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Sex Workers and HIV/AIDS: Analyzing Participatory Culture-Centered Health Communication Strategies

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An emerging trend in health communication research advocates the need to foreground articulations of health by participants who are at the core of any health campaign. Scholarly work suggests that the culture-centered approach to health communication can provide a theoretical and practical framework to achieve this objective. The culture-centered approach calls for attention to dialogue and locates the agency of cultural participants in the culture being studied. This approach underlines the import of participation of community members in the enunciation of health problems as a step toward achieving meaningful change. Based on the culture-centered approach, this article examines narratives of sex workers to analyze how participatory communicative strategies frame discourses and practices of health, particularly those related to HIV/AIDS.

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Stepping away from the traditional linear message transmission model of health campaigns, a section of health communication scholars advocate the need to foreground articulations of health by participants who are at the core of health communication efforts (Airhihenbuwa, 1995, 2007; Basu & Dutta, 2007). The culture-centered approach to health communication serves this agenda by highlighting the voices of cultural participants and by offering community participation as the foundation for developing interpretive frameworks and health communication applications (Dutta & Basu, 2007; Ford & Yep, 2003). In this approach, cultural contexts are placed at the core of meaning-making processes, and meanings are dialogically co-constructed by researchers and cultural participants.

This article adopts the culture-centered approach to examine how two sex worker communities in the city of Kolkata[1] in West Bengal, India participate in creating and sustaining health communication practices, specifically those in the realm of HIV/AIDS. It builds on earlier work (Basu & Dutta, 2008) that highlights how sex workers interact with their everyday living contexts to resist and reframe

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health communication strategies imposed on them by external cultural agents. It examines how participatory formations that emerge organically from within sex worker communities challenge commonly held notions on how participatory health communication models in marginalized spaces are and ought to be practiced. Although participation necessarily lies at the core of resistive practices, participatory health communication encompasses not only resistive practices but also communicative processes related to the nuts and bolts of organizing, staying united, and making personal sacrifices. This article focuses on participation, a vital facet of the culture-centered approach to health communication. It converges with the work of Basu and Dutta (2008) in its basic assumption that marginalized communities are not devoid of agency. Additionally, its unique contribution to the development of culture-centered healthcare applications is its illustration of how a bottom-up participatory approach is essential to impact the health of members in underprivileged sex worker communities.

In the following sections, we expound on the need to address HIV/AIDS issues among commercial sex workers in India, examine how HIV/AIDS campaigns in this population have traditionally been envisaged, and further establish the significance of the culture-centered approach to health communication. We then explain the concept of participation within the ambit of the culture-centered approach before we discuss the project's methods. Finally, we analyze and discuss narratives that emerge from our dialogue with sex workers.

Commercial sex work in India and HIV/AIDS campaigns

According to its June 2002 technical update, UNAIDS defines sex workers as "female, male, and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally" (p. 2). We use the term sex worker or commercial sex worker (CSWer) to denote females in the profession. In most countries, commercial sex work (CSW) is illegal and therefore clandestine (UNAIDS Technical Update, 2002). CSWers comprise a high-risk group in terms of HIV/AIDS infection because they are powerless and therefore unable to negotiate or insist on the use of condoms by their clients or to resist violence and coercion (Karim, Karim, Soldan, & Zondi, 1995). Such similarities apart, CSW is culturally and historically determined (Brewis & Linstead, 2000a, 2000b). For example, entry into sex work in late modern societies is determined more by a choice to resist poverty than what we see in colonized third-world contexts. In India, for instance, entry into the profession is a combination of cultural and economic forces such as being abandoned by the husband, bearing the burden of a hereditary profession, or being sold into the trade for profit (Banerjee, 2000; Nag, 2006). Cultural ideologies and gender relations, too, influence patterns and implications of CSW. In India, prevalence of early marriage, stigma of being a widow, and ostracization of women who live outside the institution of marriage render the CSW as "unchaste" (Banerjee, 2000). In "Western" settings, CSWers are

generally not deprived of welfare rights or shut out of social platforms (Brewis & Linstead, 2000a).

Similar to the global scenario, at sex worker sites in India such as Sonagachi, in Kolkata (West Bengal), CSWers are poor, they live in unhealthy conditions, and they have limited access to healthcare facilities, justice, finance, and/or education; they are exploited by landladies, moneylenders, the police, and clients; they lack a credible voice that matters in mainstream platforms (Chattopadhyay & McKaig, 2004; Jana, Basu, Rotheram-Borus, & Newman, 2004). Additionally, as Banerjee (2000) traces in his account of CSW in colonial Bengal, CSWers have been stigmatized as well as subjected to moral, cultural, and economic sanctions. Their voices are absent from history except when documented through the colonial lens of "morbid curiosity and prurient voyeurism" (p. 1). In other words, discourses that emerge from sex worker spaces constitute "obliterated pasts and forgotten presents that never made their way into the history of knowledge" (Shome & Hegde, 2002, p. 250).

Marginalization of CSWers has been accentuated by their being subject to surveillance and discrimination due in part to the high incidence of venereal diseases and (now) HIV/AIDS infections among them (Nag, 2006). The National AIDS Control Organization (NACO), India's central AIDS monitoring agency, estimates that 2.9 million women or 1.1% of adult women in the country are CSWers. Of them, NACO estimates 5.38%, that is, 1,55,064 are living with HIV (NACO, 2008). In some states like West Bengal, NACO adds, reported HIV infections among sex workers is rising, despite cases that go unreported being more than those that are. As grim as this figure is, even more unnerving is NACO's admission that sex workers constitute a population that is at extreme high risk of being infected with and acting as conduits for the spread of HIV because the Indian epidemic continues to be concentrated in populations with high-risk behavior characterized by unprotected paid sex. Such a scenario highlights the need to urgently address HIV/AIDS issues in this population.

In India, HIV/AIDS is located within capitalist economic assumptions about health and disease, which attribute health behavior to individual lifestyle choices without fully contemplating social structure (Lupton, 1994, 2003; Zoller, 2005). The assumption is that citizens are duty bound to act in ways that justify their behaviors as responsible. This belief leads to creation of high-risk groups (such as CSWers), which are stigmatized and isolated (Bharat & Aggleton, 1999). They are considered subjects of health interventions aimed at preventing the spread of HIV infection. CSWer communities in India have long been testing grounds for such interventions, most of which focus on promoting condom use. Some CSWer communities have resisted such top-down campaigns. For instance, CSWers at Sonagachi and Kalighat in Kolkata, West Bengal demonstrate awareness about, and resistance to, mainstream communication patterns that portray them merely as passive subjects of persuasive messages (Basu & Dutta, 2008). It is in the backdrop of top-down formulations of health communication such as these that the culture-centered approach opens up possibilities of listening to the voices of CSWers.

Culture-centered approach to health communication

The culture-centered approach (Dutta, 2008; Dutta-Bergman, 2004a) highlights the agency of cultural participants and their ability to frame communication strategies. It emphasizes dialogue with participants in developing an understanding of key health issues that members of the community face (Beverly, 1999). Drawing extensively from subaltern and postcolonial studies, the culture-centered approach notes that marginalized communities have historically participated in cultural and political processes articulating and challenging the structures their lives are embedded in (Bhadra, 1997; Chakraborty, 2000). In the culture-centered approach, participation is recognized as central to the articulation of health issues and as a primary step toward initiating change that is meaningful to community members (Guha, 1988; Guha & Spivak, 1988). Guided by its postcolonial roots and articulations in critical reflexive ethnography (Denzin, 2001; Madison, 2005), this approach seeks to listen to and document participatory communication patterns emanating from marginalized spaces and introduce these texts to mainstream platforms that have traditionally viewed them as absences (Shome & Hegde, 2002). Culture, structure, and agency are three key and intertwined tenets of this approach (Dutta, 2008). Culture is conceptualized as a process that is in a state of production and reconfiguration through communication, leading to a social, economic, and political web characterized by values, attitudes, perceptions, and communication patterns (Airhihenbuwa, 1995). Structure refers to forms of social organizing that provide or limit access to resources. These resources, according to Radcliffe-Brown's (1958) structural functionalist philosophy, script human behavior that guide culture and conduct. Agency, on the lines of Weber's formulations on social groups (Wolf, 1999), refers to individual and group actions, meanings made of such actions, and how such actions work with and challenge existing structures (Dutta, 2008; Giddens, 1984, 1990). Agency often materializes in local participatory processes, which continually negotiate social structures, as in the case of the Santalis in India (see Dutta-Bergman, 2004a, 2004b). Participation can be regarded as the connection between theorizing and enactment of communicative practices by which cultural participants foreground local issues.

