



**REVIEW OF EXISTING AND EMERGING PATTERNS  
OF SEX WORK IN BANGLADESH IN THE CONTEXT  
OF HIV AND AIDS**



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A STUDY ON BEHALF OF  
REGIONAL SUPPORT TEAM, ASIA AND THE PACIFIC, UNAIDS

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## Acronyms

AIDS	Acquired immunodeficiency syndrome
BSS	Behavioral Surveillance Survey
CARE	Cooperative for Assistance and Relief Everywhere, Inc
CBO	Community-based organization
DFID	Department for International Development (United Kingdom)
DNS	<i>Durjoy Nari Sangha</i>
FHI	Family Health International
FSW	Female Sex Workers
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GOB	Government of Bangladesh
HIV	Human immunodeficiency virus
HSV-2	Herpes simplex virus–2
ICDDR B	International Centre for Diarrhoeal Disease Research, Bangladesh
IDU	Injecting drug users
INGO	International Non-governmental organization
MSM	Men who have Sex with Men
MSW	Male Sex Workers
NASP	National AIDS and STD Programme
NGO	Non-governmental organization
NMS	<i>Nari Mukti Sangha</i>
STD	Sexually transmitted diseases
STI	Sexually transmitted infections
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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## EXECUTIVE SUMMARY

This study was commissioned by UNAIDS to review the existing and emerging patterns of sex work in Bangladesh in the context of the HIV epidemic. It was a rapid ethnographic snapshot; validating some of the secondary data with perspectives from the ground level informants including gatekeepers from the government, research organizations, civil society and the communities. The study used key informant interviews and focus group discussions as its method. The field study was for 5 days and the study was completed over one month's time.

### FINDINGS :

#### Sex Work Scenario

Sex work in Bangladesh has traditionally been brothel-based. The past decade has seen the growth of newer typologies. Street-based was the first one to be identified. Hotel and residence-based operations are more recent trends. The last two categories are more fluid with some overlap between them. In fact, while there has been no increase in the numbers in brothels, a growth has been seen in street-based, hotel-based and residence-based sex work.

Sex work appears to be moving from institutionalized settings mediated by *dalals* (pimps), brokers and *sardarni* (madams) to individualized operations, which have limited intermediaries. Hotel Managers and pimps do play an intermediary role in several settings, but women now do retain some autonomy and control over choice of customers and over their earnings. Communication technologies like Internet and mobile communication tend to strengthen the network between clients and sex workers in hotel and residence-based sex work.

Hotel-based and residence-based sex workers are also largely partially hidden sex workers, who may practice it on a part time basis. This commercial sex activity is changing contours and moving into difficult to reach areas, which escape HIV prevention interventions.

#### Risk Profile

Bangladesh has had an HIV response in place for the past 12 years. It has also maintained a low HIV prevalence. Yet, the risk and vulnerability profile of various populations has not adequately changed. STI prevalence is quite high, with a majority of women in sex work in all settings (hotel, brothel and street), reporting lifetime prevalence of at least one cervical or vaginal infection. The client turn over is high with hotel-based sex workers having up to 40 clients a week (the highest reported in Asia) and

condom use is still low with only about 40 % overall reporting condom use with the last client, and only 14 % reporting consistent condom use, with regular and new clients. There is a high level of non-marital sex in Bangladesh but the risk perception is low, despite high awareness about HIV. The increasing mobility and purchasing power of men is having its impact on the demand for sexual service.

There is also a considerable overlap of the sexual networks between female sex workers, IDUs, and male sex workers adding to the risk within these populations. While male circumcision could be contributing to keeping HIV down in sexual transmissions, this protective cover is absent in IDU epidemics. The overlapping sexual networks thus increase risk for all these populations.

### **Interventions and coverage**

Interventions have been able to reach a significant number of brothel-based and street-based sex workers. All the nine identified brothel areas have been covered; street-based sex work interventions, particularly in Dhaka and Chittagong, have achieved good coverage. Street-based sex workers have benefited from interventions, which address their specific contexts. However, considering the mobile nature of street-based sex workers, sustained interventions are needed for longer periods of time in the different sites, in order to move beyond individual behavior change to community norm change in terms of safe sex, and health seeking practices.

The coverage of hotel and residence-based sex work is however poor. Residence-based sex work, as an emerging category, has not been systematically mapped or enumerated. Since most of the hotel or residence-based sex worker are hidden and may be practising sex work on a part time basis, they need interventions which are different from the current models so that their identity as 'sex workers' does not threaten their other identities. The interventions have to be less intrusive, use a mixture of staff and peer groups, and focus on service delivery.

The impact of the existing interventions can be seen in the gradually decreasing STI rates, as well as increasing use of condoms. But these interventions need to be stable and continuous over a longer period of time to ensure that these trends sustain, and significantly reduce the HIV risk. This means that there needs to be better consistency in funding support for the interventions across different categories of sex work.

### **Rights Based Framework and Empowerment**

In Bangladesh, there has been a constructive synergy between HIV prevention efforts and larger efforts at empowering sex workers and helping them claim their rights. These empowerment efforts have had

Significant impact in changing power relations related to sex work. The brothel-based committees are having an influence over the life of women in brothels both with regard to violence by the *sardarni*, law enforcers, clients and pimps as well as the availability of condoms and STI services. However despite reports of a declining trend, bonded sex work is still reported by all the stakeholders,.

What is striking in Bangladesh is the large-scale ownership of these issues by women in sex work. These influence various processes of confronting violence, demanding rights and negotiating safe sex. This position of demanding social justice has drawn in other women activists and gained the sex worker movement a larger platform.

### **Drivers**

Socioeconomic factors like poverty, lack of employment opportunities, lack of adequate wages, or lack of freedom at home are factors which seem to drive women into sex work. Sexual exploitation at home, or at the workplace, also influences women's choice to enter sex work. Trafficking both within the country and across the borders is a related problem. Yet trafficking is not limited to overt abduction and coerced sex work. It also takes a more subtle form of luring of young women and girls into sex work.

At another level, the changing social environment and increasing the empowerment of women has created aspirations for a better life. The socioeconomic changes and globalisation that is sweeping through Bangladesh is bringing women to the cities in search of better livelihood opportunities. Most jobs available are low paid and the comparatively more lucrative income that sex work provides do appear to influence the choice to enter sex work as well as to, remain in or re-enter the profession.

### **Other Issues**

The size and diversity of client groups do pose a great challenge. So does the picture of concurrent regular partners for women in sex work. They will need to be have to be addressed.

The vulnerability in relation to trafficking/migration has not been adequately explored. The vulnerability reduction being taken up through life skills education of youth and adolescents is critical, but these need to be backed up by economic opportunities. The emerging strength of the sex workers' organizations and their rights based capacity need to be harnessed to reduce both their overall vulnerability and the specific risk of HIV infection.

### **Summary of Recommendations**

1. Conduct in depth situational assessment (ethnographic study) as well as mapping, estimation and enumeration of the emerging group of residence-based sex workers, in order to

understand needs, dynamics and current coverage.

2. Identify different models for interventions with residence- based sex workers, who are hidden and therefore need less intrusive, more service linked interventions with a mix of staff and peers carrying out the interventions, so that their identity as sex workers is not exposed.
3. The overlapping of sexual networks among the people with high- risk behavior means surges of prevalence in any one group can compound the risk for the other groups as well. Therefore interventions across the different groups need to be stepped up, with tight linkages between them.
4. Vulnerability Reduction among in women before and after they enter sex work needs to be an important objective of the new national programme with specific focus on age of entry, coercive entry and livelihood related vulnerability.
5. Both risk reduction and vulnerability reduction are a priority, and need consistent funding. They should be seen as complementary, and not replacing each other.
6. The women's movement needs to be involved in some of the crucial empowerment issues like stigma and discrimination towards sex workers, access to critical services and intimate partner violence.
7. Organisations of women in sex work have a critical contribution to make in reducing HIV risk as well as vulnerability in their constituency. There has to be a significant Institution building and leadership development in these organizations.
8. In the context of a huge potential client population which defies classification, larger communication based interventions and intensive workplace interventions are needed. The two risk factors of unprotected sex, and concurrent multiple partners across different sexual networks should be key reiteration area.
9. A multi-sectoral response including relevant agencies at the national and local levels, and including engagement with the relevant ministries is needed. NASP,s management capacity needs to be enhanced to serve as the hub of all national and international interventions with women in sex work.

