ABORTION ASSESSMENT PROJECT - INDIA

"PROFESSIONAL" ABORTION SEEKERS: THE SEX-WORKERS OF KOLKATA

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HEALTHWATCH TRUST

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Centre for Enquiry into Health and Allied Themes

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Swati Ghosh

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PREFACE

Abortions have been around forever. But at different points of time in history it has received attention for differing reasons, some in support of it, but often against it. Abortion is primarily a health concern of women but it is increasingly being governed by patriarchal interests which more often than not curb the freedom of women to seek abortion as a right.

In present times with the entire focus of women's health being on her reproduction, infact preventing or terminating it, abortion practice becomes a critical issue. Given the official perspective of understanding abortion within the context of contraception, it is important to review abortion and abortion practice in India.

The Abortion Assessment Project India (AAP-I) has evolved precisely with this concern and a wide range of studies are being undertaken by a number of institutions and researchers across the length and breadth of the country. The project has five components:

I. Overview paper on policy related issues, series of working papers based on existing data / research and workshops to pool existing knowledge and information in order to feed into this project.

II. Multicentric facility survey in six states focusing on the numerous dimensions of provision of abortion services in the public and private sectors

III. Eight qualitative studies on specific issues to compliment the multicentric studies. These would attempt to understand the abortion and related issues from the women's perspective.

IV. Household studies to estimate incidence of abortion in two states in India.

V. Dissemination of information and literature widely and development of an advocacy strategy

This five-pronged approach will, hopefully, capture the complex situation as it is obtained on the ground and also give policy makers, administrators and medical professionals' valuable insights into abortion care and what are the areas for public policy interventions and advocacy.

The present publication is the Eighth in the AAP-I series of working papers. This paper looks at abortion and contraceptive practice amongst sex workers in Kolkatta. It is based on a fiscal study done by the author.

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We look forward to comments and feedback which may be sent to cehat@vsnl.com Information on this project can be obtained by writing to us or accessing it from the website : www.cehat.org

Ravi Duggal
Coordinator, ***CEHAT***

14th October 2003

ABSTRACT

This is a paper on the practice of abortion and prevention of pregnancy among the sex-workers. In recent times sex-workers are emerging as a category of professionals claiming workers' rights. Identified as a high-risk group for AIDS, the use of contraceptives has become a very important issue within the profession. This paper explores the impact of the workers' rights movement on termination of pregnancy and contraception in the last few years in Kolkata. Secondary data being scarce, the study is based on in-depth personal interviews of brothel-based sex-workers. Information regarding abortion services, contraceptive devices and childbirth are collected from traditional red light areas of Sonagachhi, Kalighat and Khidirpur in Kolkata. Aspects such as access to abortion services, prevailing patterns of contraceptive use and family structure of the sex workers have been examined. Apart from data, practices, experiences and linkages within the trade were also enquired upon through the interviews.

It is observed that the incidence of abortion is high among the sex-workers. With legalization of abortion, dependence on unregistered private clinics has been largely replaced by state hospitals. The nature of power structure within the trade and the income differential among women were two important determinants regarding choice of the service. Sex-workers bonded within power relation were forced to avail unregistered, clandestine health clinics for termination of pregnancy that did not guarantee safety and care. Areas, which were not strongholds of the sex-worker's forum, could not attempt to break through the power nexus of the trade yet. Legalization of MTP had enhanced autonomy and mobility for sex-workers but only for the ones with greater relative autonomy. The differential nature of the trade persisting at different locations shaped the economic standing of each woman and hence influenced her choice.

Sex-workers depended on traditional mode of prevention although use of modern devices was initiated. Rather, termination and prevention of pregnancy existed simultaneously. The shift from abortion to a specific preventive mode of condom use was yet to be established although it was projected as the most effective preventive against infection from STD/ HIV. The sexual trade market was demand driven and the only route to universal use of the condom in sex-work would be possible through the education of the male client to be responsible in the relationship at one level and strengthening the regulations at the supply end for compulsory condom use.

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"Professional" Abortion Seekers: The Sex-workers of Kolkata*

I. Introduction

This paper deals with the practice of termination and prevention of pregnancy for a specific group of women- the sex-workers. The sex-workers are in a way the largest client group for abortion service. In recent times sex-workers are emerging as a category of professionals claiming workers' rights. Identified as a high-risk group for AIDS, the use of contraceptives has become a very important issue within the profession. This paper explores the impact the workers' rights movement has had on termination of pregnancy and contraception in the last few years in Kolkata. The paper is divided into four sections:

- The first section is the introduction that defines and frames the problem.
- The second section deals with methodology and describes the construct of the study. The sex-workers are a somewhat less visible and accessible group. Since secondary data is not available, the study as organised on primary survey has been described in the section.
- The third section discusses the findings and explores the new dimensions in the arena of reproductive health for women sex-workers on issues like abortion, childbirth and use of contraceptives. It examines the changes resulting from the workers' movement, which claims to make the brothel-based sex-workers a socially aware group of professionals.
- The concluding section raises issues and concerns that emerge from the findings.

The sex-worker is a 'public' woman, associated with sexual pleasure and stands in opposition to the family oriented woman. She, by her very existence is *excluded* from the domain of procreative sex and this makes her a specific subject of study. With the socially assigned role of fulfilling male desire, the sex-worker's body becomes a significant site for exploration with respect to the reproductive health of a woman. We examine the various aspects of conception, contraception and abortion related to the brothel based sex-worker woman.

Reproductive health acquires new meaning with respect to a sex-worker. In spite of the fact that reproduction is socially prohibited for a sex-worker woman, the sexual performance that is required of her cannot isolate pleasure and procreation as two separate spheres of activity. The sex-worker as the active female partner of the non-familial, heterosexual activity carries out a contractual performance in exchange for money. The activity is a means of livelihood for her and whether out of volition or out of coercion, she has to fit into the pleasure-giving role assigned to her within a sexual interaction. The onus to remain within the non-reproductive, non-familial, pleasure-giving domain rests on her.

