To recap, social science criticism of these models has mainly questioned their over-simplistic and empiricist representation of knowledge, and their representation of social action as lacking in meaning or agency. Indeed, the very use of the term 'behaviour' implies a domain of action that is unreflecting, predetermined (by cultural beliefs or structural location within society) and symbolically meaningless (Evans & Lambert 1997:1974). By contrast, various social scientists (Bloor et al 1993, Day 1990, Watney 1990, Holland et al 1990, 1992, Shedlin et al 1992, Hornik 1989, Stainton-Rogers 1991, Bunton et al 1991, Davies 1992, Ingham et al 1992, Kendall 1995, Hart 1996) propose that the discourse of risk or sexual behaviour should be re-cast as "social action, endowed with meaning and negotiated within a social environment" (Hart & Boulton 1995:58), so that 'behaviour' is explained with reference to the "meanings of the activities and the constraints on behaviour that derive from the....immediate social context" (ibid:61). Hart & Boulton (1995) note however that while most such authors recognise structural constraints, few have gone beyond the 'immediate social context' in their analyses (with some exceptions, cf. Holland at al 1990, 1992, Schoepf 1991, de Zalduondo & Bernard 1995, Farmer 1997). Hence, social structures have tended to be seen as something static, held as constants in an analysis of local context or viewed as acting deterministically upon behavioural outcomes within specific contexts, rather than being an integrated part of the analysis itself (Clatts 1995:247). There is a need therefore to integrate structure, context and actor (agent) in thinking about safer sex and behavioural change.

Cognitive/Social Psychological Theories of Behaviour Change

Chapter seven has already questioned representations of 'knowledge' and its perceived role through health education in influencing behaviour. In addition, my material indicates that 'understanding', risk perception and even the proposed shifting of social norms that occurred among sex workers was not enough to enable condom use in every instance, and it is this problem which cognitive/psychological theories of behaviour change fail to adequately address. I illustrate this with a few examples below.

Both the Health Belief Model and Theory of Reasoned Action place primary importance upon an individual's intention or motivation to enact a particular behaviour (Rosenstock I et al 1988, Ajzen & Fishbein 1980). However, these are clearly inadequate in a context where safer sex is the result of negotiations between at least two and sometimes up to four actors, including madams and pimps. Some of the case studies I presented in this chapter do make explicit sex workers' 'intentions' to practise safe sex (cf. Theory of Reasoned Action) and also seem to confirm that explicit cost-benefit-type cognitive processes do sometimes occur (cf. Health Belief Model). However, sex workers' structurally-defined relationships with madams, with particular customers or with *babus* had a more powerful influence upon the way and extent to which cognitions were acted upon. Likewise, the every day exigencies of sex workers' living and working environment meant that intentions or motivations appeared often to be the servant not the master of immediate contextual demands.

Other social-psychological theories of behaviour change similarly resonate with some parts of my material but not with others. For example, social expectation models which postulate that individual practices are substantially the result of conformity to expectations of others, especially the peer group (Rogers 1983, Hewstone & Young 1988, Hornik 1991), may help to explain the apparently successful strategy of peer education in changing attitudes towards, and norms around, condom use within the redlight areas, especially since key trade controllers were included in this effort. These models are more anthropological in orientation in so far as they emphasise the importance of social context. Thus, these models propose that the process of social influence may take place without any requirement that people make complex cognitive judgements about their practice. These models would suggest that condom use increased because an environment had been created where conformity to the expectations of a social network required it and that people came to act habitually, and in a way that is consistent with how others act and expect them to act. Such models also propose a rather weak role for 'knowledge' by suggesting that it is only when social norms are consistent with

'knowledge' that individual knowledge will have an effect (such as sex workers being willing to enforce condom use with customers but generally not with *babus* even when they knew they might be at risk). However, these models fail to take account of how political economy influences practice so that even though condom use may have become a social norm, whether actual practice could reflect this norm or not often remained contingent upon contextual and structural factors.

Personality theories suggest that, for example, a self-confident extrovert may find it easier to insist upon condom use with customers than a timid introvert (cf. Wallson et al 1978, Lau & Ware 1981). This makes intuitive sense and could have had explanatory use in some of the condom use case studies I presented, but clearly it can only operate as a theory if all other variables are taken to be constant and as having an insignificant influence on behaviour change which is evidently not the case. Self-efficacy theories by contrast focus not upon inherent but on learned aspects of human behaviour (Bandura 1986) and could possibly accommodate the effects of SHIP strategies that have focused upon training, building up sex workers' negotiation skills (especially for the PEs) and counselling. This theory may also explain the variation in condom use among sex workers according to experience. But again, it addresses only part of a much more complex picture. Finally, the extreme behaviourist models (Seligman 1975) propose that if a behaviour is rewarded or associated with a pleasant experience, it is likely to be repeated (or not if the experience is unpleasant). In this model individuals are represented almost as automata being manipulated by their interactions with the environment. Nonetheless, it could be used to explain the cases I described where women only began to use condoms after repeated experiences of painful STDs and equally painful treatment. As with the other theories, in certain situations its propositions may appear to hold true, but not in others and it is unable to account for this variation.

Structural Theories of Behaviour Change

Turning to the structural theories of health behaviour[8], my material has clearly shown how the practice of safer sex is very strongly influenced by the social-power relations inherent in the organisation of the Calcutta brothel based sex industry (cf. Whittaker & Hart 1996), whose structure in turn is shaped by aspects of macro-level political economy and relations of class, ethnicity, and, in particular, gender. Structural theories have tended to accord a secondary role to human agency, representing behaviour as being strongly determined by the influence of

[8] This is a vast literature. For summaries of some the main structural critiques of health education/promotion and health behaviour theories, see Nettleton & Bunton 1995, Daykin & Naidoo 1995, and Kelly & Charlton 1995.

external macro-level forces. However, my research showed how women were not passive victims of circumstance. Though some resorted to alcohol or other destructive coping strategies, many actively tried to manoeuvre within the spaces available to them, to protect their well being, to find security and intimacy, and to do their best for their families. Likewise, the case study of Sett Bagan shows how women did not perceive themselves as passive beneficiaries of an external intervention (though some perhaps would have liked to have been!). Rather, the SHIP entered into, and became part of, a complex social world where it was immediately perceived as a potential resource and was interpreted and interacted with in various ways according to different women's personal and political needs.

Social Action and Performance

The ethnographic material in this chapter indicates that certain general factors that influenced safer sex behaviour can be identified and incorporated into the cognitive or structural behavioural theories described above (such as personal risk perception, or occupational autonomy). However, my material suggests that (in spite of the obvious structural constraints) sexual practices were not entirely predetermined, but, rather, were *performative* (i.e. women were 'agents', actively negotiating their sexual encounters and the constraints posed by their environment). Hence, the outcome of particular encounters were, to some extent, context-dependent.

It is this contextual variation (as well as over-determination) that tends to confound attempts to formulate universal theories or models of behaviour change (King 1999). Indeed, I suggest that the endeavour to do so is inherently problematic. As noted in chapter one, the predominant focus of much work on behaviour change has been to examine the beginning (for instance, structural constraint or motivation/intention) and end of a sexual encounter (safe/unsafe sex) rather than its *performance* in time and in context. Richards (1993:67), speaking with reference to farming practices, has suggested that this kind of approach may "confuse intention and result, to misunderstand what has *happened*". Taking a perspective of safer sex as performative social action overcomes this problem to some extent (cf. Taylor & Lourea 1992). Thus, to take the example of Maya given above (in the sub-section on socio-economic position), to search for general psychological or structural 'determinants' to her condom use practices would be to falsely seek a cognitive/structural logic, where what mattered to Maya was a sequential adjustment to unpredictable conditions on a particular day. The same applies to Podda's example above of non-condom use with a potentially violent customer. Here, clearly, non-condom use was an appropriate, rational and essential survival

strategy to avoid confrontation and, possibly, a slashed face or worse. Most sex workers I spoke to implicitly acknowledged the performative aspect and contextual contingency of their condom use. General questions such as "do you use condoms with your customers?" were usually answered with a "well, I try – but it is not always possible".

Models of behaviour change models can be useful in the sense that, through deconstructing aspects of the 'individual' or 'society', they may be able to identify some of the 'stage props' and 'acting repertoires' that *may* influence a (sexual) performance, but these in themselves cannot *determine* how the performance may turn out. Hence, they have only limited explanatory and predictive value. It may, therefore, be possible to identify and analyse pieces of a jigsaw but not to fit it all together to yield a complete picture – one or two pieces will always end up missing. On this, Richards (1993:71), referring to Giddens (1979), has aptly concluded that:

> A central point that modern social theory requires us to grasp is that social life is simply not corrigible by outside observers. Outsiders may be able to rebuild the set (or, to mix a metaphor, move the goal posts) but they do not make the action".

Conclusion

In this chapter I have shown how, constraints notwithstanding, many sex workers had internalised a sense of risk and tried to negotiate these constraints to protect their interests. Their strategies with difficult clients and madams showed a tremendous capacity for resourcefulness, creativity and resistance. Nonetheless, the environment in which sex workers lived structured the ways in which women defined what their 'interests' were, and delimited the scope of strategies for action available to them. From this view point, safer sex was only one dimension of women's relationships at work or with their *babus*. These also involved varying aspects of social identity, were woven into different strands of social and economic activity and were imbued with different meanings. Safer sex was thus just a part of a complex fabric of sex workers' short and long term strategies for survival, protection and well being.

The material has illustrated how varying combinations of sex workers' occupational, economic or hierarchical positions within the sex trade had a significant impact upon possibilities for enforcing safer sex (e.g. 'A' vs. 'C' or *adhia* vs. independent). Although the impact of these structural dimensions upon safer sex were very discernable in a general way, safer sex outcomes were not always predictable but rather, were very much context-based, and it is this that accounts for the variation in condom use noted at the beginning of the

chapter. Safer sex outcomes depended upon the dynamics of the customer-sex worker (and in some cases, madam and pimp) negotiation and of the actual encounter, as well as upon a complex interplay of market forces, personal business strategies, biographical circumstances, and also, to some extent, chance (for instance, whether an uncooperative customer happened to come at the beginning or the end of the day). Moreover, this and the previous chapter have indicated that changes in safer sex practices may also be related to an overall shift in social norms around condom use that appears to have taken place since 1992.

In spite of seven years of intervention effort and the strategies employed by many sex workers to try and practise safer sex, the SHIP's last three surveys indicate that reported condom use appears to have reached some kind of plateau, albeit quite a high one. This suggests that contextual variation notwithstanding, it is structural forces manifested through the sex trade environment that play the lead role in defining (though not determining) the possibilities for safer sex. As such, the ethnographic material presented so far lends weight to the SHIP's contention that for sex workers, sexual health depends upon women gaining "control over the structural conditions that regulate their lives and claiming their right to self-determination" (Bandyopadhyay & Banerjee 1999:21).

CHAPTER NINE

CONCLUSION

Introduction

In this final chapter, I assess the implications of the material presented so far. I consider the meanings that HIV and the SHIP have taken on for sex workers in the context of the Calcutta sex trade, the implications of these for constructions of identity and community, and, in turn, for possibilities of social change among this group. I then go on to examine key concepts in sexual health and behaviour change discourse, arguing that in order to understand processes of social change and intervention, particular attention must be paid to the process, meanings and contextual relevance of particular intervention strategies. I then apply the research material to the current practice of constructing 'best practice' intervention models and consider the complexity of project replication. I end with a discussion on anthropology's role in sexual health research.

Contested Identities: Meanings of Sex Work and of an HIV Prevention Project

In this thesis I have been able to provide hitherto undocumented information about the nature of the Calcutta sex trade and women's lives within it. In doing so, I have described a highly complex social and occupational structure in which sex workers have little autonomy, status or (prior to the SHIP) solidarity. The stigma associated with their profession fractures sex workers' sense of identity as 'respectable women' and this change in self-image is reinforced through their interactions with (and exclusion from) mainstream society and, often, their own families. I have described the consequent ambivalence of sex workers' sense of identity and have shown how the sex trade structure severely limits possibilities for resisting their material situation or the ascribed label of 'whores'. As a result, brothel-based sex workers have tended to seek social mobility, identity and security internally, within the sex trade by forming relationships and family units with *babus*, and through forming relationships with local power brokers within a complex system of patronage relations in which state institutions and political parties are intricately bound up.

Entering into this complex world, I have shown how, through giving practical help to sex workers and advocating on their behalf, the SHIP, and, more specifically, its director, came to

act and be viewed locally as a kind of sex workers' patron. Hence, it created an opportunity for sex workers, especially the PEs to voice, and obtain support in acting upon, their concerns.

The SHIP entered into sex workers' life worlds in a variety of ways and took on a variety of meanings. For perhaps the majority of women in Sonagachi, it was seen as a medical service provider and, via the peer educators (PEs) and project supervisors, a source of general information and advice. For others however, such as Durga, other *Mahila Sangha* (MS) members in Sett Bagan and the PEs it represented a new resource that was utilised (in the case of Durga and other MS leaders) to serve personal political aspirations and (in the case of other women) to secure employment. Employment as a PE was highly valued, partly because it represented financial security, but importantly, because it also provided an opportunity for re-negotiating self-identity, enabling PEs to represent themselves as 'respectable' health workers and hence also, opening up renewed possibilities for re-entering mainstream society and kin-networks. Indeed, for the PEs themselves the SHIP came to take on the role of a locally based kin-group, association with which provided a sense of community and belonging.

