CHAPTER FOUR

Discussion: The Comparative Study
"Well: should property and pauperism exist? Should marriage and prostitution, family less ness exist?

All these conditions have developed into their opposites and, only through the greatest of lies and illusions could these be treated as simply positive states of affairs".

Karl Marx 1844-47

This is a discussion chapter making a comparison between the previous two chapters. Here I would like to make an attempt to compare the interactions of syphilis and HIV&AIDS with prostitution at the turn of the twentieth century and at the present times, respectively. I would also try to reflect on the nature of public health discourse and the role of public health as a provider of better quality of life for the women in prostitution.

I

A_Comparison_between Social History of Disease and Prostitution in Bengal: From Syphilis to AIDS

The work is not only an outcome of the researcher's study of the phenomena of prostitution and STDs from an interdisciplinary perspective of public health, history and women's studies, but also a study in/on time. It is a comparative study in multiple layers.

First of all it compares broadly between the cultures, societies and political economies of times at the two centurial junctures, (i.e. the late nineteenth and the early twentieth centuries; and the late twentieth and the early twenty first centuries). Then it compares between the treatments of and responses to the two sexually transmitted diseases (STDs), i.e., syphilis and HIV&AIDS, that are almost heralding the time in itself. And finally it reflects on the positions of prostitutes and prostitution central to the STD-

1 Karl Marx 1844-47/1998: 142-143. Exzerpte aus Eugene Buret: De la misere des classes laborieuses en Angleterre et en France... Cours d' economic politique (Bruelles 1843); in ; MEGA IV/3>
Exzerpete und notizen: Sommer 1844 bis Anfang 1847 berlin : Akademie verlag
debates of the two times and how these groups of women earning their livings by prostitution are interacting and responding to multiple forces of the times. The work attempts to observe and analyze the interaction of these two diseases with prostitution at the above mentioned periods.

We have seen how the sexual space that has earlier provided tolerance and acceptance to prostitution as a public institution in India, since colonial period has gradually been criminalized and transformed into commodity. And how laws in the name of Public Health measures criminalized prostitutes at the late colonial period, equating prostitutes with diseases like syphilis since the mid to late nineteenth century reflecting the Victorian moral codes of understanding sex and sexuality in an indigenous Asian society whose economy was undergoing a transformation from the feudal mode of production to the capitalist one. In the late twentieth century, at the age of neo-colonialism/globalization, the talk is of decriminalization and legalization of prostitution. Today, the market for commoditized sex has already been created the demand for the products from sex-industry as well as medical industry. Therefore freeing the sex trade becomes the discourse of the late twentieth to early twenty-first centuries for optimum profits from both the industries, i.e., sex and medicine.

In the given context, I have made an endeavor to analyze the human rights approach to public health of collectivization of the women in prostitution in West Bengal through public health programmes for the control of HIV&AIDS asking for their rights and raising the demands for decriminalization at the turn of the twenty first century.

I have also ventured to show that in the discourse of public health in prostitution and disease control at the turn of twenty first century, one clearly observes two perspectives - Foucauldian theorization of the power of institutional surveillance and regulation over the prostitutes’ body and the human rights approach of collectivization of prostitutes for better life and well being. Ironically, although these two perspectives are drastically different from one another, but in case of the


prostitutes and prostitution one perceives a synergy of the former being the genesis of the latter.

Nonetheless, we need to be sophisticated while drawing parallels to realize that not only AIDS is like the past epidemic, but also it is drastically different from it as, syphilis and AIDS generate from two different socio-cultural and political economic times in the history of disease. Both the eras witnessed a political economic and societal transformation that in turn had its' influences on society & culture and especially on health and sexual health. These two historical ages witnessed a rise in moneyed class, economic discrepancies, a gradual emergence of an aggressive foreign culture, trade and commerce-be it colonial or neo-colonial (e.g. globalization), where the existence and sexual identity of individual have come under thorough scrutiny through two landmarks diseases, i.e. syphilis and AIDS, respectively.

In short, there seem to emerge certain features that distinguish the sexual bondage of the colonial concubines from the commoditized sexuality of the women-prostitutes in the era of globalization. In the former case, the sexual aspect was essentially related to a cultural specificity of sexual sublimation. Despite the commodification of sexual labour, a concubine is a human being who is essentially a carrier of art and culture. In her case, sexual bondage was combined with a human bondage too. While in modern times she is reduced to a non-human. This is a transformation of a prostitute from a carrier of art and culture to a labourer who has very little attachment to the product s/he is producing. This transformation is strongly associated with the change in the time. Getting into human relationships demands time, emotion and intellect, other than money, that is hard either for a client or especially for a prostitute to provide in the brothels of Kolkata in the wake of globalization.

II

A Comparison between Cultures, Societies, Economies at the turn of the Twentieth and at the Turn of the Twenty-first Centuries in Bengal

Syphilis and AIDS are sexually transmitted diseases at the turn of two centuries (i.e., the late 19th and early 20th centuries; and the late 20th and early 21st centuries,
respectively) where human society, culture, politics and economy have been in the process of major transformation. All these account for the transformation of human identity as well. Sexuality, positioning itself as an important part of that identity crisis also expresses the confusion and change of the transition. Representations of the sexual cultures that may be seen manifested in the discourse of the two STDs, i.e., syphilis in the mid to late colonial period and HIV & AIDS in the era of globalization are different, yet if we are to see those in the historical continuity, then the sexual culture of the age of globalization emerges as an inevitable historical outcome of the transforming that as begun in the colonial times.

The victimization of the sexuality of the coloured women by the white men had begun since the colonial times. Especially the way white men took advantage of black women and her sexuality in the imperialist and colonial contexts. W.E.B. Du Bois states while writing for an American Audience “I shall forgive the white South much in its final judgment day: I shall forgive its slavery, for slavery is a world-old habit... I shall forgive its so called ‘pride of race’, the passion of its hot blood... but one thing I shall never forgive, neither in this world nor the world to come: its wanton and continued and persistent insulting of the black womanhood which it sought and seeks to prostitute to its lust.” And that indicates why prostitution during colonial period is different from the prostitution previously existing in the same society.

The previous cultural norms and space that had undergone a transformation since the colonial period has come up in a post-modern package. During the colonial period sexual and cultural spaces were gradually destroyed and a new sexual culture begun to emerge that created a new market for sexuality. Now the market is already created in the era of globalization and consumerism. Therefore, to sell sex in the form of a commodity, we see various pockets and sub pockets emerging.

At the times of globalization, we see the manifestation of Western sexual sickness that demands a dark, sin-free native women for sexual gratification in the sex-tourism at Hawai’i. To most Americans “Hawai’i is the “she”, the western image of the Native “female” in her magical allure” to take, use and “above all to fantasize about long after the experience”.

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The cultural spaces that had been commoditized since the colonial times are being sold in a post-modern package at the age of globalization. In the case of Hawaii one observes how the cultural spaces that were erotic have been transformed into commodity. Hula is a sacred dance performed in Hawai’i. In the words of Haunani-Kay Trask “In the hotel version of Hula, the sacredness of the dance has completely evaporated while the athleticism and sexual expression have been packaged like ornaments. The purpose is entertainment for profit rather than a joyful and truly Hawaiian celebration of human and divine nature.”... Thus first requirement is the transformation of the product, or the cultural attribute, much as a woman must be transformed to look like a prostitute, i.e., someone who is complicitous in her own commodification. Thus hula dancers wear clown-like make-up, don costumes from a mix of Polynesian cultures, and behave in a manner that is smutty and salacious rather than powerfully erotic.” 5 The author continues, “The distance between the smutty and the erotic is precisely the distance between western culture and Hawaiian culture”.6

In the mid colonial Bengal, the Cantonment Act reflected the nineteenth century capitalist concerns about how to keep the body (of the labourer) fit for its optimal functioning and productivity. English Victorian society was obsessed with hygiene, longevity and physical exercises. In this framework of thinking, the body (of the mercenary soldier) could not be allowed to be dissipated in promiscuous whoring and reckless drinking—which used to be the norms among the British soldiers and officers in the eighteenth century India. We see the similar concern over body today. Nevertheless, this concern is not for empire building by expansion through colonies by the soldiers/labourers, but for how to build the empire through globalised market economy. And in this, body, especially female body and sexuality play a crucial role.

In the present times, the concern over body has been intrinsically related to concern for commodity. The sexual/bodily desire has been linked with the desire for commodity as at certain level body has become equated with commodity. Mary E. John emphasizes, “The most obvious wider context for the mobilization of desire is that of consumer culture, with its proliferation of images and commodities, its promise of happiness through the possession of products. Many of the criticism of

6 Ibid.
Miss World contest naturally highlighted this. As is well-known, an early and widespread ploy in the world of publicity has been the display of sexuality, especially of women's bodies or body parts, to promote the desirability of a particular commodity. Sexual fulfillment has thus been a unique, if not pivotal fantasy, emblematic of the transformation in social relations that awaits the consumer. Thus, while in the nineteenth century the concern is to preserve the body for colonial expansion and industrialisation, at the turn of the twenty first century the concern over body is to represent the market and the commodity by propagating consumer culture through economic and socio-cultural globalization.

I have also made an attempt to argue that 'globalization' has created space for commodification of women's body by creating an economic and cultural situation on the basis of demand as well as supply of female body and sexuality, transforming the sexual culture from bondage to commodity, killing the previous diversities and cultural constructs. Poverty and unequal distribution of wealth in which globalization has a role to play in the late twentieth and the early twenty first centuries, gradually lead to intensification of prostitution as well as HIV&AIDS. Thus, on the one hand prostitution and HIV&AIDS can both be assumed as an outcome of underdevelopment and poverty in a globalized economic order; on the other hand, the pandemic status of HIV&AIDS and it's 'target-group' oriented approach brings the prostitute back to the focus of attention and the other side of that attention is manifested through control and surveillance of the prostitutes as reflected in the anxieties over body.