As it is, the chances of conception are very high for a sex-worker. Frequency of sexual contacts with male clients as part of

the profession is remarkably high for her compared to a single partner woman. Involved in frequent heterosexual relations and yet not conceiving is indeed a precarious situation for sex-workers. Some sort of conscious effort and intervention is required on part of one of the partners involved in the activity. Since a sex-worker serves to fulfil the impulsive, spontaneous and 'natural sexual desire' of her male partner, and she is paid for the service she provides, the male partner bears no responsibility towards sexual activity on his part. For him the sex-worker is the source of pleasure for which he is paying, therefore, restrained and planned sexual practice is not to be expected from him. It is thus the sex-worker who has to be aware of the possibilities and get rid of the chance pregnancy that might occur at the spur of the moment in intercourse with a client.

Thus, abortion becomes a familiar word for a sex-worker and to get rid of unwanted pregnancy does not bear the connotation of inhibition, as is found with women in a family setting. Conception is more a work hazard and getting rid of unwanted pregnancy is part of the trade within which a sex-worker has to function. As soon as she is initiated into the trade a sex-worker learns the trade secrets, the dos and don'ts of the profession, Thus prevention and termination of pregnancy are age-old practices that a brothel-based sex-worker learns to manoeuvre from the moment she becomes a professional.

When 'scientific' methods for prevention or termination of pregnancy were not available to a sex-worker, she took to other modes of popular, traditional knowledge readily available to her. Adoption of 'scientific' contraceptive measures for prevention or medical termination of pregnancy involved various factors other than the just the sex-worker's choice.

Firstly, the sex-worker should be made aware that such measures are available as alternatives before her choices are made.

Secondly, a shift in the decision-making process in favour of modern techniques had to be popularised as cheap, convenient and effective means of prevention among sex-workers from brothels who were to a large extent illiterate and ill informed.

Last, but most important, the proponents of the modern, 'scientific' measures needed to be aware of the sex-workers as a target group — if not as a specific category of professional workers — at least as a 'necessary evil' existing in the society[1].

The brothel-based sex-worker being excluded from mainstream society was never within the welfare policy of the state. Eugenics had always been the responsibility of the state, and therefore the family planning program had emerged as a priority in population policy of the state from the very beginning. For responsible citizens planned and restrained practice of sexuality with an eye towards the size of the family and health of the present and future family members were publicised as an important welfare agenda. But the sex-workers of the red light areas, the *lesser citizens*, marginalized in society and excluded from family and hence from the welfare measures of the state, often went unnoticed. Since the last century they have been objects of social and moral reforms and spatially isolated in the brothels as an indispensable segment of society that was an 'eyesore' but could not be done away with.

> *The health of brothel-based sex-worker women became a cause for concern only when male health was impaired from the diseased, infectious bodies of the sex-workers. This was true historically, in colonial times as well as in post-colonial India[2].*

Therefore, we find that it is only with the advent of AIDS that the health of sex-workers becomes an important subject of query[3]. As a high-risk group they have become the target of health policies across the globe. International concern regarding AIDS permeates national health policies concern-

ing reproductive health, immunity and physical well being of the sex - workers. Among others, the sex-workers of the red light areas have emerged as the significant risk-prone group infecting and getting infected by AIDS. For any intervention to take place, the recognition of prostitution as work and prostitutes as worker is of critical importance. She acquires the status of a marginal worker and the use of condoms becomes more a means for preventing infection from sexually transmitted diseases than a regular contraceptive.

In this respect, the shift from the practice of terminating pregnancies to the preventive mode of using contraceptives requires to be examined. This becomes further important in the light of the contemporary debate regarding granting of worker's right to sex-workers initiated in the last ten years in Kolkata[4]. The question of conception and prevention of childbirth becomes an important issue with respect to the workers movement at this juncture since the movement is trying to incorporate the brothel-based sex-workers as professionals in the entertainment-service by erasing the moral stigma that prevails in society.

The objectives of the study can be summarised as follows:

To study the trend in the practice of abortion with respect to awareness regarding its legalisation.

To observe the usage pattern of contraceptives among sex-workers, and

To trace/access the impact of workers' rights regarding the issues of abortion and

contraceptive-use that has emerged in the last decade.

II. METHODOLOGY

The study seeks to deal with qualitative information regarding a very private aspect in the lives of sex-workers. It is concerned with personal decision-making about her body, sexuality and reproductive health as related to aspects of livelihood. The study is based on the content analysis of 25 case studies of brothel-based sex-workers. Since secondary data directly related to the topic was scarcely available, the significance of interview-based survey was immensely important for this kind of study. In-depth personal interviews of sex-workers have been carried out with the help of an interview guide. Information regarding abortion services, contraceptive devices and childbirth were collected, focusing on aspects such as the availability of and access to services, the prevailing patterns of usage and the nature and extent of preferences for various modes. Apart from data, attributes related to quality practices, experiences and aspirations were also enquired upon through the interviews.

Among the different categories of sex-workers, the brothel-based, flat-based, call girls/escort women, streetwalkers, 'flying' women [5], only the brothel-based sex-workers were selected for this study. The major reason for this selection was that the workers' rights movement was initiated and restricted primarily within the brothels of Kolkata and in no way has the movement been extended to incorporate the other categories of sex-workers. Prostitution in Kolkata was predominantly brothel based [6]. Besides, the sex-workers of the red light pockets are directly visible as regular practitioners and are confined to specific zones within the city. Among the other categories of women in prostitution, some are part-time practitioners and work as and when required by them. Some others are difficult to identify operating as they do on the streets at different locations, while few others in fixed locations preferred to operate anonymously without disclosing their nature of work. Since the worker's rights movement did not include them, they do not form part of the present study.