For a number of PEs, specifically the *Durbar Mahila Samanwaya Committee's* (DMSC) leadership, the SHIP's perspective that sex work is a legitimate occupation (embodied subsequently in the DMSC's slogan "sex work is work, we want workers' rights") has been of particular significance. West Bengal is a Marxist-dominated state in which social mobilisation around labour issues has a long history. Political parties have, however, never taken up the issue of sex work despite the fact that sex workers (as in Sonagachi) may be party activists and may have forged patronage-links with local party offices. Rather, the predominant view around sex work and around its potential 'solutions' has tended to remain couched within a moral discourse that sets the contours of sexual- and gender-identities within Indian society. By drawing upon a well established and politically legitimate idiom of protest in West Bengal (labour rights) and by applying it to the specific situation of sex workers, the SHIP has, for the first time, offered sex workers an alternative possibility for casting their identity – in a legitimate and socially valued idiom - as workers. It has thereby opened up a new and (importantly) *legitimate* way of constructing a (previously non-existent) sense of community among sex workers, around which large scale mobilisation could take place.

This process of community mobilisation was still in its preliminary stages at the time of my fieldwork (1995-1997) and the SHIP/DMSC had faced some opposition to their perspective on sex work. In this thesis I have related such opposition to conceptions of sex workers' agency, with some groups (feminist NGOs in particular) implying that sex workers were

being manipulated by the project director. The issue of identity is highly complex and I have shown that even some of the DMSC leaders were ambivalent about representing prostitutes simply as a group of oppressed workers, as this did not, for them, appear able to capture the stigma and sense of difference that they had experienced throughout their lives. Nonetheless, many sex workers have now shown their support for the DMSC, ambivalence notwithstanding. It is important to note however, that such support may not automatically equate with agreement with the DMSC's political ideology (though for some this may be important), but may also indicate a desire to access the opportunities for practical help and social mobility that the DMSC can offer. It is not uncommon for marginalised groups in India to adopt different identities in order to escape oppression and further social aspirations (for example, low caste groups converting en masse to Christianity, cf. Mosse 1997). As such, identity construction and self-representation are socially and politically strategic processes and, in aligning themselves with the DMSC, sex workers were clearly displaying their agency. However, I have also argued that the expression of agency may be culturally and contextually shaped, and that, in the context of political patronage relations that exist in the Calcutta redlight areas (as in Indian politics more generally), agency may be expressed by seemingly passive deference to the will of a particular leader. This however can be seen as an active strategy by which to try and reap the fruits of a particular leader's efforts on others' behalf. In Sett Bagan, women's response to Durga, the MS leader and the MS' relationship with the SHIP provides a good illustration of such dynamics. Hence, the powerful influence of the project director in facilitating the processes of community mobilisation witnessed in Calcutta should not imply a lack of agency on the part of sex workers' but merely illustrates their interpretation of his position as a leader who will act in their interests.

Globally, sex workers' struggle for an improved life and an acceptable identity remains strongly contested. However, as the Calcutta experience shows, HIV has ironically turned the spotlight onto the sex trade, providing an opportunity through a prevention project for women to access new resources and ideas and, with help, to begin a process of re-defining their position in society.

Intervention Processes and Sexual Health

Participation

The points made above regarding the varying meanings of the SHIP and the culturally specific forms of expressing agency are also relevant for understanding other intervention-

related processes, specifically participation and empowerment. These concepts are frequently used in sexual health and development discourse (to the extent that their inclusion in a project proposal is almost mandatory) but they are only rarely defined, and even less rarely examined as they play themselves out in the course of project implementation (Nelson & Wright 1995). By taking an ethnographic approach in which the intervention itself is viewed as a social actor I have been able to illuminate some of the complexity underlying these concepts. I noted above that for some sex workers, the SHIP represented a social and symbolic resource, and that their interaction with the project was defined by the particular meanings it took on for them in their own life worlds. As such, for those in Sett Bagan for example, participation in the project was strategic, representing an attempt to secure jobs, social mobility, a 'respectable' identity or political ambitions. Sex workers' participation in project events, particularly at the beginning of the project was often underlain by these personal interests rather than out of a broader concern with 'community' well being. Yet outsiders to the redlight areas were frequently impressed with what they felt was the depth of 'community' participation. My material also shows how the SHIP itself used the concept of participation in a variety of strategic ways. With sex trade gate keepers, it was to secure their support for the project. With any trouble makers (including sex workers) participation in the form of being given employment was used to co-opt opposition. Likewise, the project sometimes drew upon the general support for the concept of participation within the development field as a specific strategy with which to counter external opposition to its work. With the PEs, the SHIP used participation as an important mechanism of capacity building in preparation for the time when the project would be handed over to them.

Hence, participation takes on different forms and has different uses at different times during a project's implementation. Similarly, the concept of community itself is a dynamic one. My material illustrates that communities may not always exist, may be heterogeneous and characterised by conflicts of interest, and, in some cases, first need to be built up. In the Calcutta redlight areas, communities were primarily defined around neighbourhoods and were controlled by local power brokers (local men, gangs, political parties) and sex trade controllers. Hence, when community organisation did occur, as in Sett Bagan, it was usually concerned with neighbourhood disputes and did not extend to address more general sex work issues. The development of any broader sense of community among sex workers themselves was hindered by the extremely negative social connotations of the prostitute identity which could not, therefore, form a basis for community mobilisation. Sex workers also lacked access to material and intellectual resources (specifically, ideologies from which alternative, positive, unifying identities could be constructed). In addition, the divisive structure of the sex

trade kept women pitted against each other, and, in Sonagachi, the heterogeneity and mobility among sex workers also hindered community development. Thus, in view of this lack of pre-existing community, enabling sex workers' participation required first *constructing* a sense of community among them. The SHIP approached this in three ways. Firstly by representing the PEs as representatives of *all* sex workers, in spite of their differences thereby creating a public image of community with which to advocate on sex workers' behalf. Secondly (as described above), by re-conceptualising sex work as work so that a common bond could be established between women regardless of other differences, and finally, by actively facilitating a process of mobilisation around women's working identity.

In the context of the sex trade, inviting the participation of sex workers and engaging in a community building process with them represents a challenge to vested interest groups and, therefore, is essentially a political process which involves the negotiation of power relations. In this thesis I have illustrated the various ways in which the SHIP has gone about this process - which the project itself has described as playing a political game. The SHIP did not establish its own office within the redlight areas, but rather, its presence there was embodied in the PEs and certain clubs. By working through and utilising pre-existing power structures such as the clubs, party offices and other influential individuals, and by representing itself as a neutral medical project, the SHIP did not appear to be posing a serious threat to vested interest groups (though it did face initial suspicion). In this way it was able to gain acceptance in the redlight areas and also establish a firm community base from which community building and mobilisation could take place.

The local positioning of the SHIP/DMSC meant that they could, in certain circumstances, directly challenge abuses against sex workers. However, by providing sex workers with an alternative place to seek help (i.e. acting as an alternative patron), they were also indirectly breaking dependency relations between women and traditional exploitative sources of protection. More recently, by establishing self-regulatory boards in three redlight areas (but not yet in the most highly controlled localities such as Sonagachi), the DMSC has taken on a more direct role in influencing the sex trade structure. Hence traditional power relations may have begun to shift and spaces have begun to open up, not just in the redlight areas but also in civil society for sex workers to act in their own interests, to assert their views and demand action around issues that concern them.

It appears then that participation both of sex workers (represented by PEs) and (nominally) of vested interest groups was crucial in enabling the SHIP to operate. The challenges to

traditional power structures that the SHIP brought with it, came in, so to speak, through the back door, and, remarkably, the project has faced relatively little serious opposition from within the sex trade itself despite its position on sex workers' rights.

The close examination of processes of project implementation indicates that of crucial importance in this instance was their cultural appropriateness in the context of local and state-level power structures and political practice. The SHIP worked through existing community institutions and, in its dealings with local power brokers, worked through the local power hierachies, bringing the influence of those higher up to bear upon those lower down, in a manner characteristic of conflict resolution and political practice more generally in Calcutta. Hence, when conflict of interests occurred (as in Sett Bagan), it worked within the structure of power relations in the locality to resolve the problem, thereby (intentionally or not) enhancing its own position as a more powerful patron than the MS leader. Attempts to introduce new ways of operating within existing institutions or of re-focusing their work onto the broader interests of a sex *worker* community, were, as the example of the re-vamped MS showed, unlikely to succeed. Hence the SHIP eventually facilitated the formation of a new institution, the DMSC, that was not directly connected into neighbourhood-based politics but, rather, represented a pan-Calcutta (and later pan-West Bengal) constituency. On a more macro-level too, through its organisational structure, rhetoric and activities, the DMSC has followed established patterns of social mobilisation in West Bengal which (some opposition notwithstanding), has enhanced its popular appeal and has enabled it to obtain the tacit support of the ruling party as well as other prominent figures in Calcutta society.

Here I am making the point that processes of participation and empowerment are in themselves dynamic, meaningful and contested, but the means by which they are operationalised and the relative degree to which can make a difference are also closely related to the socio-political context in which they occur. I will return to this point again when considering the possibilities for replication of interventions.

Health Education

The above mentioned importance of process and of the extent to which this is culturally appropriate is also highly relevant for illuminating other intervention strategies such as health education. For example, if one were to investigate the content of the SHIP's health education work, especially its emphasis on formal biomedical knowledge and consequent neglect of local beliefs and some of sex workers' key concerns, it would be quite easy to point to its lack

of cultural appropriateness. However, in this thesis I have suggested that the *process* of health education (specifically, peer education) that took place in Sett Bagan and Sonagachi was highly appropriate, and, indeed, of greater significance than its *content*.

My material indicated that prior to the SHIP, some sex workers already had well developed understandings of 'line diseases' but that these were learnt through experience, and expressed through every day actions oriented to maintain health. By contrast, through its didactic approach and its biomedical content, the flip chart used by the SHIP to impart knowledge represented an alien way of learning about an alien medical system. Though PEs eventually came to remember the medical facts about AIDS/STDs, this was not always the case with ordinary sex workers. The latter did, nonetheless, generally develop an understanding of what to *do* to protect health (use a condom) despite limited understanding of the biomedical aetiological rationale for this. In certain contexts therefore, it may not be necessary to impart 'factual knowledge', and the results of surveys which measure whether or not subjects 'know' medical terms for, or facts about, STDs or AIDS may bear little relation to actual understanding or action. My material also indicates that knowledge is not a set of facts that exist independent of context or mode of delivery. For new knowledge or understanding to be turned into a sense of personal risk (i.e. accepted as 'true') the development of trust in the source of the message, and the credibility of the messenger is important. The benevolent but respected image developed by the SHIP and the delivery of its message via peer educators who, by virtue of their employment with a 'respectable' mainstream institution, came to be seen as influential 'insiders' appeared to be crucial in enhancing receptivity. Related to this is the potential importance of the symbolism of certain kinds of knowledge. I suggest that the presentation of the health education message within a highly respected and authoritative biomedical idiom (rather than, for example, adapting it to 'local' knowledge) may also have given the message and also the peer educators who were delivering it (and thus came to be seen as authoritative health workers) greater credibility. The unusual intensity of the health education approach employed by the SHIP also appeared to be important in ensuring constant reinforcement of the new information and in helping to establish its credibility and importance (i.e. the feeling that "they wouldn't bother so much if there wasn't something in it"). Finally, not just peer education per se, but large group-based peer work seemed to be of particular effectiveness in putting peer pressure on sex workers and in building up a sense of group-affiliation among sex workers, reflected in an overall shift in attitude towards condoms so that they became perceived as the norm, and as socially desirable.

The peer pressure was reinforced by the intensity and structure of fieldwork in which the SHIP appeared to be constantly surveying and monitoring condom use, identifying and addressing any lapses and taking on a kind of big brother role (including advocating for condom use on sex workers' behalf). Thus, the development of an understanding about the gravity of a new disease called AIDS and the need to use condoms was important for sex workers, but this understanding was gained not only through didactic teaching or knowledge of the medical 'facts', but through a complex scenario of knowledge transmission and reception in which the messenger was as important as the message, and which had to operate through, but simultaneously try and change, the social relations and norms of sex work.

Perceptions of Sexual Health and Empowerment Processes

I noted in chapter one that, although widely used, sexual health is a concept open to different meanings and interpretations. My sex worker informants in Calcutta described a number of different but overlapping discourses that centred upon the bodily experience of STD-related problems ('line diseases') but located these inextricably within their wider social and, importantly, occupational milieu. For these women, sexual health was not something that could be separated from the broader context and every day practices of their lives. Their problems were "problems of the line", structured by macro-level social and economic processes that brought them into the sex trade in the first place and, once there, led them into 'risky' situations such as sometimes having to acquiesce to unsafe sex with customers and (often) with their *babus*.