In the colonial period we see capitalism gradually booming and trying to create and grab markets transcending the geo-cultural barriers creating new political-economic canvasses around the world. However, in the time of globalization that market is already created. Sex has a market as medicine and treatments of the diseases have. Therefore, unlike the strict discipline and control over body and sexuality of the puritanical Victorian era, globalisation is the age of sexual liberation and of freeing the market. Thus, none of the intervention programmes in HIV&AIDS puts stress

solely on abstinence and behaviour rather the message is to go for “safe sex” and therefore the promotion of condoms.

The Victorian era with it’s paranoid concern over body (as it is an important means to capital accumulation) uses two mechanisms to control-criminalizing prostitution by measures related to the control of syphilis and by creating an elite class and culture devoid of previous sexual boisterousness. As a result the previous forms of sexual outlets within the cultural, the social and the religious norms were no more. To get sex outside marriage, one has to pay a price in a market and buy it against the money paid. In return market would try to assure the standard and safety of the product. Is not it ironical that although puritanical in spirit, the Victorian era was in reality trying to create a market for commercial sex, as sexual energy or use or misuse of it became a crucial factor in the colonial expansion? Therefore, we see a strange paradox unfolding it self in the sexual culture and society of the late colonial period, i.e., both the Puritanism and commoditization of sex were purported to serve the same purpose of controlling the sexual energy and behaviours of the people, soldiers and prostitutes as manifested through the discourse of syphilis and prostitution in the late colonial Bengal.

It is to be remembered we are talking about a time when labour capacity was being systematically exploited and cannot be wasted in pleasure, unless and until it reproduces itself, when the pleasure itself became a product in the market; we are also talking about a time when there is a surplus of wealth and greater role of private ownership on the one hand. On the other hand there is also an unsettled money market/inflation, especially in the colonies.

Greater the role of private ownership leading to the clear-cut succession, more the emphasis laid on the chastity of the wives and thus organization of prostitution at the same time. Historically, whenever and wherever the basis or value of private property is undermined; the foundation of fidelity is shaken and free love is on increase; e.g., rise of fornication during and after the wars, sexual license during the black death; more sexual freedom among the ‘lower order’ or poorer classes etc. As Khalid Kishtainy argues, the present outburst of sexual license in the developed

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countries may have something to do with the unsettled money market, inflation and lack of interest in saving.\textsuperscript{10} But, we also see with inflation and unsettled money market as well as socio-economic order- prostitution or supply of women and demand of women in prostitution are on increase! Thus, sexual laxity may or may not mean the decrease in prostitution as long as there is an inequality and “a certain surplus of wealth and energy among at least one class of the population and to be favoured by an unequal distribution of wealth”. And that is why “As inequality was the rule in practically all societies, there was hardly any nation which lived without its whores”\textsuperscript{11}

And the society as well as economy in the nineteenth century fulfills almost all the conditions that intensify these inequalities. One observes the similar situations and phenomenon unfolding itself at the turn of twenty-first century.

Kishtainy continues, “The only difference in prostitution between one property society and another has been one of quality, form and attitude”. It is only in the societies where private property had a very small role to play in the economic life of the community, e.g., Eskimos, Muria of India, some Arabic tribes, where a communistic form of life was followed, as in Sparta, women became equal to men, & sexual taboos were hardly known. “Prostitution in such communities made no sense and played no part, a discovery which became the basis of Marxist thought on the problem of prostitution.”\textsuperscript{12}

However, somehow the Britishers managed to overlook the fact that the growing dens of opium, gambling chambers and prostitutes’ houses were the fallout of colonialism.

Sumanta Banerjee argues, “The close association of prostitution with the new dens of crime in an urban metropolis like Calcutta reflected the economic changes that were altering land relations in the countryside, driving thousands of unemployed villagers to the metropolis and other towns, many among whom found means of survival through new, non-traditional channels like running distilleries or gambling dens.”\textsuperscript{13}

The short story, “Mahesh” by Sarat Chandra Chattopadhyay for the first time tried to

\textsuperscript{10} Ibid.

\textsuperscript{11} Ibid.

\textsuperscript{12} Ibid.

catch this historical phenomenon of the transformation of the farmer to the working class, of the rural poor to the urban poor.\textsuperscript{14} We witness today the similar rapid and skewed urbanization all over the developing countries and in case of West Bengal the rapid urbanization is not necessarily a condition to create job opportunities and economic growth\textsuperscript{15} and therefore creating the space and supply of women in prostitution through globalised trafficking.

Another psychosocial aspect that we may presume attributed to the perversion of prostitution in India especially during the late colonial period could be the absence of sexual sublimation in prostitution. Freud, from 1905, thought that apparently non-sexual activities (and especially artistic creation and intellectual enquiry) could be an expression of sexual instinct, by a deflection from sexuality. Sublimation, he argued, is not a scientific concept. We cannot switch or divert sexual energy as if it were an electrical current. Those who are revolted by sex or seek to repress it are not truly sublimating their desires. The principal operation of Freudian sublimation must be seen as involving a change into a higher cultural or spiritual realm.\textsuperscript{16} Throughout the history of prostitution in Bengal as well as in India we could see artistic expressions of sexual instincts going side by side with the physical expressions of sexuality only coming into a standstill in the late colonial period. And this absence of sublimation has become more and more perverse and prominent as we observe neo-colonial globalized economy percolating gradually into the realm of our consciousness and civilization that are so acutely reflected in the discourse of prostitution and HIV&AIDS today.

\textsuperscript{14} Chattopadhyay Sarat Chandra. Mahesh in ‘Hari Laxmi’. Gurudas Chattopadyay & Sons. 13\textsuperscript{th} March, 1926. Calcutta. First Published in Pallisree Ashwin, 1329Bongabdo and in Bangabani, Magh, 1329.


III

Observations and Analyses of the Interaction of Prostitutes and Prostitution with Syphilis and HIV/AIDS at the Given Points of Time

The most remarkable transformation in the discourse of prostitution from the era of colonization to the era of globalization is the change or an attempt to change the term from “prostitute” or synonyms of prostitute to the word “sex worker”. It not only completes the shift from a feudal artist to an industrial worker whose sole “work” is to provide “sex”, but also kills the heterogeneity and geo-cultural specificities of the term “prostitute” that earlier had various synonyms having multiple socio-cultural connotations, varying from region to region and society to society. It creates or attempts to create out of the prostitutes, the homogeneous working class in a post-colonial fully developed capitalist society and more so in the name of equity and human rights.

On the one hand the discourse has been dislodged from a Victorian moralistic perception of prostitution centered on the notions of honour/shame and Madonna Vs. Whore dichotomy. Today the discourse has expanded to include critical issues of rights and vulnerabilities of prostitutes, especially in relation to health and violence, and legal rights. The people who position prostitution as a form of labour, and sex industry as a legitimate industry where the prostitute is a worker with workers’ rights provide the following descriptions of prostitution-negotiation and performance of sexual services for remuneration-with or without intervention by a third party; where those services are advertised or generally recognized as available from a specific location; where the price of services reflects the pressures of supply and demand. Here the term “negotiation”, as opposed to coercion indicates the space for rejection of specified clients or acts on an individual basis. Within this shift in paradigm are a variety of positions ranging from a continued perception of prostitution as sexual exploitation and violation of women’s/human’s rights to that of prostitution as a form of work.
The very claim of prostitution as work by DMSC also shows the transformation of the indigenous understanding and concepts of sexuality and prostitution in Bengal as reflected through the cultural and sexual spaces in the pre-colonial and early colonial Bengal. In the Western discourse women are the keepers of affective economy, safeguarding emotional labour from its possible alienation in the capitalist economy. For women, sex is meant to be motivated by and expressive of love. In prostitution, sex occurs with many persons and therefore, probably not motivated by love, is in violation with this gendered moral imperative. As Laurie Sharge puts it, “In the English-speaking world, the term ‘prostitution’ has a kind of double, layered meaning. It designates both sexual activity that is commercially oriented, and the act of debasing oneself.” Now according to more traditional conceptualizations, work is embodied, physical labor that generates wealth and reproduces sociality. Conceptualizing sexual transactions as ‘work’ makes sense in a context where being a “worker” is a known category and can potentially enable one to leverage certain rights and benefits. This explains why prostitutes and segments of feminist movement in the Euro-American context tried hard to make it work because Euro-American prostitutes live in an economy where most people are workers. In other words, in a capitalist economy where work is alienated, and in a gendered economy where women are service workers, conceptualizing monetized sexual exchange as ‘sex work’ makes sense and even may serve strategic ends. In a context where this is not the case, i.e., where ‘worker’ is not the category with a long and meaningful history, and where the alienation of labour is not the normative condition whether the identity ‘sex worker’ makes strategic or conceptual sense is altogether a different question. It also solves the moral dilemma with sexuality in Western culture by focusing on labour issues rather than the moral ones. Holly Wardlow notes, “...it can be critiqued as the compulsion to salvage women’s morality by labeling what they do as “work”, an activity in the West is inherently virtuous and that is associated with industriousness, productivity, efficiency and so forth. In other word, according to our

17 See the discussion in Chapter-II
Protestant ethic, work is always the saving grace; if the woman is engaged in work, even if it is on her back, then it must be okay."\textsuperscript{20}

Ironically enough, DMSC literature states, "The members of DMSC want to gain control over the structural conditions that regulate their working lives and claim the right of self-determination. Therefore, DMSC is of the opinion that prostitutes themselves should be in a position to design, manage and run all targeted STD/HIV intervention programmes for prostitutes in order to ensure that their practical and strategic interests are protected and they do not function merely as targets of moralizing impulses of dominant social groups, through missions of cleansing and sanitizing, both materially and symbolically." The above analyses explains, DMSC's political agenda of claiming 'sex' as 'work' is actually reflective of the moralizing and cleansing impulses of the mindset of the neo-colonial forces and the international discourses related to prostitution and HIV & AIDS. The idea of 'prostitution' or 'sex' being a 'work' does not have a historical genesis in the Indian or Asian indigenous societies and has been alien to its socio-cultural and psycho-sexual understandings of sexuality and of man-woman relationships.\textsuperscript{21}

Despite the attempt to impose homogeneity by the coinage of the term "sex worker", there are distinct categories of women in prostitution with different work relationships, power structures and situations, specific to their contexts. The most visible of these categories in the context of West Bengal are the brothel based prostitutes in the demarcated Red Light Areas (RLAs). Other categories include that of street walkers, call girls, high way prostitutes and prostitutes operating in bars, cafes and massage parlours. Even if it is not in the scope of the thesis, male prostitution is also a category with vulnerabilities and issues particular to them in today's context.