## Chapter 1 Background

HIV prevention efforts across several countries in Asia have shown that the epidemic in Asia is largely moving between nascent and concentrated stages. There are countries, which have sub- epidemics that have generalized, but today there is hope that aggressive prevention efforts can stabilize it.

The route of HIV transmission in Asia has been largely heterosexual, with epidemiological, behavioral and socio economic factors fuelling it. While injecting drug use has been the key driver in certain pockets, this has been moving outward through the spiral of sexual networks, both commercial and non-commercial. The underlying MSM activity with overlapping sexual networks has also been seen as a contributing factor.

The speed with which the epidemic has advanced in each country has depended on several factors like the prevalence of HIV, the nature of sex work and IDU networks and their extent of overlap with the general population. In countries like Cambodia, Thailand and parts of India, the transmission route was identified as being more heterosexual .The response thus targeted high volume sexual activity. Those at risk in this context were women in sex work and their clients. In Countries like China, Indonesia and Vietnam, the entry of the epidemic was through injecting drug use. Now it has moved to the sexual networks of IDUs and into heterosexual transmission routes. Across Asia, the role of MSM networks that has been missed in the early epidemic is now being acknowledged.

The epidemic is heterogeneous across the continent, with stark differences between countries, and even within different regions of the same country, as in India. However, within the context of South Asia, there are some common structural factors, which might drive the epidemic. These include high levels of poverty, illiteracy, social inequality, gender power inequities, and poor health infrastructure and services.

Bangladesh continues to be a low prevalence country, albeit one with very high vulnerability. Levels of risk behavior, in terms of high levels of unprotected sex with commercial partners, and unsafe injecting practices, make the country very vulnerable. Condom use in Bangladesh is reportedly the lowest in Asia, although the figures have been rising, due to NGO interventions. The porous borders with India and Myanmar, which are experiencing concentrated epidemics and high labor migration both within the country and across the borders, increase the vulnerability. The HIV surveillance of 2002 reported a prevalence of about 4% among IDUs in one pocket in Central Dhaka, the subsequent round of survey showed that average prevalence was still 4 % in the area, but one neighborhood reported an increase to 8.9 %. IDUs are not an isolated population, they have considerably complicated sexual networks through their marriage, and high number of commercial or casual sexual contacts and the epidemic can spiral out.

The government's response to the epidemic has been proactive, in terms of putting in place policies, programmes and surveillance systems, Bilateral donors, INGOs such as CARE, FHI and NGOs have been significant players in this response, especially in terms of financial and implementation support. All the UN agencies have come together for a co-coordinated response through the HAPP, which has recently been renamed HIV AIDS Targeted Interventions (HATI) GFATM is also supporting some targeted interventions.

There is however concern that the overall response is not focused enough, that the efforts are too thinly spread. The co-ordination between different civil society partners and the government is also reported to be weak. The interruption in continued funding to critical and successful programmes is worrying.

On the other hand, risk scenarios are undergoing a change. New risk factors are emerging. Sex work in Bangladesh is itself going through a transition phase, like in much of the rest of Asia. Increasingly, women are moving into sex work, due to relative deprivation, rather than absolute poverty. It is no longer concentrated among the brothels, sex workers are moving into hotels and residences. Power structures are different and they need to be understood and responded to. The clients of sex workers also defy description and classification. They are no longer limited to truckers, rickshaw pullers, and migrant laborers. They include students, businessmen, uniformed personnel, civil servants and people in service etc.

Towards the end of the second decade of the epidemic, it is important to understand these changes and examine them in the light of existing policy and programme.

UNFPA with UNAIDS Secretariat have taken the lead roles in addressing sex work in collaboration with UN and Civil Society Organization partners. As a result, the United Nations Regional Partnership Forum on HIV and Sex Work for Asia and the Pacific was established on 7 November 2007 to provide assistance to countries to address HIV prevention in sex work through (a) regional advocacy and partnership, (b) policy coherence and coordination and (c) lesson learned and progress monitoring. This forum functions from mid 2007 to mid 2009.

In order to identify strategic approaches, an evidence based review and broad based discussions are needed. This review is designed to provide an exploratory glimpse into some of these areas. Recommendations made from this review could be useful for country programme formulation, programme design and regional programme planning and for future in-depth probe.

## Chapter 2 Methodology

UNAIDS Regional Support Team, Asia and the Pacific, Bangkok commissioned a rapid assessment with the following terms of reference:

Review existing and transition patterns of sex work in Bangladesh and identify points of entry for different types of sex work settings, identify strategic approaches and recommend on how to improve access to and implement effective interventions for sex workers and clients.

### Objectives

Thus objectives of the study were to examine:

- Existing patterns of sex work, relating to women in sex work, including environment; type of setting/ power structures / intermediaries/ sexual networks
- Emerging patterns including, patterns of operation, power structures; any shift from institutionalized to individualized operations, sexual networks and overlaps
- Different types of sex work practiced by women and drivers /entry points for each type STI/HIV situation; anecdotal as well as quantitative information
- Determinants of HIV in sex work
- Sex worker impressions and validation of any secondary data that is available.
- Currently how the programme addresses the needs of emerging groups: issues of access to information, peer support, condoms and STI services

The study consisted of a review of web-based literature and a field study.

### Literature Review

A web based literature review was conducted and articles and studies available online formed the preparatory work to design the field study. The field study was designed based on the Terms of Reference and information emerging from the literature. It was decided to base the study on primary and secondary data.

### Secondary Data

The secondary data reviewed included the following documents (see references for detailed list)

- Relevant National policy documents
- National Strategic Plan
- Surveillance data ( Serological surveillance and Behavior surveillance)
- Details of all existing mapping and estimation data
- Published data on current intervention models
- Documentation of interventions ; current NGO /CBO reports of interventions

- Analysis /synthesis documents
- Journal articles not on the web
- Other unpublished reports and documents

### **The primary data collection**

The field study consists of a few key informant interviews, and Focus Group Discussions, with women in sex work in different settings: brothel-based, street-based, hotel-based and residence-based. The researcher also interacted with some clients of sex workers and other women and girls in impoverished circumstances, as well as some college students.

The primary data , using qualitative methodology was collected in Dhaka and Tangail over five days through interviews with 25 key informants from the government, UN agencies, NGOs, donor agencies, and CBOs and community members ( *list attached as Annexure 1*)and through 5 focus group discussions with the following:

1. Street-based sex workers: Dhaka
2. Peers of a brothel-based programme : Tangail
3. Non peer sex workers in a brothel –based setting : Tangail
4. *Sardarni* (Madams) and Aging sex workers : Tangail
5. Hotel-based and residence-based sex workers : Tangail

### **Tools and Processes**

The tools that were prepared for this study were

1. An FGD guide for women in sex work (*Annexure 2*)
2. Probe matrix for key informants (*Annexure 3*)

The paucity of time led to a snowballing method of key informant selection. Under different categories: UNAIDS staff, Government officials, NGO staff; CBO staff, general sex worker communities and general community of women.

Secondary data reviewed included national policies and programmes regarding HIV/STI, various national surveillance studies, existing baselines and situational analysis, reports and studies carried out by different national and international organizations, documentation of relevant interventions, evaluation of different interventions, and position papers of different organizations. This material was collected, when the researcher interacted with the different representatives during the field trip to Bangladesh.

