

Sex Work

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Sex work in India, as in the rest of the world, employs a large number of people who operate on the fringes of legality. It is difficult to know how many sex workers there are in India, but it is estimated that about 1% of adult women in India could be engaged in sex work (Dandona et al. 2006). Sex work is arguably even more stigmatized in India than in most other parts of the world because of strong social restrictions on sexual behavior. Nag (2006) provides a detailed account of sex workers in India beginning with the Vedic Age in 8th century BC to the present day, illustrating the enormous diversity in Indian prostitution ranging from sex workers in the guise of *devadasis* to more commonly known brothel and street based workers. The majority of women enter the profession involuntarily, most being forced into it either because of poverty, abandonment or violence by husbands, or other family problems (Slegtholme and Sinha, 1996). They are usually contractually obligated, in a form of bonded labor, to work in a brothel under the ownership of a madam or pimp. However, a growing number of newer sex workers are entering sex work relatively voluntarily (Kotiswaran, 2008)

Much of what we know about sex work in India comes from studies of Sonagachi, Kolkata's oldest and best established red-light district, with over 4,000 sex workers working in 370 brothels that service about 20,000 clients a day. However, this is

changing as more research is being conducted in other regions of India such as Andhra Pradesh where spread of HIV prevalence is a concern (Dandona et al. 2006). Because of the intense level of stigma, sex worker sub-culture is often self-contained, shaped by a pervasive sense of exclusion from the mainstream, as well as conditioned by the market for sex work – selling a diversity of services to different clients for prices which in 1993 ranged from Rs. 15 to Rs. 600 per sexual act in Sonagachi; and from Rs. 10 to Rs. 900 per sexual act in 2003-04 in Andhra Pradesh. The average weekly income of a Sonagachi sex worker in 1993 was Rs.984 with an estimated hourly wage rate of Rs. 8.20, which was approximately double the hourly wage rate of women in urban India. Thus, despite the considerable hardships they face, sex workers are in a rather lucrative profession – this perhaps explains why more women are entering the occupation voluntarily, despite its extremely stigmatized status. While this occupational “choice” may stem from poverty and lack of better outside options in the labor market, recognizing that sex work is not always involuntary and that sex workers do respond to economic incentives is an important finding; especially for those attempting to implement effective policies which influence both entry and exit into the sex market as well as risk behavior.

An interesting fact in the economics of sex work is that returns to education are comparable to those of women who work in more conventional occupations. Sex workers with primary schooling make about 4.2 per cent more than those with no education, while those with middle schooling make about 22 per cent more. This reflects the segmentation of the market with more educated sex workers catering to more educated clients.

However, unlike other professions, age shows a sharp negative relationship with earnings

capacity indicating there is a relative premium for youth in this market (Rao et al 2003; Arunachalam and Shah, 2008).

The profession has received increased attention from social scientists in recent years because of the AIDS epidemic. This is particularly true in India where sex workers are at very high risk for contracting HIV and of transmitting it among their clients, who then have the potential to transmit to wives and family members. For example, HIV prevalence was estimated to be 16% amongst female sex workers in 2004 (Andhra Pradesh AIDS State Control, 2004) though national prevalence is estimated to still be low (less than 1% among adults). Promoting the use of condoms and other safe sex practices among sex workers is, therefore, considered perhaps the most effective method to prevent the spread of the disease.

A major challenge to implementing this strategy comes from the strong preference that Indian men tend to have for sex without a condom. This results in a “compensating differential” for safe sex; sex workers who insist on using condoms stand to lose a lot of money resulting in a major disincentive for practicing safe sex. However, estimating this compensating differential with an ordinary least squares regression that regresses sex worker earnings against condom use results in a serious statistical bias, even after controlling for a variety of other characteristics that could affect income. This is because sex workers who are able to persuade clients to use condoms are also likely to be those with the most bargaining power, perhaps because they are particularly attractive to clients. This “attractiveness” attribute is not easy to capture in survey questionnaires – a

problem that is known in the language of econometrics as “unobserved heterogeneity.” Since “attractiveness” is positively correlated both with condom use and with sex workers’ income, it causes a spurious positive correlation between condom use and income that sharply underestimates the extent of the income lost by using condoms.

One way of correcting for this bias is to use a “natural experiment” that assigns condom use among sex workers in a manner that is not correlated with income. Rao et al (2003) used 1993 data from Songachi with information on an HIV/AIDS intervention that went to sex workers in a relatively random manner providing them with graphic descriptions of the consequences of unsafe sex. This was highly correlated with a sex worker’s propensity to use condoms, but uncorrelated with their income. Rao et al (2003) were, therefore, able to use instrumental variables to correct for unobserved heterogeneity by using the HIV/AIDS intervention as an instrument for condom use. Using this method, they estimated that the average sex worker faced a loss in wages of between 66 to 79% by using condoms.

Studies in other developing countries have found similar results with male clients paying a premium for non-condom use in Mexico (Gertler et al. 2005), Ecuador (Arunachalam and Shah, 2010), and Kenya (Robinson and Yeh forthcoming). In fact, sex workers in Kenya often engage in riskier sex as a way to cope with unexpected non-labor income shocks such as someone in the household getting sick (Robinson and Yeh forthcoming). Arunachalam and Shah (2010) show that the premium men pay for non-condom sex increases in locations with higher disease rates. The loss in earnings associated with

condom use clearly represents a major disincentive in initiating safe sex programs. The problem comes from the fact that clients, most of whom do not want to use condoms, are able to exploit competition among sex workers to bargain down the price of a sex act with condoms. If a sex worker insists on having sex with a condom, the client can simply go to the next brothel where he will find a sex worker who is more pliable. The solution to this can come either by educating clients about safe sex, or by creating an agreement among sex workers to collectively agree to refuse condom-free sex, which eliminates the possibility of competition.

The Songachi intervention achieved remarkable success by primarily following the second strategy (Gooptu, 2000). Instead of using health extension workers to spread the message of safe-sex, which was the conventional practice in Indian public health interventions, the intervention decided to train a small group of twelve sex workers as peer educators to pass on information to their co-workers. The only thing that distinguished peer educators from other sex workers were green medical coats worn over their *sarees* when they engaged in public health functions. The green coats also gave the peer-educators a sense of self-worth and a “respectable” identity. But, at the same time, as members of the community they were permitted easy access to brothels and had the credibility associated with being intimately aware of the hazards of the profession.

This process of educating the sex workers and mobilizing them for the HIV-AIDS intervention, along with the increasing media attention brought about by the success of the project led, over a period of two or three years, to a metamorphosis in the sex

workers' aspirations. They founded a union to fight for legalization, reduction in police harassment, and other rights. There was also a norm that developed among them to use condoms in sex acts, and by 1995 almost all sex workers used condoms at least some of the time. As a result, HIV incidence in Sonagachi was about 6 per cent in 1999 compared to 50 per cent in other red-light areas (including Mumbai's) that did not pursue such a culturally sensitive approach.

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