In chapter six, I showed that the PEs' discussions of the SHIP's benefits gave little consideration to health outcomes as conceived in the traditional bio-medical sense (such as increased condom use or reduced STDs), but rather, stressed a perceived change in their own situation and in that of the sex trade environment. What they (and other women) described was how the project had helped to facilitate access to certain services and how this was helping them in certain practical ways (such as by opening a clinic, or helping to place children in schools). And, while the PEs certainly talked about their own personal growth as a result of their employment with the project, they also placed great emphasis upon the project's perceived role in facilitating solidarity, unity and an increased sense of belonging and social integration (that is, of 'community') among themselves, and also among the sex workers more generally. They particularly mentioned the SHIP's role in enhancing access to information and resources, and, therefore, in challenging their dependency, perceived 'ignorance', place and role in traditional social-power structures as well as their lack of

representation (both locally as well as at policy level). As such, I suggested that the PEs were articulating a collective model of empowerment through which they chose to exercise their 'agency', and that for them represented the core achievement of the SHIP in terms of their own well being. The PEs appeared therefore to hinge the possibilities for individual bodily well being upon the social position of sex workers *as a group*, and it was in the latter as much as in the former that they experienced the most profound changes.

The significance of this perspective for thinking about sexual health can be illustrated by my material on safer sex. As described in chapter eight, in spite of sex workers' strategies to try and enforce condom use with customers, their ability to do so was nonetheless circumscribed by the occupational power structures within the redlight areas. Hence, no matter how individually 'knowledgeable' or empowered a sex worker was, in certain circumstances she might still be unable to practice safer sex, and might also require help from an empowered sex workers' organisation (for example to advocate with un-supportive madams or pimps). Empowerment in this case depends upon the relation of sex workers as a group to their occupational and social position.

Taking a group-based perspective on empowerment processes also sheds light on their relationship to participation. Hence, for example, I have shown that the extent to which individual non-PE sex workers 'participated' in the project (or were even aware of its activities) was extremely variable at the time of my fieldwork, depending largely upon their relationships with the PEs, which in turn was influenced by factors such as class, ethnic group and, importantly, the extent of social control exerted over them by madams[1]. However, the patron-like relationship of the SHIP/DMSC to sex workers and the SHIP's primary focus of empowering sex workers as a *group* (rather than as individuals), meant that once these organisations had become firmly established at the community level, they could act to protect sex workers' interests and begin to shift power relations regardless of whether a particular individual was directly involved in their activities or not. Moreover, my observations and the suggestions of the supervisors and PEs imply that for individual sex workers, empowerment was to some extent perceived in terms of "having someone to speak for them", as much as in being individually able to act.

[1] However, in the 3 years since the end of my fieldwork in early 1997, the long process of capacity building among the PEs seems to have paid off, enabling them to reach a 'critical mass' of other women, subsequent to which, the project's and DMSC's activities have increased tremendously in scope and scale.

It may seem obvious that for members of a marginalised group to be 'empowered', a shift in the status of the entire group is necessary. However, with respect to sexual health, international definitions of the concept all pre-suppose the individual as subject either in terms of being free from disease or, as in the WHO's definition, in terms of achieving a "state of physical, psychological and social well being". The latter is holistic but is hardly explicit about what might be required for an individual to achieve such a state. The fuzziness in definitions such as this does little to make the connection between an individual's well being and the world in which they must live. Examining sex workers' own discourses of sexual health and of their experiences of a sexual health project suggests there is a need to recast the sexual health discourse away from biomedically structured TIs and into a more inclusive and referential universe that *explicitly* anchors the possibility of individual well being to the social, symbolic and structural changes necessary to empower sex workers according to culturally-specific constructions of community, identity, power, agency and action.

Understanding and Measuring Behaviour Change

Above, I have emphasised how interventions, and, indeed, commonly utilised concepts in the field of sexual health (including the term itself) may be interpreted in different ways, and how their operationalisation is a complex socially contested process. This implies that in order to understand behaviour change, it is necessary to analyse meanings and process. In chapter one, I described how current thinking in sexual health 'best practice' is contradictory, remaining inherently individualistic (as described above), yet also struggling with the inadequacies of conventional models of behaviour change in explaining complex field realities. I described the development of an increasingly used tri-partite discourse that refers to the need to influence individual, community and societal level processes in order to enable individual behaviour change, and noted that, though inadequately theorised, this perspective is an improvement upon theories of behaviour change that focus more or less exclusively upon individual, social or structural factors.

In chapter eight, conventional models of behaviour change were shown to be individually unable to account for the ethnographic material presented. Rather, the material I have presented supports the tri-partite discourse to the extent that it has shown how sex workers' vulnerability to HIV is influenced by macro-level social processes (poverty, gender ideologies) that manifest themselves in individual lives which in turn are played out through intermediate levels, the most important of which, in this particular case, is the redlight area environment. However, my material has also shown how terms such as 'individual',

'community' and sexual behaviour are not static categories but comprise a range of contested meanings and identities which are drawn upon by different actors in strategic ways. Change at any level therefore, must incorporate a theory of power and of social agency. Thus, in the SHIP's case, I have shown how a substantial part of the project's work and possible impacts (aside from physically providing sex workers with access to medical services and condoms), has been related to debating, constructing and re-negotiating identities and communities. Hence, understanding change requires a method that can analyse subtle shifts in meanings and power relations.

My analysis has also indicated however, that care should be taken in constructing the object of behaviour change – that is, if community or societal level factors are considered crucial in influencing vulnerability, then methods must be developed to assess changes at these levels. Presently, in spite of growing international support for an integrated approach to HIV prevention (re-phrased as 'sexual health'), projects remain judged on the criteria of their success in achieving *individual* behaviour change rather than changes in broader group-level or environmental shifts, hence remaining within a disease rather than health oriented paradigm. Achievements in capacity building, community mobilisation or locally-defined empowerment processes are presently not routinely monitored or evaluated in targeted interventions, indeed, the methodology to do so still needs to be adequately developed (Beeker 1998, King 1999, UNAC 1996). This is despite the fact that the latter achievements are clearly more relevant to the long term sustainability of an intervention or to the prospects for enabling *lasting* social change.

Another problem related to the location of interventions within a disease-oriented paradigm is that their relative 'success' (in the narrow individual behaviour change framework) is currently assessed by quantitative measurement of condom use, knowledge or STD statistics. In chapters seven and eight I have described the problems with gathering behaviour change data through survey methods. Another problem with this method is that it relates project inputs to outcomes without a full consideration of process. Process is certainly acknowledged - for example, in considering which input strategies work best - but these discussions are anecdotal and are not usually based upon a systematic exploration of how an intervention plays itself out in real lives and communities. This may lead to misunderstandings about which components of an intervention are 'working' and how. Below, I discuss this point further with reference to the current trend in sexual health circles to use successful projects as best practice models to be replicated in other contexts.

Best Practice

In the sexual health field 'best practice' documents have been produced by DFID, USAID (AIDSCAP) and UNAIDS, among others (Gordon & Sleightholme 1996, UNAIDS Best Practice Collection 1999, AIDSCAP 1997). These contain summaries of interventions and draw out some of the key features of a successful programme (e.g. multi-sectoral collaboration, community participation, etc.). They are often written by external consultants whose knowledge of what actually happened may be quite scanty, and who rely heavily on written material and brief interviews with key personnel.

Constructing best practice models can be likened to the construction of behaviour change models described in chapter eight. That is, they retrospectively identify components and strategies that clearly are key features of a successful programme, but an analysis of how these components were actually implemented is sometimes missing altogether or is over-generalised and rather 'censored'. Moreover, they tend to present project components as having been pre-designed and applied to a situation rather than as emerging out of and evolving within a particular context. The very fact that they are intended for wide readership creates the danger that all the difficult, politically sensitive or controversial aspects of a programme end up being glossed over or excluded altogether. For this reason, project accounts tend to provide a rather sanitised version of what actually happened. To take the SHIP as an example, most of its own documentation stresses the importance of 'participation' of sex workers, but there is very little information on how women came to be involved, on the varying motivations behind their involvement, on which groups were or were not represented (and the implications of this), on the problems that were faced, on the complex interactions that participation involved, or on the political strategies and behind the scenes manoeuvring that was at times required. One is left with enigmatic statements that liken project implementation to a 'political game', but how the game was actually played is skipped over, for obvious reasons. In a potentially hostile environment, where survival depends upon political acumen and where the project is still on-going, some things are perhaps better left unsaid[2]. However this leaves standard project documentation rather thin on detail, strategy and context – that is (to return to a performance metaphor), it may comprise a description of the stage, of the props, of the script, but not of the performance[3].

[2] More detailed participatory research on the process of project implementation and community mobilisation/development is currently being carried out under the auspices of the Population Council's Horizons Operations research Programme.

[3] As an example of this, I myself was recently involved in writing a summary paper that aimed to document community development approaches in sex worker HIV interventions internationally (Evans 1999). I had to rely heavily on written material for the review, and a reviewer with extensive personal experience of some of the

It could be argued that the aim of a best practice summary of course is not to give a full description of a project but is, rather, to identify those key features that would then need to be adapted in the process of replication according to specific contexts. However, without a detailed understanding of the process and context of project implementation, it is quite possible to misunderstand what the key features actually are. With respect to the SHIP, six such examples come to mind. Firstly, many people I have spoken with about the SHIP privately agree that its success (at least in the first few years) hinged to a large extent upon the vision and skills of its director, and, to a lesser extent, of its other staff who are unusually committed and hard working. I believe that the director's style of leadership, in particular his conflict resolution and political management skills, and his ability to inspire and unite diverse stakeholders (the Conglomerate) with a common organisational philosophy regarding sexual health and sex workers' rights has been of crucial importance in the development of the SHIP, yet this is nowhere mentioned in any of its own or others' documentation. To give another example, I have already described how it was not just the giving of knowledge, but the reputation of its source and the 'messenger' that were key parts of the process influencing its acceptance among sex workers. Where this is recognised, peer education is often cited the best way to influence members of marginalised groups. My material suggests however that it was not just peer education per se which was effective in shifting social norms or building up an understanding among women about the need to use condoms, but rather, it was this *combined* with the specific (group based, intensive, highly persuasive and large scale) manner in which it was implemented, which in turn was determined by the organisational philosophy of the SHIP and the occupational structure of the brothel based sex industry. The case of participation provides another example. In SHIP-related best practice documentation, the main point stressed with regard the success of the project is the need for a participatory approach but, other than stating that this was operationalised through the peer educators, there is little information on the ways in which this was done, or, indeed, precisely what was meant by 'participation'. What is unique about the SHIP however, is not just its participatory 'approach', but the strategic uses to which it was put and the *extent* to which this has been implemented, including an eventual transfer of power to the sex worker community.

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projects that I had documented commented that while my accounts were 'accurate' in terms of the issues they identified, they seemed very 'sanitised', that is: - "they sound so good on paper but I know the reality to be so messy and different".

Another point related to the participation example is the role of ideology in determining the course of an intervention. In spite of radical mission statements on poverty alleviation and good governance, the sensitivities of working with foreign governments means that donor agencies are in practice remarkably apolitical, tending to shroud political ideology behind catch-all concepts such as empowerment, participation and, in the case of sexual health, 'enabling environments'. In spite of its radical work, the SHIP itself has likewise remained somewhat apolitical, representing the DMSC as a separate, and to some extent, autonomous organisation. SHIP documentation notes that its underlying principles are humanistic, being based upon respect (for sex workers), reliance (on their understanding) and recognition (of their human rights and of sex work as a legitimate occupation). However, within the specific context of the Calcutta redlight areas, it is clearly the latter belief that has enabled the SHIP to so successfully facilitate a process of community mobilisation among sex workers to the extent that the DMSC now has a state-wide membership of over 40,000. Clearly, to treat sex workers with empathy and respect does not in itself form a basis for social mobilisation.

Related to the role of ideology is the role of socio-political context in affecting the way a project evolves and is received. I have already argued that existing political discourse in West Bengal may have had particular significance regarding the way in which sex workers have readily mobilised around an identity of sex *worker*. In addition, through the project's perspective on workers' rights and its understanding and shrewd use of local political organisations and practice, the SHIP has been able to court the ruling political party and obtain its tacit support. This has been important in order to influence those lower down the party ranks (including those party workers in the redlight areas themselves), as well as to facilitate key project activities. For example, West Bengal is the first state in the country that has allowed an organisation of sex workers (the DMSC) to register as such, rather than hiding another label such as 'housewives'. Likewise, the Ministry of Co-operatives has given the Usha Co-operative a great deal of support. The explicit linkage of sex work to Marxist theory has also given the SHIP a strong handle with which to advocate their position to other key figures in the state establishment, including the police, civil servants and civic authorities. For example, the key venue used for most of the SHIP's and DMSC's large meetings and conferences is a stadium whose use requires sanction from the Sports Ministry. The organisational structure of the SHIP and also of the DMSC, with centralised leadership and cadres of community based workers also reflect traditional forms of political organisation and representation with which people are familiar. Hence, the SHIP evolved out of, and was ideally adapted to, prevailing forms of political organisation, participation and protest in West Bengal. In other States where the dominant idiom of protest or social mobility is centred

around different concerns, for example caste politics or Hindutva (with their related gender ideologies), one can imagine that community mobilisation (or creating enabling environments) might have to take on very different contours.