What is participation?

Participatory communication involves community members as participants in the process of meaning construction (Beltran, 1975, 1980; Freire, 1970) and development efforts. It constitutes a communicative effort that enables community members to weave together individual and collective discourses on health and living (Frey, Adelman, Flint, & Query, 2000; Frey, Query, Flint, & Adelman, 1998). It has, over the years, been used in communication campaigns, especially in entertainment–education (E–E) programs across the globe (Rogers & Singhal, 2003; Singhal & Rogers, 1999). For instance, articles on *Tinkha Tinkha Sukh* describe community participation generated by the radio soap opera (Rogers & Singhal, 2003). A

campaign in Nepal on population control identifies participation as the core of its success (Jacobson & Storey, 2004; Storey & Jacobson, 2003). Recently, however, these approaches to participatory health communication have been scrutinized to seek answers to questions such as: What actually comprises participatory communication?

Dutta (2008) notes that several health campaigns that are deemed "participatory" are incongruent with bottom-up forms of participation in marginalized communities as articulated in subaltern studies (Guha, 1988; Guha & Spivak, 1988) and by Latin American scholars (Escobar, 1995, 1999; Huesca, 2002). Several participatory E–E campaigns limit the audience to the role of readers/viewers/receivers of a program and configure participatory platforms as tools that diffuse the intervention as conceptualized by the campaign planners. For example, the Radio Communication Project (RCP) in Nepal used focus groups with community members to gather inputs on the messages that were designed by campaign experts (Storey & Jacobson, 2003). In other cases, E–E programs require participation from audience members in the formative research stage and in the pretesting of messages, while maintaining the agenda of the campaign. While critiquing these top-down participatory campaigns, the culture-centered approach provides an alternative for theorizing about and enacting participation in marginalized spaces.

The culture-centered approach locates participation in a way that enables meanings to emerge from communication networks in participant spaces. The role of the researcher shifts from that of an expert to that of a listener who engages in dialogue with community members. This approach highlights ways in which members of marginalized spaces enact agency in processes of meaning making. The participatory element of the culture-centered approach is evident in the Sonagachi HIV/AIDS Intervention Programme (SHIP) and New Light's HIV/AIDS Project, two sex-worker–run HIV/AIDS campaigns in Kolkata.

Two cases of culture-centered projects

The SHIP was launched in 1992. Based on a sex-worker–driven participatory framework, the campaign is considered a success since it has been able to increase the rate of condom usage among sex workers in Sonagachi (Cornish & Ghosh, 2007). Cohen (2004) mentions that the SHIP has been lauded as an exemplar by the World Health Organization. UNAIDS Technical Update (2002) reported that in Sonagachi, Kolkata's largest red light area, the rate of HIV infection among sex workers was 11%, and condom use has been rising—from 3% in 1992 to 90% in 1999. Launched during the same period, HIV/AIDS interventions promoting condom usage in CSW communities in other parts of India have not been as successful as the SHIP. According to UNAIDS and NACO (2003), HIV seroprevalence rates among CSWers in Mumbai, New Delhi, and Chennai have been on the rise; rates of 50–90% having been reported in these cities. Similarly, condom-promotion efforts in Indonesia have not yielded encouraging results (Basuki et al., 2002). Increased condom usage at

Sonagachi is largely attributed to the SHIP, which enabled CSWers to take the lead role in the campaign, decide what was important to them, and configure strategies to address these needs (Jana et al., 2004).

It is worth noting that though the SHIP was launched with 12 sex workers managing the campaign, it was Samarjit Jana, a doctor at the All-India Institute of Hygiene and Public Health in Kolkata, who initiated the campaign. After a few years as the director of the project and with the setting up of the Durbar Mahila Samanwaya Committee (DMSC), Dr. Jana retired from active duty in the SHIP to become its advisor. The DMSC is a forum of CSWers based in Sonagachi, that owns and manages the SHIP. It is active in challenging and addressing structural barriers that affect CSWers' lives (see www.durbar.org). The SHIP has been and is funded by external agencies such as the Ford Foundation and the Bill and Melinda Gates Foundation.

Similar to the SHIP, New Light's HIV/AIDS project is a CSWer-led campaign delivered in the Kalighat area of Kolkata. Managed by New Light, a charitable trust that was set up in 2001, the project combines HIV/AIDS awareness, prevention, and control with community development activities (www.newlightindia.org). Although no evaluative studies have been conducted to estimate the success of this project, subjective indicators suggest that this project has had its share of successes. Project workers state that the condoms that New Light gets to distribute free in a month are taken up in 2 weeks. To counter the notion that CSWers sell free condoms they receive, peer health workers point to a drop in unwanted pregnancies among CSWers. Another measure of success lies in uptake of structural capacities provided through the project. These include daily meals to more than 125 children of sex workers, five free health clinics every week, and a residential hostel for adolescent girl children of CSWers. Without having to worry about what their children are going to eat, CSWers can resist being coerced into unsafe sex. These outcomes, according to the coordinator of New Light's project, count as an index of progress made by the campaign.

The goal of this article is to highlight how sex workers in Sonagachi and Kalighat participate in localized sense making related to health and HIV/AIDS. Additionally, our aim is to document participatory communicative practices that emerge from CSWer communities and how these practices challenge commonly held ideas about participatory health communication models in marginalized spaces. We present an analysis of interviews with research participants to examine the following research question: How do CSWers communicate to create and sustain participatory networks that help them negotiate health and HIV/AIDS? Our analysis adds to the literature on participatory health communication by providing insights about the ways in which such processes are talked about, and the processes through which they are developed and implemented in marginalized communities. Ultimately, developing an understanding of communicative acts through which members of a community participate in bottom-up health communication efforts is central to the development of health communication initiatives that are driven by localized needs.

Method

The overall method of this project is founded on its commitment to the culture-centered approach to health communication. We use a combination of well-established tools such as structured and unstructured in-depth interviews (our primary data gathering strategy), and field notes along with tools appropriate for the culture-centered approach such as reflexive author journals (Lindlof & Taylor, 2002; Smith, 1999). On the lines of what Ellis (2004) describes as narrative or reflexive ethnography, we take a self-conscious, reflexive–empiricist stance that is seen in postmodern interviewing (Gubrium & Holstein, 2003), in constructivist grounded theory (Charmaz, 2000), and in ethnographies of communication (Carbaugh & Hastings, 1992; Philipsen, 1989). Furthermore, aligned with the works of Conquergood (1989, 1991) and Madison (2005), who explore the role of ethnography as a political tool for listening to the voices of the marginalized, our method situates the possibilities of listening to subaltern voices in the realm of the structural linkages between colonialism and knowledge (Shome & Hegde, 2002). Our method is invested in documenting subaltern communication processes and their transformative potential (Beverly, 1999; Guha, 1988). It advocates a critical ethnographic stance (Madison, 2005), whereby our reflexive analyses of the very methods that we deploy highlight the tensions between the culture-centered approach's impetus for solidarity building and its goal of generating viable data through the deployment of systematic methods. We reflect on this dialectical tension in one excerpt from our journal:

> We record subaltern voices using methodological indices set by the discipline; at the same time we question the validity of data (in the sense of their being truly culture-centered) collected within these methodological parameters. We return with more questions from the field than answers to our original ones. These questions create further openings for integration of subaltern texts (and methodologies that can be used to engage with subalterns) into mainstream knowledge frameworks.

