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## **Subjectivity, Hygiene, and STI Prevention: A Normalization Paradox in the Cleanliness Practices of Female Sex Workers in Post-Socialist China**

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*This article illuminates the principal mechanisms that increase the risk of STIs for female sex workers in China. It draws primarily on my 26 months of ethnographic fieldwork (2006–2009) in red-light district neighborhoods in Haikou that have become centers of internal migration in post-reform southern China. Chinese sex workers here challenge dominant representations of them as illegal, immoral, and unclean subordinates and understand themselves also as sacrificing, capable, and modern women. I show how the women’s conflicted subjectivity, continuously shaped through social networks, affects their personal health decisions and, significantly, leads them to adopt clinically risky practices. I conclude by arguing that public health interventions in southern China in and around certain red-light districts should take these conflicted subjectivities into account in working to improve sex workers’ health. [migrants, sex work, STIs, post-socialist China, subjectivity]*

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I’ve had the experiences [symptoms but not diseases]. ... Every woman has that. It’s not a problem! It’s very easy to deal with. But I know some prostitutes (*xiaojie*) are very dirty, have those diseases. ... I’m clean! I understand! ... I always clean my body. ... You just need to know how to take care of yourself!

—Jasmin, 2008, 34 years old

Unprecedented market-driven reforms in China have mobilized and transformed an estimated 120 to 200 million peasants into a “floating population” of migrant workers. Although estimates vary dramatically, roughly six to ten million female migrants have become sex workers (Fu and Choy 2010:193). Within this context, sexually transmitted infections (STIs) have risen steeply in China. Chlamydia has already become an epidemic (Parish et al. 2003), and syphilis and HIV infections have reportedly risen 30 percent annually since 1994 (UNAIDS 2004). STIs dramatically increase HIV transmission rates, so their prevalence raises a serious concern that HIV/AIDS may also become an epidemic in China. However, STI prevention efforts are confounded by the cultural and moral politics of health among female sex workers. As Jasmin’s testimony above suggests, sex workers would rather not admit to having STIs for fear of being stigmatized. Because STIs are seen as a mark of having violated moral and cultural taboos, to be diseased is to be a threat to society (Das 2001; Huang et al. 2004; Hyde 2007; Mason 2012; Zhang 2011). Sex

workers recognize these cultural equivalences: To be healthy is to be clean and to be diseased is to be dirty. However, as I describe in this article, sex workers' health practices for achieving cleanliness to normalize their bodies cause a paradoxical dynamic. Paradoxically, their proactive practices of personal hygiene put them at a much higher risk of contracting STIs and HIV in particular.

From an epidemiological perspective, sex workers have been identified as a high-risk population in the spread of STIs mainly because female sex workers sell sexual services to male migrant workers from various social classes, many of whom refuse to wear a condom and many of whom infect others (wives, girlfriends, or other sex workers). Public health researchers have therefore focused on the risky sexual behaviors of female sex workers and suggested a need for preventive policies to control them. However, although epidemiological studies about this population's behavior patterns are essential to combating the spread of STIs, it is equally important to produce research that provides a comprehensive understanding of both the decision-making processes that lead these women to exhibit certain behavior patterns and the health risks that arise from the sociocultural particularities of their lives.

Very little research explains the social logic of sex workers' decision-making or the underlying social mechanisms that leave sex workers at increased risk of STIs. This article attempts to fill this gap by revealing sex workers' often unexpressed rationales and what I call "practices of normalization" in the context of their sociocultural surroundings. By focusing on women's own words and on the particular social configurations they articulate and to which they give meaning, I intend to illuminate sex workers' self-perceptions, providing a richer account of the cultural logic behind their daily decisions about their bodies and, by extension, a more detailed account of the social mechanism behind the burgeoning STI epidemic.

Comprehending these women's subjectivity or sense of self is key to making sense of their decisions about their bodies. There is no unified theory about subjectivity; rather, scholars have relied on multiple and competing perspectives in the exploration of what constitutes people's inner world (Biehl et al. 2007; Good et al. 2007). Subjectivity is not limited to self-perception; it includes affect, desire, fear, and other states and feelings that animate acting subjects (Ortner 2005). Despite the multiple approaches, the literature concerning subjectivity yields an important pattern: The ways people perceive themselves are constituted through systems of power, global economic disparity, and economic constraints (Fullwiley 2011). In studying the configuration of subjectivity, scholars have paid attention to specific ways in which political, economic, and medical institutions interact in making and remaking the subjectivity in various cultural settings (e.g., Biehl 2007; Biehl et al. 2007; Kohrman 2003; Luhrmann 2006; Scheper-Hughes 2007).<sup>1</sup>

Drawing on studies emphasizing the dimensions of value systems and social relations (Bourgois and Schonberg 2009; Das and Das 2007; Fullwiley 2011; Good et al. 2007; Kleinman 2006; Kleinman and Fitz-Henry 2007), this article demonstrates the critical roles that moral politics and social networks play in making and remaking the subjectivity of sex workers in contemporary China. Building on pioneering work in anthropology on sex workers (Hyde 2007; Jeffreys 2004; Zheng 2009a, 2009b) as well as the women's accounts of their social lives and everyday practices, I identify sex workers' constantly shifting subjectivities, which are continually shaped by everyday struggles.

These women's selves are constituted through their social experiences in a variety of temporalities and spaces—both urban and rural. Such sociocultural, political, and economic forces, which cause structural violence for these women, should be considered for a fuller understanding of health epidemics and health disparities among different groups of people (Farmer et al. 1996; Kleinman et al. 1997; Lorway et al. 2009; Nguyen 2003; Parker 2001; Schoepf 2001). Without this understanding, the complexity of these women's behaviors remains overlooked and, therefore, the behaviors themselves remain misunderstood.

Although it is true that the situation of sex workers within their particular sociopolitical structure puts them at risk for contracting and transmitting STIs, this does not mean that the workers are irrational actors—and they certainly do not perceive themselves in this way. My ethnography reveals that sex workers have moral pride in themselves even as they are aware of others' moral disdain for them and they resolve these divergent perspectives through their particular health practices. Without such a consideration of these women's complex subjectivities, current STI-intervention policies for them may prove ineffective insofar as they emphasize individual responsibility in the face of sex workers' reluctance to admit to unprotected sex and STI infection.