Finally, it is important to consider that the SHIP was implemented in the context of a specific sex trade structure – i.e. among brothel based sex workers living in discrete redlight areas for whom the identity of prostitute was part of their lived experience (other identities notwithstanding), and among whom there was relative homogeneity as Bengali working class women. The exceptions were the Nepalis and *Agrawalis* in Sonagachi, and, significantly, these women did not generally participate in the SHIP/DMSC's wider community building activities. For women who already self-identified as 'prostitutes' and who shared a common living and working environment, they had little to lose and much to gain through identifying with the SHIP/DMSC (as sex workers), and some common ground existed upon which a notion of community could be built. It is not at all clear whether this would be the case in other sex trade contexts (for example where there are no redlight areas, where women live within family and kin-groups or where women pursue sex work secretly or in conjunction with other jobs – cf. Asthana and Oostvogels 1996). In such contexts, it may be that strategies for community mobilisation or participation would again, take on very different shapes and meanings.

The way in which best practice models are constructed and disseminated has implications for replication. Information on the SHIP 'model' has been disseminated all over India, yet, to my knowledge, no other project in the country has achieved similar results in terms of community mobilisation and capacity building, and, indeed, most have remained within a conventional biomedical TI framework. In this case also therefore, best practice models might benefit from an explicit consideration of process in relation to context based upon ethnographic research.

Conclusion: Anthropology and Sexual Health Research

In chapter one, I noted that HIV has created enormous opportunities for anthropologists to become involved in international health issues. Indeed, anthropologists have been instrumental in broadening the scope of HIV-related research, arguing for risk and vulnerability to be viewed in the context of micro- and macro-level social, cultural, economic and political processes. The broad holistic discourse of sexual health is in part attributable to anthropological research that has shown the complexity of sexual practice in human societies (Farmer 1997). This notwithstanding, the process of translating social complexity into

workable prevention programmes is lagging behind. The dominance of biomedical and empiricist intervention paradigms means that anthropologists directly involved in programme-research are often forced to reduce the scope of their work to rapid procedures that try to identify cultural variables, behavioural factors or local knowledge, which, as I have argued earlier (see chapter seven), is methodologically questionable and may yield a misleading picture regarding what the key factors are that influence social action or responses to an intervention (Lambert 1998, Farmer 1997, Evans & Lambert 1997). Moreover, such anthropological in-puts tend to be piecemeal – at the beginning or end of programmes - with little opportunity to analyse the processes through which social change may be occurring. There is still a dearth of research that takes a long term perspective and that explicitly includes the intervention and other key actors (such as governments or donor agencies) within its ambit.

Though this thesis does not itself represent such a comprehensive study, it has gone some way towards this. By including the SHIP within its purview and by making a contextually embedded analysis of sex workers' lives, their perceptions of sexual health and interactions with an HIV prevention project, important insights have been obtained for understanding processes of social change and intervention that can hopefully be taken forward in future research and intervention.

GLOSSARY

Adhia	A sex worker operating under a madam to whom she gives 50% of her earnings.
Agrawali	A term referring to high class sex workers originally from Uttar Pradesh who mainly live in Sonagachi and for whom sex work has become a customary occupation.
Ayah	"Carer" - may look after children or work as a helper in a hospital.
Babu	Term referring to a man with whom a sex worker is in a long term relationship. Often considered as a husband.
Bandha Babu	Literally a 'fixed' *babu* – i.e. one who is in a long term stable relationship with a sex worker.
Bariwali	Landlady.
Bariwala	Landlord.
Basanti Sena	Condom social marketing wing of the DMSC/*Komal Gandhar*
Beshya	Prostitute.
Baithak Bhaji	Treacherous meeting.
Bhairas	Virus
Bhodro	"Respectable"
Bhodrolok	"Respectable" middle class man (a "gentleman")
Bhodromahila	"Respectable" middle class woman.
Biggaen	Science/Knowledge.
Boti	Sharp implement used for cutting vegetables and fish.
Boudi	Elder brother's wife.
Cap	Another word for condom.

Chai	Tea.
Chakor	Male servant who works in Sonagachi.
Chuachui	Literally, 'touching-touching'. Refers to diseases thought to be transmissible through contact with something 'unclean' (usually body fluids).
Chukri	Young girl in the sex trade. Usually kept in a state of bonded labour, whereby all her earnings go to a madam until she has repaid her purchase price.
Dada	Elder brother.
Dalal	Literally, "middleman". In the context of the sex trade refers to a pimp or broker.
Dalal Bari	Houses (brothels) which operate in conjunction with pimps.
Daktari Biggaen	Medical science/knowledge.
Denevala Babu	A man who contributes financially to the household of his sex worker mistress (literally, "one who gives").
Desh	Native place.
Didi	Older sister.
Durbar Mahila Samanwaya Committee	Sex worker's rights organisation in Calcutta.
Flyer	Sex worker who commutes to work and does not reside in the redlight area itself.
Garmi	Literally, 'heat'. Euphemism for genital ulcer.
Gha	Genital ulcer.
Goonda	Thug/ruffian, also gang/mafia member.
Grihastha	'Family' (respectable) household.
Grihastha Bou	Housewife.
Grihastha Meye	'Family' (respectable) girl.
Hafta	Bribe/fine.
Jhulum Bhaji	Exercise of a 'reign of terror'.

Jhummur Dancer	Type of folk entertainer in medieval Bengal who also engaged in sex work.
Jibano	Germ.
Jouno Kormi	Sex worker.
Jouno Rog	Sexually transmitted disease.
Khanevala Babu	A man who lives off his sex worker mistress (literally, "one who eats").
Khanki	Whore.
Khemtawali	Type of folk entertainer in medieval Bengal who also engaged in sex work.
Khistivala	Money lender.
Komal Gandhar	Cultural wing of the DMSC
Kirtan	Devotional song.
Kulin Brahmin	The highest caste of Bengali Brahmins, who practised polygamy, often with women of lower castes or sub-castes until the practice was stopped by the Hindu reform movements of the 19th and 20th century.
Line	Euphemism for 'sex trade' or 'sex work'.
Line Woman/Girl	Euphemism for sex worker.
Line-r Rog	Disease(s) associated with sex work.
Mahila Sangha	Sett Bagan sex workers' group.
Malkin	Madam.
Masi	Literally means "mother's sister" ("auntie"). Used generically to refer to older women. In the sex trade, can refer to 'madam' or to female servants.
Mastaan	Gangster
Maya	Affection/love/pity.
Muhuri	Legal clerk.
Mukhiya	Leader of a group of pimps.
Nagorik Committee	Citizens' Committee (a CPI-M institution)

Nari	Literally means 'vein', 'tube' or 'channel'. Refers to an internal structure located underneath the umbilicus at the centre of the body whose perceived misalignment can cause severe lower abdominal pain.
Nautch	Literally, "dance". Refers to performances given by sex workers to gatherings of men.
Niseddho Pulli	Prohibited place (used to refer to redlight areas).
Nirodh	Indian government brand of condoms.
Panchayat	Institution of local government.
Para	Neighbourhood. Can also mean mercury.
Para Chele	Neighbourhood lads/boys.
Para Dada	Neighbourhood 'big brother'.
Poka	Bug/worm/germ.
Protirodh Komota	Immune system (literally, 'preventive strength').
Rahr	Part of West Bengal that includes portions of Birbhum, Murshidabad and Burdwan.
Rog	Disease.
Sada Srav	White (vaginal) discharge.
Satta	Gambling.
Shakti	Strength/power.
Shot	Sex trade slang for straightforward, quick, vaginal intercourse.
Totka	Black magic.
Vaishnavite	A devotional religious sect that was very strong in medieval Bengal.
Vichar	Judgement (in the context of the sex trade, this is carried out by local community institutions such as the party office).
Zamindar	Landlord.

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APPENDIX ONE

FLIP CHART USED BY THE SHIP

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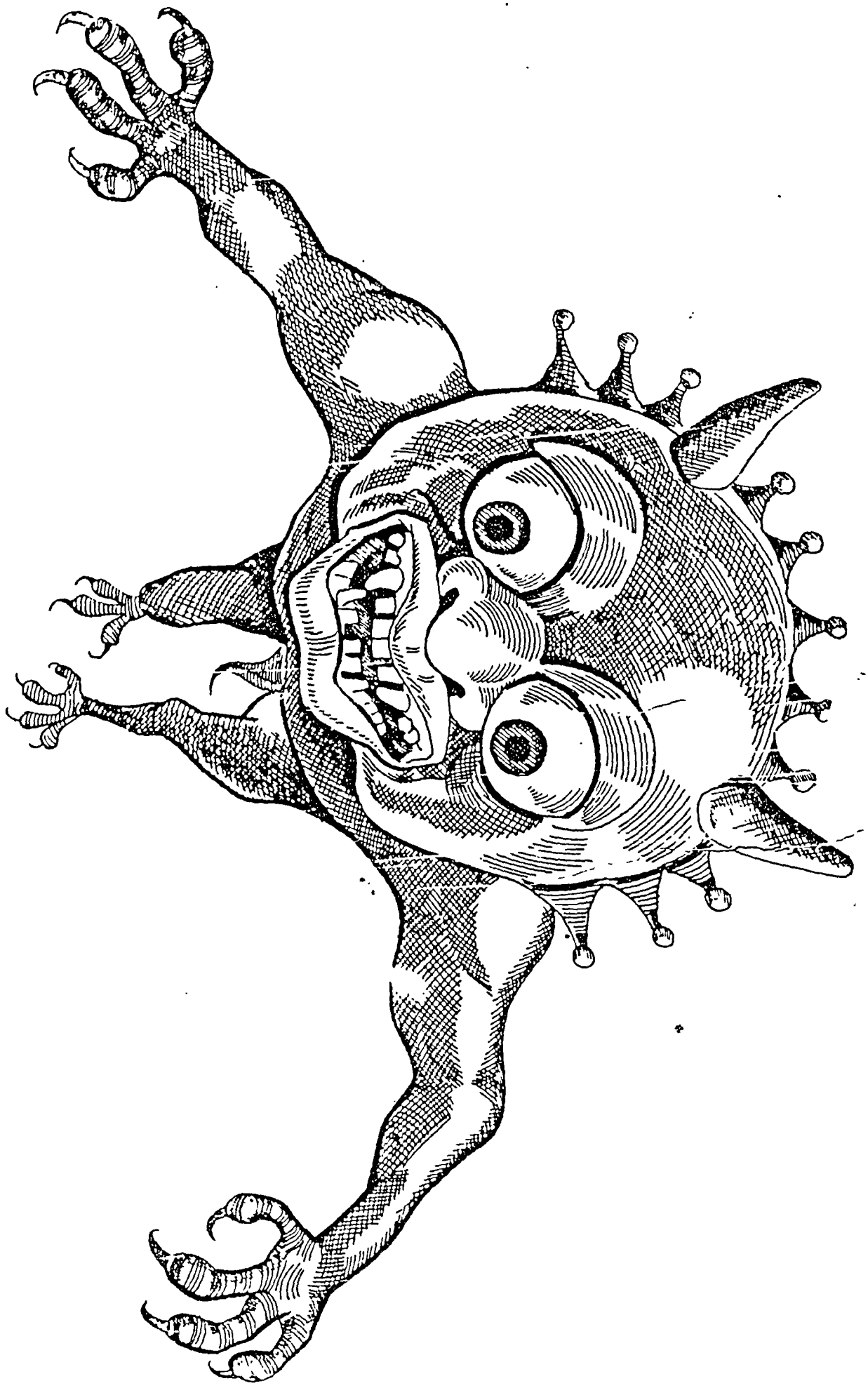