The interviews were unstructured and followed certain broad guidelines of an interview schedule The key informants were people involved in the national response to HIV, at the policy, research and

implementation levels. They were either from the government, from different health research institutes like ICDDRDB and IEDCR, or from national and international NGOs or from representatives of various UN agencies. A detailed list of the people interacted with is provided in the annexure.

Focus Group Discussion were used to gather qualitative data from the different groups of women in sex work. A discussion guide was used to structure the discussion Extensive first hand notes were taken at each of the discussions, the contents of which have been quite useful in the stages of findings as well as analysis.

The process of interviews and FGDs were also taken up during a day's visit to Tangail.

### **Limitations of the Study**

This study is more in the nature of a rapid appraisal aimed at identifying strategic approaches, rather than a comprehensive descriptive work. A major limitation of the study is the very small duration of fieldwork. Although the secondary literature reviewed, as well as discussions with the key stakeholders involved the emerging patterns across the country, the field visit and the group discussion with the female sex workers was confined to Dhaka and Tangail only.

Although an in-depth interview protocol for key informants among sex workers was prepared but due to the limitations of time and the difficulty of selecting adequate respondents from different categories of sex work, in depth interviews of community members was dropped.

The study is restricted to female sex workers and the reference to IDUs and MSMs is in the nature of overlaps only. A detailed study of these two important populations with high risk behavior has not been intended. The study does not get into the crucial aspect of funding of programmes involving sex workers.

Migration and Trafficking are major issues in sex work in Bangladesh. These need to be separately studied to bring out the causal relationships more clearly.

Considering the multi-dimensional vulnerabilities of women in Bangladesh society, which pushed them into sex work, it has not been possible to go deep into the public policy perspective on women. Interaction with the Government of Bangladesh Women Affairs department and partners working in this area were not possible during the study.

## Chapter 3 Findings

### INTRODUCTION

Bangladesh, from the beginning, has looked at the HIV scenario as located on a continuum of risk and vulnerability. *Its National Policy on HIV/AIDS and STD related issues, 1995*, states:

*HIV/AIDS is human development problem fueled by poverty, the inequality of certain sectors, and the presence of other STDs. As a result, the socio-cultural, economic, as well as health determinants of the transmission of HIV/AIDS/STDs must be addressed. In formulating a national policy for HIV/AIDS STD related issues, the need arises to incorporate the above as policy concerns as part of an action strategy for future programmes (Government of Bangladesh, 1995).*

*The National Strategic Plan for HIV/AIDS, (NSP) 2004-2010* again talks about vulnerability. Objective 2 of the NSP is clearly stated as "Prevent vulnerability to HIV infection in Bangladesh Society". This is further elaborated:

*Under the objective 2, the strategies articulated are to reduce vulnerability arising from lack of understanding of HIV epidemic; reduce vulnerability arising from gendered practice; and reduce vulnerability arising from exploitation and abuse. To reduce the vulnerability of youth, the strategies are to strengthen family communication and discussion, create safe spaces and occasions for peer discussion and mutual support, reduce vulnerability arising from physiological immaturity of young women; integrate a human rights based approach to HIV as a personal and a developmental issue into the curricula for education institutions; establish youth friendly health and well being services; reduce the vulnerability of children and young people living with and affected by HIV; and reduce vulnerability of unemployed youth (Government of Bangladesh, 2005).*

Even before this strategic plan took shape, as early as the late 1998, an HIV /AIDS response began to get shaped in two simultaneous streams: the public health and the human rights streams, both running parallel, flowing together at certain times, but directed by two separate strategic perspectives. One looked at transmission dynamics from the epidemiological and behavioral perspective and the other at empowerment, human rights and social justice to carve the path of prevention. This response is reiterated constantly in the vision for the AIDS prevention, as is seen in its national policy, its strategic

plan documents, its surveillance systems and various interventions and analytical studies. It is a fascinating journey and Bangladesh has been able to synthesize these different approaches to a great extent.

Another strength has been Bangladesh's ability, quite early in the response, to look at a wide range of vulnerable populations and the interconnectedness between them, especially the overlapping quality of sexual networks.

Despite these impressive beginnings and a good understanding of the epidemic, there seems to be dissatisfaction among the various stakeholders that these have not been fully translated into practice. There have also been concerns that the NSP has critical gaps. It does not adequately address the central issue of exclusion and related inequities and violence meted out to women in sex work. It has been repeatedly stated that despite articulation of rights in documents, there are not sufficient instruments to address violation of rights related to these populations (Ahmed, 2007).

It has been over two decades since its first National AIDS Committee was formed, and huge technical, human and financial resources have been flowing into the efforts. It is important to stop and reflect on the current scenario and review what has been achieved

This study has examined one aspect of the situation and response, that is, the work with women in sex work. It looked at its history, the impact of the responses and how the changing social, economic and cultural life of Bangladesh has shaped its current profile. It questioned whether the current approaches are adequate and whether new ways need to be devised. Finally it explored the way forward.

## **THE SEX WORK SCENARIO AND THE RESPONSE**

### **The History of Sex Work in Bangladesh**

#### *Social Exclusion and Marginalization of Sex Workers*

HIV brought the lives of sex workers into public focus; the oppressive life of the women in brothels, the denial of their fundamental rights and archaic traditional practices came to light. Although this exploitation and the social marginalization of women in sex work in the brothels in the 90s have all been extensively documented, it is important to look at it again.

It was precisely these factors that created a sense of solidarity amongst them and for them from the world outside. Bangladesh discovered that in a society whose constitution guaranteed fundamental rights of freedom, equality, justice and dignity, there were still practices of segregation and

discrimination. Women in sex work were still denied guardianship of their children, which led to difficulties in establishing a parentage for the child, which in turn denied them admission in schools. Other discriminatory practices like not allowing sex workers to wear sandals or shoes, when they were outside were prevalent. This was so that sex workers could be picked out among other women. In many cases, police prosecuted or fined sex workers who were, caught violating this practice. Sex workers of all religions were denied burial rights (Social Initiatives, 2000).

### ***Defusing Existing Power Structures***

These discriminatory practices shaped the HIV response in Bangladesh in significant ways. The sex workers movement for justice predated the HIV response, with formation of organizations like 'Ulka', even in the late 1980s, and early 1990s (Huq, 2005). But this movement gained impetus with the HIV prevention efforts. When organizations like CARE Bangladesh, one of the first agencies to implement HIV prevention programmes started working with sex workers, their social conscience did not allow them to simply enter and look at STI control and condom use in the context of such deep social injustice. On the other hand, it was very clear that the power structures within and outside the brothel would need to be taken into account while promoting safe sex and thereby preventing transmission. It was evident that such a hierarchical, profit driven power structure needed to be addressed. It was also clear that this would need an alternative structure. CARE conceptualized that a totally different platform was needed to usher in a greater sense of equality and that was – a collective of women in sex work where power would get redistributed. Not new to anyone in the HIV sector today, but path breaking at that time.

### ***Creating a larger platform with women's movements***

The eviction of two brothels in 1999 though devastating for the women concerned, turned out to be the rallying point for sex workers to organize themselves and demand their rights. Despite the predominantly moral view of sex work and of the issue of sexuality in Bangladesh society, it became the issue around which many NGOs which had till then not openly confronted the larger social systems which marginalize sex workers, also came out openly in support of the sex workers. As Shireen Huq of the Institute of Development Studies, puts it,

*Our engagement in sex workers' struggles to defend themselves against illegal eviction threats from the brothels gave new meaning to the discussions on sexuality and sexual rights that had taken place inside Naripokkho (Huq, 2005).*

Eighty-four women's and human rights' organisations and development NGOs representing a wide spectrum of views on social change had come together to form *Shonghoti* (solidarity), an alliance in

support of the rights of sex workers. The campaign to support the rights of sex workers in which *Naripokkho* was involved throughout the decade of the 1990's, not only mobilized a whole new constituency of women for the movement, it also challenged the concepts, views and attitudes of its own members (Huq, 2005).