## Methods

This study draws on ethnographic data, in-depth interviews, semi-structured surveys, and focus group discussions—each designed to gather structured and contextual information about sex workers. It is the product of 26 months of anthropological fieldwork, in the winter of 2006–2007 and from August 2007 to August 2009, partly in Shanghai and Beijing, but primarily in Haikou, the capital of China's southernmost province (Hainan).

Over the course of my time in China, I had numerous informal conversations with sex workers from diverse socioeconomic backgrounds. My fieldwork took place among lower-income female sex workers from low socioeconomic family backgrounds and with even less education; they ranged from elementary school dropouts to junior high graduates. By “sex workers,” I designate women whose primary mode of livelihood is transactional sex, who have transactional sex on a daily basis, and who largely think of themselves as prostitutes (*xiaojie*) or professional sex workers. In general, sex workers tend to be young, unmarried, with limited education, and having migrated from poor rural areas to towns or cities (Rogers et al. 2002).

I also conducted three sets of surveys with 175 interviewees over six months during my fieldwork—one focused on life histories, another on personal networks, and a third on sexual behavior. I conducted interviews with all the survey participants in an open-ended, in-depth format, and then conducted in-depth follow-up interviews with selected participants. On completion, I evaluated and cross-checked the survey results with data from my ethnographic fieldwork. I conducted the surveys using an updated version of snowball sampling (respondent-driven sampling or RDS) as RDS has been proven to increase researchers' ability to accurately identify and produce a representative sample of a given target population.<sup>2</sup>

I interacted not only with sex workers but also with various social actors in their networks (i.e., family members, urban neighbors, boyfriends, colleagues, madams, and clients). This research method allowed for a fuller understanding of the interrelationships,

multiple discourses, and mutual perceptions among sex workers and those around them. To preserve confidentiality, I use pseudonyms for my participants.

In the following section, I focus on the practice and discourse of sex workers' social lives and personal health. I start by illustrating the complex understandings sex workers hold about themselves. These shared senses of self arise from social understandings, history, and memory common to this particular group of people (Luhrmann 2006:359). Given the cultural values to which these women are subject, I conceptually categorize sex workers' complicated perceptions of sex workers into two that are seemingly at odds but that nevertheless simultaneously and prominently inform the women's self-perceptions: Women who do sex work in China are culturally condemned as "dirty whores" and, simultaneously, culturally valued as "good daughters" helping to support their families. These two self-perceptions, I demonstrate, inform the workers' risky "health" practices and, by extension, their health complications.

Central to putting the implications of this ethnography in conversation with preventive public health is the reality that sex workers do not necessarily conceive of STIs as the result of sex work. Instead, they believe that all women, regardless of profession, suffer from STIs. Finally, I argue that clinically risky health practices, such as inadequate STI treatments and repeated abortions, exacerbate the women's chronic social suffering (infertility, pain, etc.) and ultimately reinforce and reproduce the public health epistemology that classifies sex workers as a high-risk population. I conclude by offering a critical discussion of public health interventions currently available in southern China in and around certain red-light districts, arguing that taking these conflicted subjectivities into consideration might improve sex workers' health.

## **Cultural Condemnation and Subjectivity**

Through various interactions and discourses, sex workers are constantly reminded that they are illegal, immoral, and unclean. Such imputed self-perceptions are reinforced and reproduced through their daily interactions with boyfriends, clients, madams, and colleagues, as well as the police.

### *Illegality*

The women's sense of themselves as outcasts constantly engaged in illegal activities is fostered by anti-pornography campaigns or repeated anti-prostitution police raids (*saohuang*: literally "sweep the yellow," where yellow means obscene or pornographic and connotes dirt), the threat of police raids, and actual arrests. This sense of being illegal was evident in the way sex workers felt the need to constantly be on the alert for crackdowns. Those I felt close to, who often worked in "hair salons" (*falang*, or brothels), would usually flee the building through a backdoor when the police appeared in the red-light district, whether the police were patrolling or were there for other reasons.

Yet sex workers' demeaned sense of self is shaped less by actual arrests than by a constant police presence and abundantly circulated gossip about women's horrible experiences when they are caught.<sup>3</sup> These sustained discourses of fear and persecution alongside practices of daily alertness (readiness to flee while working, being alert to police

scrutiny or possible arrests) make it difficult for sex workers to forget the illegality of their own work. The continual threat of police violence and harassment haunts the edges of the women's subjectivity and, in effect, makes them into illegal beings.

### *Dirtiness*

A sex worker's body is pathologized within the local society, and her self-image suffers as she is regarded as a reservoir of contagion. This projected pathology, along with the ensuing necessity of discipline, is brought up in her daily interactions with public health personnel, clients, madams, and colleagues. Through such interactions, sex workers internalize the concept that STIs (*xingbing*) and bodies that contract such diseases are dirty.

Just as most development projects suffer from the unintended consequences of perpetuating particular forms of power (Ferguson 1994), so, too, have the education and production of statistics by public health workers contributed to sex workers' constructions of subjectivity. The degree to which sex workers are in direct interaction with public health personnel varies depending on where they work. For instance, in certain red-light districts that are considered target areas by the public health department, sex workers directly interact with public health personnel who educate them, distribute free condoms, survey their sexual behavior, or sometimes conduct STI testing for them.

Although my two main field sites were not targeted (except for a one-time distribution of free condoms in the urban red-light district one or two years before I arrived), some of my close participants, including Shy and Phoenix, worked in red-light districts that were monitored by units of the local Center for Disease Control (CDC).

Through the CDC, Shy was educated on the importance of condom use. Once, she and her colleagues each received three female condoms, a newly developed prophylactic designed to increase women's power in condom use, with the promise that more would be provided on request. The area where Phoenix worked was scrutinized even more closely: Phoenix was once examined for STIs, and a year later a survey was conducted in that district. These encounters with public health personnel remind sex workers in targeted red-light districts (and, to a certain extent, their friends who hear about these activities) that they are seen as subjects whose bodies and sexual behavior need to be controlled.

More broadly, and also more importantly, clients' often blunt inquiries and discourse reproduce the subjectivities of sex workers as unclean STI spreaders. Sometimes, the full-time, lover-type clients want to persuade sex workers to quit their jobs in places like "hair salons" or massage parlors. In such cases, their main arguments involve the "dirtiness of such places" and thus the "high possibility of contracting STIs," which reinforces the idea that sex workers can have "dirty" bodies. Madams also play a role in shaping the idea because they worry that the workers would infect clients and will harm the business. For example, I occasionally encountered middle-aged clients complaining to the madam, Elegance: "Your girls are dirty! The girl infected me the other day!" Following such complaints, Elegance repeatedly and openly reprimanded the censured women by using the word dirty.

