

## Chapter 18

### Resistance to condom use in a Bangladesh brothel

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#### Abstract

**The SHAKTI Project carried out by CARE, Bangladesh started in a 600-women brothel in Tangail in 1996. At baseline, condom use was three per cent. Initial strategies to improve usage rates included peer education and free condom distribution, with daily registration of number of condoms per woman. In November 1998, condom use was probably around 40 per cent. Issues such as divisiveness and competition, obeying madams and landowners, pleasing the donor, and facing the police, plagued the project. The locus of resistance to change was found less frequently within the individual sex workers than in the structures surrounding them. Removing these barriers produced increased condom use and, eventually, sales of condoms from sex workers to sex workers.**

The town of Tangail, located a few hours drive from Dhaka, is the site of an HIV prevention project implemented by CARE, Bangladesh, in collaboration with the Marie Stopes Clinic Society and several small local community organizations. The project is named SHAKTI, which means *strength* or *power* in Bengali and is an acronym for 'Stopping HIV/AIDS through Knowledge and Training Initiatives'. The larger SHAKTI project has expanded to include other highly vulnerable groups: street-based sex workers in Dhaka and injecting drug users in Dhaka and Rajshahi. The subject of this chapter is the first and oldest component, the brothel project in the town of Tangail. It is examined in the light of its own history, as well as with comparative information drawn from the National Behavioural Surveillance of 1998.

Resistance to change in sexual practice is not unexpected. When the brothel project began in 1995, it was clear that far more than the sexual practices taking place in the brothel would have to change if a state of positive sexual health was to be attained among the sex workers. The Tangail brothel was selected for the SHAKTI project because it was one of the less violent brothels in central Bangladesh. A committee called the *Samaj* (Society) had been formed by the landlords, the *sardanis* (madams), local political party-based youth groups, and older sex workers in order to solve conflicts as they arose. While not a democratic system, the *Samaj* represented an attempt at self-regulation. From its beginning, the project aimed at improving condom use and making STD treatment available among about 600 women living in the brothel. Measurement of changes in STD (including HIV) prevalence was built in as an indicator and the project baselines were established by clinical and laboratory research in 1996. At the time SHAKTI began, Bangladesh was thought to have low HIV prevalence and the original project designers hoped to establish a model project that would quickly be expanded to all brothels in the nation before HIV could spread widely. But high levels of condom use and STD treatment among the sex workers in Tangail and their clients have been difficult goals to attain, mainly because of structural factors surrounding the sex worker.

## Background

Residential brothels have existed for over a century in Bangladesh. Technically, their status is neither legal nor illegal. For an average fee of 10,000 Tk<sup>1</sup> paid to the local police, sex workers register their names with the first class magistrate court when they enter a brothel and sign an affidavit that they are entering of their own will and are over 18 years old. Some form of this practice appears to be have been in existence in the late eighteenth century as well (Khan and Arefeen 1989). Today this registration causes many sex workers to think they have a license to sell sex, which is not true in a strictly legal sense. However, as long as they remain in the brothel, continue to pay the police as required, and do not solicit clients on the streets, they enjoy a considerable amount of protection, compared to street-based sex workers. This protection from police violence and harassment is costly, and involves adhering to a dress code as well as arbitrary fees imposed on clients. In addition to paying police, brothel-based sex workers must pay rent for their rooms to a landlord or landlady, a fee to a *sardani* or madam, and fees to pimps and *mastans* (local hoodlums). Overall, about 60 per cent of the income earned by an independent sex worker is turned over to others. While in debt-bondage, a young sex worker (*chukri*) turns over 100 per cent of her earnings to her *sardani*, who is expected to meet all her basic needs. Heavy stigmatization from the larger society as well as internalized self-denigration are essential elements for the maintenance of this system. The potential for exploitation is enormous. For these reasons, and because greater diversification of the sex trade has now begun, the brothel business in Bangladesh as a whole appears to be on the decline.

Although violence has not been a major problem at Tangail, sex workers have been heavily stigmatized by the surrounding community. Police exercise a great deal of control. Sex workers are made to pay extra money to the police whenever they entertain a client for the whole night. Consequently, few women have all-night clients.