This acceptance within the elite among the women's movement provided visibility and a different social status to the movement of women in sex work. It also helped to redistribute power within brothels. Human rights could be discussed, rights and entitlements claimed from the outside world. Within the brothel, too, this was not without an impact. Women were more empowered, and life within the brothels changed significantly.

### ***The role of the media***

Media was highly influenced by the plight of the women during the eviction, and took their part during this whole campaign against eviction. This process also helped to sensitize the media on various issues around the larger discourse on rights of women in sex work. *Naripokko's* adoption of the slogan of '*Shorir amaar, shidhanto amaar*' (*my body, my decision*) from the women's movement to this context was not without impact. Whether there was total acceptance of it or not, it brought the debate into the public domain and helped create newer perspectives.

*The shift in terminology used by the print media was particularly noticeable as "jouna kormi" (sex worker) came to replace "potita" (prostitute, but literally meaning 'the fallen one'). This change in terminology actually meant that we had changed the terms of the debate so that women in prostitution could no longer be seen as objects of pity or of moral opprobrium, but that by renaming prostitution as sex work, women engaged in the trade could be addressed as workers who were socially acceptable rights holders (Huq,2005).*

### ***Judicial recognition***

It all culminated with the High Court Verdict in 2000. This was a landmark decision, declaring the eviction as illegal and thereby implicitly recognizing the profession of sex work (Bondurant *et.al.* 2007). This is hailed as a landmark response by the human rights activists and women in sex work.

### ***Legal environment***

The HIV-related legal framework in Bangladesh, however, continues to be ambivalent. The Constitution declares that the State shall adopt effective measures to prevent 'prostitution' as a fundamental state policy, and there are laws against prostitution-related offences such as soliciting in a public place, and

trafficking women and children for the purposes of prostitution. The Oppression of Women and Children (Special Enactment Act 1995) prohibits trafficking of women and children for the purposes of prostitution. However, a woman can work legally as a sex worker if she swears an affidavit at a Magistrates Court saying that she is over the age of 18, and is working as a sex worker 'willingly and consciously'. Thus, at one level, both the law and the judicial verdict recognise sex work as work, but another arm of the law uses parts of the law to penalise and harass women in sex work. The Code of Criminal Procedure (section 54: arrest without a warrant), the Penal Code, (section 33: prohibiting carnal knowledge against the order of nature) and the Dhaka Metropolitan Police Ordinance 1976 (section 86: penalty for being found under suspicious circumstances between sunset and sunrise) are used to harass, assault, extort money and/or to demand free sex from sex workers and MSM. (Bondurant. *et al.*, 2007). This ambiguity allows individual police officers to arrest sex workers at will. These laws also apply to harass the outreach workers who try to provide services to these populations (Ahmed, 2007). The law is silent on transgender issues and transgender experience multiple forms of discrimination that limits their ability to access HIV prevention and care services (Bondurant *et al.* 2007).

Decriminalization of sex work has been the demand of national sex work organizations and other civil society organizations working in the area of rights and HIV prevention. However, the transformation in the larger social environment is yet to take place.

### ***The formation of Community Organizations: Sex Worker Networks***

Another significant milestone in the history of the sex worker movement was the formation of two Community Based Organizations (CBO) in 1999, *Nari Mukti Sangh* among the brothel-based sex workers in Tangail, and *Durjoy Nari Sangh* among street-based sex workers in Dhaka. These CBOs have, over the last eight years, also successfully synergized the two perspectives, guiding Bangladesh's prevention efforts. They articulate the sex workers' demand for human rights and social justice while playing the central part in HIV prevention efforts among sex workers. Their efforts have been to claim their rights and entitlements as enshrined in the constitution and simultaneously initiate/ strengthen the accessibility and availability of necessary services, to enhance the quality of life of sex workers and promote safer sex practices.

## **SEX WORK AND HIV: RISK AND VULNERABILITY FACTORS: THE SITUATION TODAY**

The recent *Assessment of Sexual Behavior of Men in Bangladesh: a Methodological experiment* reports non-marital sex by 27% of never married and 13% of ever married men in the previous year. Previous studies of smaller samples present a range of 8% to 56% non-marital sex, but this study had a

more representational sample. Of these 9.9% were commercial sex interactions. These included all categories of sex work amounting to 19.2 million sexual encounters with sex workers annually involving men in the age group 18-49. This is a cause for concern as 40% of these were unprotected sex encounters and around 20% of them had 3 partners or more (FHI, 2006).

Bangladesh has several types of sex work settings, which can be broadly categorized into:

1. Brothel-based Sex work
2. Street-based sex work
  - includes floating sex workers at all public places like launch stops, bus stations, railway stations
  - includes sex work in border areas
3. Hotel-based Sex work
  - includes guest house based also
4. Residence-based sex work

**TABLE 1: SIZE ESTIMATES OF POPULATIONS AT MOST RISK IN BANGLADESH AND AVERAGE ESTIMATED NUMBER OF PLWHA IN EACH GROUP**

Populations at most risk	Size Estimates Low	Size Estimates High	Average Estimates of PLWHA
Injecting Drug Users	20,000	40,000	444
MSM and MSW	40,000	150,000	450
Brothel-based sex workers	3600	4000	55
Street-based sex workers	37,000	60,000	453
Clients of female sex workers	1,882,080	3,136,800	1,882
Hijras (Transgender)	10,000	15,000	62
Returnee External Migrants	268,000	536,000	3,015
<b>National Total Populations at Most Risk</b>	<b>2,274,680</b>	<b>3,967,800</b>	<b>6,489</b>
National Total Population at lower risk *	1,191,559	2,012,375	1,188
<b>Estimated National Total Average Number of PHWHA</b>			<b>7,677</b>
National Range of PLWHA – 7000-19,000		National Avg PLWHA – 8,000	

\* Partners of people with high risk behavior, TB patients and blood transfusion recipients

Source : Based on BSS VI data, cited in FHI 2007.

The seventh round of serological surveillance was conducted between January 2006 and June 2006. More than 10,300 individuals were tested across 43 urban sites around Bangladesh. The geographical coverage of injecting drug users has increased dramatically over the rounds, with only one city being covered in the first round in 1998 to 18 cities tested in 2006.

The population groups considered to be most-at-risk have been the same over the years and for the most recent round of the serological surveillance they included:

- female sex workers in brothels, hotels, streets, and casual (part time)
- male sex workers
- males who have sex with males (MSM)
- transgender (*hijras*)
- injecting drug users (IDU)
- heroin smokers.

**TABLE 2: PREVALENCE RATES ACCORDING TO BANGLADESH HIV SURVEILLANCE - ROUND VII**

Surveillance Round		No. of people with high risk behavior tested	HIV Prevalence
1	1998-1999	3886	0.4%
2	1999-2000	4634	0.2%
3	2000-2001	7063	0.2%
4	2002	7877	0.3%
5	2003-2004	10445	0.3%
6	2004-2005	11029	0.6%
7	2006	10368	0.9 %

Source: *Bangladesh HIV Surveillance - Round VII*

Bangladesh estimated the size of risk population in 2004 and revision of that estimate is currently underway and is expected by March 2008. However, there is a concern that the estimate may have a quantitative bias and may not take into account either the dynamics of risk behaviors or programmatic issues.

The three major sex work settings in Bangladesh that have been studied more extensively are brothels, hotels and the streets. Although residence-based sex work is also reported, this has not been the focus of any study so far. An empirical profiling of 220 sex workers, from these three different categories showed that typically the sex workers were in the age group of 15-24. The hotel-based sex workers

were generally younger. Few older women, in the age of 30-34, were sex workers, and many of them operated in street-based settings (Ullah, 2005). BSS VI reports that HIV prevalence among sex workers in all settings is less than 1 %.