Criteria for selecting the sample of sex-workers were - different urban locations, awareness about worker's right, age, income

and origin. Different traditional locations of brothels where prostitution was organised in various ways were covered under the study. Sex-workers have been selected from three important red light areas within Kolkata. The geographical locations for selecting the sex-workers included Sonagachhi, the largest red light area in the whole of West Bengal and also in Eastern India, Khidirpur, another large zone for brothel based prostitution in the dock area and a very old red light pocket around the temple of Kalighat. In each of these traditional pockets, prostitution was organised differently. In Kalighat, sex-workers were independent, self-employed workers operating without the help of pimps, in Khidirpur, the control of pimps and madams was very rigid and strong while in Sonagachhi, the elaborate trading network incorporated a wide range of sex-workers operating between different degrees of autonomy and bondage**. The difference in the status of sex-workers within the trading network was important because it influenced their decision-making accordingly.**

It may be mentioned that Sonagachhi is also the area where organisation of the sex-workers was initiated and since then it has remained the most important base for organisational activity. The NGO based STD/HIV intervention project was started at this site that soon dovetailed with the demands for health care by the sex-workers' organisation. In Kalighat the association of workers movement and health awareness was not strong. While, NGO-led health awareness projects have provided the impetus, claim for workers right is not firmly grounded or well-received among sex-workers in this area. In Khidirpur, both health awareness and concern for workers rights are only in their early stages. The extent of involvement in sharing the ideas regarding worker's rights among sex-workers was an important criterion because it influenced their views regarding termination and prevention of pregnancy. It also made them more articulate and assertive about their maternal role, reproductive right and issues on health. Their readiness to share their views and experience of undergoing MTP was also different at each site.

To get a variation in the mode of practices and behaviour across class, caste and origin, sex-workers from different age groups and different income groups have been covered. Women from Bangladesh, Nepal and from different districts of West Bengal landing up in the brothels of Kolkata were included in the sample. Age was an important consideration for selection of sex-workers. Within the reproductive span of 15 to 45 years, women from different age groups were chosen. Older women were also included to provide information regarding traditional knowledge about the methods of termination prevalent before the legalisation of abortion. It was relevant to depict the contrast in the current context. The sex-workers with and without children, the sex-workers belonging to various income levels in the different age groups were selected for the study. Per day income of sex-workers, ranging from less than rupees 250, to rupees 500 and above was used to classify them into three groups of earners. The selection design of the respondents as regards the above-discussed criteria has been given in tabular form in Annexure I.

The NGOs and local organisations working among the sex-workers with various objectives were immensely helpful in setting up rapport with these women. In spite of being legal, abortion was not discussed very openly and decisions on use of contraceptives were very private ones. This required long hours of intimate conversation with sex-workers in the brothels fitted into their busy schedule of attending to clients. The survey and the interviews could be held only during afternoon hours, before mealtime and while cooking food, when sex-workers were less reluctant to talk about their personal lives. The festival season in the month of October,

ranging from Durga puja to Diwali, being a peak season of work had to be abandoned for organising any kind of interview sessions. The study took a little more than three months to complete.

The information collected from the 25 case studies have been compiled and collated in the next section. The observations from the study have been divided under three broad themes and presented under subsections of abortion, conception and the use of contraceptives.

III. Observation and Inference

A. *Abortion :*

A sex-worker is in a way, a *typical* category of abortion seeker. In being excluded from the mainstream of society the brothel-based sex-worker belonged to a culturally marginalized section of the population but unlike other susceptible abortion-seeking women, abortion was not an unsettling affair for her. It was a professional hazard that had to be tackled without much delay and she was relatively less vulnerable in terms of procuring the service. Delay occurring from making an ethical choice was not hers as it was common with other seekers. The time lost in going from one provider to another, from the legally visible public to the illegal private providers did not occur in her case. Even arranging for finance, which could be a major cause for delay, did not bother her too much. Cash earnings were more readily available to her; if savings did not suffice, loans could be arranged within a short time. She aimed for early termination and was able to access services from professionals on a regular basis in proper time. Her problem was qualitatively different from that of other seekers in mainstream society.

B. *Nature of Services Available:*

Abortion services for sex-workers were provided through, both legal and illegal arrangements. Legal services were available from government run health units and registered private clinics. Legally, only a certified allopathic doctor at an authorised health centre could provide abortion services. Access to state hospitals and health clinics was easier to avail in Kolkata. Such facilities were also less expensive. Refusal on grounds of seeking the service within 12 weeks of conception was low. Reluctance to provide the service to women undergoing frequent abortions within a short duration was expressed at hospitals and public health clinics, sometimes to the point of refusal. With further health complications they were often refused the service and referred to private clinics. Advice about contraception and against abortion at a tender age and a first pregnancy was provided at government run clinics, though the service was not declined on this account.

Private clinics were expensive. The registered private clinics that ensured safe service charged a high rate. The charge varied with the number of weeks that passed after conceiving and increased more than proportionately after 12 weeks of pregnancy. A package of rupees 2000 to 3000 was charged for abortion in private nursing homes within 12 weeks, a charge that increased with the passage of time and complexity of the case. Post-abortion care and counselling for contraceptives were also available.

Although, the number of registered MTP centres has increased considerably over the years most of them are located in urban centres. An array of illegal services also catered to the demand for abortion. Among others, registered medical practitioners and nurses, physicians qualified in other systems of medicine and unregistered doctors without specialised training in MTP services are part of the private sector abortion providers. According to sex-workers anything between rupees 200 to 500 was charged at unregistered private centres. The locations of such clinics were common knowledge to all sex-workers, young and old, though it was the last option that they sought. Advice against

abortion due to their tender age or because of first pregnancy was not given at any of these centres. Illegal abortion services provided by traditional birth attendants (*dais*) residing in the red light localities and having a long association with the trade were losing ground.

C. Rationale for Choice :

Seeking abortion services from state hospitals were the first preference for a sex-worker. Since 1971, abortion having been legalised the sex-workers did not have problems and could avail the service from public hospitals. She was not refused the service because of her 'immoral' profession and nor had she to disclose her identity, as was common with the sex-workers in earlier times [7]. She could afford to pay for the little expenses of hospital charges and medicines. The sex-workers of Sonagachhi and Kalighat red light area preferred the state maternity hospitals while those from the Khidirpur area, being relatively less informed and more dependent on 'madams' had to obtain the service from private clinics. Apart from the degree of autonomy in choice, income differential was another important determinant for selection of the quality of service available to a sex-worker.