Some women are themselves children of sex workers and were raised in brothels, and in turn, many raise their own children at the brothel. These children have been unable to be registered for local schools because they cannot name their fathers. Tangail sex workers have not been not allowed to leave the brothel at will, and when out, must not wear any shoes or slippers, or they are fined by the police. This imposition on their rights is supposed to ensure they will not sell sex outside of the brothel. Nonetheless, at the brothel, there is a reasonably peaceful and sociable atmosphere, with open courtyards where women, children, *babus* and friends gather. This isolated and controlled environment has afforded certain advantages for the SHAKTI project; however, it is not typical of all Bangladeshi brothels and it certainly is not an environment in which sex workers have adequate control of their own lives and occupational safety.

## Implementation

### *Establishing baselines*

Between January and June 1996 the project undertook various types of formative research, including a qualitative assessment, a quantitative baseline survey on behaviour and knowledge, and an STD survey. The entire formative phase covered one year, during which time, advocacy with those in the power structure and rapport building with the sex workers was able to proceed.

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<sup>1</sup> US\$1=48Tk

The initial quantitative survey revealed that many of the women had, at one time, been married, that 97 per cent were Muslim, and that most were illiterate. Although 6.8 per cent had been resident in the brothel for less than one year, the population was remarkably stable. Selected social and demographic characteristics of the brothel population are shown in Table 1.

**Table 1**  
Social and demographic characteristics of Tangail brothel residents (n=296)

Characteristic	Statistic
Age (yrs)	avg=23.6 ± 6.0
Duration as sex worker (yrs)	avg=7.3 ± 5.6
Duration in Tangail brothel (yrs)	avg=6.0 ± 6.3
Illiteracy %	85.8
Bonded %	17.0
Have <i>babu</i> (fixed client) %	61.5
Never been in other brothel %	58.1

(adapted from Sarkar *et al.* 1997)

A two-room clinic, with a nurse and a physician, was set up at the brothel on land donated by the *samaj*. At the clinic, STDs were treated free and other sicknesses were diagnosed and prescriptions written. The initial baseline STD survey required considerable persuasion of sex workers, as they had rarely experienced pelvic examinations. Co-operative sex workers helped secure the co-operation of others by showing them how the examination would be done, using a speculum and a medical school model of women's organs. Confidentiality was maintained on all records and verbal consent taken. A random sample of sex workers was formulated, based on their room numbers. Those participating in the STD survey were given a standardized clinical examination (n=296) and tested for HIV(unlinked), syphilis, gonorrhoea and chlamydia (Sarkar *et al.* 1998). The results are summarized in Table 2.

**Table 2**  
STD prevalence among Tangail sex workers, 1996

STD Tested	N	% Positive	CI (95%)
HIV	466	0.0	0-1.00
TPHA <sup>a</sup>	437	64.3	57.24-69.65
RPR (all dilutions) <sup>a</sup>	442	45.2	40.35-49.71
RPR (dilution≥1:8) and TPHA <sup>a</sup>	442	17.9	14.58-21.84
Chlamydia (PCR)	296	18.6	14.41-23.58
Gonorrhoea (PCR)	296	20.3	15.93-25.39

<sup>a</sup>re-run syphilis results, using RPR+TPHA, Dr. Jos Bogaerts, ICDDR,B.

The samples for HIV tests were unlinked to identifying information. Prevalence of clinical signs of STDs were high, with 62.9 per cent of the examined women having cervical discharge and 32.4 per cent having vaginal discharge. A further 2 per cent had ulcers, 6.4 per cent warts, and 26 per cent had lower abdominal pain.

## Strategies and barriers

The SHAKTI project has had four major working strategies: to raise awareness; to have repeated contact of high quality with sex workers; to provide the means of behaviour change (condoms and STD treatment); and to create an enabling environment.

Specifically, the project aimed at stepwise behaviour change, through awareness, altered intention, trial of condoms, and on toward consistent use of condoms. The main mode of education was through peer educators and peer pressure. Monitoring tools were devised, especially for illiterate women, using colour-coded devices, to enable them to gather information measuring each step of the behaviour change model.

The project aimed at improving levels of condom use. At baseline, only 3.4 per cent of women were consistently using condoms. Both oral sex and anal intercourse were reported as rare, but were most certainly underreported because of their shameful connotation and because interviewers were inadequately trained. In the baseline survey, the women reported having an average of 3.5 clients per day for an average of 3.6 commercial sex acts; in addition, they had intercourse, on average, once a day with their *babus*.

