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Living with “Risky” Bodies

In Kolkata, female sex workers’ well-being is overshadowed by practices and conceptions around HIV/AIDS.

Simanti Dasgupta

At around 10:00 a.m. each day, peer educators and outreach workers involved with the HIV/AIDS prevention program started to arrive at Abinaash Clinic in Sonagachi, the iconic red light district in Kolkata. Most were current or former female sex workers and members of Durbar Mahila Samanwaya Committee (DMSC), a grassroots sex workers’ organization. They discussed topics mundane and eventful—the rising price of vegetables, a police raid on a brothel—over cups of tea until the coordinator took attendance and they gathered in groups to leave for the field. Each group of peer educators and outreach workers had a designated number of female sex workers to visit and I would accompany them as part of my fieldwork. Field visits typically involved calling on female sex workers who were part of the program to remind the women of their upcoming checkups, which are scheduled every three months. Often the checkups were overdue and peer educators would insist that the women accompany them to Abinaash Clinic to be tested immediately. Peer educators and outreach workers also spent time identifying newcomers to the district, inviting them to the clinic for an initial medical checkup, and introducing them to the Self-Regulatory Board, which DMSC set up in 2005 to prevent trafficking of minors and unwilling adults.

The main goal of the outreach program is to prevent the spread of HIV infections through condom programming based on a public health initiative, Sonagachi HIV/AIDS Intervention Program (SHIP), launched by the All India Institute of Hygiene and Public Health in 1992. However, the identification of female sex workers as a high risk group for HIV has compounded their existing struggle in which the state medical regime now construes and constructs the women as “risky” bodies in need of targeted intervention. High-risk group status has conferred a kind of hyper-visibility on female sex workers—unthinkable were it not for the looming menace of HIV/AIDS. But, the construction of their bodies as risky simultaneously renders them *invisible* in their everyday struggles for health, obscuring their claim to comprehensive medical care and their general sense of well-being. In this uneven construction of risk, can “risky” bodies claim well-being? Or does the notion of high-risk group legitimized as a public health decree intrinsically exclude those who disproportionately bear the brunt of associated social stigma? How do the female sex workers experience and negotiate this uneven terrain?

In this context I locate two interrelated themes that emerged during the field visits: the first relates to a studied reluctance on behalf of female sex workers to collect their HIV/AIDS test results. The second relates to a recurring narrative of the struggles of motherhood and maternal care.

Though some women would procrastinate over going to the clinic for the routine checkup, most would eventually attend for tests, deeply familiar with the health and economic hazards of HIV. Often the peer educators needed to play a maternal role in order to encourage testing, especially with the younger women, by reiterating the threat that contracting the virus would pose to their livelihoods. However, many female sex workers were reluctant to collect their test results at “Tropical” (the School of Tropical Medicine), the neighboring public hospital. Their reluctance revealed a deeper structural entanglement of hyper-visibility/invisibility. When I enquired about their hesitation to pick up the report, the women’s response was unanimous: they experienced discrimination at the hospital, which intensified the social

stigma they experienced every day as “prostitutes.” I offered to accompany some of them to Tropical and they appeared reassured. Perhaps my educated middle class affiliation would assuage their negative experience. And I could also act as an intermediary by communicating with hospital staff in English, a prime source of social capital in urban India.

My first trip to Tropical was with Minati-di, whose HIV had progressed to AIDS and who had also contracted tuberculosis. Minati-di had been aware of her HIV-positive status for the past four years, but when the doctor (who was directing all conversations solely towards me) broke the news of AIDS, she visibly broke down. As I was trying to console her, the nurse glibly remarked, “What else do they expect?” Her comment echoed a wider social perception of female sex workers as “fallen” women, undeserving of health and unworthy of empathy. On another occasion, a clerk saw that the address listed on test results was in Sonagachi and proceeded to cautiously and ostentatiously hold the piece of paper by the corner before dropping it across the counter to the sex worker. I witnessed a hospital staffer vigorously rub down a pen with his handkerchief after a female sex worker used it to put her initials on a form.

It is important to note that while the women actively claimed their sex worker identity within Sonagachi, they temporarily abandoned it when outside the red light district, especially when under medical surveillance in the public hospitals. During my work with National Aids Control Organization (NACO) officials in New Delhi, I mentioned these biased practices in public hospitals and the response was limited to the familiar public health discourse, in which the high-risk groups “pay the price” to protect low-risk populations. I wanted to know more: What about the male customers? Should they not be included as a bridge high risk group? The NACO members admonished me for asking and replied that as an upper caste/class educated woman I should know that “…listing customers would implicate many respectable men who visit the red light district. And we are only following global recommendations.”

On another field visit we entered a brothel and settled down with a cup of tea. The conversations among the peer educators and outreach workers and the female sex workers were marked by fluidity based on their shared experiences. The exchanges often veered in multiple directions with one consistently recurrent theme: motherhood. As several female sex workers observed, motherhood symbolizes the attainment of womanhood and an experience of sexuality that is distinct from their everyday transactional labor. Considering the nature of their work, female sex workers find it challenging to bring a pregnancy to term and they are justifiably worried about the wear and of sex work on their reproductive health. Further, many will undergo several abortions in their lifetimes. In these situations, the women prefer to pay more to private practitioners rather than subject themselves to the alienating experience of the public hospital where services are highly subsidized.

The predicament of motherhood is not new. The discourse of reproduction and reproductive rights is not exceptional; its recurrence in conversations indicates the depth of medical disenfranchisement the women experience. One sex worker, Jamini-di, when faced with the conundrum of continuing being pregnant with her lover’s child and losing her livelihood for nearly a year, reluctantly decided to abort the fetus at a private clinic. The cost to her was not simply economic but, as she reflected, the experience “was both known and unknown to me…but every time it still feels new, something dies inside me, both symbolically and really. But I also know I will be back in that clinic, again and again.” Jamini-di had a son but wanted to have a daughter. Each time she becomes pregnant, she told me, she makes “the same mistake of thinking, the time has come. The government has set up this HIV clinic here, why can they not help us with becoming mothers?”

The condom programming has been rather successful since the start of the SHIP in 1992 and as a result SHIP is promoted as a replicable model in other red light districts nationally and around the globe. The existing literature on the Sonagachi Project and DMSC leans heavily on the notion of empowering sex workers through programs such as this. And there is some merit to this argument—the use of condoms is rather high in Sonagachi and since beginning fieldwork in 2011 I have not met a single female sex worker who does not understand the etiology of HIV/AIDS and the proven prophylactic value of the condom. Nonetheless, this notion of "empowerment" does not question the construction of risk and risky bodies that by medico-technocratic design routinely buries larger issues of health and well-being of the sex workers.

The sex workers' discursive practices of reluctance and recurrence that I present here are not exclusive. Rather, they are constitutive and enmeshed in everyday negotiations and strategies intended to preserve well-being while inhabiting bodies indelibly marked out as "risky". Here, we need to ask if "risk" and health might be irreconcilable after all, especially for those in the social margins.

Note. All names used here are pseudonyms to protect the anonymity of the sex workers.

Simanti Dasgupta is an associate professor at the University of Dayton. Her current research examines a sex workers' rights movement in Sonagachhi, India, at the intersection of medicine and law. She is the author of *BITS of Belonging: Information Technology, Water and Neoliberal Governance in India* (2015)