The sex-workers who operated independently looked for private service only on being refused by hospitals and health clinics. It could happen in case of delay in detecting pregnancy as a result of irregular periods[8] or being misled by signs of menopause. In case of other associated illness they were sometimes referred to private clinics. State hospitals were not keen to provide long term and expensive treatment while the sex-workers also being eager to return back to work promptly, did not want to stay for a long duration in hospitals. Most of the sex-workers could not afford to take rest and had to start work with a gap of barely seven days after an abortion. Those able to afford the expense at private clinics, which ensured comfort along with treatment, took to private nursing homes. Only the relatively better off sex-workers could afford such services. Some of the brothel-sex-workers belonging to the high-income group showed a preference for expensive services for the relatively better comfort available from private clinics rather than the service of the state maternity hospitals. The poor sex-workers would have to be on the look out for unregistered clinics that offered the service at a much lower price where safety was not guaranteed and rest and follow-up checks necessary at registered private clinics were not essential.

Adolescent new entrants and younger women bonded within the trade were more prone to seek illegal, private services on being advised against abortion by doctors in government run hospitals and clinics on grounds of young age and first pregnancy. Since they did not operate independently, refusal in a way forced them to avail the service from unregistered private clinics. Sometimes, having to abort from the illegal private clinics was the only option for them. Seeking the abortion service from unregistered private clinics was an arrangement operating within the nexus of the trade in association with the 'madams' who organised the event out of monetary interest and made the initial payment. Rest and post-abortive care were lacking at these clinics and safety was not guaranteed. The expenses for abortion for young sex-workers were initially borne by the 'madams' who employed them and the amount of money was later deducted from their share of earnings.

D. Induced Abortion :

From the survey we find that 72 per cent (eighteen out of twenty five) of the sample of sex-workers underwent abortion at some time or the other in their work span. For all sex-workers, whether forced by the 'madam' or voluntarily decided by the individual, frequency of abortion was high in case of the first pregnancy. Youth was the time for earning money and therefore termination of preg-

nancy was easily opted for. Among those who underwent abortion, twelve out of the eighteen had it during their first conception, though all became mothers having one or more children during a later period of their life. Those who had not aborted during their first pregnancy were relatively older women. In fact some had conceived before landing up as sex-workers. For another small set it was a conscious decision to carry on with first pregnancy. Non-termination of pregnancy during the early years of their working span indicated a conscious choice on part of the sex-worker operating independently and therefore marked the degree of autonomy available to her.

Chances of conception being very high, sex-workers underwent an abortion when it was required to continue with their job and persisted with pregnancy when they could afford to do so. Among sex-workers, those women who had children before entering the profession and those who could operate independently considered pregnancy a barrier to the profession and opted for termination. Early termination within twelve weeks of conception was not a problem. It meant a loss of a few consecutive working days. For some the decision to undergo termination was not theirs, being engaged by the 'madam' with an ownership right over them, abortions were arranged, to which they had to agree. For them termination was largely a first pregnancy incidence. In such cases, the sex-workers were often young girls below eighteen years of age.

Number of abortions undertaken by each woman was pretty high among sex-workers. Highest frequency of abortion for a woman was six (she belonged to the Kalighat area) while the average number of abortions was two. Sex-workers of Sonagachhi and Kalighat reported as frequent as four to five abortions during the reproductive span of 15 to 45 years. Abortion being legal they had no longer to fake their identity to pass off as married women and supply a false address, as was required by the sex-workers 'many years back'. Abortion deaths were not heard of in recent times. The dependence on risky, illegal, clandestine clinics of the locality were becoming less significant over the years, a fact with which the women of Khidirpur were not in total agreement. They were less sure of abortion being legalised and less confidant of seeking the service from hospitals. The degree of bondage to which they were subjected to was quite explicit in their case, irrespective of their age.

The average number of live births and abortions experienced by the women in this study was 2.08 and 1.92 per women, respectively. Table 1 shows the distribution of pregnancy outcomes of women in different age groups.

Table 1 - Pregnancy Outcomes and Abortion Rates by Current Age

Current Age	Total women in sample	Total pregnancy outcomes*	Live Births	Still Births	Induced Abortion	Live Births Rate per woman	Induced Abortion per woman	Induced Abortion Rate per 100 pregnancy outcome
15 - 25 years	8	19	12	-	7	1.5	0.9	37
26- 35 years	8	32	16	1	15	2.0	1.9	47
36- 45 years	8	45	21	1	23	2.6	2.9	51
45 and above	1	6	3	-	3	3.0	3.0	50
Total	**25**	**102**	**52**	**2**	**48**	**2.08**	**1.9**	**47**

** No spontaneous abortions were reported.*

Table 1 reveals that induced abortion rates for the sex-workers are indeed very high in comparison to any statistic available for the general population. The induced abortion rate for the sex- workers in the study sample was 47 per 100 pregnancy outcomes. This sharply contrasts with 2.2 induced abortions per 100 pregnancy outcomes reported in NFHS-2 for West Bengal - even if we add spontaneous abortions to this the total abortion rate would still be only 6.2 (NFHS-2 India Report). So even if the sample in the present study is small it is clearly evident that sex-workers are resorting to very frequent abortions so that they can remain in the trade.

We must note here that no spontaneous abortions by the women in the sample have been reported. This could mean two things. First Sex workers have no reason to shy away (or feel stigmatised) about reporting abortions, and second, they are detecting pregancies early enough; perhaps every missed/ delayed period is considered a risk to their livelihood and a D & C or some other intervention is sought.

In Table 1 it is also interesting to see that the youngest current age group has the largest difference between live births per woman and abortions per woman (of 0.6) and this difference declines with increase in age indicative of the fact that their livelihood is now more important and carrying a pregnancy to full term is not desirable. In fact for the 36-45 age group the differnce is negative (-0.3). This also means that the present young group of sex workers is willing to risk child birth at a younger age.

In Table 2 we have tabbulated the same data by age at pregnancy outcome, that is outcomes occurring during a specific age span. At age 15-19 we now find the differnce between live births and induced abortions to be negative (-0.48). This lends further support to our earlier finding that women in the current younger age group are increasingly willing to risk child birth as compared to the older cohorts when they were younger.

Further Table 2 gives us a sort of trend analysis which shows that the abortion rate is highest when sex workers are in the 15-19 age group with a declining trend with advancing age, and dropping sharply in the 35-39 age group which also has the highest live birth ratio per woman. So clearly on a time scale sex-workers are taking reproductive decisions which minimize the risks to their livelihood.