There were numerous barriers to increased condom use. First, the women saw condoms as a family planning device, and 45 per cent had already adopted another mode of contraception. Others either wanted a pregnancy or relied on menstrual regulation (legal in Bangladesh) or illegal induced abortion; 29.7 per cent of the Tangail women had never been pregnant and, to some women, infertility was a problem. Second, 62 per cent of the women had *babus*, or steady lovers. While most did not live under the same roof with their *babus* all the time, the *babu* was like a husband and they saw no need to use condoms in their private relationships. Third, their clients did not like condoms. The sex workers feared, if they asked these men to use condoms, they would think that the woman was infected with a disease. And, in fact, a small qualitative study of clients revealed that they did indeed think as the women assumed they did.

With regard to STDs, one aim of the project was to reduce the time gap between when symptoms are recognized and when care is sought. Generally, at first, the women did not wish to acknowledge current STD symptoms for fear of losing clients. At baseline, women with symptoms waited an average of seven days before seeking treatment beyond their own home remedies. When they did seek help, it was from paramedics, traditional healers, and pharmacists, most of whom do not have safe injecting practices.

The SHAKTI approach required mobilizing support from the power structures surrounding the brothel: the internal brothel administration, the local government administration, the police, local opinion leaders, and the fixed clients, or *babus*, who could be reached. The project did not at first include training in negotiation of condom use or intensive work with client groups. It was considered that women were too powerless in the face of a strong brothel power structure to be able to achieve high levels of condom use through negotiation on a person-to-person level with a client. It was also considered that clients could not be reached for education and persuasion within the brothel setting. Hence, no work was done on either component.

Many of the strategies and even the educational materials drew on the Sonagachi Project of Calcutta. In the Sonagachi Project, these barriers were overcome largely by a strong emphasis on sex worker rights and the gradually emerging power of sex workers within their own organizations. Although it started as a public health intervention, the Sonagachi project has become a social reform movement, one aimed at legitimizing the workers' rights of men and women in the sex trade. In the SHAKTI project, however, the highly conservative Islamic society surrounding the brothel elicited a high level of caution from the project personnel, caution derived from fear that confrontational tactics, as might be required when developing a

concept of sex workers' rights, would lead to backlash from Islamic and government forces surrounding the brothel. The project used, instead, a conflict resolution model in order to convince religious and political leaders that it was not encouraging illicit sex, only attempting to increase its safety. Numerous formal as well as informal meetings were held with these groups. This process was also monitored with indicators and a quarterly assessment. The project has, to date, avoided taking sides in the debate about sex workers' rights. In 1996 sex workers were blocked by the local administration from participating in World AIDS Day activities. Protests were not lodged, but the next year, without confrontation, they simply appeared in the activities and nothing was said. Because there is still considerable fear that the police or fundamentalist groups will close the brothel if the women offend the local society, progress has been slow in changing the social climate around the brothel.

### *Staff attitudes*

SHAKTI staff members were uncomfortable working at a brothel when the project began. They were sensitized in a number of ways, including an anonymous survey of their own sexual behaviour, with discussions about morality and multiple partners. Emphasis was placed on showing respect to the women and recognizing their expertise in the issues involved. Within the CARE organization, several high-status persons served as role models in this regard, which facilitated attitude change. As time passed, new staff replaced old and not all the new workers were as well trained as the earlier ones. Their own discomfort with their jobs was not addressed. In particular, the belief that it was unimportant to teach any kind of negotiating skill for condom use reinforced the lack of skills in talking about sex. Even the clinic doctor was unable to discuss anal or oral sex with the women, and hence never examined them fully for STDs.