The socio-cultural and background of certain groups also constitute specific categories, e.g., particular community or tribe where prostitution is the cultural norm or way of life, such as Bedias and the Nat, have a unique context of pimp and prostitute relation where the pimp is the male member (usually the brother or father)


\textsuperscript{21} See Chapter-II
of the family. However these categories may overlap in instances, such as in cases where women who have been devdasis are brought to the RLAs. In the case of ‘pasinja meri’ (passenger women) among the Huli of Papua New Guinea, the women are selling sex as a mean to take revenge on their male kin who need the women’s cooperation for bridewealth. It is by attaining women through marriage that men are able to reproduce their clans, and it is by giving their daughters in marriage that men acquire the wealth necessary for their sons to marry and to pay back those kin who helped them marry their own wives. The huli women know that the denial of bride wealth is the best way a woman could take revenge in retaliation for failures by kin—particularly male kin—to accord women their proper social value. And the most shameful way to rob their kin of bride wealth is to ruin themselves. Women’s cooperation is necessary even after marital transfer of bride wealth. Huli pasinja meri refuse to cooperate. To pasinja meri prostitution is not a work and in their case it is the man who is the looser both ways by loosing bride wealth instead ending up paying for the passenger women for sexual exchange.

Prostitution as a structure or institution per se functions around a set of actors, beyond just the prostitute and the client. This web of actors include pimp, the brothel owner/madam or the agency or the owner of the place of the work, the police who may be taking an extortion fee, quacks or ‘doctors’ and other ‘health clinics’ in the area, shops in the area that have come up to cater to the needs of prostitutes and their clients, the tourists and so on. Prostitution today is required to be looked at, in the bigger context of the sex or entertainment industry in relation to internationally migrant male clients. Today there is an increasing globalized sex trade industry that takes different forms such as entertainment, marriage bureaus, sex tours and so on.

Therefore understanding vulnerabilities of the women (in prostitution) at the turn of the twenty first century is just not limited between colonizer or colonized and between upper caste-class exploitation of the lower order, but to be seen within the larger

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22 Lot of women who came into the Nautanki, the traditional folk theatre of Northern India, were from Bedia or tawaif deredar Muslim families. In the words of Deepti Priya Mehrotra, “Both Communities had a well-established tradition of women earning their livelihood by singing and dancing. In both these subcultures, women did not marry, led unconventional sexual lives and provided for their natal families. Both caste groups were considered somewhat beyond the pale of respectability.” (Mehrotra, D, P.Gulab Bai: The Queen of Nautanki Theatre. Penguin Books India.2006.New Delhi).

perspective of the increasing vulnerabilities of women in their family, community and society, and their abilities to securely move and seek work in the era of globalization. Prostitution is no longer limited within a secluded class of women rather there is a "prostitutionization" of women that are going on in general. We have seen that prostitution in some form has existed for centuries in different societies and cultures. It is also important to understand the particular forms that it takes in the contemporary society. Women from many third worlds countries are migrating to many other in the third world and in some cases first world countries for work. Many women from the former communist countries are also increasingly migrating to other countries looking for means of survival, increased insecurity of food availability and livelihoods are a major reason for increased migration. Numerous studies have shown that globalization and the present model of development have led to the further marginalization of poor and especially women. Women are given opportunities to work in certain sectors especially the ones without skill and education or professional qualifications. On the other hand there are certain occupations which are primarily open to women, such as the domestic labour or sex trade or entertainment industry that linked to women's domestic or reproductive labour for which neither education nor skills are required. Moreover historically women's lack of access to property and capital are an important factor in keeping them structurally and economically dependent and marginalized. Therefore prostitution today is also to be viewed in the context of women alone migrating for work.

Violence - within and outside the family are also factors to increase vulnerabilities of women and children and are often an important reason why women seek to move in order to find safer spaces or work away from their homes. It is important to understand the choices that women within limited spaces that are allowed to occupy. Due to their less access to public spaces that they continually try to negotiate in the process of looking for employment or even marriage they usually have to go through a male representative that makes them even more vulnerable to be deceived, harassed, raped or cheated.

Today's discourse on prostitution is much more diverse as it encompasses the male and eunuch who are in prostitution. The issues of prostitutes' are being placed within the much larger discourse of sexuality, gender and human rights where other marginalized subgroups practicing alternate sexuality also come in.
Despite the fact that a section of the enlightened women, especially the actresses and writers were coming from the class of prostitutes in the colonial Bengal, it is only in the contemporary period that we see the women in prostitution asking for their rights or relating to the other marginalized groups like Shabars or the bar dancers and even helping them with solidarity movements. Despite the fact that in the colonial period women in prostitution are emerging as the “darling” of colonial elites and occupying the creative space in the fields of performing art and literature, it is the individual voices that were being heard. Today what we hear from the women in prostitution is the voice of the collective or organized women. Sanlaap, DMSC and many other organizations has made successful contribution in the process of collectivization of the women in prostitution.

As there is a shift in the lives of the non-prostitute, mainstream women in general from entertainer and homemaker to the active participant in the development of the state and the people, sharing the power with the men folk; similarly the shift in the attitude and perspective could be seen in the lives of women in prostitution as well. None the less, they end up providing sexual services in both the eras, as those happen to be their job profile and due to that the vulnerabilities remain quite similar in both the periods.

Thus, applying the Foucauldian approach to understand the context of prostitution and sexually transmitted diseases (STDs) in the South Asian context in the colonial period as well as in the age of globalization, what is clearly discernable is a pathologized prostitute subject with a series of institutional discourses that seek to identify, name and regulate the sexual practices of these bodies. There are institutions ranging from the international organizations like World Health organization, academic institutions, the State and community based organizations that are busy in data collection and surveillance of HIV&AIDS among the ‘high risk groups’. In naming the sexual practices that prostitutes engage in with their clients as well as in testing their blood for HIV antibodies, the discourse of AIDS prevention not only constructs a socio-sexual prostitute identity and produces knowledge about prostitution and HIV&AIDS, but also uses the dominant discourse of international power that control, regulates and identifies the issues and programmes of disease surveillance. In doing so it objectifies

and regulates the prostitutes’ bodies in South Asia. Therefore, at both points of time there is a regulation of prostitution and the prostitute, whether through criminalization or legalization. And yet, whether criminalized or decriminalized, prostitutes succeed in gaining their voice to some extent at both the points of time. Following the Foucauldian analyses, in today’s West Bengal, with emerging awareness on AIDS and increasing funding in the related areas, we observe organizations like DMSC, Sanlaap, and also scholars and activists beginning to take live interest in the life and fate of the prostitutes, besides merely as the imagined and targeted carriers of Sexually Transmitted Diseases that is leading to the production of knowledge as well as the collectivization of the prostitutes.

An occupation like prostitution transforms one’s attitude and concept towards body. Following Foucault it could be claimed that it was in the modern period (i.e., starting from the late colonial period till the age of globalization) that the prostitute’s body was produced as a negative identity and an object of systematic surveillance and control. In modern era by an assertion of power through the institutions of public health and disease-control over the ‘other’, i.e., the prostitute; that resulted in the production of knowledge about prostitutes and prostitution. To the prostitute, her body has become ‘Gandha’ or ‘bad’, that does not deserve any social respect or recognition. She and her body are almost non-existent in the eyes of the rest of the society except as sexual objects to earn money. This concept of loosing the social value influences prostitute’s attitude towards their body and existence and violence done to it leaving permanent impact on their health. The body and health have to be taken care of in order to keep up the market value as a commodity. However, if it is a choice between earning money and keeping the body and health in a good order, then monetary aspect gets the priority.

Health and body are taken care of, but at a superficial level. As a result, when a health hazard or crisis is detected, it is almost at a critical stage when nothing much could be done to it. Economic violence or exploitation has more direct impact on health. Primarily, they may or may not be earning regularly, especially at a later stage and the younger women who are earning regularly are either having no share or half of the share of what they earn. Secondly, the money gets divided in maintaining several establishments. Other than keeping a ‘Babu’ (i.e., the live-in boyfriend/the permanent client) and educational and living expenses for the children, money goes after their
own business expenses like, buying make up, dress, drink, food, medicine, paying house rent, electricity bill and so on. Therefore, it could be understood that food intake cannot be of high nutritious quality.\textsuperscript{25}

Other than quality of food, the irregular working hours and food intake, the unhealthy surroundings and small rooms (where either sun rays or air could penetrate after hard struggle) play their own part. Irregular and infrequent food intakes are also associated with sense of low self-esteem, tensions and depression.