Table 2 - Pregnancy Outcomes and Abortion Rates by Age at Outcome

Age of Pregnancy oucome	No of women	Total pregnancy outcomes	Live Births	Induced Abortions	Live Births per woman	Induced Abortion per woman	Induced Abortion Rate per 100 pregnancy outcome
15-19	25	32	10	22	0.40	0.88	69
20-24	23	42	27	15	1.17	0.65	36
25-29	18	15	7	7	0.39	0.39	47
30-34	14	6	2	3	0.14	0.21	50
35-39	10	7	6	1	0.60	0.10	14
40-44	4	-	-	-	0.0	0.0	0
45 & above	1	-	-	-	0.0	0.0	0
Total	**25**	**102**	**52**	**48**	**2.08**	**1.92**	**47**

E. Non-seekers of Abortion :

The sex-workers who did not undergo abortion, the six out of twenty-five in the sample, used contraceptives in order not to conceive or were privileged to enjoy a certain amount of freedom regarding child-birth or did not conceive at all. Some of them could cope and continue with their first pregnancy and later adopted contraception. For some it was a combination of the chance factor and the use of traditional contraceptives whereas some did not conceive at all throughout their work span even without the use of contraceptives. A few elderly sex-workers, who did not ever have to abort in their working span, remarked that they could exert a sort of control over their bodies and 'did not conceive when they did *not want* to'. This was rather a complex issue that required elaboration. Infertility was not a cause since all of them were mothers. It could be that these women used traditional contraceptives and preferred not to disclose the exact information. It could also be that it was a natural process of abortion resulting from the continuous physical stress that a sex-worker had to undergo from her work [9]. We take up this aspect in further details in the next sub-section on contraceptive use.

IV. Childbirth

For sex-workers, it was observed that fertility was an important consideration and childbirth a sign of 'complete womanhood'. In spite of the socially renounced reproductive role, anxiety about childlessness and infertility was more significant for her than the concern of getting infected by sexually transmitted diseases [10]. All the women in the sample had conceived at one time or the other. Only two out of twenty five women did not have living children. Case histories revealed that one woman had given birth to a boy who died of illness before she entered the profession and the other had given birth to a stillborn child. Both of them never conceived later.

A pattern regarding children could be observed among the sex-workers. Within the reproductive span, incidence of live births was high in the younger age group of 15 to 25 years. (Table 1) Sometimes the sex-worker not wanting to terminate her second or third conception carried on with pregnancy and joined her profession after childbirth with a short break. All of them stated that they had worked during pregnancy. Economic crisis forced them to work as long as physical appearance of the pregnant woman could be initially concealed without much difficulty and later with considerable strain. In some cases she even had a second child after just a short gap.

Again, occurrence of childbirth in the age group of 35 to 39 years was high. (Table 2) A sex-worker preferred to have a family of her own towards the later part of her reproductive life if she could afford to do so. At this time she sort of planned to opt for children, beginning a process of withdrawing from her profession after a certain span of time. Being economically independent the decision for childbirth towards the later half of her reproductive life was relatively easy though relatively difficult to endure physically. Even if it was unplanned, childbirth in a way, if it occurred during the later phase of her reproductive period ensured to a large extent a quicker end to her career in prostitution.

It is not that childbirth or decisions regarding spacing of children were totally planned. Sometimes it was the 'madams', ex-sex-workers themselves, who decided against abortion. Pregnancy meant inability to work for a long stretch of time and survive on savings without generating earnings. Therefore such incidences were not very likely without the support of the 'madams'. For women operating independently, decisions regarding continuation of pregnancy and childbirth were conscious ones. Support of other women of the community - the ex-prostitute mothers and madams -was always

available during childbirth. Maternity hospitals were availed for delivery.

Observed Pattern

Chances of conception being very high, sex-workers underwent abortion when required to continue with their job and persisted with pregnancy when they could afford to do so. Among sex-workers, those women who had children before entering the profession and those who could operate independently considered pregnancy a barrier to the profession and opted for termination. Early termination within twelve weeks of conception was not a problem. It meant a loss of few consecutive working days. For some the decision to undergo termination was not theirs, being engaged by the 'madam' with an ownership right over them, abortion was arranged to which they had to agree. For them termination was largely a first pregnancy incidence. In such cases, the sex-workers were often young girls below eighteen years of age.

Table 1 and 2 also indicate that the completed fertility (live-births) of sex-workers is not very different from the general population as evident from NFHS data which shows a TFR of 2.29 for West Bengal as a whole and 1.69 for urban West Bengal. This means that the desire to have a 'normal' number of children by the end of their reproductive span is very much there amongst sex workers.

The sudden rise in the live births and reduced abortion rate during the later part of the reproductive period of 35 to 39 years again suggests that the possibility of continuing with a pregnancy are high for a sex-worker during this period.This observation supports the fact that the desire for family that a sex-worker woman longs for throughout her life can be fulfilled at a later age when economic and other obligations are perhaps, relatively less demanding.

A. *FAMILY :*

In spite of having to serve three to seven customers per day, the rate of conception was low. Though women with as many as four children and women undergoing as high as six abortions were available in the sample set, they did not constitute a large percentage. For sex-workers, the number of children varied from one to four. A small proportion of women entered the profession with their children while the others had conceived while they were in the profession. The average number of children was two. Location-wise variation or extent of a bondage relationship was not a significant determinant for the size of the family.

As soon as a sex-worker was even partially free of the rigid monetary obligations towards the 'madam' who employed her, she longed for a regular companion apart from her clients. Almost every sex-worker maintained a relationship with a male partner who was either a regular customer or a lover in a passing relationship. Such relationships, even without a monetary transaction, found its manifestation in enacting codes of domesticity between partners. The longing for a family, however unstable, is an aspiration for the sex-worker and she willingly conceives to beget children from her significant partner, however short-lived the relationship. The *babu* is often passed off as the father of the sex-worker's children without having to bear any responsibility towards them.

Sex-workers consider children as a psychological gratification in times of social isolation that may come in the future. Girl-child and boy-child are both welcome to her and no discrimination regarding gender was expressed. Though a girl-child was usually oriented into the mother's profession, occasionally she was not. An attempt to get the girl married far away in a rural home was not uncommon. In the last ten years, providing education to children was one of the major aspirations of the sex-worker mothers. These were to some extent being fulfilled through

the efforts of their organisation. Those who could afford to arrange for education, tried to provide at least a minimum level of learning both for the boy and the girl. Mothers who had to dwell and earn their living by selling sexual service in a small room or even in a shared space did not consider their children as an unwanted work hazard, though a rough childhood awaited every child living there.