And the discourse on the possible dirtiness of sex workers' bodies, and thus on sex workers in general, is not limited to their interactions with men and women in different professions but extends to colleagues as well. Moon commented:

I saw two [former] colleagues who contracted those diseases. ... One of them was so stinky down there! Once she sat down, the spots became [temperature] hot! So hot! No one wanted to sit on her chair or wherever she sat on. Everyone got scared to contract her disease! People told me she got AIDS. It must be AIDS! She was so stinky! Very stinky!

Because of the discourse blaming individual sex workers for the dirty nature of their work, and thus of their bodies and minds, my close participants were very sensitive to and deeply offended when others accused them of being dirty (*angzang*). When Moon criticized Love for leaving her underwear in their public bathroom by using the word dirty, Love, who was typically easygoing, immediately became infuriated and shouted back: “Dirty? Why do you have to say such a word for such a small mistake! You can directly criticize me for such and such a thing. But don’t ever say such a word to me again!” Like Love, who refused to acknowledge the possible dirtiness of her body and mind, sex workers must constantly endeavor to contest the subjectivities attendant on their professional identities.

### *Immorality*

Sex workers also found their self-esteem and sense of normalcy challenged by constant reminders of their “immorality” and the reality that they might have to deny their identities as sex workers to keep their boyfriends. Opinions about the immorality of sex work and the consequent inferiority of sex workers are echoed by people around them, especially boyfriends and clients.

The example of Moon and her fiancé is illustrative. Like many other boyfriends of sex workers, Moon’s fiancé, from a suburban area, did not know exactly what Moon was doing in the city. One day, he came to the town, and all the “sisters” (*jiemei*) headed to a restaurant for a Chinese hot pot dinner. As we all passed a cluster of brothels on the way to the restaurant, he suddenly spoke out loudly: “Look, they [sex workers] all are pretty! ... They’re also young! They have everything, have legs, and also have arms. They’re so healthy, so pretty, what can’t they do? Why the hell would they want to be whores (*zuoji*)?”

Beauty right away whispered to me:

He says that every time we pass this avenue! I’m worried. Worried to death!

He doubts whether I’m also a whore! It seems he knows I’m doing this. ...

Maybe he doesn’t know. ... Last time, I said “People must have their own reasons! What the hell are you saying that so loud for!” and he doubted me

even more, I won’t dare say such things again!

Moon, like many others with whom I interacted, sought to ignore the sense of guilt that was constantly provoked in her interactions with her fiancé. Even though most of my participants told me that their feelings of guilt became blunted over time, and that their major concerns were more practical, social stigma against sex workers was reinforced and reproduced in their interactions with their boyfriends and husbands.

My research supports the common findings in existing literature that clients tend to stigmatize sex workers less than those outside sex workers’ networks and can even confirm certain valued self-images of the women, but I also found that many clients condemned the women with whom they had transactional sex. A participant who used to frequent sex workers told me that older clients, after receiving sexual services, often offered sex workers

moral lessons. Surprised, I brought up the issue to the women, and Star, a 24-year-old sex worker in a massage parlor, observed that just the day before a client had told her, “You are good looking. What the hell do you want to be a whore for? Don’t do this! This kind of work is bad! Find something else!” Such moral attitudes and gendered double standards from clients exacerbate the women’s sense of themselves as immoral.

Most women who engage in sex work hold the stigma against the sex trade before they enter it. This point was restated by many sex workers I interviewed. Love once explained to me that she was aware that “all people look down on us [sex workers].” When I asked her how she knew, she recalled the way people talked about sex workers when she was a child: “Lots of stories [TV shows] were about the past, people wearing those traditional clothes. And often there were those women. People cursed those women. Especially, elderly people told us that kind of women were bad and we shouldn’t do such a bad thing!”

Love’s story exemplifies Link et al.’s (1989) modified labeling theory, suggesting that social stigmas are perceived and shaped through a socialization process; mental patients recognize public stigmas through socialization before internalizing the official labeling that occurs in psychiatric treatment. Similarly, sex workers recognize the community’s devaluation of them through socialization before that stigmatization is made official and internalized by police raids and public health interventions. Still, my research showed that the strongest influence on their self-conceptions derived from their various daily interactions and experiences. This supports Das’s (2001) notion of intersubjective stigma—stigma produced and experienced interactively within social networks.

In the media, stories about and images of sex workers construct them as “immoral,” contagious, and law-breaking, criminal Others, whose bodies are, however, eroticized. But, more importantly, denunciations of the morality of sex workers—castigating them for their indulgent promiscuity, blaming them for family breakdowns and the spread of STIs, and criticizing the sex workers’ materialistic pursuits—were routinely invoked in discussions with sex workers as well as with other social actors. The women I spoke to and observed continuously resisted this image of themselves as immoral through appeals to equally, if not more, powerful cultural traditions of the responsibility of family-caring—traditions that are understood as essential cultural values for Chinese women.

### *Cultural Valorization and Subjectivity*

Set against perceptions of sex workers as illegal, immoral, and unclean outcasts, are sex workers’ own competing portraits of themselves as good people, primarily in the women’s attempts to relocate their subjectivities from outcasts to altruistic daughters, wives, and mothers.<sup>4</sup> This strategy for coping with stigmatization, preserving self-esteem, and conceiving of themselves as valued parts of a community makes the women’s lives meaningful, despite the difficult circumstances they encounter daily.

In migrating and taking up residence in urban areas, the women cultivate a multidimensional, culturally valued sense of self that conforms to socially constituted images of proper women, images in line with current historicity. These selves include the filial (showing gratitude to and repaying parents) and family-caring woman; the independent and self-made rural migrant taking advantage of new opportunities in the

Chinese post-reform market system; the savvy woman who has come to understand city life by overcoming various struggles; and the modern woman, cultivating trendy images (of fashion, beauty, and diet) as a consumer. Although these culturally valued perceptions of themselves are regularly undermined in many social interactions, they are reaffirmed in other social interactions, especially with family members, colleagues, and urban neighbors. This supports Corrigan and Watson's argument (2002) that not all stigmatized people have low self-esteem; rather, self-esteem depends on personal experiences of discrimination and how one interprets such discrimination.