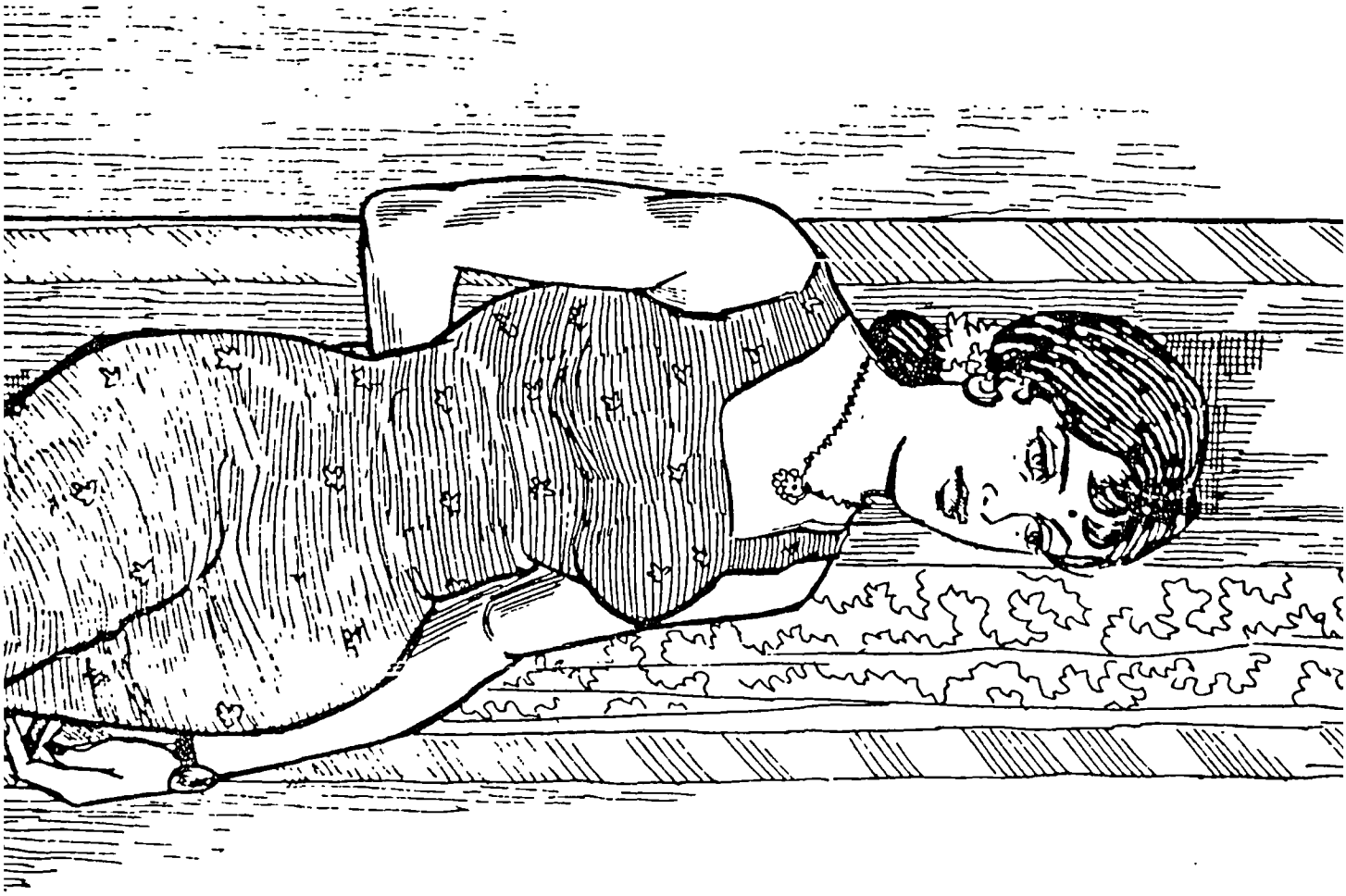

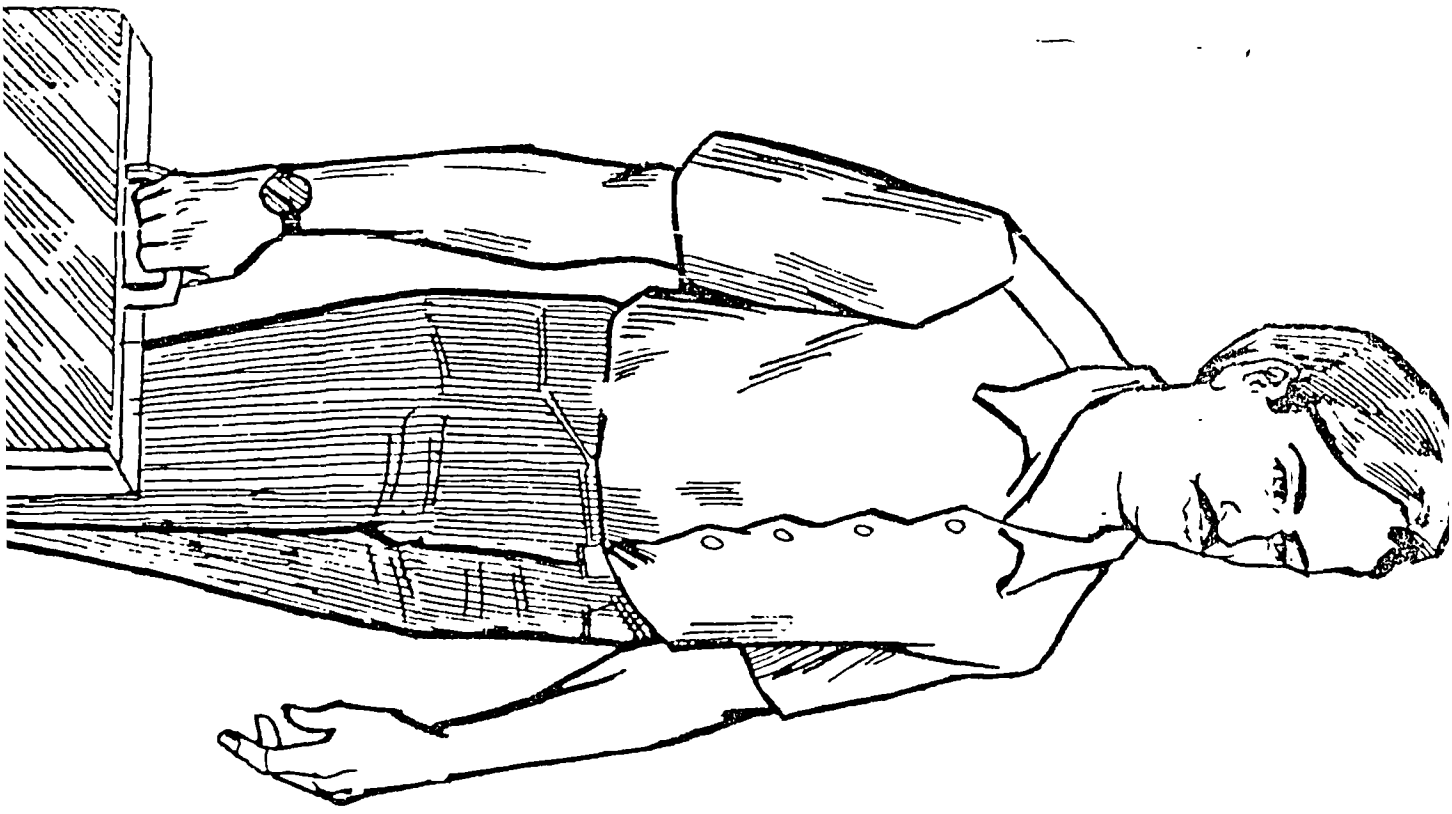

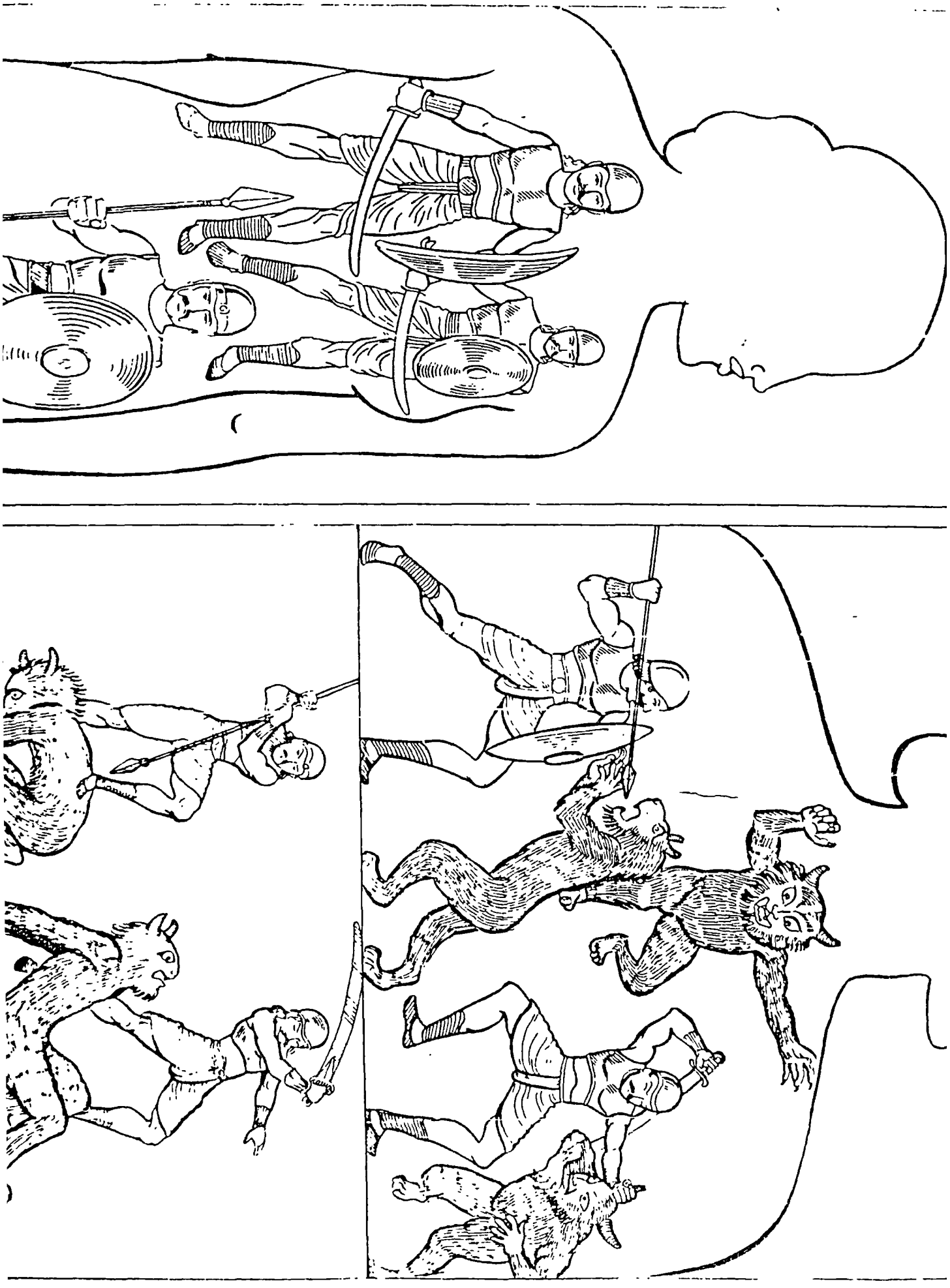

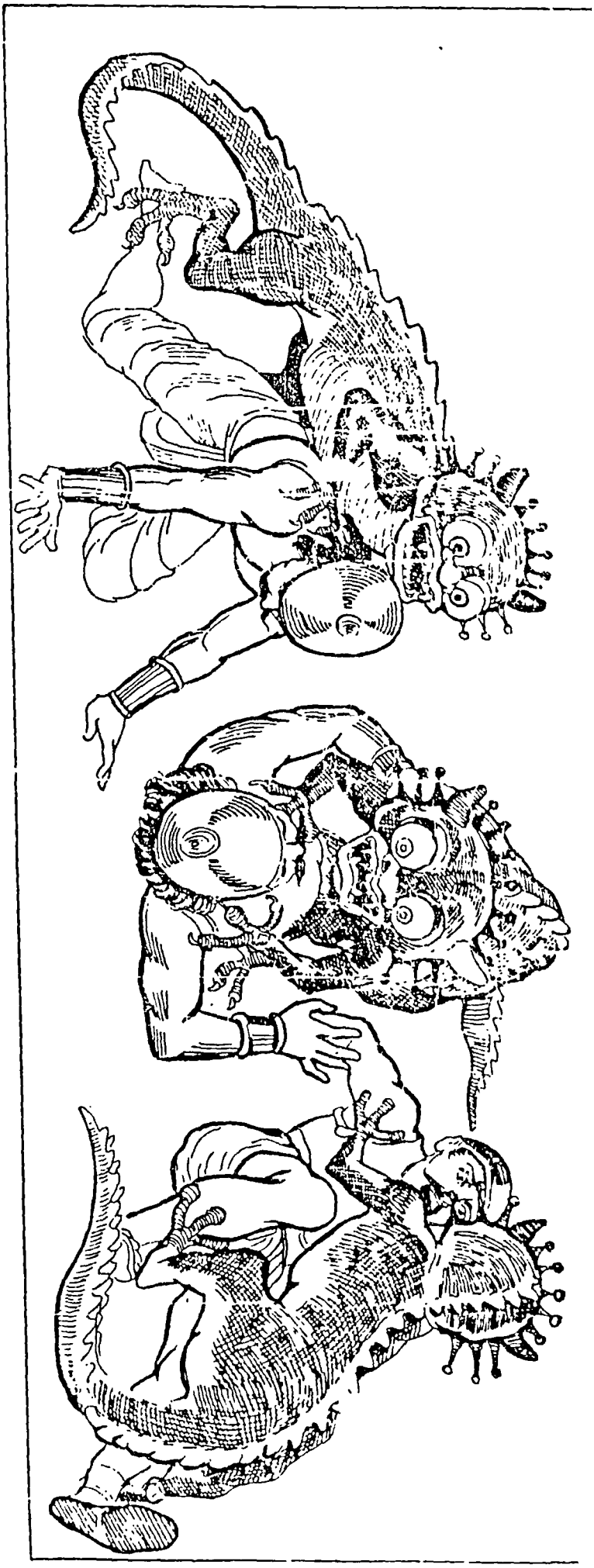

এক মাসের বেশী হয়।

যক্ষ্মা রোগীর থুথু