V. CONTRACEPTIVES

Sex-workers for the most part did not use modern contraceptives. They were aware of the modern methods of contraception through television advertisements and NGO activities. In their opinion contraceptives were related to family planning programs and therefore to be used as a preventive device within families. Their preference was for traditional methods of contraceptives.

A. TRADITIONAL MODES :

Traditional preventive modes, both temporary and permanent were in use by sex-workers. The senior professionals, the ex-sex-workers and the 'madams' passed on the information about traditional contraceptives. These were mostly roots, leaves or stems of herbs and plants in powdered or paste form to be consumed orally. The dose and timings for consuming these traditional medicines was prescribed by local or even rural practitioners and passed on as common knowledge. Some of these traditional medicines were for temporary prevention to be consumed at regular interval while some were permanent contraceptives to be consumed once and for all. The sex-workers preferred temporary traditional modes for they wanted to conceive at some stage in life. The ones who already had children adopted permanent traditional measures. Along with oral consumption of herbs and plants, sex-workers believed that the magical power of certain roots to be kept in 'constant touch with the body' would yield expected result for them. Some of the traditional 'medicines' were available locally while some were obtained from a specific 'medicine-man' of rural origin and had to be fetched personally.

B. MODERN METHODS :

The modern methods of contraception were not popular with the sex-workers. Very few had adopted the permanent method of sterilisation on the advice of doctors after an abortion, particularly if they had already borne children. The use of temporary methods such as copper-T or oral pills was not common at all. They thought these temporary contraceptives were devices for family planning and not meant for sex-workers. Other women, falling into the general population group used them because their husbands wanted them to, while sex-workers had no one to oblige. The resistance to copper-T was because an external object was being placed within the body, it was considered to be obstructive to natural fluid flow in the body. The easy to use oral pills were rejected on the ground that it caused irregular menstrual flow and pain in the lower abdomen with prolonged use. With considerable frequent experience of pain perhaps due to physical strain from her work, a sex-worker woman no longer wanted to experiment by using elements 'with unknown effects' on her body. She preferred to use traditional preventives that were familiar to her and which she could rely upon. A sort of demonstrative effect was also operative, since all women in the profession used traditional preventives none of them was ready to adopt the modern devices applicable for women.

Use of male contraceptives such as condoms was thought to be effective. According to them the use of condoms had been initiated in the last few years and was now a widespread practice among clients. Further probing revealed that it was 'not a trivial matter' to expect male clients to use contraceptives on their own. Sex-workers asserted that men considered condoms to be objects that would spoil sexual pleasure. Since cus-

tomers paid for the desired service, the sex-workers were often forced to comply into sexual activity without asking for condoms to be used by their partner. Peno-vaginal penetration was the most common demand in addition to other non-penetrative desires expressed by the clients. Therefore, sex-workers had to arrange for preventive measures on their own that would be effective and available. And so they took to traditional medicines, which was within easy reach.

The sex-workers of Sonagachhi were convinced about the positive role of condoms. In addition to its contraceptive role they thought of condoms more as a preventive measure against contamination from body fluids. Therefore, its use was beneficial for women against infection from diseases and also prevented conception. The sex-workers claimed that they insisted on the use of condoms by their clients and were often successful in persuading them. While the sex-workers of Kalighat mentioned that compulsory condom use was a difficult proposition to execute in reality since they were subject to the client's authority while earning a living. The sex-workers of Khidirpur were almost sure about the impossibility of regular condom use in spite of its disease preventing function. The differential influence of a worker's forum in each site was reflected in such views.

Table 3 shows that eight respondents (thirty two percent) used modern methods of contraception, of which six preferred temporary methods while two went for permanent sterilisation. This can be contrasted with figures for all of West Bengal from the NFH survey that shows 70 per cent of women used modern contraceptives. Among the thirty two percent of sex workers the ones who mentioned the use of condoms were members of the worker's forum while two opted for sterilisation on the advise of the doctor. There were the ones who depended on both modern and traditional methods simultaneously, as and when they found each method suitable to their need. While condoms were initiated only in the last few years with the sex-workers' forum attempting to achieve their widespread use, traditional methods had always existed. Use of condoms by the male partner was preferred by the sex worker but was only a new alternative that could not be ensured. The ones not using any type of contraceptives in practising 'own mechanism of control' have been discussed earlier.

C. Other Practices:

With an average of four clients per day, the rate of conception could have been higher for a sex-worker. However, she claimed that low conception level could be achieved because of certain 'control over the sexual interaction with the client' so that it was possible for them not to conceive even without the use of preventives. A few aged and experienced sex-workers claimed to have ac-

Table 3. Types of Contraceptives by use

Type of Contraceptives			Number of Women
Modern	Temporary Permanent	Condoms Sterilisation	6 2
Traditional	Temporary Permanent	Medicinal plants Medicinal plants	9 4
Both modern and traditional	Condoms + medicinal plants		7
None of the above	'Own mechanism'		3

Source - Field study data: interviews.

quired a skill at physical manoeuvring of the act of intercourse. Since intoxication was part of the game, the sex-worker skilled and competent in her job, took the chance to intoxicate her partner and cause him to spill the sperm externally. They also claimed that it was difficult for the relatively young and the new comers to have expertise in such stratagems. To control and to manoeuvre the act comes with experience and age.

Sex-workers also claimed to have a technique of their own for *functional* prevention and thus escape conception even without regular use of contraceptives. They learned the technique from their seniors as soon as they were initiated into the trade. It was external 'washing' of the vagina with water and antiseptic solution (they had mentioned Dettol) after every intercourse with the client. They thought that the (alkaline) medium of the antiseptic de-activated the (acidic) sperm and prevented conception in a natural process. Though they were not completely assured of the results, it was a regular practice among all of them.