These socially respected self-perceptions often emerge as sex workers evaluate their lives and achievements against those who stay in rural areas, female migrants in other sectors, or their past selves (before entering the sex trade). I often heard sex workers criticizing poor female migrants for not taking care of their families and having failed to advance because of their "stupidity" or "lack of bravery."

This criticism and relative sense of superiority often came up in my participants' conversations. For instance, I heard many such discussions while accompanying women to their rural hometowns. The Lunar New Year is the biggest holiday period in China, and many women become excited about visiting their families, bringing plenty of gifts with them. On one such visit, Moon, like other sex workers, was attired in a very modern and sexy style, dressed in a black leather miniskirt, a sleeveless blouse, and four-inch high heels. She also wore professional makeup and a fashionable hairstyle that she had had done the day before in one of the most popular shopping districts. This image, or embodied social meaning, depicts her as someone with a successful urban career, someone with life circumstances significantly better than those of many other migrants or rural residents who have not benefitted from the social transformations of booming industrialization. On this same visit, Moon took me to meet a villager who was about the same age as she and was working in a teahouse in a nearby suburban area. On the way, Moon told me:

Her family's still so poor 'cause she hasn't helped her family. She's just a teahouse waitress in the suburban town where I used to work. How much can you make from doing that? I only made 300 dollars [RMB] per month. Her family is now the poorest in the village! 'Cause my dad died early, we [Moon's family] used to be the poorest. ... Her family owns the last building made of grass and mud in the village. It's ugly and dirty! You'll see it soon. Very dirty! How poor her family is! They wear dirty clothes. ... I suggested I'd introduce her to a good "hair salon" to work in. But she said she's too afraid and can't do such work. How stupid she is! Very stupid! She's immature! ...

Through the above discourse from Moon and similar commentary from other sex workers with whom I bonded closely, I witnessed the women's sincere pride and satisfaction in having taken advantage of opportunities made possible by China's economic development to advance themselves and help their families.

## **Subjectivities and Risks**

The subjectivities of these rural migrants are not only performed but also embodied. Their continuously shifting self-perceptions, which include socially respected characteristics, are, as we have seen, important for providing self-esteem, communal value, and

meaningfulness. However, these self-perceptions that have been shaped by challenging environments, and the moral politics that surround their lives have dire consequences for the women's bodies. As I will show, the health practices they adopt in the struggle to not only cope with stigma but also conform to culturally valued images of themselves as "good," paradoxically bring about detrimental effects to their health. It can therefore be argued that sex workers' various facets of self-perceptions *jointly* shape their everyday decisions to engage in risky health practices, practices that ultimately result in these women's lifelong suffering.

### *Condemned Subjectivities: Harmful Health Practices*

To compensate for the stigma of their work, sex workers adopt certain individually nuanced purity rituals, which intend to normalize their bodies but, in actuality, exacerbate their health risks. These rituals vary from routine antibiotic injections to everyday cleansing practices, such as routine vaginal cleansings, on either a daily or a post-intercourse schedule. Although these practices portray a woman as diligent about having a clean body, these self-validating cleansing practices actually make it easier for women to contract STIs and thus to suffer more frequently. For instance, vaginal douching and vaginal substance use may increase the women's risk of HIV and STI infection (Morar et al. 2003) by making their genital areas more vulnerable. However, these everyday cleansing rituals are also important in maintaining a clean image when one suffers from serious STI symptoms. If a patient is a poor practitioner of daily cleansing rituals, she will be condemned for the consequences of her behavior.

Furthermore, because of the widespread public contempt for sex work, health information is mostly circulated within one's small circle of "sisters" or close colleagues; such closeness, however, distorts and limits the workers' knowledge about health. The closed nature of this information sharing is unsurprising given the stigmatized nature of the job, so colleagues must serve as the most experienced and accessible social resource for these workers. Sex workers, by extension, tend to trust their closest colleagues' opinions about "good practices," "good clinics," and "good treatments." Love, for example, wanted to wait until Chrysanthemum, her trusted colleague, brought her to "the excellent clinic" for treatment of her STI symptoms, even though Love had been suffering from extremely irritating genital discomfort for days. Also, the circle of my closest participants considered periodic antibiotic injections an efficient and wise preventive practice (see also Abellanosa and Nichter 1996). Additionally, although sex workers do not contest medical knowledge, they nevertheless show their noncompliance by seeking out traditional medicine or a less expensive practice recommended by colleagues.

### *Valued Subjectivities: Harmful Health Practices*

A mixture of sex-work-linked-to-subsistence and sex-work-linked-to-consumption imposes a heavy financial burden on the women and hinders them from making healthy decisions about their bodies. It is commonly assumed that developing a culturally valued subjectivity would bring about positive behavioral consequences, but, in this case, self-validation can have harmful consequences. The combination of sex workers' particular self-perceptions

(i.e., that they are socially respected women), alongside their economic marginalization and men's dislike of condoms, leads to their engagement in risky health practices and subsequent disregard of their health.

Feeling good about herself as a sacrificing woman who contributes to her family's economic vitality may boost a sex worker's self-image, but putting her family's needs above her own can hamper her commitment to her health care. Most sex workers I encountered divided their resources between family support and their own health treatments, even when they needed immediate treatment for STIs. Phoenix's help to her family, as she was suffering from severe STI symptoms, demonstrates that her self-perception within family-oriented gendered roles and her strong concerns for her family's welfare exacerbated what were already harmful health practices. The normative expectation to be a family-supporting woman reaches deeply within these women's bodies.

Furthermore, sex workers' aspirations to conform to the image of the fashionable modern woman often lead them to spend money on fashion and beauty instead of health, another economically burdensome practice. Although the nature of their work may make consuming fashion itself a prerequisite for subsistence, many of these young women engage in fashion consumption that goes beyond practical need. Fashion is highly valued in contemporary China, and images from mass media symbolize modernity (Rofel 1999). In that cultural context, by selling her body to acquire the latest fashions, a woman embodies her aspirations for the fantasy of modernity.

Certainly, these aspirational consumption habits do not help these women's economic situations when they influence choices about seeking efficient STI treatments. For instance, Love often suffered from STIs, as do most other women in the trade, but she often went shopping instead of having STI treatments. Consequently, she later suffered tremendously from the physical and emotional pain (which is deeply informed by local cultural perceptions: Luhrmann 2006) of serious STI symptoms. One hot afternoon, I encountered Love, apparently still in great pain after receiving a treatment that she had worked the whole previous night to pay for despite the fact that she was experiencing a good deal of vaginal irritation. When I asked her about the effectiveness of the treatment, Love smiled and told me that she thought Treasure's new cell phone was cool and had bought one like it instead of getting the treatment. Then Love showed me the new phone with pride. Another time, Love chose to forgo treatment and instead had her make-up and hair done professionally and bought a sexy dress for her date with her new boyfriend.