Sites of data collection

Data for this project were collected at two CSWer communities in Kolkata: Sonagachi and Kalighat. The Sonagachi CSWer community in north Kolkata is more than 100 years old. Earlier called Sonagaji, the place derives its name from a Muslim religious preacher (Banerjee, 2000). Approximately 9,000 CSWers—6,000 of who are full-timers (i.e., those living in the area) and 3,000 casuals (i.e., those commuting to the area) work here. Kalighat is a historic pilgrimage site in south Kolkata, adorned by the Kali temple located on the banks of the Adi Ganga river. In the vicinity of the Kali temple, which was built in the mid-19th century, is a red light district. Nearly 3,000 CSWers, from Kolkata and the districts, as well as neighboring countries such as Nepal and Bangladesh work here. The sex worker community in Kalighat is a

5-minute walk away from Mother Teresa's Nirmal Hriday (home for the dying destitute). It is also the site of New Light's HIV/AIDS Project.

Establishing contact and data collection

Access to the Sonagachi site was established through the local networks of a doctor who was involved in conducting health clinics for CSWers in the area and was a member of the SHIP campaign team. Developing initial contact involved multiple visits, e-mail exchanges, and telephone calls. Once contact was established with the leadership in the DMSC, the research team had to seek permission from DMSC's internal research review board. Given the emphasis on understanding the nature of participation in the campaign, the local leadership as well as the health workers in the campaign were identified as key interview participants. In-depth interviews were conducted with five sex workers, who were also stakeholders in the SHIP campaign. Three of them were executive board members of the DMSC, one was a leader of the DMSC/SHIP program, and the other was a peer health worker. None of them were comfortable stating their ages and all of them preferred to speak in Bengali, the primary language spoken in the region. The interviews were conducted in Bengali because Bengali is also the mother tongue of both members of the research team. All interviews were conducted in May 2005 in the conference/meeting room of the DMSC office in north Kolkata. Between 45 minutes to an hour and a half in length, the interviews were structured in the opening and then became relatively unstructured to leave room for dialogue and ideally create openings for theorizing through the participation of cultural members. A list of primary questions that prompted the dialogues is included in Appendix A. In concert with the tenets of the culture-centered approach, this combination of structured and unstructured interviewing facilitated emergence of concepts from the ground level through a dialogic engagement with the participant. Thus, one primary topic often overlapped with another, and it was often not possible to use the same sequence of questions for each interview. We realized that in Sonagachi we were working with leaders of the community, given their positions in the SHIP and DMSC. Hence, we tried to be reflexive about making community-level representative claims from the emergent narratives.

Access to the Kalighat site was facilitated by a local journalist who had worked with members of New Light and contacts were established with the project's peer workers, all of whom were also CSWers. The research team spent approximately 1 year communicating with the initial contact via e-mails, letters, and telephone to establish rapport and trust. Similar to Sonagachi, interviews and group discussions conducted with eight field workers at the site were structured at the outset and then became relatively unstructured. The purpose of the two group discussions (each lasting close to an hour) was to familiarize participants with the agenda and focus of the research project and with one another. They were conducted before the individual interviews. Of the eight participants, three were sex workers and four were peer health workers. Three of the peer health workers stated that they were also CSWers, but served only known clients. One of the interview participants was

a coordinator of New Light's HIV/AIDS Project. The interviews and group discussions were conducted in May 2005 in the project's office and were audiotaped. The interviews ranged from about 40–90 minutes. Research participants indicated they preferred to talk in Bengali. The question template used in Sonagachi was tweaked for use in Kalighat. The confidentiality of participants was maintained by destroying the tapes after transcription and by changing names of the participants on the transcripts and in this article. The transcripts were stored on secure computers. Besides Bengali, the two research team members, both males, are also fluent in spoken and written English. Hence, transcription of the interviews was combined with translation into English and with data analysis. This allowed for reflection on the interview process and modification of questions. The reflections were discussed with a sampling of research participants, helping the research team review and consolidate the authenticity of interpretations (see Frey, Adelman, & Query, 1996; Frey et al., 1998, 2000 for a similar approach).

Data analysis

The emphasis of this study was on documenting contextual meaning making. Hence, the grounded theory method of analysis was considered well suited to analyze data (Charmaz, 2000; Strauss & Corbin, 1998). The transcriptions of the recorded interviews and group discussions spanned approximately 47 pages of translated text. These data and the team's field notes and journal entries were analyzed using open coding, axial coding, and selective coding techniques (Strauss & Corbin, 1998). While the interviews were translated, transcribed, and then analyzed, the field notes and journal entries (written in English) were analyzed directly. The data analysis commenced with open coding to identify concepts that could be easily labeled and sorted. We identified chunks of data (paragraphs, or at times an isolated sentence) that appeared to speak to distinct categories as our units of analysis.

We chose to select variable length data extracts as our units of analysis because our aim was to examine what major idea/ideas came out of a sentence or a paragraph. Strauss and Corbin (1998) describe this as one of the "variations on ways of doing open coding" (p. 119). Given the culture-centered focus of our project, we were interested in how concepts crystallized from participant articulations. This purpose, we realized, could best be served by considering a single sentence and/or a group of sentences as our unit of analysis. We sorted these units into 22 open categories (see Appendix B). We noted that these conceptual categories aligned with our understanding of the three key tenets of the culture-centered approach to health communication and were highlighted in extant research findings. According to Lindlof and Taylor (2002), researchers often look to existing theory for categories and apply them to their data as starting points of analysis. We checked and validated these initial concepts with a sample of research participants. We then sought to find out how these categories were related to each other in terms of either (a) their causal conditions, (b) their contextual conditions, (c) their interactiveness, or (d) any combination of these (Strauss & Corbin, 1998).

A reassembly of the 22 initial categories based on the cross-cuts and linkages between them led us to five higher-order notional or axial categories (Lindlof & Taylor, 2002). They are: Subaltern life, Health is contextual, Collaboration/organization, Risks and sacrifices, and Resistance and agency. Finally, through selective coding, emergent theoretical concepts were tied together to achieve theoretical integration (Strauss & Corbin, 1998). Two themes related to health and HIV/AIDS emerged, one of which was "Participation." "Risks and sacrifices" and "Collaboration/organization" were the two axial categories that collapsed into the Participation theme. The narratives (and open categories) that formed these two axial categories (Collaboration/organization; Risks and sacrifices), and hence the "Participation" theme, were broadly reorganized into four subthemes to take into account the overlaps and connections between them. The four subthemes are: (a) ownership and organizing, (b) taking risks and making sacrifices, (c) participatory framing of health discourse and practice, and (d) sustainability of participation. In the next section, we elucidate these subthemes to explain the processes of participatory health and HIV/AIDS communication among sex workers in Kalighat and Sonagachi.

Results

Ownership and organizing

The seeds of meaningful participation were sown at the outset of both campaigns. For the SHIP campaign, Dr. Samarjit Jana made it clear that the project would proceed only when CSWers were made an integral part of its functioning; that is, for projects to be culture centered, participatory processes ought to begin when campaign agendas and processes are being configured. In Kalighat also, program strategies mentioned that CSWers would be at the helm of the campaign—assisting in health clinics, counseling peers, and managing crèches for their children, as well as organizing community events. Demonstrating this sense of localized ownership, Gitadi notes: "We know what is best for us. We go around our community talking to people. They tell us what they need. Here we are in charge of things. We take care of the project that we run here." In the same vein, Phullora says: "It is at the end of the day our organization (referring to the New Light project), we are proud of it. You might not have believed in us, but see where we are today."