### *Peer education*

Peer education has been the main communications strategy used by the project. This began in August 1996. A total of 50 peer educators were originally trained, with 28 actively working (a ratio of 1 to 20 sex workers). They were each assigned zones in the brothel: a zone was made up of 10-14 apartments. Peer educators received 50 taka per day, which was later raised to 100 Tk per day, and worked one half-day a week. Their tasks were to visit the women in their assigned zones, discuss safe sex, HIV knowledge and STD treatment, and ask about condom use in the previous 24 hours. They also collected the condom package covers. Rubbish bins for condom disposal were placed in strategic locations, but were really needed in each room. Used condoms in the bins were counted, but only irregularly. These data were recorded on a monitoring map, according to zone and room, by the peer educators with colour codes. Then, the results were summarized on a monitoring board in the brothel. This process of education with monitoring and feedback reached about 70 per cent of the women. The remaining 30 per cent were resistant; it was said they did not take clients as they had *babus*. Because these sex workers were not monitored, they were not included in the monitoring denominators.

The trainers of peer educators, called field trainers, wore white laboratory coats and a badge around the brothel and the peer educators themselves wore a badge and blue apron when working. This approach was copied from the Sonagachi project in Calcutta. The field trainers felt they needed these uniforms to distinguish them from sex workers, so that clients would not ask them for sex. While the peer educators enjoyed the status conferred by these uniforms, they were marked by them as different and distinct from the other sex workers. The peer educators were privileged with more attention, a daily small income and other rewards. Several made repeated trips overseas and were often asked to represent the project at sex

worker meetings and other meetings. This gave them a sense of power and raised self-esteem but also created jealousy among the non-peer educator sex workers.

### *Condoms*

Male condoms were purchased from a single source by the project and given out free by peer educators. Not all the women accepted condoms, but those who did were supposed to receive as many as they requested. However, many stated they did not receive the number they asked for and peer educators were often placed under pressure not to give more than four daily to each woman. Problems arose when the condom source company had a labour strike and no condoms were available. No other source had been found. Options such as female condoms and the addition of lubrication to safer sex practices had never been contemplated.

### *Health care*

The clinic was staffed by a female doctor and two nurses, one male and one female. Although the doctor was dedicated to helping the sex workers, she had never been given specific training in STD management. The clinic was open five days a week from 9 a.m. to 1 p.m.. The women were free to bring their children for any illness. STD drugs were given free, but drugs for other illnesses had to be bought elsewhere, with a prescription provided by the clinic. Immunizations were provided for children by the government health service and special immunization days were held. General clients did not have access to the clinic, but in 1998 the project opened the clinic in the evenings to the *babus*.

### *Social development*

The baseline survey identified a number of concerns of the sex workers and the project attempted to address these. These were economic stability and savings; education and literacy; medical services; freedom of movement outside the brothel; welfare of children; and social acceptance, including burial in Muslim cemeteries.

Economic stability has not been addressed directly. By mid-1998, peer educators were paid almost enough to cover their daily rent and voluntarily chose not to take clients for the few hours per day that they worked as educators. For a number of reasons, including the closure by authorities of brothel alcohol shops due to several deaths of clients from drinking methanol, sex workers reported that the number of clients had dropped significantly over the past 18 months. Losing easy access to alcohol, some clients turned to the use of Phensedyl, a codeine cough syrup, and had less money available for buying sex. It was also suspected that the high visibility SHAKTI brought the brothel and the large number of visitors (about 200 days of visitors in 1997-98) contributed to a decreased number of clients. More sex workers have come to rely on their relationship with *babus* for security. Although we have little evidence that the average number of clients has really decreased, incomes may have diminished overall. Daily rental payments to the *sardanis* and landlords, however, have certainly not diminished and there are frequent threats to increase the rent. The women do not feel they have the power to negotiate a reduction; but they have been successful so far in fighting off an increase in rent. A severe flood in 1998, periodic Islamic holidays that reduce client flow and perhaps a growing cautiousness about HIV may be affecting their incomes. Competition for clients in the brothel is intense.

Skills training in alternative modes of supplementing income began in February 1998. Several associated local NGOs began to provide training in embroidery and sewing to 20 women, with a view toward the sale of products produced by the women. Some staff

believe that such an approach is gender-typed and not likely to yield an important source of income.

Literacy and education are highly appreciated. Many women had hired private tutors before the coming of SHAKTI. After starting, SHAKTI initiated a program of literacy with the peer educators; 40 women attended but 12 dropped out. Literate peer educators are now teaching literacy to 60 other sex workers. Those who can now read and write are clearly proud of their accomplishments, and have begun to apply these skills to project activities.