### Forgoing Condom Use

Sex workers' unstable economic conditions further push them to forgo safer sexual practices. A condom is considered the most effective and cheapest form of protection; everyone I met in the field knew about this "common sense" (*changshi*) prophylactic and had easy access to them.<sup>5</sup> However, forgoing condom use with clients remains the most common unsafe practice among these sex workers. This can be attributed, in part, to sex workers' attempts to procure more, especially higher-paying, clients. An even more critical part is that clients refuse to have protected sex. This finding confirms the pattern that: sex workers who do not practice consistent condom use do so because of their clients' refusal (Choi and Holroyd 2007:491). A typical Chinese man who earns a higher income and

socializes and travels often is likely to want to have unprotected sex with a commercial sex worker (Parish et al. 2003).

Many clients offer to pay about twenty percent more than the usual price, equivalent to 20 RMB or three U.S. dollars more, to forego condom use. In the local area, 20 Chinese dollars [RMB] is equivalent to four bowls of noodles, four lunches of a couple of dishes over a rice bowl from a high-school cafeteria near a massage parlor, or two packs of the cheapest cigarettes. This seemingly minimal amount, in exchange for protected sex, is an attractive offer for most sex workers because additional income can help them to either take care of daily needs or contribute to a financial reserve; their social world is unpredictable and their survival is precarious.

It is also important to note that, as many studies have shown, the women do not always have a choice when it comes to protecting their health. This pattern is magnified during irregular seasons of bad business when the women are short on work or when they are in desperate need of extra income. Worse, they do not have much negotiation power over condom use for fear that a male patron will choose another worker. As a “safety net,” sex workers may rely on their own methods of telling whether a client is clean or disease free, such as checking for irregular colors, odors, or boils on his penis, checking his marital status (assuming that married men living with their wives are STI free), and observing his general appearance. Knowledge about sexual health through such practices can be accumulated throughout a sex worker’s career, and I often heard that, if properly applied, the strategies could catch ill clients. Not surprisingly, however, these safety measures do not necessarily work.

### Low Quality Clinics

Concerned about the cost and speed of treatment, sex workers usually choose low quality or insufficient treatment for themselves. The higher prices of hospitals, along with the social stigma against sex workers expressed by some medical practitioners, lead the workers to go to cheap and unlicensed clinics. Many clinics serving sex workers are run by practitioners who have neither passed a doctor’s exam nor undergone any formal training in medicine. Rare exceptions occur when the women have personal relationships with doctors as steady clients or when the workers require serious surgery.

The doctors in the clinics around red-light districts often offer antibiotic treatments for temporary relief, and some clinics even offer stronger mix-and-match medical injections of antibiotics and sometimes antiphlogistics for quicker results. They provide an affordable, fast, and critical service to low-income sex workers, care that temporarily alleviates their physical suffering so that they can resume work. However, such temporary relief often backfires. Because their suffering is alleviated in the short term, the women may fail to do what is necessary to ensure a more complete healing.

### Irregular Treatments

Infected sex workers usually find it extremely difficult to firmly commit to STI care, which requires regular treatments and extended time off from sexual contact. Such long breaks from work would significantly harm their standing and thus their financial situation.

Complete treatments for STIs are usually expensive and require spending a relatively long time away from work, which might hamper their retaining a steady and full-time clientele. Sex workers in massage parlors suffer a similar lack of options when it comes to caring for their health. When they suffer from serious symptoms, they can only offer regular massages, but they quickly realize that they can hardly survive by being masseuses only. The very few women who opt for longer periods off for STI treatments are those with comparatively significant support, either from natal family or a serious boyfriend.

For these reasons, most sex workers will risk their health instead of risking their careers. To return to work, they routinely adopt the tactic of treating only their most urgent symptoms rather than the underlying illnesses. For instance, when Phoenix was diagnosed with syphilis, she was forced to resume work immediately after getting the required injections to repay the madam who had paid both for her treatment, lodging, and food.

### **Lifetime Suffering**

STIs and induced abortions negatively affect sex workers' fertility. STIs, including chlamydial and gonorrheal infections, can cause pelvic inflammatory disease (PID), and PID can result in chronic pelvic pain, ectopic pregnancy, infertility (Kasper et al. 2004; USPSTF 2001), and greater risk for HIV infection (CDCP N.d.). According to an epidemiological study, 50 percent of patients who have three or more episodes of PID develop infertility (Miller 2006). These negative effects of PID, exacerbated by delayed or improper treatments, parallel what I learned through my ethnography of sex workers' experience with STIs and infertility. In addition, an induced abortion, a common practice among these women, further increases the risk of secondary infertility arising from various complications (Tzonou et al. 1993).

Sex workers, who often suffer from sporadic but continuous contractions of STIs or undergo a series of abortions, are thus much more likely to become infertile, either temporarily or permanently. Ultimately, infertility can cause sex workers serious trouble fulfilling their important normative expectations: getting married and producing offspring (see Greenhalgh 1994; Handwerker 1998; Hershatter 2007). To these young migrant women from poor rural families, fertility is a prized attribute, especially if they hope for hypergamy. However, job-related infertility may ultimately prevent a young woman from marrying or from maintaining a stable marriage.

### **Paradox: Personal Responsibility Discourse**

Paradoxically, although STIs are virtually unavoidable in the industry, sex workers use a discourse of personal responsibility as the primary mode to discuss disease. Colleagues blame those who suffer from serious or repeated symptoms of STIs individually. That is, because individual health falls in the private sphere, the prevalent discourse among sex workers emphasizes that individual practices determine one's health condition.

This paradox stems from a problematic belief that sex workers tend to share: The STI symptoms they suffer are not necessarily or directly related to the nature of their work. In deciding to become a sex worker, particularly in discussions with experienced sex workers and observations of their lives, a young rural migrant usually learns that sex work

may have its complications but, if well managed, will not result in critical repercussions for her health or her ability to reproduce.