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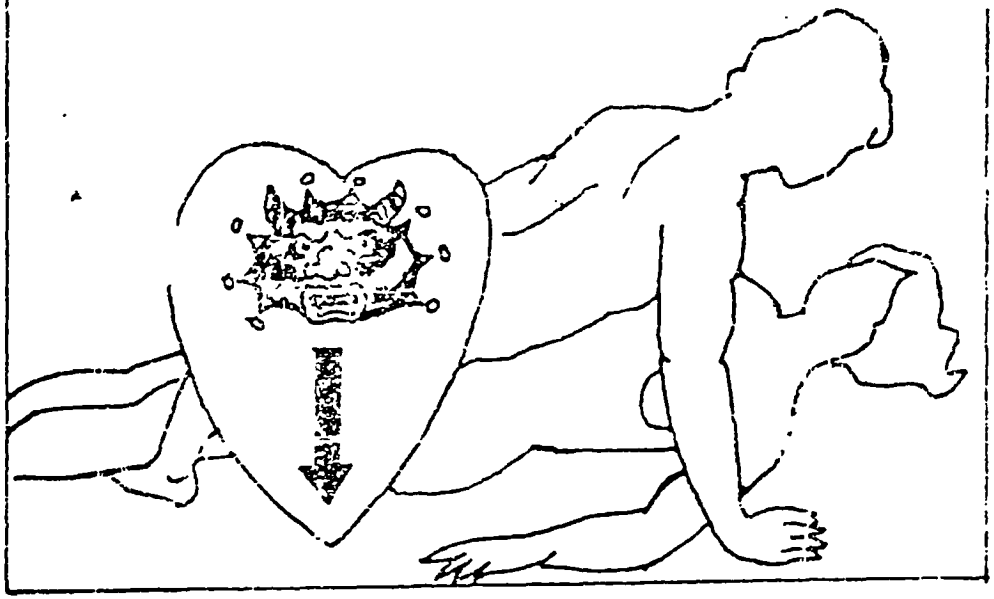

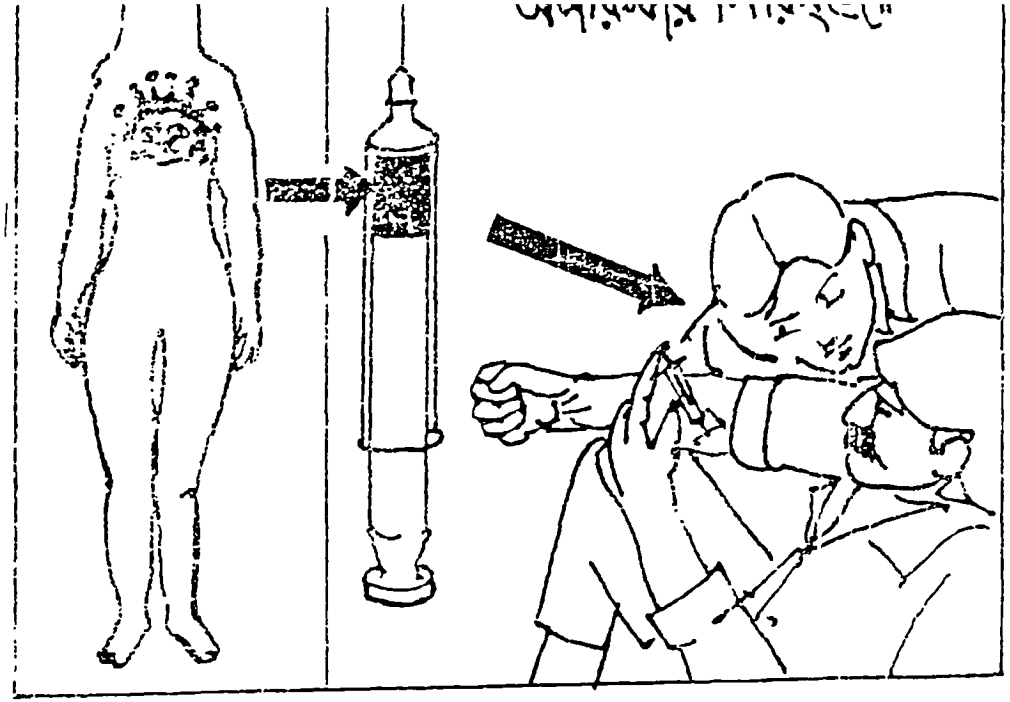

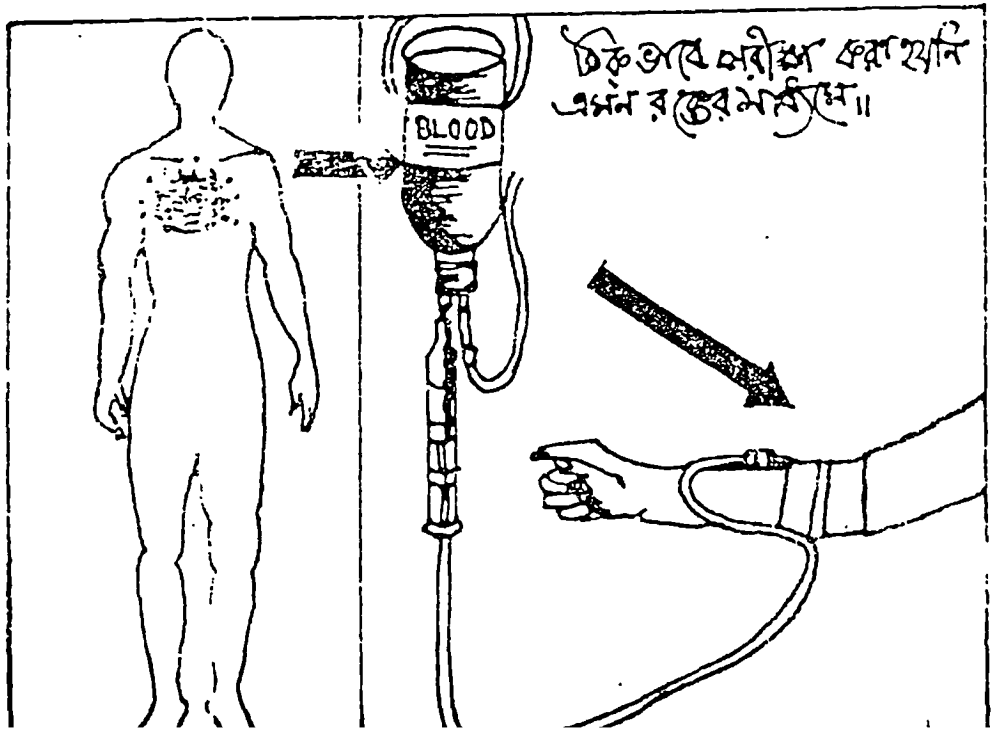

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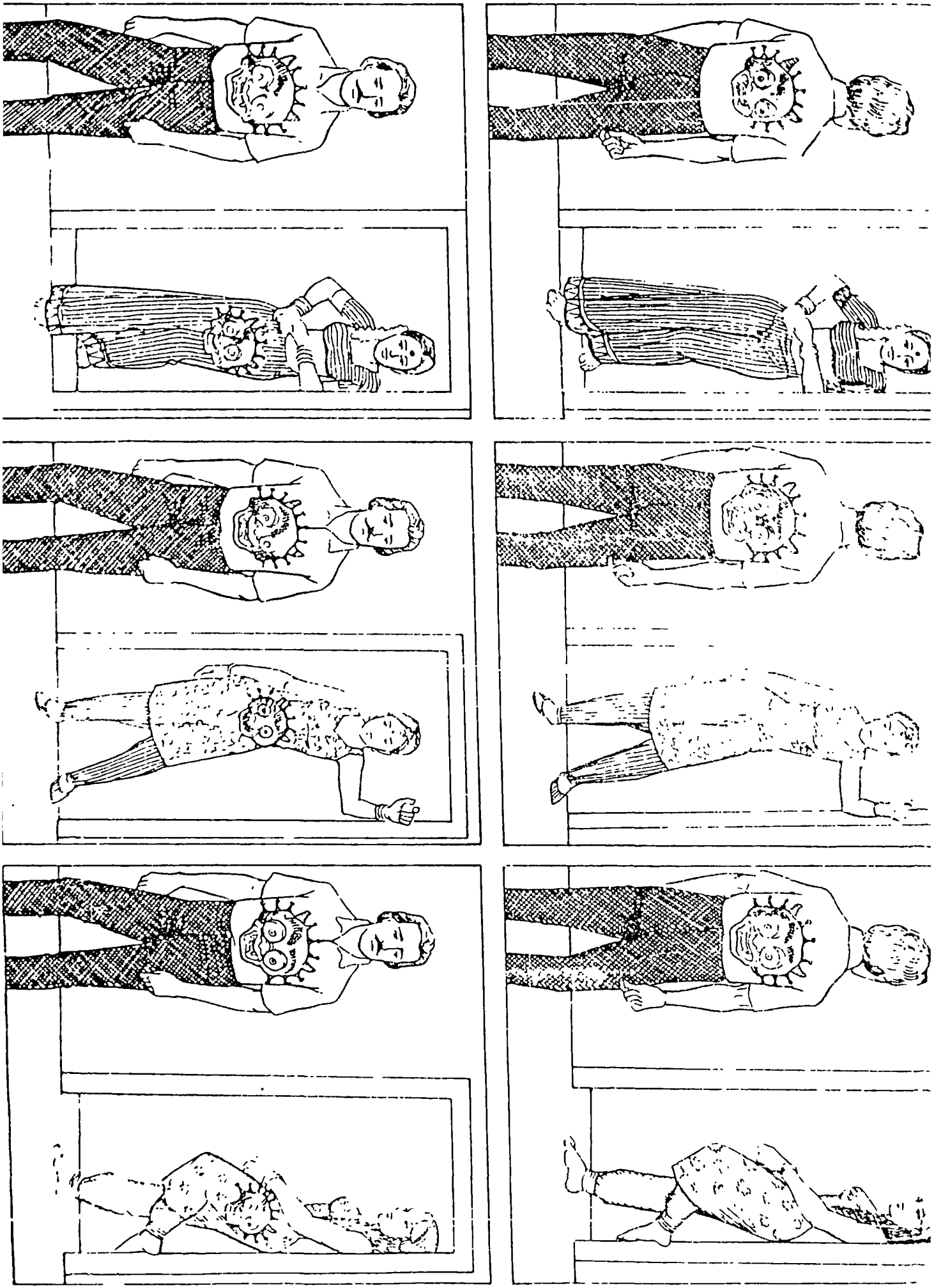