In India and Bangladesh, children are a major issue in brothels. Women want their own or adopted children, partly to ensure an income when aged, and partly to satisfy their emotional needs for nurturing and attachment. Some sex workers have been able to educate their children by sending them away from the brothel, but most are unable to do this. SHAKTI co-ordinated with another NGO to provide a non-formal elementary school for brothel children.; about 45 children were enrolled. The partner NGO has purchased land on which they hope to build a training centre for the brothel children. SHAKTI built a community centre for the sex workers and their children at the brothel.

Numerous events have taken place in which selected peer educators have made public presentations about the project, both in Bangladesh and in other countries. SHAKTI sex workers attended the Fourth International Asia-Pacific AIDS Conference in Manila, and the Twelfth International AIDS Congress in Geneva; both sex workers and brothel keepers (owners and *sardanis*) attended the First National Sex Workers Conference of India in November 1997. On other occasions, sex workers from Tangail have attended meetings with the sex worker organization in Calcutta, and Calcutta women have visited Tangail. Although, under the influence of foreign sex workers, Tangail women had formed their own committee, called Mukti Shango, it had been relatively inactive. Picnics, parties and other gatherings held by CARE for sex workers and CARE staff are other instances in which sex workers were given a small opportunity to feel less stigmatized. These have been, however, inadequate to meet the needs of all the women in the brothel and much larger structural changes to community attitudes are required before a sex worker in Bangladesh could feel equal to any other woman. Because the status of women in general in Bangladesh is very low, it might be argued that sex workers do not suffer a great deal more than most women of the poorer classes and many, in fact, have far greater incomes than other poor women. The social stigma associated with prostitution, however, is severe. These women are almost never able to marry and be accepted in the main society. They are often, but not always, disconnected from their families, which is a source of considerable personal grief in a kinship-based society.

### *Clients and lovers*

*Babus* are very important men in the brothel. Although some are abusive and exploitative, most of the women value their relationships with these men. Many *babus* pay their rent, buy them food and clothing, and help with their children. Most of the *babus* have wives and children outside the brothel and some are *babus* to women in other brothels as well. In February 1998, a *babu* study was carried out, showing that, among 233 men, 14 per cent were permanent residents of the brothel and 56 per cent visited for only one or two days at a time. About 30 per cent of women in the brothel claim they do not need to use condoms as they have no clients and remain faithful to their *babus*, but project staff dispute this. The *babu* study, however, corroborated this belief with 28 per cent of *babus* claiming their mistresses take no clients. However, in the three months before the survey, 16 per cent of *babus* had sex with another sex worker in the same brothel and 16 per cent with a sex worker away from the brothel. In addition, 60 per cent had wives. If it is true that about 30 per cent of Tangail's sex workers take no other clients than their *babus*, it is also true that these women are at risk from

the multiple sex partners of their *babus*. In the same survey, 55 per cent of *babus* claimed to have used condoms during the last sex with their mistresses. This is highly unlikely to be true.

### *Power structure*

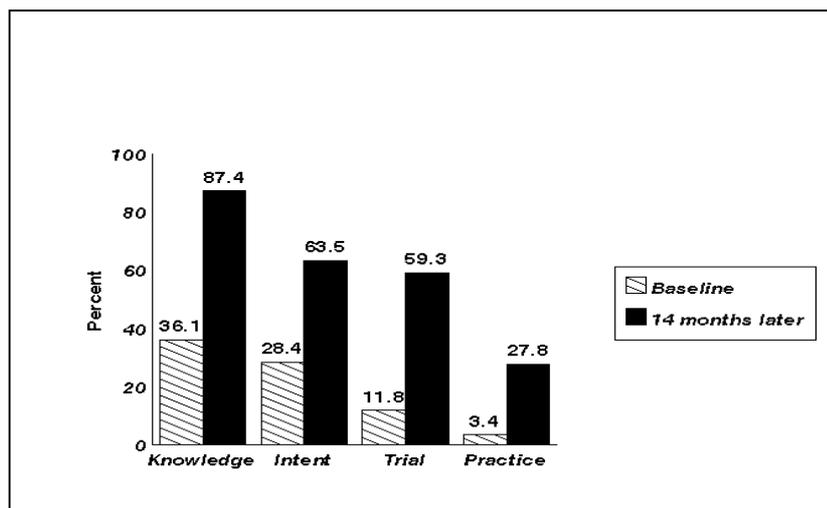
In late 1997, discussions with brothel gatekeepers and local government administration personnel turned to the ensuring of a 100 per cent condom policy because of its clear success in diminishing the HIV epidemic in Thailand. In the Bangladesh case, it was hoped this could be accomplished without any kind of coercion. Special peer education began in order that the 100 per cent would include *babus*. There was, however, little agreement among the sex workers on how to proceed with implementing this policy: most women did not wish to refuse sex without a condom as this simply drove the client to another more willing sex worker. A more coercive approach was favoured by local administrators.