Thus, as the opening quote from Jasmin shows, sex workers tend to interpret all their experienced pains as minor ailments and believe that occasionally contracting gynecological diseases (*fukebing*) is normal for all women, regardless of their jobs. This misleading belief is inadvertently reinforced by public health policies in China that promote the idea of self-help: Disseminating knowledge about “safe” practices, they promote change on the part of “responsible” workers. Such an approach to health intervention, where it is the individual’s personal, even moral, responsibility to prevent disease, reflects a particularly neoliberal trend in public health (Lochlann 2007; Lupton 1995).

The problem with this approach is that public health services make it seem as though one can be free of STIs if one simply takes the proper precautions. The assumption is that if individuals are responsible about protecting themselves and gain the proper knowledge about STIs, they will modify and transform their sexual behavior (Zheng 2009a). As we have seen, however, the material conditions under which these women work, coupled with their sense of themselves as responsible family members and as clean, capable modern women, may lead them to engage in precisely the behaviors the public health system is trying to counter.

In his well-known work *Learning to Labor* (1977), Willis demonstrates that the British school system produces a group of British working-class students who resist the conformist pressures of society, but, because their resistance takes the form of rejecting school culture in favor of taking on factory work, it ultimately serves to maintain and reproduce the very social order that they have rejected. My study of sex workers reveals an analogous pattern to this paradoxical cultural process. However, in my case, both the women’s resistance and their active self-validation to conform to socially expected gender norms precipitate the process of social reproduction.

When a sex worker contracts a serious STI (e.g., syphilis or HIV/AIDS), even her closest colleagues blame her for her careless, dirty health practices. The emphasis on self-help knowledge, which, according to the official health discourse in China, is supposed to entail self-regulating practices, plays a role in the development of the sex workers’ subjectivity. It does so by inviting individual women to blame themselves for lacking relevant knowledge and proper practices and by shifting the attention away from socially imposed vulnerability and their social suffering.

A practical problem arising from these paradoxical discourses is that because the responsibility is placed on individuals and private practices, a sex worker does not want to admit to suffering from STIs. Long-term ethnography based on rapport with the participants furthers these findings by revealing that STI infection among sex workers is far more ubiquitous than they admit in one-time survey interviews. This reality, however, is not accurately reflected in public health studies, which are usually conducted in scientifically constructed settings in which sex workers would rarely share their personal experiences.

## **Discussion**

My study was limited, for the most part, to lower-income female sex workers now living in Hainan Province. Thus, I make no claim that my results are broadly representative but rather that they offer an important model for facilitating comparisons with other cultural settings. My positionality as a non-sex worker researcher has yielded both strength and weakness to this study.

The limitation of my research methods—ethnographic observations, in-depth interviews, and surveys instead of participating in the sexual labors myself—set limits in examining the formations of the women’s inner, emotional world. In the same vein, even though I succeeded in positioning myself as a “sister,” there remained a researcher–subject hierarchy. On the other hand, such distance and multiple methods yielded a broader set of results.

This study fills a critical gap in the existing scholarship on commercial sex workers’ daily interactions (Hyde 2007:135). Its ethnographic investigation of the women’s daily discourses and health practices allows us to ultimately connect the two distinctive scholarly traditions (epidemiological and feminist studies) that have studied this population. It does so by addressing the two arguably inseparable dimensions of these women’s lives: health issues and life circumstances.

I have sought to expose the ways in which Chinese sex workers’ subjectivities are constituted through their daily interactions with people in their social networks at various sites and the way in which their subjectivities, in turn, shape their risky health practices. More specifically, I demonstrate that Chinese sex workers understand themselves more as sacrificing, capable, and modern women than as illegal, immoral, and unclean subaltern subjects.

These self-conceptions lead the women to adopt tactics that include medically risky behaviors. That is, their active resistance to the widespread view of them as a dirty, STI spreader leads them to pursue cleansing practices that, paradoxically, increase their risk of getting seriously sick. Finally, I have shown here that because STIs are regarded in the public discourse as being caused solely by irresponsible, uneducated individuals rather than by larger structural conditions, the individual sex worker is blamed for being diseased, a disgrace that makes it difficult for her to admit to her health condition and seek sufficient help.

Through the lens of subjectivity, this article has illuminated the underlying mechanisms through which the stigma against sex workers is reproduced. The reality that a large portion of sex workers suffers from sporadic and continuous symptoms of STIs supports the public health epistemology that classifies sex workers as a major high-risk STI (e.g., HIV/AIDS) population or as the primary spreaders of STIs. In other words, it is believed that infection transmission remains concentrated in paths that lead from commercial sex worker to husband/steady partner to wife/steady partner (Parish et al. 2003). The awareness reinforced by this classification contributes to the reproduction of the epistemology about sex workers’ bodies. Consequently, this socially constituted paradoxical dynamic continues.

Public epidemiological studies have focused on surveillance and control to curtail the problem of sexually transmitted infections but they address only one part of this epidemic (Hyde 2007:207). Such a method focuses on spreading proper epidemiological knowledge to promote healthy behaviors and thus prevent/control disease. However, by

emphasizing sex workers' theoretical ignorance of risk-enhancing behaviors and overlooking their sociocultural economic conditions, the current system places sex workers in a position that is actually more, not less, vulnerable to STIs.

Additionally, women's active resistance to the stigmatized prostitute category paradoxically leads them to revert to the very category that they have rejected. The idea that they are dirty compels them to engage in cleansing practices that actually put them at higher risk. Furthermore, since the sex workers think all women have these problems, this dynamic of forces that are hard to decouple does not necessarily rely on public health understandings of STIs as a risk of sex work.

This study confirms the existing literature that suggests that increased STI risks are largely structural. Still, we must ask what cultural processes allow this risk to occur and continue. This study's findings extend and amplify previous studies by articulating the detailed mechanisms behind such structural violence (increased STI risks and consequent reproduction of stigma). That is, it illuminates the powerful, irresistible force of the social structure on social actors by looking at how it is reproduced daily and how its stigmas are realized in micro-settings by marginalized if nonconformist agents. Thus, it offers an apt site to explore the micro-processes through which agency takes place. These processes support established models that depict a dialectic relationship between structure and agency (e.g., Giddens 1979). My conclusion thus supports a basic anthropological observation: Social structure does not automatically reproduce itself but needs to be continually reproduced, and it takes considerable effort to maintain the status quo at every level.

This study thereby confirms important scholarly findings by providing further evidence that local, cultural forms of power shape complex subjectivities and are inscribed on bodies. My findings amplify and extend the guiding concept of subjectivity by suggesting that social networks are more formative than any other domain. In other words, sex workers' subjective social positioning is continuously constituted and reproduced in the course of everyday discourses and practices in social relationships and intimate daily interactions with various actors in their personal web. The local shapes their lives deeply.