Owning the processes that influence their community's well-being is important for the CSWers. Lakshmi says: "We realized that to get sex workers to use condoms, go for regular check ups, the first thing we needed to do was determine the root of our problems and figure out ways we can address them. You have to live here to really know what's going on. You can't just come in, ask questions, and tell us what to do." Thus, the locus of expertise shifts from outside to the local community, challenging the prevalent logic of communication flow in health interventions where problems/solutions are configured by outside experts based on data gathered in the community. At Kalighat and Sonagachi, however, there is acknowledgment for the aid and impetus that comes from outside. Lakshmi notes: "When the organization

(SHIP) started, then it took us some time to understand the functioning of an organization. So we needed support from outside. On some areas we still need support, like on the technical side." CSWers are equally affirmative about their stance that external aid agencies/individuals should engage in dialogues with them. An excerpt from our journal reflects this tension: "The CSWers say they do not need to be instructed by us (outsiders). Yet they want us to give them resources that we have at some point, over the generations, usurped. And they want to be allowed to participate in local sense-making processes, free of interference."

Local participation and ownership of these participatory processes, CSWers argue, are tied to their ability to come together, brainstorm about community issues, and come up with solutions. To a probe on why community participation is important to the SHIP, Rani says, "I could spend my valuable time coming to our meetings because I knew that we were there for each other. We made mistakes, but these were our mistakes. We learned from them, and then we did new things, but all along, we were working together to solve our problems." Here, participation is rendered meaningful through a sense of local control over the communicative processes of decision making and problem solving, that is, defining local problems and configuring solutions. Niyoti supports Rani's argument on this issue: "This [the SHIP] is real. The problems are ours and we can solve them. You are not coming to tell us what to do. So here, we can sit together and figure out what works and what doesn't. And that makes me have faith in this [the SHIP]."

The CSWers talk about the importance of being there for each other, of figuring out their problems collectively, and of finding ways to solve them collectively. Concerning how participation was envisioned in the SHIP, Lakshmi states that CSWers understood that their problems could not be addressed individually. She adds: "As individual sex workers, we were vulnerable. The local political leaders, policemen, and our pimps, they harassed us every day. But today we are together, and we have more power because of that." Individual vulnerability and harassment (threats to better health) were countered through organizing and by creating and legitimizing a communicative platform that helped them to communicate with each other and be heard inside and outside their communities. Niyoti adds: "When we came and talked together, we knew that this was not just my problem, or Deepti's problem, or Shefali's problem. But this was our problem and we were going to solve it. I am not alone." Jayanti, in Kalighat, says: "We take care of the project that we run here. We work with the doctors, we work with the children, we work with our peers and some of our clients." Her co-worker Mala explains how sex workers communicate about health(ful) practices in the community. She notes: "We try to talk to our peers and convince them of the need to come for regular STD tests. We have been trying very hard to impress upon all of us the need to use condoms." In Sonagachi, Sundari notes that she and her co-workers ask everyone to stand together and refuse to serve clients who will not use condoms. Communication is central to this act of forging collaborative ties within the community; collaboration in turn stokes the community's urgency to participate in the process of organization.

As the SHIP campaign progressed, it acted as a catalyst for the sex workers to organize into a quasi-trade union, the DMSC. The DMSC, which Lakshmi notes, "is a baby of the SHIP," fights for rights of sex workers besides managing the SHIP. The SHIP also acted as the catalyst for CSWers setting up a cooperative bank called Usha, which provides low-interest loans to CSWers, and a cultural wing for CSWers and their children called Komal Gandhar. In Kalighat, New Light's HIV/AIDS Project acted as an initiator for programs such as setting up a shelter for the children of CSWers while they are on the job and organizing health and legal counseling sessions for CSWers. Thus, the organizing of the campaigns served as points for organizing around issues critical to the community such as money and shelter for children.

Addressing how Usha has helped her and her peers gain financial strength and stability, Shyama states that CSWers can now resist being bullied by clients. "If a client refuses to use a condom, I let him go. I need not worry about money all that much now. I know that if I am in real need for money, I can go to Usha," she notes. Rani explains that before Usha was launched, CSWers had difficulty negotiating with clients who refused to use condoms. CSWers were worried that they would have to borrow money from moneylenders if they continued to refuse clients. Communication processes, then, that bring the community together to participate in localized sense making also enable the CSWers to plan and implement strategies (such as setting up Usha) that address their material needs. The capacity to engage in health(ful) behaviors such as using condoms without succumbing to structural pressures (such as need for money) is facilitated by these communicative platforms.

Serving as a link between organizing and participation, platforms such as the SHIP and New Light's HIV/AIDS Project also enable CSWers to reach out to their clients and madams and get them to participate in the community's health communication efforts. The *babus*[2] and the madams were initially reluctant to join the CSWers because, according to Lakshmi, they thought they were losing control over the CSWers. But then, says Shyama, they realized the health of the community was paramount if they had to earn money. "Now many of them support our work," Lakshmi notes. Such stories, Rani mentions, serve as exemplars in sex worker–sex worker interactions, reinforcing the community communicative web within the SHIP. It is through organizing and ownership of the campaigns that the CSWers are able to initiate changes in the exploitative structures that promote unhealthy behaviors. However, participating in these communication platforms that seek to transform existing structures and discourses entails risks.

Takings risks and making sacrifices

Organizing in marginalized contexts is intertwined with the individual risks that need to be taken to sustain the organization and its local discourses. To the extent that the subaltern speaks, he/she is at risk. Narrating the SHIP's participatory strategy, Lakshmi says CSWers were considered incapable of working on the project, and Dr. Jana had to face stiff resistance when he inducted CSWers at the core of the campaign. In CSWer contexts, the state of being silenced serves the status quo.

Therefore, the presence of CSWer voices imparts a risk. Organizing that is directed at making these voices heard is imbued with threats to the lives of individual members as well as to the well-being of the collective. Niyoti talks about the opposition she and other sex workers faced in their communities when they wanted to join the DMSC. She states:

> I have been working in Tollygunge. Earlier, I was just a member of the DMSC and paid my annual subscription of Rs 25 (per year). But gradually I started to take more interest in DMSC meetings organized in the area. When I started showing up regularly to these meetings and then tried to get other sex workers to do the same, I was threatened by the local goons. Even the local leaders warned us against joining the ranks of the DMSC.

In this context, participation is paramount in the creation and sustenance of platforms that enable CSWers to resist mainstream discourses that seek to marginalize them and those that enable them to create their own countercommunicative frameworks. Thus, participation becomes meaningful in the realm of the risks and sacrifices of individual members. Participation is not merely a matter of going to ready-made platforms that fit the dominant agendas but rather is embodied in creating alternative structures that challenge the basic inequities and injustices bred by the mainstream structures. For Lakshmi, CSWers were at risk for raising their voices because the dominant power structures would want them to be silent. Niyoti's risk lies in defying the orders of the local political bigwigs who did not want her to become an active member of the DMSC. "I was spat at on the road, I was heckled, and ultimately they (goons) threatened to lock me out of my living quarters. This meant I would not be able to work. They could not stop me from joining the DMSC though," Niyoti notes. She conceptualizes participation as the act of being ready to take risks and make sacrifices for the sake of creating and contributing to a platform that helps sex workers like her take charge of their lives. Mita in Kalighat and Rani in Sonagachi also narrate their stories of being abused by local goons, being spat at, and threatened for bearing the flag of their respective organizations. Such occurrences reiterate that the individual self must bear personal risks to sustain the collective self; and it is through the sustenance of the collective self that the organization draws its power to challenge the dominant social structures.

At times, like in Lakshmi's life, sacrifices go beyond losing one's livelihood. It also amounts to making sacrifices related to one's family and children. She was working in Barrackpore and had taken up leadership of the newly opened DMSC's area unit, when, she states:

> Our *babus* were afraid that they would lose their control over us and our earnings. The local goons realized they could exploit us no more. And the political leaders believed we would oppose their free reign in the area. So, we had to bear the brunt of opposition and brickbats, and of course physical violence when we started our work on the project [SHIP] and our organization

> [DMSC]. I was beaten up more than once; my son, who was a teenager, was jailed. And the local goons, political forces and police colluded on this.

The *babus* and the hoodlums ganged up against her, trying to prevent her from working for the DMSC. When the threats did not work, Lakshmi says, her son was made the target.