### *Monitoring and evaluation*

The peer educators monitored condom use once a week. Their coverage of sex workers' apartments and levels of condom use were recorded using pictorial devices, as described.

Interest and opinions of other involved persons were also monitored and cleverly displayed with colour-coded buttons on a board at the SHAKTI office. After 14 months of peer education in October 1997, the monitoring data showed an increase in knowledge that STDs can be prevented through the use of condoms, as well as increased intent, trial, and reported use (Figure 1). Knowledge that STDs can be prevented through the use of condoms rose from 36.1 to 87.4 per cent. The intent to use condoms rose from 28.4 to 63.5 per cent and the trial of a condom within the last 24 hours rose from 11.8 to 59.3 per cent. Self-reported consistent condom use, defined as condom use with 50 per cent or more of clients in the last 24 hours, rose from 3.4 per cent to 27.8 per cent (Sarkar *et al.* 1997).

**Figure 1**  
Behaviour change indicators, baseline and 14 months later, Tangail brothel



In mid-1998, Tangail was included in a random proportional sample of all brothels as part of the National Behavioural Surveillance, employing independent and well-trained interviewers. At this time the monitoring data collected by peer educators showed 43 per cent consistent condom use the previous night by the 70 per cent of women actually monitored. According to the Surveillance data, 27 per cent of vaginal and anal sex acts were protected by condoms during the previous week, and condoms had not been used in any reported oral sex acts. Twenty-seven per cent of women stated they had engaged in anal sex the previous week with an average of 1.8 times each. Only one per cent of vaginal and anal sex acts carried out with *babus* involved condoms in this survey, although the monitoring data a few months later showed 28 per cent. These discrepancies increased suspicions that many false answers were being given, probably because the sex workers did not want CARE staff to feel their work was unproductive. It is assumed that, as they were receiving a great deal of attention and funding from CARE, they feared a loss of approval. It is also possible that neither CARE staff nor peer educators wished their superiors to see realities.

An STD survey conducted at the same time, in mid-1998, corroborated the lower condom use levels, in that it showed no reduction in STD levels compared to baseline. Table 3 shows the pre-intervention and mid-intervention levels of chlamydia, gonorrhoea and syphilis, using the same laboratories and tests in each case. Sampling procedures were also the same. As TPHA simply tests whether a person has ever been exposed to syphilis, differences between the pre- and mid-intervention surveys do not reflect any direct action of the project. No significant differences in age or proportion of bonded women between surveys were found. It is clear that, between mid-year 1996 and mid-year 1998, no reduction had taken place in prevalence of major STDs. It is striking that HIV incidence also had not risen.

**Table 3**  
Comparisons of pre-intervention and mid-intervention STD levels

STD Tested	Pre-intervention		Mid-intervention		Mantel-Haenszel	
	N	% Pos	N	% Pos	$\chi^2$	P-value
HIV	466	0.0	386	0.0	-----	-----
TPHA	437	64.3	386	52.8	11.09	0.0008
RPR (all dilutions)	442	45.2	386	47.3	0.34	0.557 ns
RPR (dilution $\geq$ 1:8) and TPHA	442	17.9	386	13.7	2.64	0.105 ns
Chlamydia (PCR)	296	18.6	298	15.1	1.24	0.265 ns
Gonorrhoea (PCR)	296	20.3	296	18.2	0.5	0.479 ns

After the mid-term review was completed in 1998, alterations were made to some of the implementation strategies. The objective changed to helping the brothel residents become independent of CARE and able to conduct their own safe sex work by the middle of the year 2000, when the project would end. The first step was to address the growing social distance between peer educators and their sex worker colleagues, at least symbolically, by abolishing the blue uniforms worn at the brothel. The field trainers also stopped wearing their white laboratory coats.