## Notes

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1. Scholars of subjectivity have provided complex context and sophisticated analysis of specific forms of social life in particular cultural and historical settings. For Kleinman (2006; Kleinman and Fitz-Henry 2007; Biehl et al. 2007), morality (“what is most at stake”) and social relations are critical in the continuous production of subjectivity. That is, “intersubjectivity” is produced through ethical and moral experiences in the social realm. For Biehl (Biehl 2007; Biehl et al. 2007), location and movement play a pivotal role in constituting people’s subjectivity. Biehl regards displacement (not having a location), social abandonment (exclusion from family and community), and gender as integral forces at play in constituting the subjectivity. For Good et al. (2007), subjectivity is actively negotiated through social relations and spiritual experiences. For Scheper-Hughes (2007), moral, affective, and symbolic experiences are critical in the production of subjectivity. For Luhrmann (2006), subjectivity is emotional and psychological experiences in negotiating competing and contradictory emotional codes. For Kohrman (2003), modernity, nationalism, and authority are at play in the production of a top elite’s subjectivity, which, in turn, becomes a discursive force for establishing a new biobureaucracy. For Fullwiley (2011), subjectivity is produced at the intersection of familial relation, religious interpretation, and social obligation. What all these scholars have in common is that they have shown that subjectivity is both an empirical reality and an analytical category (Biehl et al. 2007:5).

2. It is difficult to apply classic sampling procedures to stigmatized and illegal populations (Bernard 2006). RDS is more effective than simple random sampling in studying sex workers because it extends access in a sample pool to all potential members of the hidden population by identifying respondents through their peer social networks (Salganik and Heckathorn 2004).

3. The number of sex workers arrested and held at administrative detention centers for “reeducation” (40–50,000 per year) (Gil et al. 1994:319) constitutes only one–two percent of the estimated number of women in the sex trade.

4. Sex workers consider themselves average women following the same life cycles as everyone else in China where life-cycle occasions (e.g., marriage, birth) or the rites of passage have remained highly standardized over the centuries (Cooper 1998). Indeed, the majority of my participants told me that they planned to leave sex work and return to conventional life within a few years.

5. Free distribution of condoms was common in my field sites. The motels and hotels frequented by my participants with their clients often placed free condoms in the rooms, shops selling “adult products” (*chengren yongpin*) were prevalent in and around the red-light districts and they sold various kinds of condoms, and madams often offered free condoms to sex workers. The real problems were client refusal and low-quality condoms (higher priced, personally purchased condoms were reported as more sturdy and comfortable).

## References Cited

Abellanosa, I., and M. Nichter  
1996 Antibiotic Prophylaxis among Commercial Sex Workers in Cebu City, Philippines:

- Patterns of Use and Perceptions of Efficacy. *Sexually Transmitted Diseases* 23:407–412.
- Bernard, H. R.  
2006 *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. Walnut Creek, CA: AltaMira.
- Biehl, J.  
2007 *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton: Princeton University Press.
- Biehl, J., B. Good, and A. Kleinman  
2007 Introduction: Rethinking Subjectivity. *In Subjectivity: Ethnographic Investigations*. J. Biehl, B. Good, and A. Kleinman, eds. Pp. 1–23. Berkeley: University of California Press.
- Bourgois, P., and J. Schonberg  
2009 *Righteous Dopefiend*. Berkeley: University of California Press.
- Centers for Disease Control and Prevention (CDCP)  
N.d. Chlamydia—CDC Fact Sheet. <http://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm> (accessed April 14, 2012).
- Choi, S., and E. Holroyd  
2007 The Influence of Power, Poverty and Agency in the Negotiation of Condom Use for Female Sex Workers in Mainland China. *Culture, Health & Sexuality* 9:489–503.
- Cooper, G.  
1998 Life-Cycle Rituals in Dongyang County: Time, Affinity, and Exchange in Rural China. *Ethnology* 37:373–394.
- Corrigan, P. W., and A. C. Watson  
2002 The Paradox of Self-Stigma and Mental Illness. *Clinical Psychological Science Practice* 9:35–53.
- Das, V.  
2001 Stigma, Contagion, Defect: Issues in the Anthropology of Public Health. Paper presented at Stigma and Global Health: Developing a Research Agenda Conference, Bethesda, MD, September 5–7. <http://www.stigmaconference.nih.gov/FinalDasPaper.htm> (accessed April 28, 2012).
- Das, V., and R. K. Das  
2007 How the Body Speaks: Illness and the Lifeworld among the Urban Poor. *In Subjectivity: Ethnographic Investigations*. J. Biehl, B. Good, and A. Kleinman, eds. Pp. 66–97. Berkeley: University of California Press.
- Farmer, P., with M. Connors and J. Simmons, eds.  
1996 *Women, Poverty, and AIDS: Sex, Drug, and Structural Violence*. Monroe, ME: Common Courage Press.
- Ferguson, J.  
1994 *The Anti-Politics Machine: “Development,” Depoliticization, and Bureaucratic Power in Lesotho*. Minneapolis: University of Minnesota Press.
- Fu, H., and D. Choy  
2010 Administrative Detention of Prostitutes: the Legal Aspects. *In Gender Policy and HIV in China: Catalyzing Policy Change*. J. Tucker and L. Dudley, eds. Pp. 189–200. New York: Springer.