The violence faced by the prostitutes, could be divided into two main categories – covert violence, (i.e. psychological, economic/commoditized) and overt violence, (i.e., physical/sexual, verbal and clinical). All covert and overt forms of violence do have direct and indirect impact on the existence, well being and the health of the prostitute.\textsuperscript{26}

Once in prostitution, the prostitutes are exposed to continuum violence and vulnerabilities, which affect their physical, mental and over all well being. They are denied legal, constitutional, civil and human rights. Women who are in prostitution are seen as “shameful” women who have lost their honour in the eyes of patriarchy, meaning they are the commodities to be used by everyone and their beings not to be safeguarded by either natal or marital family structures as they are no more an intact and exclusive product. Families and communities thus often reject these women and do not give them a space because they are seen to bring “dishonour” to the family.

Children of the prostitutes are discriminated in the school and within the community. On the one hand the children face the constant threat of being taken away from their mothers; on the other hand if they stay at the RLAs they are to live under extreme vulnerabilities and violence from within and outside. The women are discriminated when they seek medical or health care. Once identified as prostitutes they are immediately suspected of STDs that stigmatizes them even further. The violence and vulnerabilities start from these combined stigmatizations of being a prostitute and panic associated with STDs like HIV&AIDS. And it seems a far fetched dream to imagine asking for legal rights or “legalization” might change the “stigma” factor.


\textsuperscript{26} Ibid.
What emerge feasible are the decriminalization, destigmatisation, sensitization and
transformation in the attitude of people and somehow the mobilization and
movements of prostitutes in today’s context have brought out some of these crises and
debates in the public unlike the colonial era.

The law serves to criminalize the prostitute creating space for police brutality against
her. Even in the countries with liberal legal systems the stigma isolates women from
the society.

The laws serve to perpetuate the stigma rather than to dispel it. Studies have shown
that prostitutes face overt and covert, physical and non-physical violence. Most of the
cases go unreported due to the nature of the trade, the position of the women in the
trade and the ambivalent position of the law as well as the attitudes of the police and
judiciary. The police are largely negligent and take the advantage of the
powerlessness of the women in prostitution either in the form of monetary of sexual
extortions. However, as mentioned, a change could be seen in West Bengal with the
gradual collectivization of women in prostitution. Prostitutes live a life of harassment,
verbal assault, malnutrition, sleeplessness, physical and sexual abuse. Alcohol is often
part of the process of serving clients and under their exploitative conditions, drugs and
alcohol may become addictions that too have its violent ends.

Women in prostitution suffer due to geo-political vulnerabilities as well. Many
women migrating for work find themselves victims of trickery and manipulation. In
instances where women agree to migrate to sex industry but may be coerced into debt
bondage; they are forced to repay their traffickers for transportation or other “fees”.
More so, because these women have entered the country often illegally and are
working in an illegal industry they remain afraid to turn to local authorities or are
unable to access other protections provided by other laws.

Like syphilis in the colonial period, the HIV&AIDS have intensified the
vulnerabilities of these women in certain ways. Since the early 1980’s prostitutes have
been subjected to increased public scrutiny and have almost universally been
classified as a “high risk group” and targeted by HIV&AIDS interventions. Among
the main discourses identified as a response to HIV and prostitutes, is a moral one that
attributes HIV transmission and disease to personal and social immorality. Measures
to control HIV therefore include measures to control socially marginalized groups and
“dangerous outcastes” such as prostitutes even where this infringes upon an individual’s human rights. Here we see how the State, whether colonial or post-colonial, has been using both the STDs, i.e., syphilis and HIV&AIDS as tool to suppress the marginalized. Though the demands for legalization apparently seem to be liberal and freeing the prostitutes, but in reality, legalization in the neo-colonial period attempts to regulate the women in prostitution in the same way criminalization had done in the colonial times by regulating their lives with licensing and legally categorizing them as prostitutes. However, as analyzed, HIV&AIDS also led to the collectivization and mobilization of the women in prostitution in West Bengal, eventually. It has not been witnessed that syphilis was becoming an instrument of mobilization of women in prostitution in the colonial period rather it ended up being a crucial tool of marginalization of the native women in the hands of colonizers.

The prostitutes covered by the Cantonment Act – captives under direct administrative supervision and control-could be described as belonging to what we today term as the ‘organized sector’. Beyond this sector, which was confined to the regimental bazaars and cantonments, there existed the vast majority of women who practiced the trade in Calcutta and other major cities in the nineteenth century. They had always remained outside any centrally-run organization. The Contagious Diseases Act of 1868 was an administrative intervention in the practice of their occupation. While allowing them to pursue their occupation and retain their unorganized structure, the Act sought to curb their free movement by imposing regulations like compulsory registration at police stations, medical examination at certified clinics, segregation and confinement to specified areas of the cities and towns, and heavy penalties for violation of these regulations".27 However, at the turn of the twenty first century we see no such demarcations such as organized and unorganized prostitution. In the present times, there is no state sponsored or organized prostitution as were in the late colonial period. The form of prostitutions we witness today could all be broadly understood as unorganized one in the context of India and West Bengal. However, the interesting part is that there is an increasing demand to make it organized that apparently seem to be coming from the bottom - i.e., as the demands of the prostitutes. However, it could be assumed that there are political economic actors behind the demand. Nonetheless,

representation of the prostitutes in a demand to make it an organization or collectivization of prostitutes in itself reflects the elements of human rights. The fact that any demand for collectivization or legalization has to come from the marginalized themselves marks the difference between the two eras.

Although there was no mobilization of women in prostitution at the context of Bengal in the nineteenth century, yet, at the same time in England, Josephine Butler for the first time was able to see the analogy between the violation of women's bodies and the violation of civil rights in the context of compulsory examination as an element of the Contagious Diseases Act. She used her paper The Dawn to publicize investigations into the state regulated prostitution in India and also recent developments on behalf of women in England. She taught women through her prostitution related campaign that it was their right to speak on behalf of their sex, be they in Britain, Europe or in India. Women's participation in repeal movement acted to break down the boundaries of separate spheres between men and women and established women as social, intellectual and political counterparts. The repeal campaign across these two continents won significant legislative victories, yet, ironically, those only served to demonstrate to Butler the striking anomaly of women's questions being debated, voted on, legislated and enforced, exclusively by men. As stated, unlike the nineteenth century England, the twentieth century India and West Bengal have witnessed the growth of a strong women's movement and also the mobilization of women in prostitution in that context. However, till today, especially as observed in the cases of certain organizations, e.g. DMSC, where men has played and still play a prime role in debating or raising women's questions and issues. This may or may not be viewed as a problem as long as it serves the purpose for the well being of the poor and marginalized women. But we really need to ask-does it?
IV

A Comparison between the Treatments of and Responses to the Two Sexually Transmitted Diseases (STDs), i.e., Syphilis and HIV&AIDS in Bengal

The public health-response to control the diseases mainly emphasizes the response to deal with the disease. It could be categorized as governmental or non-governmental. These responses could have various manifestations that could mainly be categorized as clinical, legal and social in the contexts of syphilis in the colonial period and of HIV&AIDS in the contemporary one.

If we compare between the intervention and treatment of syphilis in the colonial era with the intervention and treatment of HIV&AIDS in the contemporary times in the context of prostitution, the change in the magnitude, depth, dimensions as well as varsity of the treatments are revolutionary (though the fact remains that in colonial Bengal there was no cure for syphilis and same may be applicable to HIV&AIDS. Despite various scientific researches and innovations done, both these epidemics seemed to be beyond the humane controls and rather controlling their respective times).

It is mention worthy that the way a colonial state responded to tackle the issue of syphilis in the late Colonial period and the ways that a nationalist government decides to handle the problem of HIV&AIDS in the era of globalization represents certain differences between the approaches to the treatment of STDs from the colonial to the nationalist state. Nonetheless, we see international/neo colonial discourses are privileging certain kinds of policies and programmes that are emphasizing on legalization. While organization working on the issues of trafficking or focusing on the issues of demand and supply of the women in prostitution under the larger discourse of political-economic marginalization of the South remains neglected or less highlighted. In this context one seriously needs to question the agenda behind promoting legalization that would actually intensify the demand. We see the State agencies like WBSAP & CS are also propagating this politics of DMSC, knowing well that DMSC model are not being successfully replicated at other places in the
state of West Bengal. Therefore, like colonial era, one observe the international agendas are controlling the state policies of disease control either through government or through the non governmental bodies in favour of their political economic interests at the time of globalization.