Meetings were held and the continuing disagreements about condom use were addressed by asking the women what they could agree upon. They all stated they wanted to wear shoes when out of the brothel, but the *sardanis* did not like this. Although it altered the non-confrontational attitude SHAKTI had taken earlier, the women were advised to go out in groups of five with shoes but without make-up, to report what happened to the *sardanis*, and to wait a few days to see if the police came to threaten them or the *sardanis*. Within a few months, over 200 women had gone out of the brothel wearing shoes without any mishap and eventually all have done so. Now they state they never realized that the proscription against

shoes was not a law, but was only in their minds. Staff members had known there was no legal aspect to the taboo, but had never considered it important to tell the women. At present, the women are trying to change other aspects of dress codes imposed on them and training in legal rights has begun.

The previous system of condom distribution was also changed. The aim was to cease distributing free condoms altogether, but resistance to this was very great, especially among project staff members. They feared a fall in monitoring figures and condom use. However, many sex workers complained that they did not like the process of being asked daily by the peer educators how many clients they had the previous night and how many they had used condoms with, and being given only four free condoms no matter how many they might really need. Change in condom distribution was introduced gradually. The first phase of this change was to place open boxes of condoms at several places in the brothel and let sex workers take as many as they wanted. A staff member, not a peer educator, was then placed on duty at each condom depot to write down the number of condoms taken by each sex worker. Within the first month, a further 10 per cent of those sex workers who had resisted accepting any condoms, began coming for condoms, and within a few months nearly all of the sex workers were taking some condoms. The system then changed again. The previous peer educators, who continued to receive their daily pay, were used to train an additional 60 peer educators. The sex worker-run committee was revived and a system of sales set up through which peer educators could buy condoms at a very low price from the committee, then sell the condoms with profits shared equally between the seller and the sex worker committee. Their daily payments ceased and the women were asked instead to top up their incomes with profits from condom sales. A great deal of resistance eventually emerged, as it became clear that many peer educators had ceased selling sex when receiving their stipend. They had lost their customer base and become dependent on the Tk100 per day received from CARE. It also became clear that managers were manoeuvring to retain power. The intended shift to assist the sex worker committee to handle specific project tasks on their own, such as condom sales, was undermined by poor leadership in the committee. The project manager had selected the committee's chairwoman, without giving the sex workers the right to select their own leader. This was eventually clarified, and the sex worker committee was reconstituted with another group-selected leader and a new name, the Nari Mukti Shango. Procedures were begun to register the committee as a community-based organization with the Social Welfare Department.

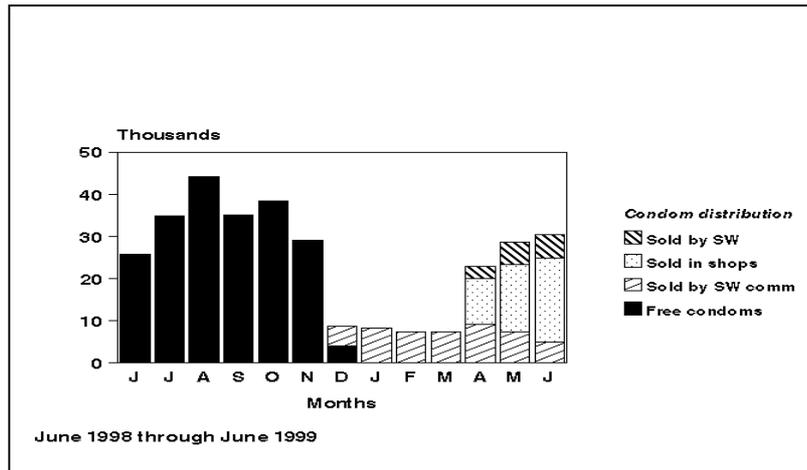
Monitoring, which had become fairly burdensome and was not used by project personnel and brothel residents for adjusting strategies, was simplified to the registration of number of condoms sold. Resistance to this was considerable, at first, as the peer educators felt they had to continue writing down the name of the woman to whom they sold the condoms and the number sold, and ask about condom use. Those who had become literate were proud to be able to write down these names. Eventually, this type of monitoring was relaxed.