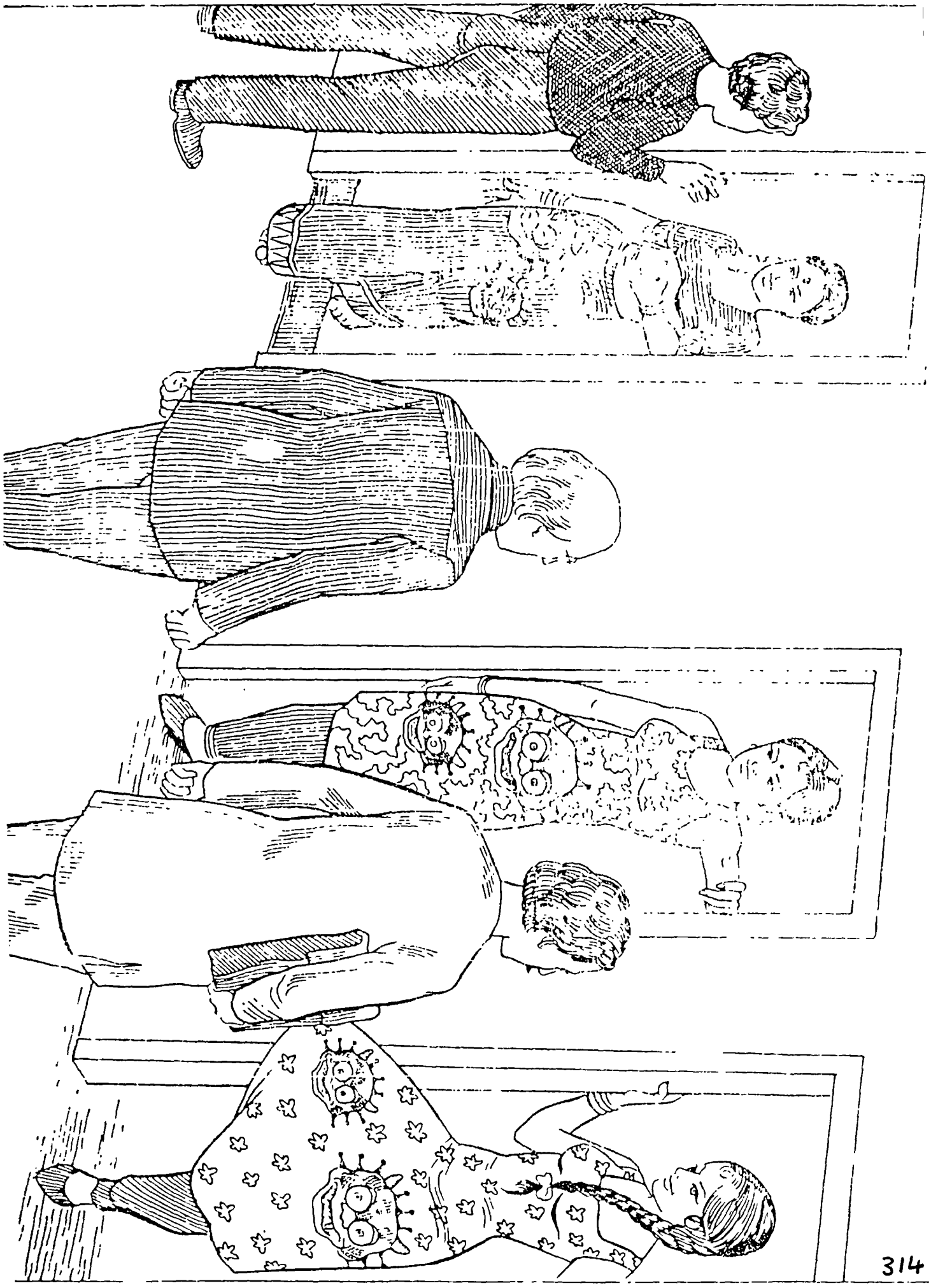

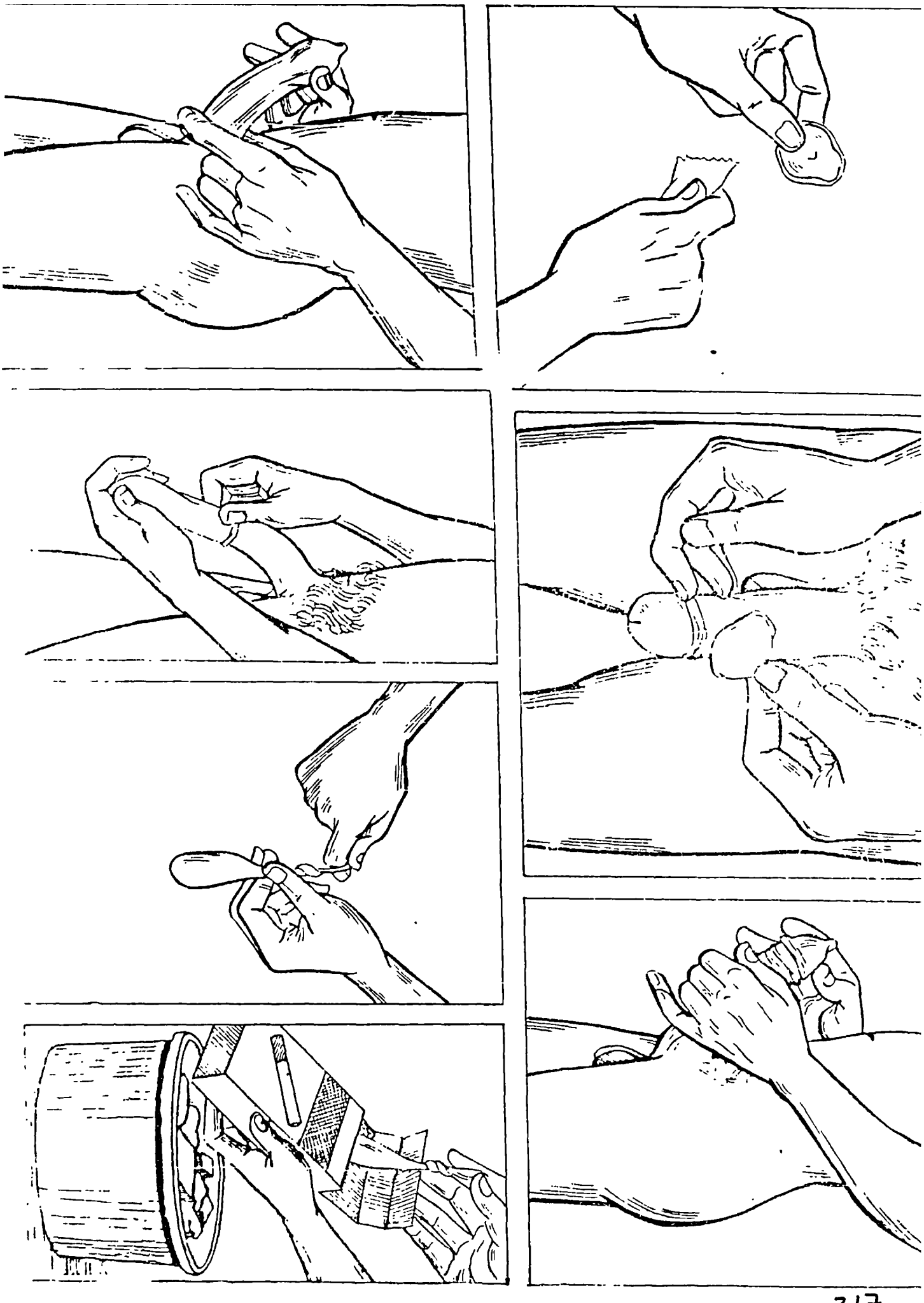

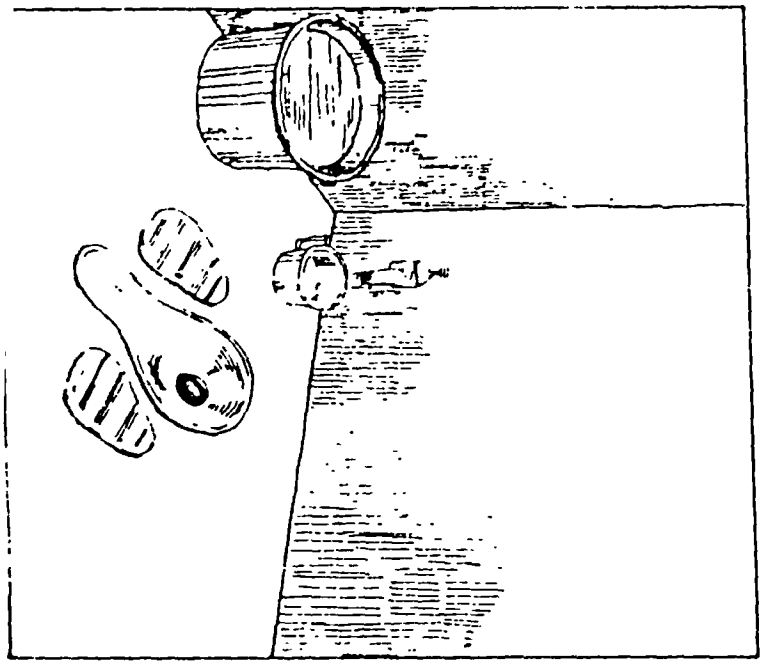

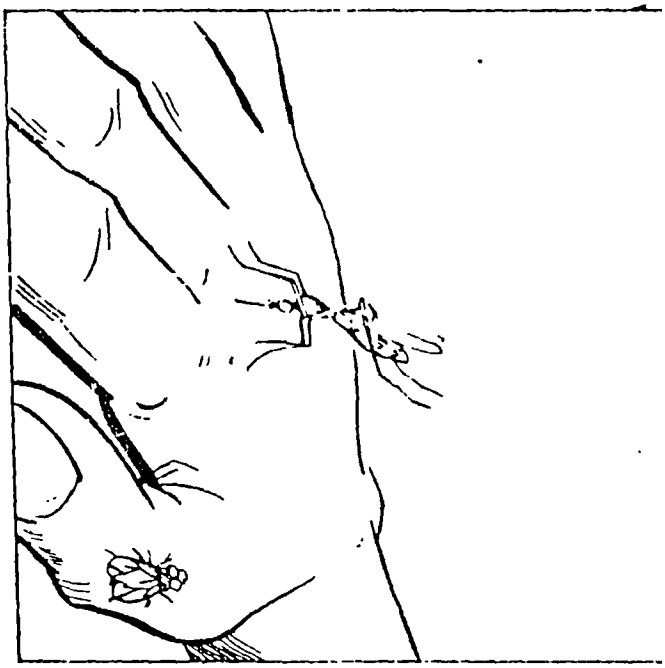

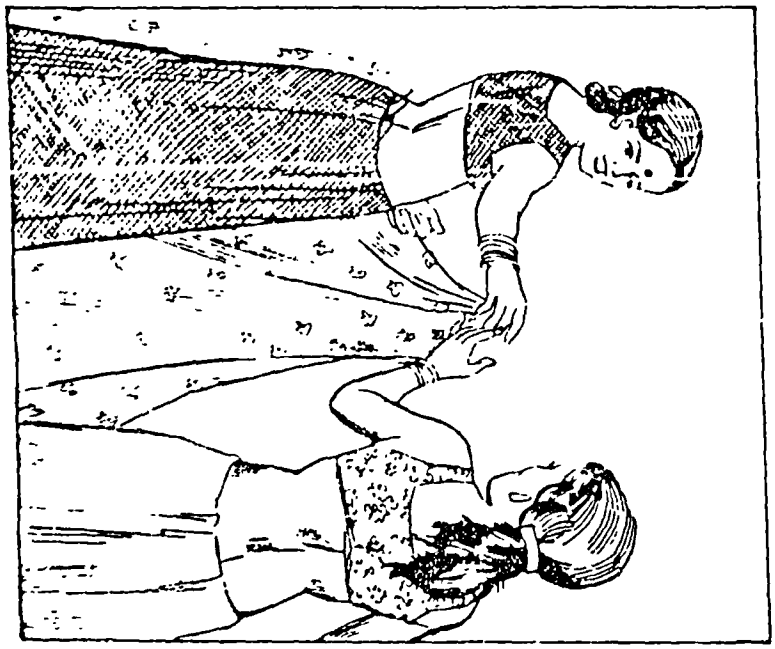

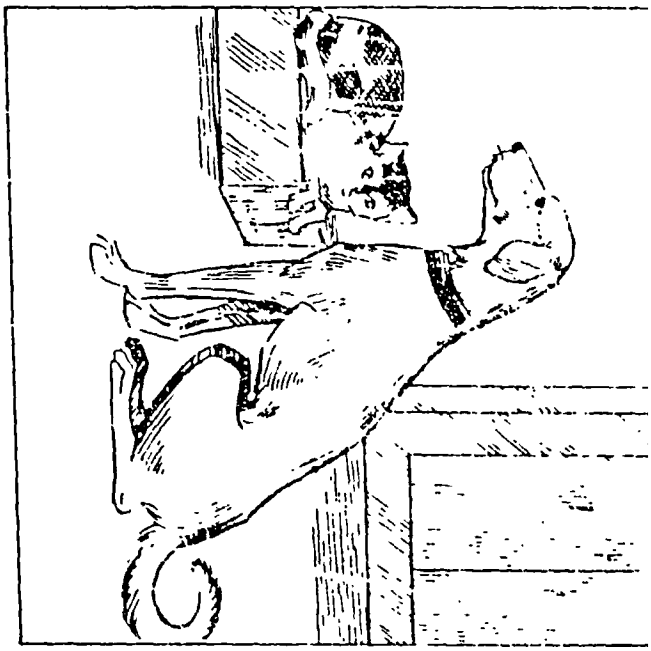

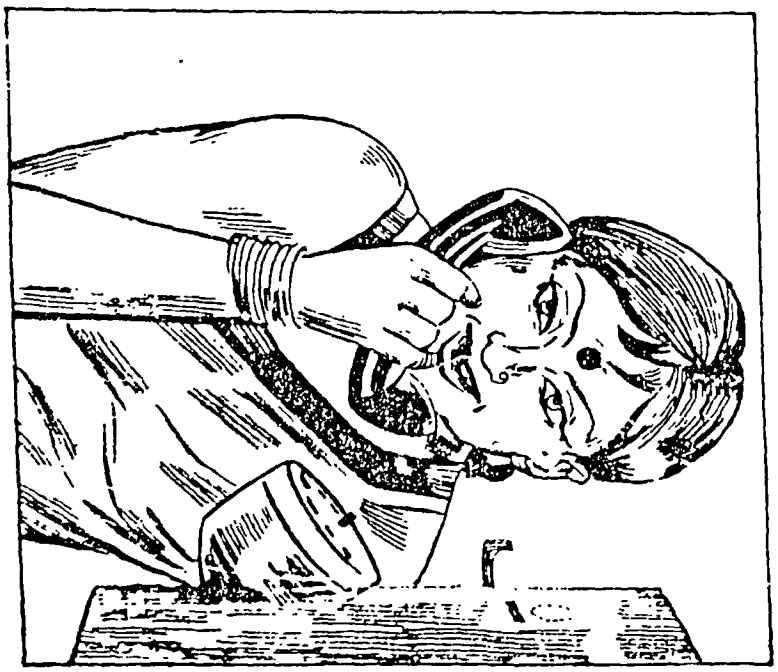

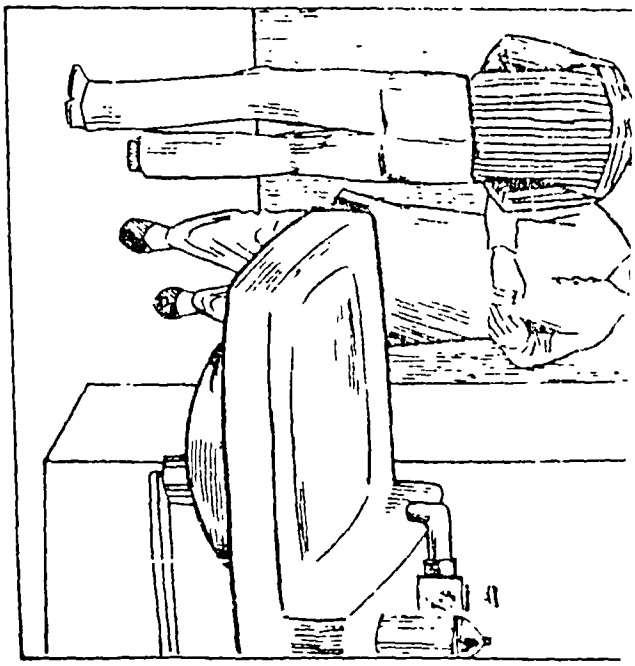

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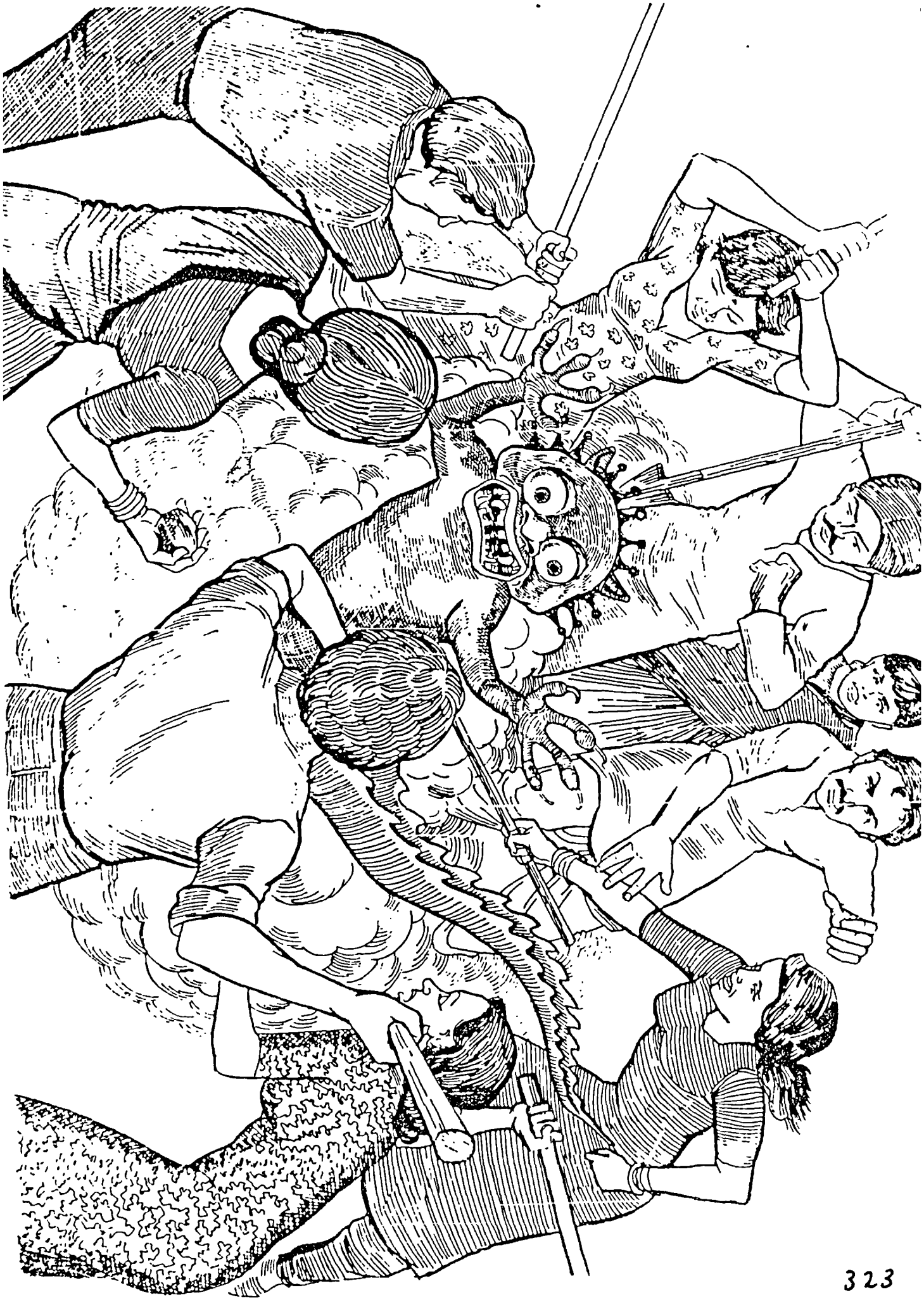

যৌনমিলনের আগে কনডমের ব্যবহার করুন।

APPENDIX TWO

NARRATIVE ACCOMPANYING THE SHIP'S FLIP CHART

(Verbatim narration by an experienced peer educator, June 1996)

Page 1.

This is the flip chart. The name of the flip chart is 'unknown facts about sexual disease'.

Page 2.

How does it look? It looks like a demon, how dangerous it looks - that's how dangerous it is - so dangerous is this disease. This is the AIDS disease.

Page 3.

This is the world. Many groups (*jat*) of people are here, the AIDS germ is over their head. Is it actually like this? No, it is travelling all over the world and it is looking for an opportunity, and it will enter adults by means of sex without condoms, and for children and elderly people, how will it enter? If they have fever or some disease and they go to a doctor and if there is an unclean syringe - one that has been used before, then the disease may be helped to enter the body. If the child needs blood and this is given without testing the blood, then it may also enter like this.

Page 4.

See this lady, how beautiful she looks, and this man is so good looking, he carries a briefcase, he wears good clothes and a wrist watch. To look at them, would you think they had a disease? No matter how good looking a customer is, don't have sex without a condom. When you see someone from the outside you can't understand anything, but if you test their blood there's bound to be some disease.

Page 5.

This is the shape of our body. Inside the body there are pictures of people standing with swords and a shield. Can anyone stand like this inside the body? These are actually our blood's immune strength (*rokto protirodh komota*).

These are the small diseases like fever, cough, cold, syphilis, gonorrhoea, that we might have inside our body and you can see they are fighting it and this is how we get cured.

Page 6.

These are AIDS disease germs. You can see that it is killing them, biting them and fighting them. Is it actually doing that? No, they stay in our blood. These are the AIDS germs and when they enter the body they stay quiet for a while within us and gradually spread in the body,

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killing our immunity. Then we have to lie in bed and no matter how much medicine we take we won't get well because there is no medicine for this disease.

Page 7.

This is a beautiful girl, and she is dressing up. If we hide this spot can you make out that she has a disease? When she was well she had a child. When the child is three or four, then the whole disease has spread in the mother's body - see there are black circles around her eyes, her stomach is sunken in, her hands and feet have swollen up and she has lost weight. When the child is nine or ten, then Ma is absolutely on her death bed. Ma is holding her son and crying and he is hugging her. She says "what disease have I got? Whatever I have earnt I have spent behind medicines and if I die what will happen to you? You will become an orphan".

Page 8.

What are the symptoms of AIDS? Over one month fever - if TB happens to you or if you generally get a fever you will get better if you take medicines, but if you have AIDS and take medicines you won't get better.

In the mouth on your tongue there are white spots. If we have a normal cold we might get that and if you take honey or medicines you will get better but if you have AIDS inside you, you won't get better.

This is a skin disease - any rashes are known as a skin disease - if we have normal itching or scabies and we use neem leaves or raw turmeric or go to the doctor and eat medicines then we will get well. But if you have the AIDS germ inside you it will not heal - from one spot to another, it will increase and increase.

These are swollen glands in the throat, in the underarms and in the groin. If you have a cold you might get this, or if you walk on an uneven road you might get this. If you gargle with hot water or go to the doctor and eat medicines then you will get well, but if the AIDS germ is inside you, you will not get better.

Page 9.

This is a deep kiss. Don't do deep kiss. I am saying not to deep kiss because some people, while brushing their teeth, they bleed and have pyorrhoea. It's not that you will get AIDS, but you might get other diseases like TB, syphilis, gonorrhoea - if the man has it the woman will have it and if the woman has it the man will have it.

Page 10.

The AIDS disease, how does it spread? This gentleman has AIDS and he doesn't know it. This girl is having intercourse with him without a condom, this is how it is spreading.

In this lady is AIDS and she doesn't know it. She has fever and she goes to the doctor - she needed to take an injection and then she went off. People who take heroin, they are together going to take it. The same syringe that was used by the girl, that unclean syringe was used by all of them.

This gentleman has AIDS but he doesn't know it. He has come to the blood bank and whether he donates or sells blood, whatever he has done he has gone off. This man, he has maybe a