## **SITUATION AND RESPONSE ANALYSIS: BROTHEL-BASED SEX WORK**

### *Profile of women in the brothels*

As seen, of the estimated 90,000 sex workers in Bangladesh, 4192 are reported to reside in brothels (Ahmed, 2007). There are 14 acknowledged brothels in the country where interventions are taking place. 7 are in Dhaka, 6 in Khulna and one in Barishal division. According to BSS VI, more than a half (59.7 percent) of them have no education. Although, a small portion (1.9 percent) of them are currently married but more than one-third (36.9 percent) are currently living with regular sex partners. A brothel-based female sex worker, on an average, seems to stay in the profession for more than 6 years (Government of Bangladesh 2005).

### *Entry mechanisms and determinants*

An anthropological study done in Daulatdia Brothel in 1993-1994 (Blanchet, 2001) estimated that 40% of the women in the brothels were below 18 years. This study reports that of the 92 case histories recorded, 25% had voluntarily come in and 25% were born in the brothel, but 50 % of the women were sold to *sardarnis* from outside (Blanchet, 2001)

While a lot of the focus has been on cross border trafficking, more and more organizations are looking at internal trafficking. Figure 1 refers to cross border trafficking, but much of it is very relevant to the process of procurement of young women into the brothels (Gazi *et al.* 2001). In the area of trafficking of women and children for labour, or employment of women and children in sub-optimum conditions, there seems to be significant commonality between cross border trafficking and internal trafficking. It seems difficult to separate trafficking for sexual services from trafficking or luring for labour with low wages. Sexual exploitation in the latter situation seems to eventually end in sex work. In the brothels, the intention of drawing the young girls working as domestic workers into sex work has no ambiguity. They were sold into the brothels for only one purpose: sex work. But often in other settings it is labour under inhumane or unacceptable conditions, which include extreme vulnerability to sexual exploitation. What is important is the physical and psychological impact on women and children, who are forced to cope with life, after they have been lured or coerced into working in adverse conditions. As

Blanchet states, "Lured, deceived, cheated, deprived of freedom and/or income, compelled to engage in work against their will, women who are trafficked painfully learn and acquire skills useful to their survival. In an adverse situation the incentive to learn can be very strong. After being trafficked, life goes on with the need to earn, tackle risks and manage in an environment offering poor protection. There is usually no return to a pre-trafficked situation." (Blanchet, 2002).

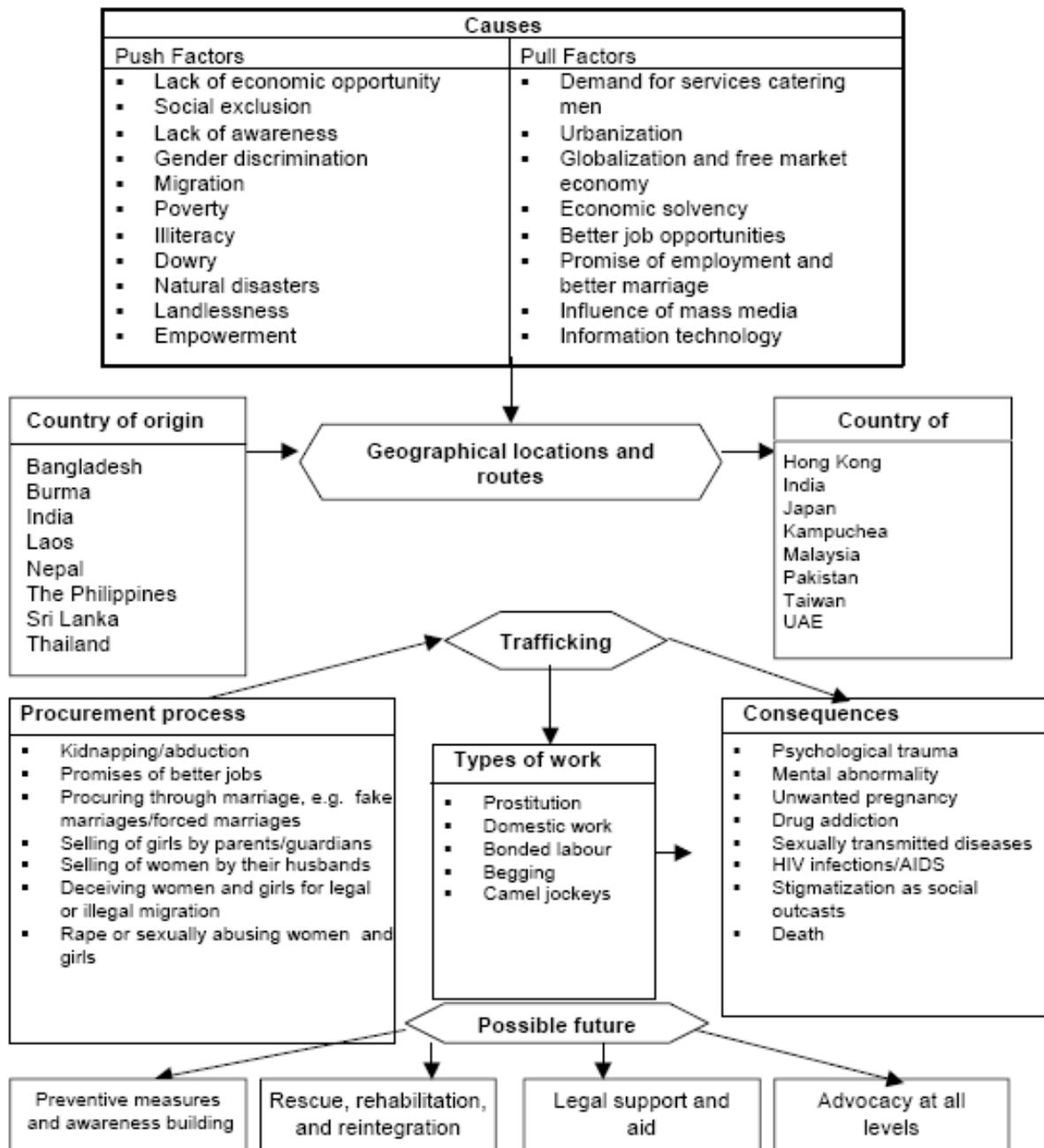


FIGURE 1: CONCEPTUAL FRAMEWORK OF THE TRAFFICKING PROCESS

Source : Adapted from Proceedings of the Fact-finding Meeting and the National Workshop on Trafficking in Women and Children Dhaka : Center for Women and Children Studies, 1997 (18) cited in Gazi et.al. 2001

### ***The brothel subculture in Bangladesh***

The brothels in Bangladesh have a unique subculture. They are really a community of residences, each controlled by a *sardarni* or madam. The brothel hierarchy typically has the bonded sex workers (*chukris*) on the lowest level, then the *bharatias* (independent sex workers), *sardarnis* (madams) and *bariwalis* (referring to madams, who also entertain clients). It may vary from brothel to brothel, but each brothel could have around 6-10 women with their own rooms where they entertain clients.

### ***The special vulnerabilities of bonded sex workers***

The numbers of *chukris* has always been difficult to estimate on a larger scale as their status in the brothel is illegal: They have been trafficked and sold into the brothel, have most of the time, been provided with a false affidavit of being over the age of 18 (Ara, 2005) and have had all their earnings taken away, this information about the bonded status is kept completely hidden to all outsiders. *Sardarnis* claim the girls to be their own or adopted daughters. The BSS VI round reports the average age of a brothel-based female sex worker is around 22 years old. It could also be based on the false records provided. Anecdotal evidence points to a much larger proportion under the age of 18 and more than a 0.5 (59.7 percent) of them have no education.