In addition, the overall number of CARE staff at the brothel was reduced from 20 to five. The clinic doctor was formally trained in syndromic STD management and the Marie Stopes Clinic Society took over supervision and maintenance of clinic operations. A clinic management committee was formed of clinic staff, *babus*, *sardanis*, landlords and sex workers. One staff member working at the brothel was given formal training in HIV counselling. Earlier, female condoms were introduced on a trial basis and results of this trial indicated an interest in their use by at least 30 per cent of the women. Water-based lubricant was also introduced and very well accepted.

The outcome of all these changes is still being monitored. Figure 2 shows the growth in condom sales over the ensuing months. Additional condoms supplied by clients are not

counted in these totals, but such information will be gathered as part of the newer quarterly survey system.

**Figure 2**  
Condom distribution figures for June 1998 to June 1999, Tangail brothel



In November, the month before condom sales began, a behavioural survey was conducted by an external team. They suspected that over-reporting of condom use was continuing and a special meeting was held to discuss this again. In the end, the reported rate of condom use for vaginal and anal sex combined was 54 per cent during the last 24 hours and 44 per cent during the past week. Condom use with *babus* was reported as 23 per cent the previous week. Monitoring of condom use between December 1998 and May 1999 varied between 42 per cent and 47 per cent consistent use.

High levels of STD symptoms continued to be reported in the quarterly survey: 41 per cent stated they had some type of discharge and 19 per cent had either internal or external sores. At the time of survey, 46 per cent had done nothing about these possible infections. Seventeen per cent reported having had anal sex the previous week; it was discovered that the clinic doctor asked if there were anal symptoms, but the women invariably stated there were not, so she did not examine them. Special discussions about anal sex and anal STDs were then started and it was decided that the doctor would no longer ask, but make a thorough examination in all cases. Eventually, anal STDs began to be recorded at the clinic.

## Discussion

In mid-1998, HIV had still not reached Tangail brothel, though the prevalence at other brothels was recorded as 15 per 1000. Tangail women still have problems visualizing the disease. They have asked for pictures and when shown them, felt they did not look frightening enough. Those in the power structure, including *babus*, continue to give a great deal of verbal support to the project, but do not seem to be altering behaviour very quickly. The maintenance of the project by the sex worker committee will be hampered unless the power structure gives in to various demands, many of which the women still feel powerless to make. A move has been made to address one of the most troublesome issues to the women, being allowed to be

buried in a regular Muslim cemetery, and, like the shoe-wearing taboo, they have learned that there is no law against their being buried along with other citizens. There will have to be pressure to change this custom in practice, which will be more difficult if community members think the women have died of AIDS. At present, the brothel is seen as relatively safe and its size is increasing each year. In 1998 about 50 new women joined, mainly the younger sisters of sex workers already there. When queried, they stated that their sisters were safer at the brothel than in the villages, given that many were fatherless and likely to be raped before marriage. Police interference has remained minimal but the women fear that when all CARE personnel are gone, it will increase again.

Facilitating the women's access to what they need, and diminishing the tyranny of the power structure will be required before the Tangail brothel is one in which women control their own occupational safety. Community empowerment as a strategy is espoused by some staff members, but brisk competition among NGOs in Bangladesh contributes to fears of the project's withdrawing from the brothel, lest another organization enter. Given the needs of the surrounding society to keep prostitution highly stigmatized, it is unlikely that empowerment can come about without confronting society's hypocritical attitudes that permit men to demand the services of sex workers, but punish women who work in the trade. By mid-1999, the political impetus to rid the country of prostitution had grown, with internationally-funded projects to rehabilitate brothel and street-based sex workers through marriage and low-paid, more respectable jobs, such as street sweeping. Violence against sex workers had also grown, although at the time of writing, Tangail brothel was not yet been affected. Coercive policies, including the closure of brothels and the eviction of women, are under way. When, in July 1999, murder and threats of eviction occurred in another brothel nearby, Nari Mukti Shango rallied and sent dozens of women to public demonstrations of sex worker solidarity.

The SHAKTI project has a battle against time, trying to strengthen the sex workers' organization and capacity to demand their legal and human rights before a political impetus pushes government into regulating prostitution in its own manner.

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