A general inference could be drawn from such observations that the possibility of the rate of conception being low even without the use of contraceptives was because the frequency of intercourse that a sex-worker had to participate in, acted as a *natural barrier* against conception. Sheer physical stress exerted from frequent penetration at a very early stage after conception could effect a *spontaneous abortion* without any further intervention of any sort. Perhaps all these methods together - the use of traditional preventives, certain successful attempts at physical manoeuvring of the act, external washing of the vagina after every contact and natural damage due to high frequency of intercourse immediately after conception - had a cumulative effect and prevented conception without the use of modern contraceptives.

VI. Effect of Worker's Movement

In Kolkata, the worker's rights movement of the brothel-based sex-workers in Sonagachhi emerged with the introduction of the sexual-health project to tackle the public health issue of AIDS among them. In the last ten years since its initiation in 1992, the positive response to the intervention project spread further than the initial objective of awareness raising against AIDS. It now incorporates related issues such as women's health, STD prevention and promotion of condom use. The movement has gathered momentum in the last five years, with respect to worker's rights taking shape across the red light areas of Kolkata and its neighbourhood. The women involved in the movement claim to belong to a special category-the sex-workers-similar to other wage workers in contractual jobs. As sex-workers they demand professional identity, safety and a better work environment.[11] They refute the charge of being designated as the most risky group for AIDS by practising an almost 'compulsory' use of condoms.

We find certain important changes taking place in the last ten years regarding the use of contraceptives. Introduction of modern methods of contraceptives among the sex-workers has been effected in recent times. While sterilisation was the only modern method adopted by women while being advised on health grounds at hospitals, condom use has emerged as a new and effective alternative to the prevalent traditional methods of contraception. The workers forum also claims to have effected a change in the attitude of sex-worker women such that they have learned to safeguard their health through the use of condoms. They claim that the use of condoms has gone up from 3 per cent in 1992 to 82 per cent in 1995 with '50 per cent habitual use and 32 per cent as frequent use.[12]' More than a contraceptive, the use of condoms is being projected as an effective means to prevent infection from sexually transmitted diseases including AIDS. On the one hand incidence of genital ulcer, syphilis and sexually transmitted diseases

are on the decline, and on the other, condom use has enhanced awareness regarding AIDS. A few sex workers reported that the clients are requested, motivated and even refused service if they demand to perform without condoms, The demand on the clients to ensure usage of male contraceptives could definitely increase the bargaining power of the sex-workers but only within limits.

As it was with the idea of enhanced condom use, location-wise difference persisted among the sex-workers regarding the incidence of abortion. Sex-workers reported that the incidence of abortion has not undergone a major decline in the last ten years. Incidence of abortion was observed to be highest in Kalighat, followed by Khidirpur and Sonagachhi respectively. It was in Sonagachhi that the worker's movement was the most active. The incidence of abortion too had been reported to be relatively low in the last five years among the sex-workers of the Sonagachhi particularly among those who were involved directly with the movement. It could be because the active members of the forum with higher bargaining capacity could ensure 'almost compulsory' condom use. Though, NGOs and the organisations leading the movement were hopeful about the present decline in sexually transmitted diseases and the probable reduction in abortion rate in the future, among the sample sex-workers currently the rate of abortion continued to be high.

VII. Conclusion

The major problem in case of sex-workers was poor health resulting from the number of abortions that an individual had to seek. This study found that the incidence of abortion remained high given the number of clients the women had to attend to per day as part of their job. This affected the reproductive health of the woman severely, as apart from a short period of rest, post-abortion care and follow-up check ups were almost not existent.

With legalisation of abortion, dependence on unregistered private clinics was largely replaced by state hospitals. It was evident to sex-workers that change in the availability of abortion services was possible because of legalisation of termination of pregnancy. The independent sex-workers considered that choice of safe and legal abortion services was lacking for their seniors, which they could now access for themselves with ease. The nature of the power structure within the trade and the income differential among women were two important determinants regarding choice of the service. Sex-workers bonded within power relations were forced to use unregistered, clandestine health clinics that did not guarantee safety and care. Being subject to greater domination, the extent of choice was almost absent for them and there was no choice except to terminate pregnancy through illegal, private arrangements.

The more independent women could exercise their freedom of choice in selecting safe and comfortable health services as long as they could afford it. Areas, which were not strongholds of the sex-worker's forum, could not at this point attempt to break through the power nexus of the trade. The differential nature of the trade persists at different locations and shapes the economic standing of each woman and hence influences her choice. This was irrespective of the reach of the sex-worker's movement in each location, since the movement has to go a long way before changing the power structure of the trade. Legalisation of MTP had definitely enhanced autonomy and mobility for sex-workers but as long as ownership right over her own body was not achieved and she remains tied to the power network of the trade, her freedom to opt for a specific safe and legal service was highly restricted.

A decline in the rate of induced abortion was observed in the last ten years but to what

extent the reduction in the rate is due to the introduction of modern methods of contraception like condom use or the effectiveness of the prevalent traditional modes, could not be ascertained. It was observed from the study that for sex-workers dependence on traditional mode of prevention was immense while they remained somewhat sceptical about using modern devices. According to the worker-participants of the movement, the decline in the incidence of abortion in the last five years was the result of enhanced use of contraceptives. However, that did not indicate that the termination mode was replaced by the preventive mode. Rather, both existed simultaneously. The shift from termination to a specific preventive mode was yet to be established.

With the initiation of worker's rights, condom use as the modern preventive mode had achieved a substantial level of success in terms of usage within a short period. Although, enhanced use of condoms did not ensure a natural choice for a more 'scientific' mode as claimed by the peer-sex-workers of the forum, it was projected as the most effective preventive against infection from STD/HIV. Since it was an important agenda of the organisation, sex-workers attempted to use it but not to the point where they could risk their livelihoods. Therefore, they continued to use the traditional preventive modes and attempted to convince their clients to adopt condom use wherever it was possible. Location-wise discrepancy in projecting the success of condom-use was distinct. The sex-workers not directly involved in the workers movement mentioned the lack of authority and control on the part of sex-workers as a stumbling block in their ability to enforce male clients in the compulsory use of condoms.