> There was some festival that day. My son was on holiday. At 2 am police came to my house. "Lakshmi, open the door. Your son has raped a 14-year-old girl, looted Rs 10 lakh, how can you sleep peacefully?" they said. I said, "Listen, if my son had raped and looted, he would not sleep peacefully; he would be hopping mad now." They said, "We don't want to hear anything. We have an order to take your son." I said, "OK, take my son. If I can prove that my son is not guilty, I will bring him back." And they took away my son.

At the police station, Lakshmi says, the officer in charge told her: "You are fighting those people who have never been challenged. That's why you are facing this now." She was ultimately able to get her son's release order from the Barrackpore Court, but only after he had spent 7 days in jail. "My son was howling," Lakshmi adds. "He was in 10th standard[3] then. He refused to go back to his school hostel. He said if his friends get to know that he has been accused of rape and jailed, he would be too ashamed to ever come back home." Lakshmi shares her devastation:

> We tried to convince him [Lakshmi's son]. But then I thought he had just suffered a blow, let him not go through anything else again. So, he started studying from home. With great difficulty I had him admitted to a residential school. And now that was gone. In a few days time, he wanted to leave the area. And he said he would give up studies too. Finally, I also had to leave my locality. I was also jailed. I felt very sad. It's fine that I did everything for the organization. But I felt that I gave up everything. I felt that I had lost this opportunity to educate my son, and there's nothing I could claim to have done in my life.

Lakshmi sacrifices not only her place of work and shelter, and the risk of having little to feed her family, but also her son's schooling and his peace of mind. Yet, she says, in the back of her mind she realized she was making a sacrifice for the DMSC. "I was prepared to bear the uprooting and humiliation for the organization." Lakshmi's narrative demonstrates that organizing carries a risk and sacrifices have to be made so that the organization can have a voice. Individual sacrifices are located in the backdrop of the need for organizing. "Whenever our work hurt other's interests, we have faced problems," notes Gitadi. In Kalighat, she says, a local criminal used to harass, exploit, even murder the sex workers "whenever we failed to live up to his demands." People like him vehemently opposed the participation of sex workers in New Light's project. She adds: "He even hired with few members of our community and tried to shut down our programme. We feared for our and our children's lives.

But we were willing to take the risk and work in the project to better our lives." In this context, participation is understood as an inherently political process, whereby community members are willing to take risks to achieve their goals, that is, creating and sustaining a platform that helps them communicate about their needs and about strategies to address these needs; ultimately reifying participatory processes that organize the community.

Sacrifice is also embodied in the number of hours spent with the organization and the continued commitment to it, especially at times when support was limited. Sonali notes that she and several of her co-workers had to burn "midnight oil" to establish their organization and its motives among members of the community. She states that sex workers were initially unwilling to believe that the project was aimed at improving the health and living conditions of the community members. The sex workers believed that peer workers like Sonali in Kalighat or Sundari in Sonagachi were more concerned about the growth of the organizations that paid them than the well-being of the sex worker community. Therefore, trust needed to be established with the community, and to do so, personal time and resources needed to be sacrificed to demonstrate the commitment of the organization. Tied to this notion of sacrifice, and placing oneself in harm's way for the organization, is the ability of the CSWers to unite and frame discourses that shape their lives, their health, and their well-being. These discourses offer alternative ways of theorizing health communication in marginalized sectors of the world.

Participatory framing of health discourse and practice

Participation in the HIV/AIDS initiatives at both Sonagachi and Kalighat is noticeably organic in the sense that cultural participants are at the core of the meaning-making enterprise. Our dialogue with sex workers exemplifies their ability to engage with the context and structures that embody their daily lives, make sense of it, and organize communication platforms and strategies based on assessments of these contexts. This mode of participation materializes through a realization that context needs to be at the core of any sense-making exercise and that community members should take charge of these sense-making processes. Rani's comments make this argument clear. Regarding what her community does and has done to address its health needs, specifically those related to HIV/AIDS, she says: "We began to list our problems—with the police, the goons, the madams, the pimps, the politicians—as a first step towards forging strategies to ensure better health." Here, an alternative discourse on HIV/AIDS prevention is articulated. It suggests the importance of communicating about structural barriers rather than merely emphasizing individual-level behavior such as condom use. And the impetus comes from participating in a communicative platform (SHIP) created by CSWers themselves.

On the same issue, Mita (in Kalighat) makes a point about a need to combine available resources to tackle health issues like HIV/AIDS and STDs. Explaining the participatory initiative in her community, she notes that it is difficult to conduct surveys on HIV/AIDS infection rates as it is a very sensitive topic. So she suggests that

the New Light HIV/AIDS project continue to create awareness about HIV/AIDS. Additionally, she emphasizes: "We should strengthen our health worker network, so that through interaction among ourselves, we are able to monitor our health and that of our children." These suggestions, Mita notes, she has already made to campaign workers at New Light. By being part of a discourse she has created with her peers, Mita is able to assess available resources in the community and suggest localized health communication strategies. Here, once again, the focus of health communication shifts to addressing social contexts as opposed to the individual lifestyle emphasis of the dominant literature on campaigns. Sonali, Mita's co-worker, describes another strategy that the New Light project has adopted. She says: "We cannot force people to come for HIV/AIDS tests; so we are looking at avenues to touch base with the sex workers. And one way of doing it is by working with their children." Participation is contextualized in how the sex workers enumerate their health concerns and collectively communicate tactics that address these concerns. That is, they participate in an organic process that helps them attend to and take care of their health.

Similar to Mita, and Sonali's articulations, awareness about one's living context is evident in Lakshmi's observation about what she perceives are the main HIV/AIDS-related concerns facing her community. She says that because sex work is a stressful and an emotionally draining profession, some of her peers give in to client demands to drink with them. And sometimes, she notes, they become alcoholics themselves. However, she adds: "We warn them that being drunk when on the job could be dangerous as clients might find it easy to convince them to have unprotected sex." The discourse draws attention to the nature of the profession and the use of alcohol in that realm, a point emphasized by Brewis and Linstead (2000b). They highlight the tension inherent in sex worker articulations of risks associated with using alcohol and/or drugs and not being clearheaded as a result, and the use of drugs and alcohol to cope with the pressures of job. Alcoholism, as Lakshmi notes, "is not looked down upon" in the community because it is considered a part of the trade but is certainly "an issue that needs to be urgently addressed."

There is a realization that the community's customs and professional risks need to be addressed at the level of structural capacity to harbor hopes of helping sex workers lead healthier lives. Being able to communicate the community's health needs based on appraisal of its structural capacities is the first step toward meaningful participation that seeks to improve the health and well-being of the individual and the collective. We find more instances of such participatory acts at our research sites. Jayanti states that CSWers assess their needs and decide upon a course of action based on a localized assessment of resources. On setting up 24-hour shelters for their children, she notes:

> We have been able to set up a 24-hour shelter for the children of the sex workers. The children who live here and come to this informal school [at the shelter] are also sent to formal schools around the area. We have been able to

> provide lunch to a few of the children here. In most cases they do not have fathers, their mothers are drug addicts, alcoholics and hardly do work. Around 15 of the 70-odd who stay have lunch here.

She adds that sex workers wanted such shelters because they can then be assured that their children have a place to sleep and food to eat when they are working. This discourse reiterates how the sex workers engage with relevant environments, communicate about what is needed in the community, and design strategies to fulfill these needs. The participatory spaces created by the CSWers thus often serve as the sites for materially engaging the structural constraints. Also worth noting is how sex workers emphasize bolstering their structural capacities to engage in healthy practices. Providing food and shelter for their children is a constant concern for them. "In several cases sex workers are simply not able to turn away clients who refuse to use condoms because they are worried about having money to provide for their children. New Light's shelters take care of this basic vulnerability among us," says Sonali. Health and HIV/AIDS communication in the community shifts in its emphasis from educating sex workers about condom use to first addressing sociostructural constraints that affect their health. Communication within the community to reach a consensus about health needs is central to this model of participation. In turn, this model sets into motion a communication network that privileges group decision making and feedback. Lakshmi explains:

> Like me, the staff for the project [SHIP] are sex workers. It's not that I am taking decisions alone. We discuss what needs to be done with our peers, how we can increase condom use. It comes up in our group discussion what works best.