Although much has been gained by the various rights based intervention with sex workers, bonded girls continue to exist. All NGOs/ CBOs working in the field acknowledge it. In focus group discussions, sex workers themselves acknowledged it,

Of all kinds of sex workers, *chukris* appear to be the most vulnerable with serious threat to their mental and physical health. Obviously, their risk for HIV and STI is extremely high. Many of these girls were 10 or 11 when they were sold and the average age of entry into the profession is reported as 13.5 years (Blanchet 2001). Even today, it is no different. This was confirmed in all the key informant interviews and FGDs. The *chukris* are reported to have no control over choice of clients, number of clients or the income they generate; in fact, their life in total. The rates of condom use are lower than among them than other brothel-based sex workers. Their client volume is also very high in the 3-4 primary years because of high client choice and the desire of the *Sardarni* to realise the amount she paid for her. Always under the watchful eyes of the *Sardarnis*, the *chukris* are waiting to run away and often do so with the help of clients. This is one population that is reported to love power cuts!!! The *chukris* have been often found to run away under the cover of darkness.

### ***Initiation of children born in brothels into sex work***

Therese Blanchet's study on the Daulatdia brothel indicates that a possible 25% of the sex workers

working in the brothels are born there. Information from other brothels is very varied. Key informants stated that many mothers continue to initiate their daughters into the profession. Most children appear to be psychologically pressured by their guardians, biological mothers, or *bariwalis* (adoptive mothers) or *sardarnis*, (brothel mothers) Childhood having been snatched away from them, often their security lies in compliance and pleasing the “mothers” (Blanchet, 2001).

Added to this, social norms and social stigma prevent most of these children to have a life outside the brothel, increasing their risk and vulnerability in every way. Schooling or any education for these children is still a problem. Where available, as in Tangail brothel, where the NGO has started a non-formal education centre for children, it restricts interactions with other children in the outside world, and normal child development. Choices in life are extremely limited, if not non-existent. Whether all these women in sex work really had a ‘choice’ to enter sex work, as children, remains an issue.

### ***Aging sex workers or “Mashis”***

Another group among the brothel-based sex workers, who need attention is the *Mashi* or aging sex workers. They are generally over the age of 35 or 40, and no longer have any clients. The reality of lives of women in sex work are such that years of high income are very short. Lifestyles and power structures do not promote savings or planning for times of need. These women are essentially left with no economic security, when their working days are over.

A few of the older sex workers may go out and establish themselves in the larger society outside of brothels. However, many of them continue to remain in the brothel. Those with adequate savings and contacts, become *Sardarnis* or *Bariwalis* perpetuating the same exploitative cycle with new *chukris*. The rest remain as unpaid domestic workers within the brothels. Some kind of social and economic security for them needs to be addressed. *Durjoy Nari Sangh* and *Nari Mukti Sangh* have started seriously looking at these issues, currently in terms of income generation activities (Mishra and CARE Bangladesh, 2007).

### ***Impact Mitigation***

In the current scenario, it is widely accepted that rehabilitation of all sex workers, or even of all brothel-based sex workers, is neither necessary nor possible. The independent sex workers certainly do not wish it. The demand is high and few livelihoods (given the education and set of skills the women have) seem to match the income generated by sex work. Rescue and Rehabilitation methods have limited value as even in situations of coerced entry, social conditions and stigma prevent the women from wanting to return (Blanchet, 2001).

However, coerced entry of very young sex worker is both an ethical and an HIV risk issue. The situation of the aging sex workers also requires attention, as in the absence of alternative livelihoods, there is reportedly a high likelihood of them bringing in girls under the age of 18, or buying trafficked girls as bonded workers. These questions certainly need to be addressed.

*The National Strategic Plan* also recognizes the social and economic circumstances that force some women into the profession and that it may not be possible to do away with sex work

*The ultimate goal with regard to prostitution should be to offer women, men and children realistic alternatives, so that they will not be induced into prostitution neither by a person, nor economic nor by social circumstances (Government of Bangladesh, 2005).*

Even though this may sound moralistic, there is an understanding of the lack of realistic alternatives for women, and the socio-economic vulnerabilities. For, sex work as work can only gain universal acceptance when it is a choice, and not a coercion. There has to be caution, however, that this concern to reduce vulnerabilities does not result in forcible rescue and rehabilitation measures .

### ***Impact of initiating empowerment processes***

How then have the rights-based approaches adopted and the empowerment processes invested in, borne fruit?

Meetings with sex workers revealed that the numbers in the brothels are declining slightly as independent sex workers in the brothels are leaving to set up residences outside. There is sense of newfound confidence and courage to break the shackles of the stigmatizing and exploitative situations in the brothels and set up shop by themselves.

Even within the brothels, a formal mechanism of redistributing power has been the setting up of Brothel Committees by the NGOs and CBOs. These committees, which are now functioning in all the brothels, have managed to gain a voice and have a certain social standing in the brothels. They are attempting to address the issue of condom use and negotiation with clients and have very actively promoted condom availability.

In one focused group discussion among the brothel-based sex workers, the women reported that condom increased from about 20% a few years ago to a current level of about 70 %. Although this could be a socially desired response, with the presence of NGO staff in the group, it can be accepted that various influences are contributing to an increase in condom use.

The women in the focus groups also reported that there is action now about the entry of young girls. Identity cards are being denied if actual age is lower than that indicated in the affidavit. The brothel committees are immediately informed of the girls and the committee would inform the "thana" and action would be initiated as per the process. While women reported that the committees took a strong position on coercion and bonding, and also reported freeing many bonded women, NGOs acknowledge that although there may be a reduction in the number of bonded women, the problem has not gone away. With the high commercial element involved, a much more strident role of the sex worker networks may be needed to support the brothel committees to achieve this.

Yet, a larger achievement of these committees has been creating a greater self-esteem among the women. In turn, this has enabled them to stand up to the existing power structures on various issues. With the *babus*, a change has been noticed in two areas: increased condom use and reduced intimate partner violence. The change in the *sardarni* has also been reported. At least 75% of the *sardarnis* are reported to be treating the women better. Allowing condom use, counseling and regular health check ups including treatment of STIs is a major area of change reported. However, the much more significant gain seems to be their allowing the women to attend Nari Mukti Shangha (NMS) meetings. The brothel committees are also reported to have the power to act on reported violence of *sardarnis* against the sex workers. Some women also reported a change in attitude of police. Women, at least in Tangail brothel, reported decreasing instances of harassment under the different acts, false arrests and demands for exorbitant bribes for release.

Commanding respect from the *sardarnis* and the pimps and negotiating with the police has not happened overnight. But supported by the various rights capacity building programmes initiated by the various NGOs and UN organizations, it seems to be growing. Micro-credit, income generation and savings have also contributed to a feeling of empowerment.

To sum up, visibility, funding, savings, new social status, exposure to the world outside, support of networks from other sectors and different countries all have contributed in creating a high level of confidence in the CBO leaders and among key members in the community. Sex workers now report that there is a greater respect in the way *sardarnis* treat them, the most notable indicator that power structures are indeed getting reorganized. What is crucial now is that the committees retain their democratic nature, and do not begin to function as another component in the existing power structure.

## **HIV RISK IN BROTHEL-BASED SEX WORKERS**

Of the nine brothels under surveillance, HIV prevalence has remained low in all of them. However, risks continue with high client volume and turnover, STI prevalence, and non-use of condoms, despite knowledge about the need to use condoms.

### ***Client profile and volume***

The brothel-based sex workers reported that on an average, they had sex six days in the previous week. On an average, a brothel-based sex worker reported approximately 9 new clients as well as 11 regular clients in the previous week. In addition, more than one-third (36.8 percent) of the brothel-based sex workers reported to have more than 20 clients per week. The BSS VI has identified the usual partners of brothel-based sex workers as people in business, rickshaw pullers, truckers and students. Almost one third (32.7 percent) of them also reported having sex with non-commercial partners (Government of Bangladesh, 2005). All this points to not only high client volume and partner turnover, but also high levels of long term concurrent partners, both commercial and non-commercial. Many of the sexual acts with long term partners are likely to be unprotected.

### ***STI profile of brothel-based sex workers***

Total syphilis seropositivity has shown an overall decline in most of the brothels over the six rounds, although in the last two rounds some of the surveillance sites show no improvement. With respect to other STIs, however, the picture is different. Although syphilis prevalence has been taken as a marker for sexual risk, it is possible that addressing syphilis through presumptive treatment within interventions could have reduced its prevalence and hence the HIV risk attached to syphilis. However, this may not be an indicator of risk behaviour as other STIs are reported to prevail. Studies on sex workers in 5 brothels have reported an average of presence of any STI to be 32.7% (Reddy, 2007).