In spite of the positive projections in areas with active participation of women in sex-workers' organisations, the use of the condoms was difficult to implement in practice. It was revealed that the adoption of male method of contraceptives could not be ensured as a full proof arrangement. Though sex-workers were organising themselves and trying to convince their male partners about condom use, the power relations within the trade network did not change. The madams and pimps were unwilling to permit any insistence on condom use for male clients by sex-workers under their control and self-employed independent women found insecurity from competition within the trade too pressing. The behaviour of clients also does not indicate any radical transformation regarding sexual practices. Condom use had increased to quite an extent but far from what it should ideally be.

The sexual trade market is presently demand driven. Hence the only route to universal use of the condom in sex-work would be possible through the education of the male client. To hold him responsible in the relationship at one level and at another to strengthen the regulations at the supply end for compulsory condom use in the interest of public health. In the environment of HIV/AIDS this should not be very difficult to achieve and with this dependence on abortion and its consequent fallout on reproductive health problems would be lessened. The sex-workers movement should strive towards such a strategy.

VIII. End Notes

[1] Though the position of the sex-worker existing as a 'necessary evil' in society is largely accepted, it has been contested by a section of feminist scholars. They consider prostitution as a product of patriarchy enclosing sex-worker women within the process to fulfil male sexual desire and therefore want to abolish it. Existence of sex-workers as a necessary social evil at least calls for intervention and inclusion of the sex-worker women within the welfare programs.

[2] During the colonial period the Contagious Disease Act of 1868 tried to identify the sex-workers by legally pushing them into spe-

cific zones demarcated as red light areas. Sex-workers had to register themselves and had to undergo compulsory health check ups. The ones infected by syphilis were treated in special state hospitals so that they would be free from diseases and thus the sexual health of the English soldiers would be preserved (ref. Ratnabali Chatterjee, Queen's Daughters, 1991). In the post-colonial period in India, the sex-workers again emerged as the subject of health reform with the emergence of AIDS, as in many other third world countries.

[3] Refer *Confronting AIDS: Public Priorities in a global Epidemic*, Policy Research Report, World Bank, Oxford University Press, 1997.

[4] The different positions regarding the worker's rights movement of the sex-workers are held by Durbar Mahila Samannaya Committee and Sanlaap, the two large organisations working among sex-workers in Kolkata. While DMSC operates primarily at Sonagachhi, Sanlaap has strongholds in Kalighat. The major point of difference between DMSC and Sanlaap is that DMSC claims legalisation of sex work while Sanlaap is concerned with rehabilitation through awareness creation and education for children among sex-worker women.

[5] The term *flying* is a name given to part-time sex-workers by themselves. They are housewives who had to take up prostitution primarily due to the exigencies of economic crisis. They belong to a section of the floating sex-workers in Kolkata who live in the rural or sub-urban hinterland and operate as streetwalkers in the city.

[6] There are an estimated 6,000 sex-workers who live in the largest red light zone of the city, the Sonagachhi area and an estimated 20,000 men visit them daily. The number might have increased in recent times. Information regarding the number of call girls, streetwalkers and flat-based sex-workers are not available. According to NGO sources, there are a several hundreds of them within the city proper. (Ref. Base line survey, All India Institute of Hygiene and Public Health, Assessment of Sex Trade in Kolkata and Howrah, 1993).

[7] The women could not specify the exact date when MTP was legalised and they could get the service from state hospitals without having to be 'humiliated' for their profession. It must be 'some twenty or twenty-five years ago ' they remarked. Even the older sex-workers above 45 years stated that in their youth unregistered private clinics were the only option for abortion. Abortion deaths were frequent in the hands of (quack) practitioners and illegal clinics existed in large numbers within the red light areas. But they could not say from when their number and importance started dwindling.

[8] The sex-worker women reported that irregular menstruation was a common feature but it did not bother them.

[9] I am grateful to Dr. Anup Dhar (a physician working as a research fellow in social science at Asiatic Society, Kolkata) for suggesting the idea of the natural process of abortion that could be a result of stress that a sex-worker woman was subject to because of the number of intercourses she had to undertake every day.

[10] This fact was revealed by Dr. Smarajit Jana the Director of All India Institute of Hygiene and Public Health, in his writing on the reaction of sex-worker women on being initiated in the use of contraceptives for preventing sexually transmitted diseases (ref. Sujata Singh).

[11] Among other demands, repeal of Immoral Traffic Prevention Act, uninformed blood testing, vaccine trials and entry of children and adolescents into the trade, formation of a Board to regulate the trade are important ones not directly relevant to this paper.

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ANNEXURE

Annexure I - Selection design for the Study on Sex-worker Women

	Characteristics for selection	Number of Women
I	**Age Group in years**	
	From 15 to 25 years	8
	From 26 to 35 years	8
	From 36 to 45 years	8
	More than 45 years	1
	Total	**25**
II	**Location of red light zones**	
	Sonagachhi	11
	Kalighat	8
	Khidirpur	6
	Total	**25**
III	**Region/Country of Origin**	
	Bangladesh	3
	Nepal	2
	Bihar	3
	Madhya Pradesh	1
	West Bengal	16
	Total	**25**
IV	**Income per day**	
	Less than Rs. 250	9
	Rs. 250 to 500	12
	Rs. 500 and above	4
	Total	**25**
V	**Participation in organisation**	
	Participants	6
	Non-participants	19
	Total	**25**

Source – Field study data: interviews.

About The Author

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Swati Ghosh is an economist by training from the University of Calcutta, India. Her PhD is on capital-labor interaction in third world economic space where informal labor forms are negotiated and redefined continuously. She has worked on marginal workers, undertaking studies and surveys among the slums and squatters of Calcutta. Her publications broadly include identity, sexuality and worker-status of women in colonial and postcolonial setting with focus on widows, prostitutes, migrants and deserted women. She has published articles in Economic and Political Weekly, occasional papers and articles in two books on the above issues. Gender and Development are areas of constant interest to her. She is a member of the editorial collective of *from the margins*: a journal of concerned writings on gender, coloniality, and postcoloniality from Calcutta. Her present work is part of a larger study on prostitution regarding body, sexuality and subjectivity. She has participated in international seminars: summer school at Amsterdam (SEPHIS) in 2001and Afro-Asia Dialogue (CODESRIA) in 2003. She teaches Economics at Rabindra Bharati University and is a guest faculty at University of Calcutta.

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