Prior to analyzing the differences and similarities in the approaches to treat the two respective STDs, i.e., syphilis in the late nineteenth and early twentieth and HIV&AIDS in the late twentieth and the early twenty first centuries, I would like to discuss the changes brought about in the legal arena from the colonial period to the era of globalization accompanied by the legal debates of the time. The Immoral Trafficking Prevention Act 1986 (ITPA) was initially enacted as the Suppression of Immoral Traffic in Women and Girls Act,1956 in pursuance of the International Convention for the Suppression in Traffic in persons and the Exploitation of the Prostitution of Others signed in New York in 1950. The Act is divided into two parts, the first criminalizing activities such as trafficking and keeping of brothels and the second part which contains certain welfare measures that are directed towards the rehabilitation of prostitutes. In practice the act is used against the prostitutes themselves and now there is a revised bill that proposes to criminalize the clients as well. Other provisions in which prostitutes are implicated are also found in the Indian Penal Code,1860 (IPC, Chapter titled “Of Kidnapping ,Abduction, Slavery and Forced Labour”), that contains general sections against trafficking and slavery of women and children as well as state level police, railway, beggary, health and public order statutes. The Constitution of India (Article 23, 39, 42) also contains certain provisions that address the issue of trafficking in human beings.28

Unlike the prostitutes of the colonial state, in the contemporary-globalized time, the prostitutes of various nations have been organizing themselves for over twenty years in many parts of the world and more recently in India. From the different voices we are hearing strong demands for ensuring their rights, safety from violence, good health care, the right to work, to decriminalize their lives and work, ensuring rights and safety for their children and families. And most significant of all, they are demanding to be seen as people with dignity and the right to a life that is recognized

as worthy and a part of the society we live in. Thereby, we observe a greater attention to the over all conditions of prostitutes by the state and the international bodies.

It is felt by a large section of groups of prostitutes, activists, feminists and others that the debate around prostitution and legislation has its own complex dynamics and there is a need for complex solutions. It has been felt that the concerns confronting a woman when she enters into prostitution are different than those confronting a woman who is already into prostitution. Similarly there are different concerns confronting a woman when she exits prostitution several parallel and conflicting debates have emerged over the last two decades.

Criminalization approach looks at prostitution mainly in two forms - abolition and toleration. Both these approaches view prostitution as a social evil and relating the concepts of morality to sexuality to promote the idea that such “immoral” conduct should be criminalized. We see this approach beginning and being predominant since Colonial rule in India for its own political-economic reasons. Legislation based on this approach is silent about whether the activity itself is legal or illegal. It criminalizes the outward manifestation of prostitution such as soliciting, brothel keeping, and trafficking. The Immoral Trafficking Prevention Act, 1986, that is in the line of colonial legacy adopts this approach.

Decriminalization approach is based on the assumption that prostitution is a personal matter between two consenting adults if it is a personal choice. It aims at complete decriminalization of voluntary prostitution and all related activities and abolition of laws that criminalize these activities. Prostitution as per this view should be under the purview of general laws.

Under this approach forced prostitution is treated as a separate issue, with the recommendation that the existing law relating to trafficking, especially in minors, fraud, coercion, and forced labour be strengthened. This approach was debated among the prostitutes at the First and the Second Sex Workers Conferences held in Calcutta in 1997 and 1998.

The legalization approach is similar to decriminalization as far as it involves taking the subject of prostitution outside the realm of criminal law. Nonetheless, in contrast to decriminalization, this strategy involves legalizing and heavily regulating prostitution through a whole host of zoning and licensing laws. Apparently, its
objective is to curb the worst side effects of prostitution for the clients, such as the spread of STDs & so on.

Legalization implies the recognition of “prostitution” as “sex work” and a lawful activity by the State. Nevertheless, it is debatable whether the interest of the State in any regime to permit such legalization is the “sex worker” or her rights.

The human rights approach\(^{29}\) of legalization for empowerment recognizes that it is not sufficient to merely remove prostitutes from the operation of the criminal law but also to protect their legal rights. In doing so, it attempts to address the specific abuses that women in prostitution face. This approach supports occupational safety standards in the practice of prostitution. It favors the specific recognition of civil liberties of the prostitutes; such as right to liberty, retain custody of her children, minimum remuneration, social security in the form of welfare fund, and soliciting. The last right is important to guarantee protection to prostitutes such as protection from police harassment, protection from being kept in quarantine or isolation, forcibly medically examined or being denied access to health care facilities. This approach emphasizes the need to protect a prostitute’s legal rights. Under a human rights approach a prostitute cannot be picked up by law enforcers for being a “public nuisance”, as her work will be supposedly lawful. It addresses the specific abuses that women in prostitution experience and provides that the criminal law can be used to address the harms that these women experience and moves way from criminal remedies, which involve the State. It also incorporates some specific health provisions that are for the women’s benefit and makes provision to protect her civil liberties in this context.

Nonetheless, the anti-legalization approach supports decriminalization. But they see the paradox in the legalization and “sex work” as it is felt that in the context of developing and underdeveloped countries legalization would only help to intensify prostitution. This approach prefers to refer to the women as ‘Prostitutes’ or ‘Women in Prostitution’ rather than ‘sex workers’. As per this approach the term sex-worker sterilizes the inherently exploitative nature of prostitution and invalidates the

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\(^{29}\) There were no concepts of human rights in the colonial period as the colonial imperialism was depended on empire building by land. The nascent capitalism had not then grown out of it’s predecessor ‘feudal mode of production’. However, in the contemporary times, that witness a mature phase of capitalism, the imperialist expansion is based on ‘capitalist mode of production’ and economy. Therefore, the need to create a free working class not tied up by the families and communities are crucial. In this context human rights play an increasingly important role by securing the individuals choices and rights and sometimes at the cost of family or commune responsibilities.
women's traumatic experiences of subjugation, degradation and pain and thus naturalizing and making acceptable in society the sexual exploitation of women or children. Considering sex a work, makes it convenient for different states and governments to deny its responsibility and to ignore the structural social, economic and political policies that force women into prostitution.

Very often governments, policy makers and buyers of prostituted sex argue that women chose prostitution as a work option over working in sweat shops, domestic servitude or other forms of hard or cheap labor. They seemed to purposely not recognize that for women, other options have been limited in terms of highly paid employment (especially when higher education is lacking or husbands/fathers decide or have control over a woman's time), and prostitution and pornography remain among the more highly paid occupations available to unskilled and uneducated women, while, the fact remains that economic and social policies make other lucrative employment unavailable to women and that gender discrimination and occupational segregation funnel women into particular occupations. People supporting anti-legalization approach feels, the term sex-worker categorizes prostitution as a kind of work. Prostitution cannot be categorized as work as it disconnects the self from the activity. It always involves penetration of the body. If and as woman's sexuality is an integral part of herself, it is not only selling of body but also the selling of the self for sex. To cope with the experience, many women in prostitution detach themselves emotionally from their bodies- effectively segmenting themselves, or entering into out of body experiences. So besides risking disease or death they suffer from the deep psychological trauma of alienation from their own bodies.

According to anti-legalization approach labor movements can and do guarantee certain minimum conditions and standards for workers, providing for energy and time needed for the worker to be a fulfilled human being while prostitution inherently cannot do so. For all labor movements strive for minimum wages. In prostitution, no minimum wage could be guaranteed as the price of a woman varies with age-attractiveness, time of night, and location. Moreover, in brothel-based sex there is no

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30 The prostitutes' noninvolvement with the clients is one of many ways to keep the clients at a distance. The condoms if used not only protect them from STDs, but also from intimacy with the client as there is a rubber between them. Keeler, Laura & Jykinene, Marjut (Eds.). Who is Buying: The Clients of Prostitution. Proceedings of the Nordic Research Meeting on Prostitution, 1997, Helsinki. Council for Equality. 1999.
such thing as minimum wages. For the first five years, the brothel owner owns the woman or child and keeps her like a bonded slave and spends an amount to keep her in a subsistence condition. For the next five years, she may give half of what she earns, later she is allowed to keep all that she earns but her earning capacity comes down. Specify this data is for Kolkata.

All labor movements aspire to certain minimum working conditions. In prostitution, all women face violence that cannot be legislated away as they are ultimately alone with the buyer of prostituted sex. In both brothel-based and non-brothel based prostitution, women are forced to speed up the process of earning more money by servicing an increasing number of buyers, sometimes up to twenty. They are also forced to provide all kinds of services and high-risk activities. They are kept locked up in brothels, have no access to medical care or education and often are sold when they are children. Their children play on the floor while they service their buyers. They live in small rooms with barred windows end up with insomnia, repeated abortions, jaundice TB, cigarette-burns, HIV and AIDS and trauma. And while some of these conditions can be regulated in brothel-based sex, they cannot be regulated in street-based sex at all.

All labor movements work to guarantee retirement benefits such as old age pension. Prostitution cannot guarantee old age benefits as there is no defined employer in street based sex and in brothel based sex, the women or child is often sold again and again from one brothel owner to the other. Mortality rates in prostitution are high due to sexual violence, sexually transmitted diseases such as HIV and AIDS and repeated abortions and suicide attempts related to psycho-social trauma. Additionally, the older a women in prostitution gets, the less she is able to earn an income and very often ends up on the streets, with no income, a disease ridden body and a few children.

Finally and most importantly for labor movements is the question of dignity of the worker. Labor movements have ensured that miners do not have to crawl into mines anymore but walk upright. However, in prostitution the woman or child is constantly humiliated physically, emotionally and psychologically. Her price is constantly negotiated as the night wears on or as she grows older. She is forced to sexualize her body for a time—period and then desexualize it again at another time.
The term ‘sex-worker’ gives a false impression of agency and choice exercised by women and children in prostitution. Prostitutes’ life-experiences reveal that the choice and agency in prostitution, talked about in some policy circles, is a choice allowed by the exploiter in an exploitative situation as in the days of slavery as the normal time-span that the body of a woman can cope with prostitution is no more than ten to twenty years in normal circumstances.

Moreover, changing the term from prostitute to sex worker does not help to escape the stigma rather by giving license it intensifies the stigmatization as it happened in the colonial period too with criminalization (widows who were practicing prostitution under cover committed suicides as the colonial laws brought them in the limelight).