Reports from other cross sectional study presents an even more alarming report. Of the 439 sex workers enrolled from randomly selected brothels, 49.6% had vaginal symptoms and a total of 67.4% were positive for at least 1 cervical or vaginal infection. While the possibility of the use of more sophisticated tests could be one reason, the data taken alongside with the BSS data, gets validated (Nessa *et.al*, 2005).

The 3 rounds of surveillance showed the self reported STIs range from 70% (Round IV) to 54% (Round V) to 63.1% (Round VI). It still remains very high considering that all brothels have been covered with interventions. Treatment access and treatment seeking have improved, but there is still a gap between noticing symptoms and accessing treatment.

### ***Awareness but lack of consistent condom use***

The data reveals that despite awareness about condoms, the use of condoms in different settings is still low. The following table gives the frequency of condom use among sex workers in different settings in the surveillance sites.

**TABLE 3: FREQUENCY OF CONDOM USE IN VAGINAL OR ANAL SEX WITH CLIENTS AND NON-COMMERCIAL PARTNERS**

Indicators % (95 % (CI)	Brothel National (n=683)	Street Central-A (n=438)	Street Southeast- A (n=314)	Street Southwest- A (n=314)	Hotel Central- A (n=337)	Hotel Southeast- A (n=108)	Hotel Southwest- A (n=151)
Frequency of condom use in vaginal or anal sex with regular clients last week (Denominator- Sex workers who reported regular clients last week)	n=669	n=384	n=238	n=271	n=266	n=69	n=121
Always	12.6(10.3-15.3)	34.4(28.4-37.0)	65.6(58.8-71.8)	10.7(7.3-15.4)	7.8 (4.8-12.6)	0	24.8 (17.2-34.4)
Frequency of condom use in vaginal or anal sex with non-commercial partner last month (Denominator sex workers who reported non commercial partner last week)	n=222	n=137	n=161	n=98	n=132	n=53	n=92
Always	5.9 (3.4-9.9)	45.2 (5.0 - 55.8)	55.9 (47.3-64.1)	0	6.9(3.8-12.5)	0	11.9 (6.1-21.9)

Source : BSS VI data, based on Reddy, 2007

If the data on condom use is also looked at, then over the last few rounds there has been a significant improvement. Condom use during last sex with new client shows a shift from 39% (Round V) to 70% (Round VI). With regular clients, it has moved up from 24% to 45%.

However, considering the very large number who reported good knowledge of and very easy access to male condoms it is significant that only 12.6 reported consistent use in the last week with regular clients and only 5.9% reported it with non commercial clients According to one respondent, outreach workers from the community have done a good job by covering almost 100% with awareness but behavior change is lagging behind because of inability to change the unequal power relations completely. *Sardarnis* reportedly do not allow condoms in some of the brothels.

## **THE ROLE OF NGOS**

The NGOs have played an important role in promoting knowledge about STIs and treatment seeking behavior. NGO interventions have promoted treatment seeking from NGO clinics, and medical practitioners, rather than local healers, although the average time between noticing symptoms and seeking treatment is still high at 10 days. One study involving sex workers in a brothel in two interviews over a span of two years (1998 and 2000) showed that treatment seeking at NGO clinics increased, and women reported that they were more open to seeking STI services, since they found it to be the intervention least threatening to their livelihoods (Jenkins and Rahman, 2000). These indicate that while there have been some changes, taken as a whole; levels of risk still remain high. Low HIV prevalence at this point of time may give a false complacency.

### ***Decline in coverage of brothel-based sex workers***

Through HAPP, targeted interventions are being implemented by mostly NGOs and also the sixth round GFATM project has limited targeted intervention coverage. However, the numbers of sex workers covered by interventions in brothels seems to have dropped from 88.5% to 75.4%. The reasons for this drop in coverage are not clear. Irregular or interrupted funding could be a reason for this. There might also be a fatigue with service delivery. It needs to be examined whether CBO priorities have shifted from HIV prevention to other rights and entitlements issues or shifted the focus of interventions to other social entitlement issues. While it has always been clear that both are *concurrently* needed for effective HIV prevention, often once the sex worker CBOs are empowered and have gained capacity, resources are reduced. The purpose of women organizing themselves is to claims their rights and entitlements. But one of them is a right to protect themselves from HIV/ its impact. It can simply not be one or the other Given the dynamic nature of sex work, especially in Bangladesh, where the average number of years even in a brothel is only about 6, addressing new entrants, and an ongoing intensive programme will be needed for much longer.

## **OTHER ENVIRONMENTAL ISSUES IN BROTHELS**

There are other issues concerning life of women into brothels. One is education on and access and availability to contraception. Bangladesh Women's Health Coalition (BWHC) has tried to address this need in its clinics, as it has a larger reproductive health programme and been able to see women in sex work holistically as "women". But this approach does not seem to be universal. Contraception is not available to women unless they come under the "eligible couple" category. Blanchet's analysis of motherhood in the brothels seems to suggest a cultural reverence for the first pregnancy, and a reluctance on the part of any sex worker or *Sardarni* to abort a first pregnancy on the grounds that it may be "inauspicious" (Blanchet, 2001)

Given the fact that formal sexual debut with first client for most bonded sex workers seems to be at the age of 13 or so, contraception education and access seems critical. While condoms are the best option and may be available, there needs to be a backup plan given the low consistent condom use in brothels. At 13, the child can neither deal with motherhood, nor will the *sardarnis* allow them that space. This lack of access to reproductive health services including contraception has been brought up by many stakeholders.

The sex workers also operate in extremely unhygienic conditions. Brothels are crowded, cramped and lack adequate water and sanitation facilities. These are issues, which are strongly articulated by both NGOs and women in sex work as being detrimental to their general health.

## **SITUATION AND RESPONSE ANALYSIS: STREET-BASED SEX WORK**

### **Early interventions and programme formulation**

Recognition of the phenomenon of street-based sex work seems have been there in Bangladesh from the early phase of the epidemic leading to an early intervention by CARE Bangladesh in 1998. Over the years an understandings of its dynamics have deepened.

CARE followed a peer educator model to reach street-based sex workers with behavior change communication, condoms and STI services. This was delivered through a system of drop-in-centers (DIC) which met the need for women living on the streets for basic amenities such as bathing, cooking and resting. Several activities were organized at these centers, which the women could attend when they were "off" work. CARE's intervention helped formulate a national strategy and strategic plan for the Government of Bangladesh 1998-2002. By the end of 2004, it had three DICs for street-based sex work. In addition to CARE, there are other NGOs working with street-based women in sex work On the whole

the work of CARE has influenced street-based sex work interventions by other NGOs too. *Durjoy Nari Sangh* that was set up in 1999 as a CBO of women in sex work with some registered affiliations) and it., contributed significantly to highlighting the plight of street-based sex workers.

## **The current scenario**

A very large numbers of street-based sex workers have been estimated across Bangladesh, which even at the lower end of the estimated range of 37000 – 66000, is high. Significantly, a large proportion of the street based sex workers are covered by NGO interventions. They are highly vulnerable as they practice their profession in public places, with no safe place for the sexual act and no place to negotiate safe sex. They are always on the move and face a lot of violence from the police and *mastaans*. The HIV programme in a way has really made a difference to the lives of these women The drop in centres have provided time and space to discuss client, *mastaan* and police problems as well as risk and STI treatment among themselves. The peer educator model with its on-site supply of condoms has been critical. Durjoy's model of on-site mentoring and crisis support has helped to create a greater confidence and courage, which are critical for life on the street. This was clearly visible to the researcher in the field.