serious disease or has had an accident and he needs blood. He has come to the hospital and needs blood and without testing the blood he receive that blood. He came to heal his disease but returned with a very serious disease to his house.

If any mother has AIDS and she is pregnant, then the child may be born with AIDS. Why? because a ma is connected to her child through blood.

Page 11.

Here are three men. Are they three men? No, that is one man. One customer doesn't go to a definite place no? This gentleman has AIDS. In three different areas there are three different line girls. One day he has gone to that girl and without a condom they had sex and he gave her AIDS; another day he went to another girl and without a condom had intercourse and gave the girl AIDS; and a few days later he went to that girl and without a condom had intercourse and he gave the girls AIDS.

Page 12 and 13.

Those three girls are standing in three areas and they don't know they have AIDS. These three men have come to them - this one has a family. They are bargaining here, and they are returning home having had intercourse without a condom, and AIDS has got inside them.

Page 14.

I told you, this man has a family and he came back home and like they do, he gives his bag to his wife - he gave his wife his things and she didn't know her husband was out in a 'line house'. When both were healthy they had this child. Now at night after dinner they have intercourse without a nirodh - the housewife will never take a nirodh no? She got the AIDS germs and she conceived. Here she is pregnant and here she has given birth to a child. In one family three lives are spoilt - what happens to this child? This child has aunts and grandparents but will they take care of him like his own parents? If the father dies the mother will look after the child if she works as a servant or sells herself, but if both die then he has nobody.

Page 15.

Bananas! How do you use a nirodh? Our *didis* give us the nirodh and we don't have to check the date. If we buy from the shop then we have to check the date or we should ask the shop keeper to check for us. If I get a customer I can't immediately say you use a nirodh. make him sit down and talk for a while; we explain to him that see, there are so many diseases like syphilis and gonorrhoea, you don't come to me every day - like this we chat and when his lingo becomes hot we tear the nirodh packet from the side and bring it out and check the front and back and press the nipple to bring out the air. Many men have fat skin and we pull this back from he lingo and put it on. He's doing the work and after he finishes we take it off immediately. We must take it off immediately because some men continue doing it even after the seed has come out, so we quickly take it off and tie a knot and maybe in a cigarette packet we put it in this and put it in the rubbish dump. If we throw it on the road then the children won't know and they may play with it.

Page 16.

The AIDS disease is not infectious (*chuachui*). If a mosquito or a fly bites, it won't happen; from a dog or a cat bite it won't happen; from washing at the same basin, it won't happen; from

using the same bathroom it won't happen; if one has AIDS and you share a sari then it won't happen; using the same phone it won't happen - AIDS is not an infectious disease.

Page 17.

If you shake hands it won't happen; if you kiss on the cheek it won't happen, if you cough in front of someone it won't happen but if there is TB then that might happen because TB germs fly in the air; this man has AIDS and she's massaging him and it won't happen; the mother has AIDS and if the children share her food then it won't happen - AIDS is not an infectious disease.

Page 18.

Our madam is explaining to five different girls to use Nirodh - she says that with every customer you should use a nirodh, also so that these girls don't get a child in their stomachs every few months, and that they don't get syphilis and gonorrhoea. She says this new disease has come called AIDS and you will be free of that if you use a nirodh with every customer - then you will remain healthy. I will earn two paise for myself and you will earn two paise for your family.

Page 19.

This is our clinic - it is open every morning - the *daktar babu* sits there and it is free of all cost.

Page 20.

Every three months your blood is tested - this girl is giving blood and this one is scared and the third girl tells her it is just a little blood, don't be scared - like this she is breaking her fear and she also gives blood.

Page 21.

See, the AIDS disease germ, they are trying to kill it. With sticks and stones, will it die like this? If we follow these four rules - use a clean syringe, use tested blood, have intercourse with a nirodh and don't do deep kiss - if you follow these four rules then this disease will not spread in this country.

Page 22.

Here you are shown a clean syringe and tested blood. And what is this? this is where they test your blood and stay away from syphilis and gonorrhoea. Those who have syphilis, it's like grainy ulcers (*dhana dhana gha*) and those who have gonorrhoea you get blood and pus coming out. For syphilis you can test blood and find out and for gonorrhoea you can do a swab test and find out - and for every time you have intercourse, use a nirodh.