Could it be possible then that the treatment of prostitution through legal measures (whether criminalization or legalization) is in itself a stigmatizing activity? Is it the power of the state that by responding to public health problems like HIV & AIDS attempts to produce a pathologized ‘prostitute-subject’ as manifested through the debate over ‘legalization’, so that each woman in prostitution will have to get a license, an official paper that solidifies her identity as one of a ‘sex worker’ in black and white?

It is also noteworthy that like medicine, engineering and so on, prostitution too is a service sector. Therefore, like other service sectors, the recognition and acceptance of this sector remains incomplete only with legalization unless and until there are overall institutionalization of it through proper formal training and placements as happened partly in Ancient India. Could that be a feasible reality in the contemporary India?

Therefore, anti-legalization approach does not use the term sex-worker. They do not believe that prostitution is a profession. It is a forced occupation. The term “prostitute” or “women in prostitution” may be a better accepted term in this context because it is felt that if these women have other opportunities they would have exercised them. Moreover, just by using the term sex worker stigma of working in prostitution does not wither away. The observation made during my M.Phil. dissertation was many women in prostitution do not want any license and legalized document because they felt this would officially stamp them as prostitutes therefore
destroying their hope and chance to go back to the their ancestral villages after “retirement”.31

The anti-legalization approach rejects the argument in favour of the “Right to be a Prostitute,” as it reinforces patriarchy and limits women’s choices and as prostitution is never seen as a career option. The issue here is the “Right not to be a prostitute”.

Significantly, in the colonial period as well as in the neo-colonial one we would see an attempt to impose legal measures in the name of preventing STDs like syphilis or HIV&AIDS. Now, though criminalization or legalization on the women in prostitution apparently seem to be measures with opposite goals and dissimilar intentions, yet they both try to curb women’s freedom, attempting to regulate their sexuality by strict legal measures, by periodic check ups, licenses and cards. Could it be said legalization is actually an old wine in a new bottle? Is it not just the other side of the coin of criminalization? Is it the paranoia of deadly epidemics or is it a fear of female sexuality or is it an equation of female sexuality with a fearsome disease? Or does STDs simply provide an excuse and an opportunity to curb the sexual space and control the social and sexual powers of women?

The human rights approach to prostitution comes accompanied by the human rights approach to the issues of HIV&AIDS as the prostitutes happen to be one of the “high risk groups” in the context of the disease. These human rights violations are many a times created by the hype and panic fabricated around HIV&AIDS as well as the lack of clarity or the misconception in defining the meaning of “high risk”. In her article, “Paradoxes of the AIDS and Human Rights Debate” Ritu Priya states, “The focus on public health of the high-risk groups had three negative consequences—(i)perception of the disease as a problem of ‘the other’ and therefore non-perception of the threat to oneself, and (ii) ‘victim-blaming’ which provided a social rationale for discriminatory behaviour and (iii) the AIDS control programmes focusing on the high risk groups ignoring the group from which much larger number of cases are expected to occur on a long-term basis. As the epidemic graduates into an endemic women are likely to be the largest group affected”.32 While defining the “high risk group”, as per Ritu Priya

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few things must be taken into considerations, e.g., that the high risk are those who are more vulnerable to the infection and therefore in need of more support and medical help. However, in public health programmes the meaning of "high risk" has gone through a convulsion meaning people who are "high risk to the society". It is also important to understand why "high risk" categories are more prone to a certain disease like HIV&AIDS. For women in prostitution it is an occupational hazard as their source of infections are the clients. It is important to remember those who engage in a "high risk" behavior, do so due to the lack options for survival. It is the societal and political economic conditions that are discussed in previous chapters that led to the creations of "high risk groups" and "high risk behaviours".

While we see the responses of the colonial state to the disease of syphilis, the paranoia of the Colonial Govt. from the 'vectors of syphilis'-the native prostitutes, become quite evident. As the empire building was the priority of the time and therefore the good health of the soldiers was crucial and to be secured at any cost as well as the lust of the military men, prostitutes became a very crucial point in the discourse of syphilis for the sake of their colonial clients and thus the criminalisation. Nevertheless, in this context it is important to recognize the role played by contemporary medical technologies, like, condom that was absent in the colonial period. Could it be possible criminalization and its implementation through lock hospitals had to happen partially because there were no such technologies available at the turn of the twentieth century? As there were no concepts of human rights functioning in the late colonial period, the cruelty and harshness of the treatment of these women became quite evident from the discussion in the earlier chapter. Nonetheless, here certain differences and similarities emerge from the following discussion to measure the public health responses of the State or the Government to tackle the issues of HIV&AIDS, especially in the context of prostitution.

Today in the context of West Bengal as well as in the world, though the approach to the treatment has largely remained target specific, yet the treatment of the target groups or the vulnerable communities have become more humanitarian and have gone beyond the clinical attention. It is to say, in the present times, public health has rightly

33 See Chapter-II
made an attempt to take into consideration, many aspects like human rights, cultures, gender issues, political-economic conditions and so on while planning or implementing any programme related to HIV&AIDS and also the specificities that are inherent and typically associated with any vulnerable community. With time the scope and definition of the vulnerable communities have gone beyond women in prostitution. The discourse of HIV&AIDS today includes MSMs, IDUs, truck drivers, and blood donors and so on. The mainstream population is also timely gaining the attention of the State and the public health authorities and gradually coming under the folds of HIV&AIDS programmes.

For a society that is experiencing the growing consumerism and market economy, it is just not the groups of empire building soldiers, but the over all profit generating working class and profit making consumers, in short everybody related to and functioning for capitalist production process needs to be protected, e.g., the Bula di campaign in West Bengal. Today condom replaces the lock-hospital. While the lock hospital used to run in a loss the medical technologies and medical industries, e.g., condom and drugs in themselves have become profit generating industries. Interestingly enough, as there was a kind of sexual space within the pre-colonial socio-cultural norms, in the post colonial, post-modern times we see a different kind of sexual space in emergence. But then, what exactly differentiate and demarcate the two kinds of sexual spaces over a gap of a century is the question. Could it be the possible answer that the pre-colonial sexual space as well as pre-colonial prostitution was in tune with indigenous socio-cultural elements, forms and people of the times while today it is more in tune with the contemporary globalised commercial and consumer cultures for profit generation?

Nonetheless, HIV&AIDS, a global public health challenge, continues to spread unabated in many parts of the world where it is wiping out developmental gains over the past decades, threatening the peace and stability of nations and sub-regions, and sending communities into destitution. The epidemic targets the poor, overwhelmingly hitting the world's poorest communities, marginalized women, men, boys and girls, particularly in countries with greatest gender inequalities, disparities in income and access to productive resources. The issue has the dynamic interplay of poverty, violations of fundamental rights and human dignity, and intense burden of suffering among affected individuals, households and communities. In this light, it is important
to question why despite the fact of West Bengal being a low intensity state in comparison to some of the states in India in terms of the spread of HIV&AIDS, it remains the stage for the phenomenal success of the SHIP and other projects in terms of collectivization of the women in prostitution? Could it be attributed to the specific cultural and social dimensions discussed in the previous and in this chapter? As mentioned, in the contemporary West Bengal we could witness a highly successful collectivization of women in prostitution and awareness generation about HIV&AIDS epidemic among them by the NGOs leading to a greater use of condoms and better say in terms of bargaining with the clients, combined with the successful IEC, BCC campaigns by the GOs targeted at the general population that takes into account the socio-cultural specificities of the state, e.g., the 360 degree Bula di-campaign.

However, at the same time we observe in West Bengal at the turn of the twenty first century, the discourse of HIV&AIDS are majorly influenced by the dominant international discourse represented by DMSC focusing more on the organization of women in prostitution demanding ‘legalization’ of ‘sex work’ are more publicized and highlighted in comparison to other models followed by organizations like Sanlaap that takes a feminist and leftist approach by focusing on the issues of underdevelopment, commoditization of women, trafficking, sexual abuse of children, rehabilitation and over all well being of women in prostitution in the context of larger political economy. Although the State understands the need to stop trafficking and the fact that issues of prostitution are related to the larger issues of women’s marginalization and underdevelopment, yet it propagates and follows the similar principles and objectives of the international discourse of disease control of HIV&AIDS at the times of globalization.

In Bengal, at the turn of the twentieth century the public health responses were equivalent to the response of the Government. But at the turn of the twenty first century, one visualizes not only Government and Non-Governmental bodies working in unison and independently, but also the inter-sectoral collaborations between the State and the public & privates sectors for the successful implementation of the HIV&AIDS programmes to reach out the mass.

The population covered for treatment of syphilis during the colonial period by the then British Government was mainly of two categories-Tommies (soldiers) and the prostitutes while in the present West Bengal the coverage for treatment or for the generation of awareness regarding HIV&AIDS range from the prostitutes to the public.
Significantly, during the colonial period the discourse of syphilis developed and centered on the British soldiers and their getting infections from the native prostitutes. The Cantonment Act and the Contagious Diseases Act were mainly being used just not to make the prostitutes healthy but to keep a section of women in prostitution clean and sanitized to be sexually accessible to the Tommies. Other than the Tommies there were noveau riche Babus and the other aristocrats as well as commoners who used to visit prostitutes as that was the “fashion of the day”. Today, the discourse of HIV&AIDS has undergone a shift from the client to the prostitute. Unlike the discourse of syphilis that was shaped by the concern over the clients and their health, in the present times the HIV&AIDS programmes directly target the prostitutes. However, the clients remain a less explored category unless and until they too are targeted as “high risk group”, as during the thesis it was found that studies done on the buyers of sex are negligible in comparison to the sellers of sex. This alteration related to the client in the discourse of STDs, i.e., syphilis and AIDS respectively at these two eras mentioned, signifies the transformation of the clients from the patrician to the plebian; from the imperialist to the proletariat. However, it is not to say that class of clientele in the colonial period were all rich and at the time of globalization they are all poor. Similarity in both situations, then the woman got criminalized, not the client. Now she is the major target of programmes.