On how feedback from sex workers helps the health workers design health promotion strategies, Mala states: "We ask the sex workers how they would like us to approach them or when they would like to give us time . . . We take everybody's views." Participation is constituted in the collective and articulated as a group decision-making process. In addition, sex workers emphasize the need to not only initiate this dialogic process but also ensure that it is sustained.

Sustainability of participation

The urge to maintain the participatory process and the organization's vitality is a priority at both sites. At Sonagachi, Sundari reports that the organization has to function optimally to ensure that the changes in the economic conditions initiated by the SHIP campaign are sustained over the long term. When asked to talk about the future plans of the DMSC and the SHIP, Shyama reiterates Sundari's stance. She states: "We need to keep organizing ourselves as we have just begun our struggle. We can't lose patience, we have to keep going." This commitment to the long-term sustainability of the participatory discourse in their community is also noted by Niyoti, who says: "It has taken us this long to have this [referring to DMSC]. We

can't lose it now. Not at any cost. This is where we meet and solve our problems." By maintaining the local collective spaces for communication, the CSWers can keep the dialogue going, within and outside their communities, and find ways of articulating locally derived solutions to their health problems.

Sustaining the organizations that give them a voice becomes a duty, as Lakshmi explains: "We will step down in July [2005] and it is my duty to ensure that the person who will replace me does better than I did." At Kalighat, Sonali notes that she and her co-workers follow a policy where every health worker is in charge of training and preparing the person who will replace or join her. In fact, several participants in Sonagachi even talk about how they plan to keep the DMSC functioning even if the SHIP comes to the end of its tenure. They are aware that external aid to fund the SHIP might dry up, which is why they emphasize the need to strengthen the DMSC. "The organization [DMSC] is more important," they note, and add: "Even if the project [SHIP] stops, we can run our own HIV/AIDS project. We ourselves will educate the sex workers, we ourselves will bear the medical cost of the sex workers, we will pay the doctors." To keep the organization operational, participants identify plans to involve their children as well. Lakshmi states: "The DMSC is headed by Bachchu, who is the son of a sex worker. It is not that we want our children to join our profession. However, if the need arises, we can always call upon their support to manage the SHIP and our own HIV/AIDS campaign for the community." At Kalighat, Seemadi says (and this is noted in our field data) older children of sex workers have already been inducted into project-related duties like helping out at the health clinics and supervising infants at the project's children's shelter.

Sustainability, according to the participants, is central to ensuring that the collective voice of the CSWers continues to be heard, issues identified, and action steps developed collectively. Involving the children, according to the participants, is central to ensuring that the DMSC/New Light project continues to function in the future. What gets articulated in the excerpts here is the commitment to the participatory processes that would sustain a discourse that encourages dialogue, brainstorming, and solution deployment in the community.

Another element of sustainability is in maintaining the connections between the internal and the external stakeholders of the organization. Even as the organization highlights its collective identity drawn from its members, its members also suggest the importance of connecting with outside stakeholders like policymakers, media organizations, and academicians. Rani notes that a distinguishing feature of the way the DMSC operates is the level playing platform that it provides for everyone, be it a doctor, academician, politician, or sex worker: "We work together to tackle issues and resist violence." The organization's betterment is dependent not only on input from inside the community but from outside as well. The CSWers are aware of it, and, to this end, are willing to locate and acknowledge the dialectical tensions between the internal and the external publics within which their organization is situated. Lakshmi notes that the DMSC is always open to debate about the lives of CSWers, their rights, and their concerns: "Let debate happen. Debate is always

good." The acumen to encourage debates that enable sex workers' voices to be catapulted to the mainstream public sphere is noteworthy. Niyoti argues:

> Like there was a press meeting on Avinash, the hospital in Sonagachi. There were many writers, intellectuals, and journalists. There were disagreements on whether what the sex workers do is right or wrong? If I have a debate over my profession with you, I think that's a good thing. You will give me arguments, I will give you arguments and others get to listen. Those who are listening will evaluate the arguments—they will try to think of the quality of the arguments. If there is no debate, the issues will not get clear.

Opening up the organization for feedback from within and outside the community serves as an essential tool to enhance the vitality of the communication network that the sex workers have created and are determined to sustain. Participation is thus central to not only creating the platform that gives them the capacity to voice and address their health concerns but is also at the core of the need to nurture and sustain the platform.

Discussion

The narratives that emerge from our dialogues with interview participants at the two sex worker sites challenge the dominant paradigm of health communication, which has not recognized the potential for agency in marginalized spaces (Dutta-Bergman, 2006). Further, the narratives demonstrate that CSWers continually engage with the structures that embody their contexts and organize themselves in participatory platforms. This process aligns with the culture-centered approach that foregrounds the ways in which members of marginalized spaces participate in social change endeavors. We notice that within its cultural spaces, the CSWer community is able to assess and engage with the structural resources that impact its members' health. For example, the CSWers demonstrate knowledge of their financial vulnerability, and how this susceptibility impedes them from being able to negotiate safe sex practices with clients. Health among CSWers is thus negotiated in a dialectic tension between structures that constrain health, and human agency that seeks to transform these structures (Giddens, 1984, 1990). Participants act as agents of change as they are constituted by structures and at the same time seek to transform these structures. This structure–agency interaction finds outlets in community participatory acts.

One goal of this project was to examine how participatory communication materializes in the context of two CSWer-driven HIV/AIDS campaigns. To this effect, we note that CSWers engage with culture, structure, and agency to participate in a localized sense-making exercise that enables them to forge their own communicative strategies toward better health and living. This mode of participation highlights the need to locate participatory health processes in marginalized sectors as organic and culture centered. It seeks to extend the conceptualization of participation in health campaigns where cultural participant voices are largely restricted to

their responding to campaign agendas and queries (Cooke, 2001; Mosse, 2001). Ongoing participation, as presented here, supports the relevance of community ownership and process-based collective mobilization in the realm of health campaigns. Genuine participation takes center stage as an organizational process in campaign design, implementation, and evaluation. Aligned with a growing body of campaign scholarship that calls for the importance of campaigns to engage with the populations they are targeting (see, for instance, Alberts, Hecht, Miller-Rassullo, & Krizek, 1992; Dutta, 2007), this project calls for additional scholarship that explores the role of participatory processes in health communication campaigns. It is important to examine the epistemological, ontological, and axiological bases of the different objectives, forms, and strategies of participation and organizing that are deployed in health campaigns.

At the Kalight and Sonagachi sex worker sites, organizing provides entry points for sex workers to participate in processes, that shape and transform structures that influence their health and living contexts. Through organizing, participation plays out as a process and an outcome of coming together under one umbrella, sharing anecdotes of success, communicatively fostering a sense of ownership (of the organizations they create), and creating opportunities to take charge of the discourse that influences CSWer lives. Collective participation is thus framed around messages that emerge from within the webs of the sex worker community. Communication processes link the members of the community to their communicatively created spaces, which contribute to their ability to initiate and sustain structural and material shifts that influence health.

These participatory formations demonstrate that underprivileged classes like sex workers indeed can and do come together to talk about their own health needs and develop communicative strategies to address these needs, and that they do not need to be educated (by campaign agents) on health and HIV/AIDS-related practices. Thus, being able to set up communication platforms (e.g., SHIP and New Light) that voice CSWer concerns and being able to inculcate a sense of ownership and pride in these communication platforms is a portrayal of and an enactment of sex worker agency (Basu & Dutta, 2008). Participation in this sense offers the individual and the collective a framework to engage in a culture-centered process of communicating about health and HIV/AIDS, where sex workers are able to collaborate in a community-based decision-making procedure to attend to their health needs.