- Fullwiley, D.  
2011 *The Enculturated Gene: Sickle Cell Health Politics and Biological Difference in West Africa*. Princeton: Princeton University Press.
- Giddens, A.  
1979 *Central Problems in Social Theory: Action, Structure, and Contradiction in Social Analysis*. Berkeley: University of California Press.
- Gil, V. E., with M. Wang, A. F. Anderson, and G. M. Lin  
1994 Prostitutes, Prostitution, and Social Control Measures in Contemporary China. *International Journal of Offender Therapy and Comparative Criminology* 38:319–337.
- Good, B. J., B. Good, M. D. Good, and M. A. Subandi  
2007 The Subject of Mental Illness: Psychosis, Mad Violence, and Subjectivity in Indonesia. *In Subjectivity: Ethnographic Investigations*. J. Biehl, B. Good, and A. Kleinman, eds. Pp. 243–272. Berkeley: University of California Press.
- Greenhalgh, S.  
1994 *Controlling Births and Bodies in Village China*. *American Ethnologist*. Berkeley: University of California Press.
- Handwerker, L.  
1998 The Consequences of Modernity for Childless Women in China: Medicalization and Resistance. *In Pragmatic Women and Body Politics*. M. Lock and P. A. Kaufert, eds. Pp. 178–205. Cambridge: Cambridge University Press.
- Hershatter, G.  
2007 *Women in China's Long Twentieth Century*. Berkeley: University of California Press.
- Huang, Y., G. E. Henderson, P. Suiming, and M. S. Cohen  
2004 HIV/AIDS Risk among Brothel-Based Female Sex Workers in China: Assessing the Terms, Content, and Knowledge of Sex Work. *Sexually Transmitted Diseases* 31:695–700.
- Hyde, S. T.  
2007 *Eating Spring Rice: The Cultural Politics of AIDS in Southwest China*. Berkeley: University of California Press.
- Jeffreys, E.  
2004 *China, Sex, and Prostitution*. London: RoutledgeCurzon.
- Kasper, D. L., with E. Braunwald, S. Hauser, and D. Longo, eds.  
2004 *Harrison's Principles of Internal Medicine*. 16th ed. New York: McGraw-Hill Professional.
- Kleinman, A.  
2006 *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*. New York: Oxford University Press.
- Kleinman, A., with V. Das and M. Lock, eds.  
1997 *Social Suffering*. Berkeley: University of California Press.
- Kleinman, A., and E. Fitz-Henry  
2007 The Experiential Basis of Subjectivity: How Individuals Change in the Context of Societal Transformation. *In Subjectivity: Ethnographic Investigations*. J. Biehl, B. Good, and A. Kleinman, eds. Pp. 52–65. Berkeley: University of California Press.
- Kohrman, M.

- 2003 Authorizing a Disability Agency in Post-Mao China: Deng Pufang's Story as Biomythography. *Cultural Anthropology* 18:99–131.
- Link, B. G., F. T. Cullen, E. Struening, P. E. Shrout, and B. P. Dohrenwend  
1989 A Modified Labeling Theory Approach to Mental Disorders: An Empirical Assessment. *American Sociological Review* 54:400–423.
- Lochlan, J. S.  
2007 Cancer Butch. *Cultural Anthropology* 22:501–538.
- Lorway, R., with S. Reza-Paul and A. Pasha  
2009 On Becoming a Male Sex Worker in Mysore: Sexual Subjectivity, “Empowerment,” and Community-Based HIV Prevention Research. *Medical Anthropology Quarterly* 23:142–160.
- Luhmann, T. M.  
2006 Subjectivity. *Anthropological Theory* 6:345–361.
- Lupton, D.  
1995 *The Imperative of Health: Public Health and the Regulated Body*. London: Sage.
- Mason, K. A.  
2012 Mobile Migrants, Mobile Germs: Migration, Contagion, and Boundary-Building in Shenzhen, China after SARS. *Medical Anthropology* 31:113–131.
- Miller, K. E.  
2006 Diagnosis and Treatment of Neisseria Gonorrhoeae Infections. *American Family Physician* 73:1779–1784.
- Morar, N. S., with G. Ramjee, E. Gouws, and D. Wilkinson  
2003 Vaginal Douching and Vaginal Substance Use among Sex Workers in KwaZulu-Natal, South Africa. *South African Journal of Science* 99:371–374.
- Nguyen, V.-K.  
2003 Anthropology, Inequality, and Disease: A Review. *Annual Review of Anthropology* 32:447–474.
- Ortner, S.  
2005 Subjectivity and Cultural Critique. *Anthropological Theory* 5:31–52.
- Parish, W. L., E. O. Laumann, M. S. Cohen, S. Pan, H. Zheng, I. Hoffman, T. Wang, and K. Hang Ng  
2003 Population-Based Study of Chlamydial Infection in China: A Hidden Epidemic. *The Journal of the American Medical Association* 289:1265–1273.
- Parker, R.  
2001 Sexuality, Culture, and Power in HIV/AIDS Research. *Annual Review of Anthropology* 30:163–179.
- Rofel, L.  
1999 *Other Modernities: Gendered Yearnings in China after Socialism*. Berkeley: University of California Press.
- Rogers, S. J., L. Ying, Y. Tao Xin, K. Fung, and J. Kaufman  
2002 Reaching and Identifying the STD/HIV Risk of Sex Workers in Beijing. *AIDS Education and Prevention* 14:217–227.
- Salganik, M. J., and D. D. Heckathorn  
2004 Sampling and Estimation in Hidden Populations Using Respondent-Driven Sampling. *Sociological Methodology* 34:193–239.

- Scheper-Hughes, N.  
2007 Violence and the Politics of Remorse: Lessons from South Africa. *In* Subjectivity: Ethnographic Investigations. J. Biehl, B. Good, and A. Kleinman, eds. Pp. 179–233. Berkeley: University of California Press.
- Schoepf, B. G.  
2001 International AIDS Research in Anthropology: Taking a Critical Perspective on the Crisis. *Annual Review of Anthropology* 30:335–361.
- Tzonou, A., with C.-c. Hsieh, D. Trichopoulos, D. Aravandinos, A. Kalandidi, D. Margaritis, M. Goldman, and N. Toupadaki  
1993 Induced Abortions, Miscarriages, and Tobacco Smoking as Risk Factors for Secondary Infertility. *Journal of Epidemiology and Community Health* 47:36–39.
- UNAIDS  
2004 China: Epidemiological Fact Sheets. Geneva: UNAIDS.
- USPSTF (U.S. Preventive Services Task Force)  
2001 Screening for Chlamydial Infection: Recommendations and Rationale. *American Journal of Preventive Medicine* 20(3S):90–94.
- Willis, P.  
1977 Learning to Labor: How Working Class Kids Get Working Class Jobs. New York: Columbia University Press.
- Zhang, E.  
2011 China's Sexual Revolution. *In* Deep China: The Moral Life of the Person. A. Kleinman, Y. Yan, J. Jun, S. Lee, E. Zhang, P. Tianshu, W. Fei, and G. Jinhua, eds. Pp. 106–151. Berkeley: University of California Press.
- Zheng, T.  
2009a Ethnographies of Prostitution in Contemporary China: Gender Relations, HIV/AIDS, and Nationalism. New York: Palgrave Macmillan.  
2009b Red Lights: The Lives of Sex Workers in Postsocialist China. Minneapolis: University of Minnesota Press.