What we see about sexual practices in the context of prostitution in the late colonial period is about exercising a power relation or domination of imperialist male sexuality to dominate the female colonial sexuality, i.e., to say sex being used symbolically and physically as well as deliberately as a mechanism of control and domination. To explain perversion, Ronald Hyam continues, “...it is the sexual urge reduced to impersonal terms, becoming in the process indifferent to evoking a pleasurable response in a partner. Intention is all-important...but first let us agree that an act is perverted if its primary aim is domination rather than mutual enjoyment; if it becomes an expression of power rather than sensuality, and is thus so to speak pondering rather than worshipping.”34 This unequal power relation perverts the occupation by the incorporation of the new elements of sadism at a psychosocial level that largely expresses itself through criminalization. But unfortunately, the same mechanism of

control backfires against the colonial imperialists by ‘de-vitalizing’ and ‘de-masculinizing’ them, especially making the class of soldiers totally unfit for empire building. In the words of Mishra, “The patriarchal order of the society produced a specific discourse on the disease. Essentially gendered in nature, the discourse portrayed syphilis as a typically feminine disease. Women, particularly prostitutes were seen as sole carriers of the syphilitic contagion, and the prevention of the disease got directly associated with their control. This deliberate gendering proved especially fruitful in colonial situation as it gave a free hand to the authorities to put the blame of the disease on the colonized other. It also provided a tool for the extension of the colonizing space through a control of the state over female privacy...They brought about a radical shift in the very perception the prostitute as belonging to a marginalized class, staying at the periphery out of necessity...she now emerged as a criminal at the center stage of the colonial rule—as one who infected the colonizer and demasculinized him...It also had an important bearing upon the treatment of prostitutes as subjects in the preventive discourses of the state. Unlike in England, where prevention of disease through control over prostitutes was closely associated with their rehabilitation in the mainstream society, in India, the entire discourse on the prevention of venereal diseases precluded any such responsibility of the state towards rehabilitation of these classes. In its attempt to rescue the soldier from the evil effects of his sexual indulgences, the state, despite recognizing him as equally responsible, spared him, and held the prostitute—the colonized subject and an unequal partner—as sole guilty, and made her pay for it”. 35

The basic paradox of the British colonial policy lay in the fact that after promoting a vulgar culture on the basis of sexual commercialization they tried controlling STDs and regulate it through various public health laws and policies and consequently all of those measures failed either to stop or to control syphilis. The similar venture could be seen in the present times, as after promoting a commoditized sexual culture through mass media, the attempt to control HIV&AIDS are being made by the revised IT (P) A Bill, 2006, that talks about criminalizing the client as a means to control commoditised or marketised sexual behaviour and therefore to control STDs as well as HIV&AIDS. It is a paradox and rather unfortunate that the public health

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policies/measures of controlling prostitution and STDs should either talk of
criminalizing the prostitutes at the turn of the twentieth century or think of
criminalizing the clients at the turn of the twenty first century, but it would never
address the real issues like the propagation of a commoditized sexual culture that
perceives human being especially women as bodies for sexual gratification in the
market as well as means of marketing and selling of the consumer goods for
accumulation of wealth. And therefore, creates the demands/market for
commoditized sex.

However, getting back to the late colonial period, the male contraceptive has come up
by the nineteenth century. Despite the fact lock hospital continued to exist as a mean
to disease control by controlling the prostitutes. Could it be attributed to the fact that
use of condom has just began and people were not into the habit of using yet? Or does
it show the fact that at the late nineteenth century lock hospital was more prominent a
measure of disease control in keeping with the Victorian spirit of the time while today
social marketing of condoms are more effective in an economy that is globalised and
a commoditized society that is speaking of human rights and civil liberties?

Syphilis made substantial inroads initially, but the treatment reached a deadlock.
Mercury began to fall from favour because of doubts as to its efficacy and the fact that
it was shamelessly exploited by charlatans. However, there was a single line of
defense; the male contraceptive has come into existence in England. “A new subject,
Syphology, was born, with university chairs, national and (soon) international
societies; & conferences. From this point onward a whole department of medicine
began to open up”.36 In 1905, the major event in syphilis was the fact that Schaudinn
and Hoffmann drew attention to the pathogenic agent of syphilis – a pale coloured
treponema. Quetel states, “Five years later Ehrlich created Salvarsan,also known as
‘606’,thus inaugurating the era in which syphilis was treated with arsphenamines and
putting an end to the increasingly disputed reign of mercury”. From this turning point
onwards numbers of questions merited separate treatments, e.g., connection between
syphilis and madness or between syphilis and imbecility. The other favourite
relationship was between syphilis and prostitution.Similarly, the treatment of
HIV&AIDS has undergone changes from time to time. Though there are no new

subject like Syphology has come up, but lots of scientific experiments and interdisciplinary, social as well as clinical researches are being done across the various fields of health and medicine on HIV&AIDS. Unlike AIDS, syphilis does not kill, but it has successfully “ lulled us into a state in which we no longer fear it, a state in which we even overlook it. It endures” \(^{37}\).

Unlike in England, where initially prevention of disease through control over prostitutes was closely associated with their rehabilitation in the mainstream society, in India, the entire discourse on the prevention of venereal disease precluded any such responsibility of the state towards rehabilitation of these classes. In its attempt to rescue the soldier from the evil effects of his sexual indulgences, the state, despite recognizing him as equally responsible, spared him, and held the prostitute—the colonized subject and an unequal partner—as solely guilty, and made her pay for it. \(^{38}\)In India rehab certainly emerged as one, while at the turn of the twentieth century we witness an amalgamation of and debate between several approaches, namely-decriminalization, rehabilitation, legalization, anti-legalization, human rights and so on as discussed.

As it is so significantly stated by Ronald Hyam, “within a period of little more than a hundred years the sexual scene for British officials in India had changed radically. If in the eighteenth century this was characterized by an active rate of overt sexual intimacy with Indians, by the twentieth century the predominant atmosphere was one of physical aloofness and suppressed eroticism.” \(^{39}\) The outcome of the racial policies adopted by the Empire builders meant for a common soldier that he could neither marry nor keep native women as a companion. Thus and therefore, he has to go to the prostitutes sanitized and testified by the authority. These indirectly led and encouraged a culture of voyeurism, a culture that encouraged multiple sexual involvement and discouraged emotional involvement (in the colonial context at the pretext of skin colour). There lay the basic paradox of the British colonial policy that after promoting a vulgar culture on the basis of sexual commercialization they tried

\(^{37}\)bid


controlling STDs and regulate it through various public health laws and policies and consequently all of those measures failed either to stop or to control syphilis. Similarly in the present context we see a gradual emergence, promotion and culture of consumerism that commoditize women’s body and sexuality. After promoting a culture of sexism and sexual commoditization, a law like IT (P) A attempts to criminalize the client. Could we presume then, by learning the lessons from the past, that probability of successful disease control by making legal measure like these are bound to fail at any point of time, given the context of a culture of commoditized sex and sexuality?

However, by the researcher’s experience and impression of being in the RLAs, it appears, as if the NGOs of today have taken the place of the Imperial Government of the colonial times. They are the guardians and controlling agencies behind the live of the women in RLAs at the contemporary time. We have witnessed how the colonial prostitute were kept in “Chakla”s for the consumption of the British Tommies. The then colonial government had created a physical space separating the women in prostitution from other and thereby criminalizing and controlling their lives. At the turn of the twentieth century, we do not see government creating and controlling the women by making any such physical divide between them and the common people, but we undoubtedly witness NGOs/CBOs as well as bilateral/international agencies and the national government taking keen interests and percolating into Red Light Areas controlling the lives of the residents, either through mobilization or by targeted Intervention programmes. Prostitutes are never to be set free or left alone. Is it because they are equated with disease and the fear of transmission of STDs that drive the authority of the respective historical times to control these women? Or is it because deep in our psyche there is an obsession with female sexuality whether in the form of mother goddess or in the form of whore women?