Related to this bottom-up mode of participation in sex worker spaces, another key theoretical concept that emerges from this project is the concept of personal risk. As indicated earlier, participation in the culture-centered approach is conceptualized in terms of the dominant social structures that participatory organizing seeks to transform. Therefore, such organizing brings with it certain individual-level risks that community members have to bear to engage in the collective organizing. These concepts of sacrifice and risk are imperative as we conceptualize the politics of participatory communication in marginalized spaces. In marginalized contexts, risks and sacrifices embody a process of resisting (Basu & Dutta, 2008) as well as

communicating defiance to the dominant social order. Furthermore, the sacrifices are made to ensure that the collective communicative spaces that the sex workers have created can be sustained. As Lakshmi notes: "All of us have some stories to tell about our sacrifices. And they go a long way in keeping us together." Sharing personal stories is vital to strengthening the organization and inducing an urgency to participate in the struggle to sustain the organization.

The importance of sustainability in participatory processes is also foregrounded. Participatory communication, as constituted here, is meaningful when engaged in the long-term presence of spaces for transforming the unhealthy structures in marginalized communities. To maintain the sustainability of collective organizing, members suggest that external stakeholders have to be involved and engaged with such that the issues and agendas identified by the community are articulated within the broader public spheres where policies are passed and implemented. This tension between the internal and the external publics suggests that participatory spaces are contested spaces imbued with tensions. A journal entry (postdata collection) makes note of another apparent tension in a community-driven participatory process:

> Are we missing out on the cracks and fissures within subaltern participatory formations? We have only spoken to the leaders of the respective organizations. Are their voices representative? We noted traces of "othering" in our discussions. We found in Gitadi's tone a sense of looking down upon CSWers who she says refuse to listen to their [health workers'] requests to not to drink too much. There are social and economic hierarchies within the profession. How do these stratifications affect the participatory processes?

This journal note points to the vulnerability of our research methods as entry points into subaltern spaces and the impossibility of adequately "mapping out" subaltern participation. Even as sex worker voices are articulated through our interviews, discussions, observations, and journal notes, these voices are those that become accessible to us through our methods, perhaps suggesting that there remain other voices beyond the realm of these participatory spaces that we engaged with (Beverly, 1999).

This project also highlights the need to reexamine the Eurocentric ideals of democratic participation and the notion of an egalitarian public sphere in a postcolonial underprivileged context. As Bhabha (1989, 1995) and Prakash (1994) note in their studies, the homogenous character attributed to subaltern communicative practices needs to be reconceptualized. CSWer participatory platforms reflect the unequal social relations in which they are embedded (Cornish & Ghosh, 2007). The SHIP and New Light's HIV/AIDS Project demonstrate that public spheres that act as catalysts for emancipatory health practices in subaltern sectors are contested platforms, dotted with inequities and conflicts (see Beverly, 1999); they are not symmetrical in their distribution of communicative opportunities (Habermas, 1990).

Embedded in their postcolonial context, participatory processes in the CSWer communities are therefore uniquely transformative in their stance. They seek to invert mainstream health communication discourse, which undermines CSWer ability to forge health practices for their own good. Participation emerges from within the CSWer population and is incumbent on engagement with context and culture and the enactment of health and HIV/AIDS communication practices. This emphasis on a culture-centered approach to health communication is emancipatory in the way CSWer agency resists mainstream communication patterns and restates the individual-centered persuasive message strategies traditionally used to promote health in sex worker spaces (Guha, 1982; Shome & Hegde, 2002).

Summary and limitations

What then are the points of action and connection that we can extrapolate from this project? The narratives articulated here emphasize that to connect theorizing on communicative practices in marginalized contexts to action, there is a need to reframe communication practices that transmit meanings from outside the realm of cultural participants. Participation has to be reconceptualized in ways that solicit meaning making from the living spaces and communicative actions of the marginalized communities. What this analysis demonstrates is the need for dialogue as a process for listening to the voices of members of marginalized communities and as an opportunity for engaging with the collective politics of marginalized settings. In the realm of sex work and HIV/AIDS, we offer an alternative framework of structuring and applying health communication campaigns that embed the involvement of community members. By conceptualizing subaltern studies and postcolonial theorizing in communication within a culture-centered approach to health communication, we highlight the transformative essence of participatory communicative processes among CSWers. In doing so, we make a case for further research and exploratory application of participatory culture-centered communication strategies in HIV/AIDS campaigns directed at sex workers.

At the same time, this study has limitations that call for critical reflection. The themes on participatory health communication that emerge from our data are based on our dialogues with CSWers and other stakeholders in the SHIP and New Light's HIV/AIDS Project; most of them occupy leadership positions in their organizations. As we note in one of our journal entries, questions about whether the research participants we engaged with are representative of most CSWers in their respective communities remain unaddressed. Related to this issue is the need to theorize how subaltern spaces themselves foster subalternity, and how the fragmented nature of participatory processes in a marginalized context creates opening for engaging with inequities and conflicts that exist in already underprivileged settings (Basu & Dutta, 2008). Finally, to reify our findings, and to seek additional insights to questions from the field, there is a need to engage with a broader cross-section of sex workers at each site and for extended periods of time.

Notes

1 Kolkata is the capital of the eastern Indian state of West Bengal. It was once the seat of the British colonial empire. The city was, till a few years ago, known as Calcutta. The people of West Bengal are called Bengalis, so is their mother tongue.
2 *Babus* are fixed clients of sex workers.
3 In the Indian school system, 10th standard (or Class 10) represents the final year of middle school. It is followed by 2 years of high school.

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Appendix A

Interview protocol

How long have you been associated with the SHIP/New Light's HIV/AIDS project? In what capacity?

How would you describe the SHIP/New Light's HIV/AIDS project? What are its salient features?

What attributes of SHIP/New Light's HIV/AIDS project do you think contributed to its success/failure?

What is the future direction in which the SHIP/New Light's HIV/AIDS project is headed?

How long have you been in Sonagachi/Kalighat?

How long have you been engaged in this profession?
Let's talk about a typical day in your profession.
Let's talk about family, children and friends.
What do you do to take care of your and family's health?
What do you know about HIV/AIDS?
Let's talk about the work that SHIP/New Light's HIV/AIDS project does on HIV/AIDS.
What are your concerns regarding HIV/AIDS?
How has your community addressed health concerns/HIV/AIDS concerns?
What issues affecting your community do you think need to be addressed?
What resources are your community is most need of?

Appendix B Open coding categories

Open code	Example of narrative	Frequency
Marginalized existence	"We are still harassed and exploited by our *babus*, the pimps, and the police."	13
Context that influences health/HIV	"I always felt the urge to protest against injustice, against what was wrong. But I never had a chance to do so for lack of institutional support."	11
Promoting solidarity	"I could spend my valuable time coming to our meetings because I knew that we were there for each other. We made mistakes, but these were our mistakes. We learned from them, and then we did new things, but all along, we were working together to solve our problems."	13
Long-term commitment to community	"It has taken us this long to have this [referring to DMSC]. We can't lose it now. Not at any cost. This is where we meet and solve our problems."	7
Making sacrifices	"He even hired few members of our community and tried to shut down our programme. We feared for our and our children's lives. But we were willing to take the risk and work in the project to better our lives."	26
Organizing	"We know what is best for us. We go around our community talking to people. They tell us what they need. Here we are in charge of things. We take care of the project that we run here."	12

(continued)