V

Some Lessons could be Learnt from this Comparative Study

In the case of syphilis at the turn of twentieth century and in the case of HIV&AIDS at the turn of twenty first century, we witness fear of these two STDs and stigma attached to them being important motivating factors in shaping the responses of
medical approaches, public health policies and strategies of interventions as well as the response of the common mass. The last years of the nineteenth and first of the twentieth witnessed considerable fear of sexually transmitted infection, not unlike the ones we are observing today. A series of important discoveries about the pathology of syphilis revealed a range of alarming pathological consequences from sterility, paralysis, blindness to debility and insanity. In this age of antibiotics perhaps it is possible to some extent, to forget the fear invoked by syphilis in the colonial period, but not completely. One of the reasons to invoke this fear was the theory of casual transmission. The various modes of transmission catalogued by the doctors at the turn of the twentieth century ranged from medical procedures to pen, pencil, toothbrush, towel and bedding. We know now that syphilis cannot be contracted in these ways. This poses an intriguing historical question- why did the doctors believed it could be? Is it due to the lack of proper diagnosis and cure or is there some deeper meaning to it? I would here like to quote from Allan M Brandt that probes into this issue of irrational fear related to syphilis, “Theories of casual transmission reflected deep cultural fears about disease and sexuality in the early twentieth century. In these approaches to venereal disease, concerns about hygiene, contamination, and contagion were expressed, anxieties that reflected a great deal about the contemporary society and culture. Venereal disease was viewed as a threat to the entire late Victorian social and sexual system, which laced great value on discipline, restraint, and homogeneity. The sexual code of that era held that sex would receive social sanction only in marriage. But the concerns about venereal disease and casual transmission also reflected a pervasive fear of urban masses, the growth of the cities, and the changing nature of familial relationships.” Today, persistent fears about casual transmission of HIV & AIDS reflect a somewhat different, yet significant social configuration. The discourse of HIV & AIDS strongly associated with behaviours that are traditionally seen deviant by the mainstream society, e.g., homosexuality, prostitution, intravenous drug usage etc. In a similar way as syphilis created a xenophobia at the turn of twentieth century, AIDS today has created a homophobia. “AIDS has recast anxiety about contamination in a new light. Among certain social critics, AIDS is seen as

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"proof" of a certain moral order." Despite the fact that HIV cannot be casually transmitted, the scientific, medical and public health experts have failed to completely assure people or give any guarantees. This not only shows a communication gap between the policy makers, experts and the public, but also reflects the inherent uncertainty of science. The response to HIV&AIDS would be shaped partly by response to these fears leading to the violation of human rights. These violations are reflected in many ways- the social ostracism of HIV&AIDS patients, refusal of some physicians to treat AIDS patients, job and housing discrimination against those infected, refusal of admission or entry to schools of HIV infected children and so on. Undoubtedly, then public health policies need to find out ways to address these fears more successfully by developing techniques to assist individuals to distinguish irrational fears from realistic and legitimate concerns.

Education related to sex and sexually transmitted diseases (STDs) is an important mean to that end. There is a need to put an end to the "culture of silence"—the Victorian code of sexual ethics that considered all discussion on sexuality and STDs as immoral and taboo in respectable societies. Physicians had also contributed to this taboo in the colonial period by not revealing the real state of affairs to the patients and their families and terming it as "medical secrets" or 'rare blood disorders". In the words of R.N. Wilson, "Medical men are walking with eyes wide open along the edge of despair so treacherous and so pitiless that the wonder can only be that they have failed to warn the world away. Not a signboard! Not a caution spoken above a whisper! All mystery and seclusion...As a result of this studied propriety, a world more full of venereal infection than any other pestilence." Nevertheless, there are some instances of successful STD-education campaigns. During World War II, the military initiated a massive educational campaign targeting the soldiers. However, as the condom was very much into existence and use by then, it reminded the soldiers that STDs could be prevented by the use of condoms and that were widely distributed. Military understood the need for the modification of sexual behaviour, but realized that calls for outright abstinence are likely to fail as that put a check on male sexuality. And given the need for an efficient and healthy army a pragmatic approach was maintained that separated long term measures from the immediate prevention.

42 Ibid.

43 Wilson R N. The relation of the medical profession to the social evil. JAMA. vol.47.No.32. 1906.
Similarly, in the disease control programmes for HIV&AIDS, despite the mention of A(abstinence), B(behaviour), C(condom), the stress always to be seen more on C instead of B or A. Even at the turn of twenty-first century the male sexuality remains as privileged as ever. As discussed in the previous chapter, the programmes of government and non-governmental bodies remain largely contraceptive centered. Therefore, AIDS education and programme need a confrontation with those aspects of human and male sexualities that are generally avoided and encouraged. Also, as the history of STDs unfolds itself, we need to study the nature, course and behaviour of the diseases through social and epidemiological sciences. If education is to have an impact then we need to be far more sophisticated, sensitive and resourceful in terms of creating and implementing any programme with a clear understanding of human sexuality in its specific historic and socio-cultural contexts. With that understanding a public health approach to the crisis of HIV&AIDS could perhaps could respond better.

The history of attempts to control syphilis at the turn of the twentieth century shows the limitations of compulsory measures and laws that ranged from required premarital testing to quarantine and confinement of the women in prostitution to the lock hospital or measures like compulsory health checkups. These kinds of measures are neither advisable nor effective, especially in the context of human rights and civil rights at the turn of the twenty-first century. We have learnt our lessons from history that those compulsory measures and laws had to be repealed ultimately. As discussed, neither the criminalization of prostitution in the nineteenth century nor the demand for legalization in the late twentieth century could be seen as a pragmatic and rational way out by using the law to tackle STDs. Neither the legalization nor the criminalization frees a woman in prostitution instead chains her under legal obligations along with societal stigmatization and sexual exploitations.

It has also been learnt, from the historical experience of syphilis, despite the effectiveness of penicillin as a cure, syphilis persisted. The issue therefore, is not merely the invention of effective vaccine or treatment, but the process by which they are delivered and made accessible to people—whether those are related to the larger issues on underdevelopment, unemployment, poverty and so on, whether common people are in apposition to access and afford the treatment. These are indicative of certain flaws in the bio-medical model of treatment of disease. Diseases are complex
phenomena that may be mitigated by addressing social, cultural, political, economic and developmental issues along with scientific interventions. No single intervention could be effective to tackle a multifaceted epidemic like AIDS. And there lies the significance of a more complete intervention and public health shows the possible ways. History does points to a range of factors that influence disease and those issues need to be taken care of if the disease is to be addressed effectively. I would like to repeat that any such approach demands the complete understanding and recognition of social, cultural, political, economic, development and epidemiological issues through an interdisciplinary-multidisciplinary approach to public health.

VI
Policy and programmatic Implications

The UN Charter's preamble speaks of a determination "to promote social progress and better standards of life in larger freedom" and it proposes, "to employ international machinery for the promotion of the economic and social advancement of all peoples." But over fifty years later, with worsening poverty and a deepening environmental crisis, the global economic system and the UN's capacity seem tragically flawed. And prostitution in the context of the developing world is an outcome of economic poverty. Fundamental change is urgent to assure the future of human life on the planet and putting a full stop to the exploitation of women on the grounds of gender is a part and parcel of it.

The principle of gender equality is enshrined in the Indian Constitution in its Preamble, Fundamental Rights, Fundamental Duties and Directive Principles. The Constitution not only grants equality to women, but also empowers the State to adopt measures of positive discrimination in favour of women.

Within the framework of a democratic polity, our laws, development policies, Plans and programmes have aimed at women's advancement in different spheres. From the Fifth Five Year Plan (1974-78) onwards has been a marked shift in the approach to women's issues from welfare to development. In recent years, the empowerment of women has been recognized as the central issue in determining the status of women. The National Commission for Women was set up by an Act of Parliament in 1990 to
safeguard the rights and legal entitlements of women. The 73rd and 74th Amendments (1993) to the Constitution of India have provided for reservation of seats in the local bodies of Panchayats and Municipalities for women, laying a strong foundation for their participation in decision making at the local levels.

India has also ratified various international conventions and human rights instruments committing to secure equal rights of women. Key among them is the ratification of the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) in 1993.

Independent India brought in uniform law applicable across the country. The Suppression of Trafficking in Women and Children Act, (SITA) was passed in 1956. It used UN Conventions as it's template of human rights. SITA was designed to punish those who coerce and/ or benefit from prostitutes' labour. It criminalized procuring, trafficking, brothel keeping, pimping, and living off the proceeds of prostitution. It was not actually designed to punish prostitutes per se, although, SITA has become the Prevention of Immoral Trafficking act of 1986, it has not led to the prosecution of procurers, pimps, brothel keepers. Instead, prostitutes have been prosecuted under the section that prohibited soliciting, indecent behavior or the carrying on of prostitution in the vicinity of a public place.

There are acts like The Immoral Traffic Prevention Act (ITPA) 1986, that was initially enacted as the suppression of Immoral Traffick in Girls and women act of 1956. Other provisions in which sex workers are implicated are also found in the Indian Penal Code (IPC), 1860 which contains general sections against trafficking and slavery of women and children. The Constitution of India (Art. 23, 39. 42) also contains certain provisions that address the trafficking in human being.

In spite of all these written and legal commitments at the level of policy, the reality speaks a very different language. Especially, if we try to explore the socio-economic background of the common prostitutes in India, it is not much hard to understand the gap between policy and reality.

The goal of this project is to bring about the advancement, development and empowerment of prostitutes. The Policy will be widely disseminated so as to encourage active participation of all stakeholders for achieving its goals. This thesis expects to have the following policy & programmatic implications that include:

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• Creating an environment through positive economic and social policies for destigmatisation and decriminalization of the prostitutes enabling them to live a life of a human being.

• The de-jure and de-facto enjoyment of all human rights and fundamental freedom by the prostitutes on equal basis with the rest of women in all spheres – political, economic, social, or cultural.

• Equal access to prostitutes to health care, quality education at all levels, career and vocational guidance, employment, equal remuneration, occupational health and safety, social security and public office etc.

• Changing societal attitudes and community practices by active participation and involvement of both men and women.

• Mainstreaming a gender perspective in the development process.

• Elimination of discrimination and all forms of violence against women and the girl child

• Building and strengthening partnerships with civil society, particularly women’s organization.

• Changes in sexual practices by prostitutes across a time span of years not only reflect the change in the sexual culture of human society, but also how importantly a sexual culture or the empowerment of prostitutes are controlled by diseases; and also the differences in these practices between prostitutes and other women in the matter of sexual health protection. Therefore, this thesis hopes to significantly intervene in the area of reproductive and sexual health in the context of gender empowerment as well.

• Considerations of cultural, social, economic and legal issues in the formulation of the intervention programmes of HIV&AIDS and other STDs leading to the practice of a more complete and egalitarian approach of public health.