Appendix B *Continued*

Open code	Example of narrative	Frequency
Working beyond call of duty, persisting	"During the early days of the project, the 12 peer workers had to face a lot of opposition from sex worker colleagues. When they visited sex workers and talked to them about HIV/AIDS and asked them to use condoms, most told them that they need not intervene in their lives, not act as doctors and paid agents of the project. They said that they had been in the profession without using condoms for years and they had nothing to do with AIDS. We faced stiff opposition. But we did not back off. We persisted. If we were sent away one day, we followed it up with consecutive visits for the next 10 days and we tried to reason that our profession made us vulnerable to STDs, including HIV/AIDS . . . "	5
Pride in organization	"It is at the end of the day our organization [referring to the New Light project], we are proud of it . . . "	6
Collective decision making	"When we came and talked together, we knew that this was not just my problem, or Deepti's problem, or Shefali's problem. But this was our problem and we were going to solve it. I am not alone."	9
Need to address basic health-related capacities	"We began to list our problems—with the police, the goons, the madams, the pimps, the politicians—as a first step towards forging strategies to ensure better health."	9
Awareness about HIV/AIDS	"Come on, they know they have to survive, they know about HIV. So they are aware and they use condoms. This has come into their minds."	6
Fighting against exploitation	"The DMSC gave us the strength to resist. We knew we could do it. We took up a sex worker's cause when we found that a madam had usurped her earnings, or when the police picked up a gang of us on charges of immoral trafficking."	9
Self and children's health	"I try to take care of them as best as possible. Try to keep them clean, give them baths, prepare food for them, take them to school, bring them back, take them to the doctor when they are ill, ensure they take their medicines, I too try to remain healthy, eat well, and maintain good standards of sanitation."	7

(continued)

Appendix B *Continued*

Open code	Example of narrative	Frequency
Stigma	"No matter where you are rehabilitated, no matter where your son takes you when he gets a job, someone might just recognize you and remind you that you are part of a lowly profession."	11
Demanding respect, recognition	"The government cannot stop this attitude toward a sex worker. They can at least look after the well-being of the sex workers."	5
Organizations and health capacities	"We realized we needed a financial unit we could call our own. That was how Usha was formed."	7
Money is critical	"If a client refuses to use a condom, I let him go. I need not worry about money all that much now. I know that if I am in real need for money, I can go to Usha . . . "	8
Harassment by state machinery	"We have also had problems with the police. The police used to come on their whim, knock on our doors, pick up our clients, and even some of us, and lock us up in the local police stations."	6
Facing violence for involvement in project	"I was spat at on the road, I was heckled, and ultimately they [goons] threatened to lock me out of my living quarters. This meant I would not be able to work. They could not stop me from joining the DMSC though."	7
Getting *babus* to cooperate	"Now many of them support our work."	3
Collaborating with external publics	"Like there was a press meeting on Avinash, the hospital in Sonagachi. There were many writers, intellectuals and journalists. There were disagreements there on whether what the sex workers do is right or wrong? If I have a debate over my profession with you, I think that's a good thing. You will give me arguments, I will give you arguments and others get to listen. Those who are listening will evaluate the arguments—they will try to think of the quality of the arguments. If there is no debate, the issues will not get clear."	3
Researchers, media as exploiters	"It is true that over the years there have been so many NGOs, so many research scholars who have come to us, so many of us have been interviewed for films and others. But we have not gained out of any of these. It is the people who have interviewed us, photographed or filmed us who have gained."	3

Les travailleuses du sexe et le VIH/sida : une analyse des stratégies participatives centrées sur la culture en communication sur la santé

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Résumé

Une tendance émergente dans la recherche en communication sur la santé insiste sur le besoin de mettre en relief les articulations de la santé faites par les participants qui sont au cœur des campagnes de santé. La recherche suggère que l'approche de la communication sur la santé centrée sur la culture peut fournir un cadre théorique et pratique pour atteindre cet objectif. L'approche centrée sur la culture réclame que l'on s'arrête au dialogue et elle situe l'agentivité (*agency*) des participants culturels dans la culture à l'étude. Cette approche souligne que l'inclusion de la participation des membres de la communauté dans l'énonciation des problèmes de santé est un pas vers l'accomplissement d'un réel changement. À partir de l'approche centrée sur la culture, ce manuscript examine les narratifs de travailleuses de l'industrie du sexe afin d'analyser la façon dont les stratégies communicationnelles participatives cadrent les discours et les pratiques de la santé, particulièrement ceux liés au VIH/sida.

Sexarbeiter und HIV/AIDS: Eine Untersuchung zu teilnehmender kulturzentrierter Gesundheit

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Ein wachsender Trend in der Gesundheitskommunikationsforschung propagiert die Notwendigkeit, die gesundheitsbezogenen Aussagen derjenigen in den Mittelpunkt zu rücken, die der Kern von Gesundheitskampagnen sind. Wissenschaftliche Forschung legt nahe, dass ein kulturzentrierter Ansatz der Gesundheitskommunikation einen theoretischen und praktischen Rahmen bieten kann, um dieses Ziel zu erreichen. Der kulturzentrierte Ansatz verlangt, die Aufmerksamkeit auf den Dialog zu lenken und lokalisert die Wirkpotential von kulturellen Teilnehmern in der Kultur, die untersucht wird. Dieser Ansatz unterstreicht die Teilhabe der Mitglieder einer Gemeinschaft an der Artikulation von Gesundheitsproblemen als einen zentralen Schritt zu bedeutungsvoller Veränderung. Basierend auf dem kulturzentrierten Ansatz werden in diesem Manuskript die Erzählungen von Sexarbeitern analysiert, um herauszufinden, wie teilhabende Kommunikationsstrategien Diskurse und Gesundheitspraktiken, insbesondere zu HIV/AIDS, rahmen.

Los Trabajadoras del Sexo y el VIH/SIDA: Analizando las Estrategias Participativas de Comunicación de la Salud Centradas en la Cultura

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Resumen

Una tendencia emergente en la investigación de la comunicación de la salud defiende la necesidad de poner en primera plana las articulaciones de salud de participantes que están en el centro de cualquier campaña de salud. El trabajo de los estudiosos sugiere que el abordaje de la comunicación de la salud centrado en la cultura puede proveer de un marco teórico y práctico para alcanzar este objetivo. El abordaje centrado en la cultura llama la atención hacia el dialogo y localiza la agencia de los participantes culturales en la cultura bajo estudio. Este enfoque subraya la introducción de la participación de los miembros comunitarios en la enunciación de los problemas de salud como un paso para alcanzar un cambio significativo. Basado en el enfoque centrado en la cultura, este manuscrito examina las narrativas de los trabajadores del sexo para analizar cómo las estrategias de comunicación participativas marcan los discursos y las prácticas de la salud, particularmente la de aquellos relacionados con el VIH/SIDA.

性工作者和 HIV/AIDS： 分析参与式、以文化为中心的健康传播策略

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健康传播研究的一个新兴趋势是促使处于健康宣传核心的参与者表达他们的健康问题，并将其放在前列位置。学术性著作认为以文化为中心的健康传播方法能为实现这一目标提供理论及实践框架。以文化为中心的方法要求我们关注文化参与者的对话，并确定它们的文化寄居所。该方法强调社区成员积极参与、表达他们的健康问题是迈向有意义变化的重要一步。基于这种以文化为中心的方法，本论稿检验了性工作者的讲述，分析参与式传播策略怎样构造了健康，尤其是与 HIV/AIDS 相关的疾病，的说辞和实践。

매춘종사자들과**HIV/AIDS:** 참여적인 문화중심적 보건 커뮤니케이션 전략들의 분석

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요약

보건 커뮤니케이션 연구에서 각광을 받고 있는 신경향은 보건 캠페인의 중심에 있는 참여자들에 의해 보건 문제가 최우선적으로 고려되어야 한다는 입장을 지지하고 있다. 학문적인 연구들은 보건 커뮤니케이션에 대한 문화중심적 접근이 이러한 목표를 달성하기 위한 이론적 그리고 실제적 프레임을 제공할 수 있다고 추론하고 있다. 문화중심적 접근은 대화를 강조하며 문화연구에 있어 참여자들을 연구중심에 위치시키고 있다. 이러한 접근은 의미있는 변화를 달성하기 위한 단계로서의 보건선언에서 커뮤니티 구성원들 참여의 중요성을 강조하고 있는 것이다. 문화중심적 접근에 기초하여 본 논문은 참여 대화적 전략들이 대화와 보건 실행들—특히 HIV/AIDS와 연계되어 있는—을 어떻게 프레임하는가를 연구하기 위하여 매춘 종사자들의 대화를 조사한 것이다.