A large number of street based sex workers have been covered by NGO interventions. Based on reports by the different NGOs, it is seen that nearly 26,000 street based sex workers have been reached through the combined interventions of CARE/DFID Programmes, HAPP, FHI and other interventions. 21 NGOs operate interventions in 20 districts of the country including 6 City corporatons. Two regions in Bangladesh, Dhaka and Chittagong, reportedly have excellent coverage of street based sex workers, and this is reflected in their significant decline in STI prevalence, and increase in condom use.

## **Determinants of entry into sex work**

Entry into street-based sex work seems often voluntary, driven by abandonment by husband or loss of social support or having been abused or leaving home due to family conflict. Reports of women coming into street-based work during times of disaster have also been observed. A rise in numbers has been reported, following the recent cyclone.

Being lured into it by *dalal* or pimps is also common. Street-based workers also seek protection from some males; some of them might have a 'station husband', a policeman, who provides them with some security (Ara, 2005). So, although some are bonded to *dalals* or need to pay their daily commission to the policeman or protector, on the whole they have more freedom and control over their earnings.

Although street-based sex workers do not have as high a client turnover as hotel-based ones, this has

changed since the last round of surveillance in both Dhaka and Chittagong with 21%- 28% women reporting this higher volume.

## **STI profile of street-based sex workers**

There have been several studies of gonorrhea prevalence among street-based sex workers, from which an average prevalence rate works out to be 36.7 % (Reddy, 2007). There have been other studies, one study of 269 street-based sex workers in Dhaka attending a government rehabilitation center, reports that the prevalence of any one STI is 84 %, of which 35.5% were positive for *N. gonorrhoea*, 25% were positive for *C. trachomatis*, 45.5% were positive for *T. vaginalis*, 32.6% were seropositive for *T. pallidum*, 62.5% were seropositive for HSV-2, and 51% had infections with two or more pathogens (Rahman, 2000).

Data on STI prevalence and condom use vary from one study to another and across periods of time. Gaps and inconsistencies are reported to be high. Variance in methodologies could be one reason for some of these inconsistencies. Another could be that within a population group, there is constant mobility and the same cohort is not followed up over a period of time. There is a need for more intensive data collection, which attempts to track the same cohort, in order to understand the impact of the interventions.

## **Significant Increase in Condom Use**

Interventions appear to have had their impact as in all the three sites surveyed, there has been a dramatic increase in the sex workers reporting use of condom during last sex with new clients. Khulna (26% in Round V to 51% in Round VI) Dhaka (38% to 81 %) and Chittagong (14% to 91%) This pattern continues with the women reporting a similar increase in use during last sex with regular client. Khulna 15% to 24% Dhaka 34% to 74% and Chittagong 8% to 82%. In consistent condom use, the rise is even more dramatic. Khulna 3% to 24% Dhaka 12% to 43% and Chittagong 4% to 76%.

Even discounting socially desired responses, there is a consistency in this data across related parameters. Even if the limited client population of rickshaw pullers and truckers sampled is considered, both reported higher condom usage over last round (although condom use is still low among them). With heroin smokers and IDUs, again the condom use with commercial sex workers shows a significant increase over last round. The latest FHI study with men also reports as high as a 40% condom use with sex workers. STI symptom reporting by street-based sex work also tallies with these patterns, with a marked decrease in Chittagong (from 84% to 19%) followed by Dhaka (76% to 43%) and Khulna (89% to 67 %).

If all these changes are seen in the context of programme interventions, the gains are directly proportional to the coverage of interventions.. Changes in Chittagong have been attributed by various stakeholders to strong NGO interventions there supported by FHI.

## **Long term interventions needed**

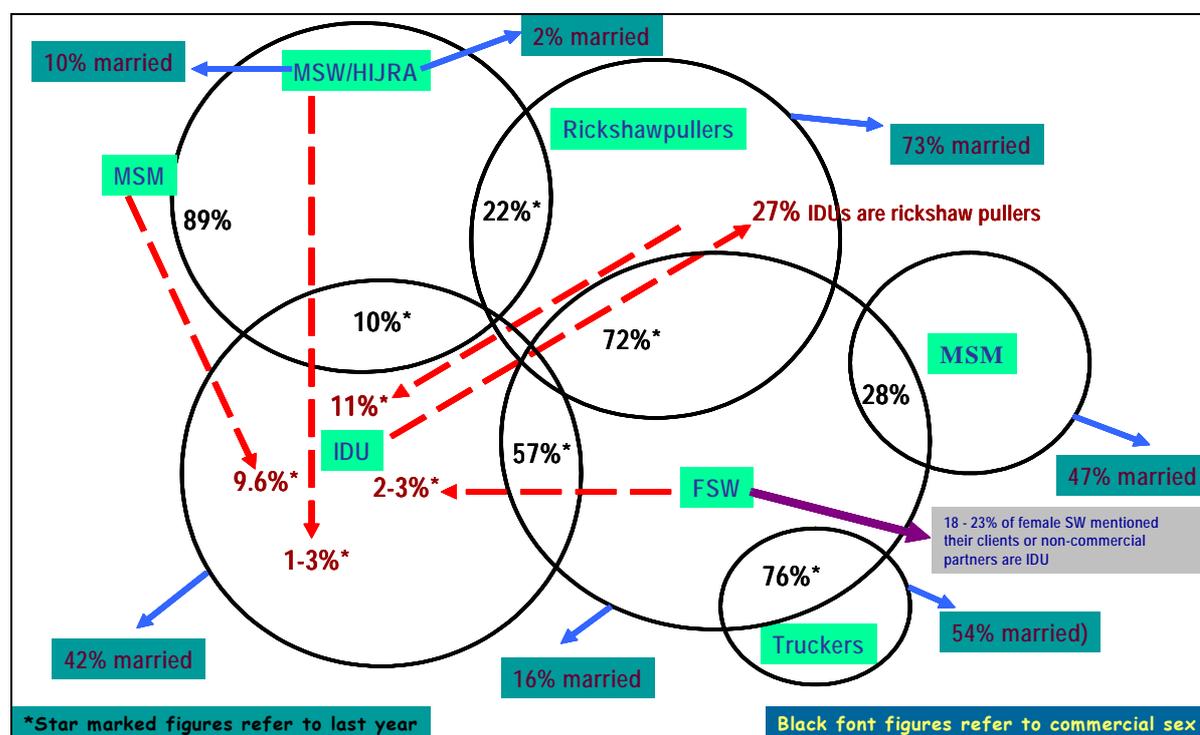
One significant point is that most street-based sex work seems to work only for a period ranging from 2-3 years and then a new crop of street-based SWs take over. This data from BSS VI, then, is very specific to time bound interventions. BSS does not track the same cohort over the different rounds. So the interventions need to go on for much longer. They need to form some sort of collective practice of safe sex, which becomes the norm. The normal time estimated for this to happen is 15 to 20 years. Otherwise although interventions reach individuals in street-based work, there is no sustained change in the setting. The STI prevalence is also dynamic being affected by other contributing factors such as testing mechanisms, methods of treatment etc.

## **Risk Profile of IDUs, Overlapping Sexual Networks and Need for Holistic Programming**

In 2006, in 18 cities that IDUs were studied, HIV was found in four cities (two central cities, and one city each in the southeast and northwest). In one of the sites in central Dhaka HIV prevalence in male IDUs had increased from 4.9% to 7% in just 12 months In another neighborhood it increased from 7.1% to 10.5%. This taken against the context of high STI prevalence doubles the risk for both IDUs and their injecting as well as sexual partners.

The escalation of the nascent HIV epidemic among IDU in some pockets of central Bangladesh has far greater ramifications seen in the light of the interconnectedness between the different populations that have been identified as at risk. The overlap in the sexual networks of IDUs, female sex workers, male sex workers, transgenders, MSM and other client populations has created a great deal of concern among all stakeholders. While male circumcision may have some impact on sexual transmission, chances of transmission through needle sharing remains high. The figure below illustrates the growing gravity of the situation in Bangladesh.

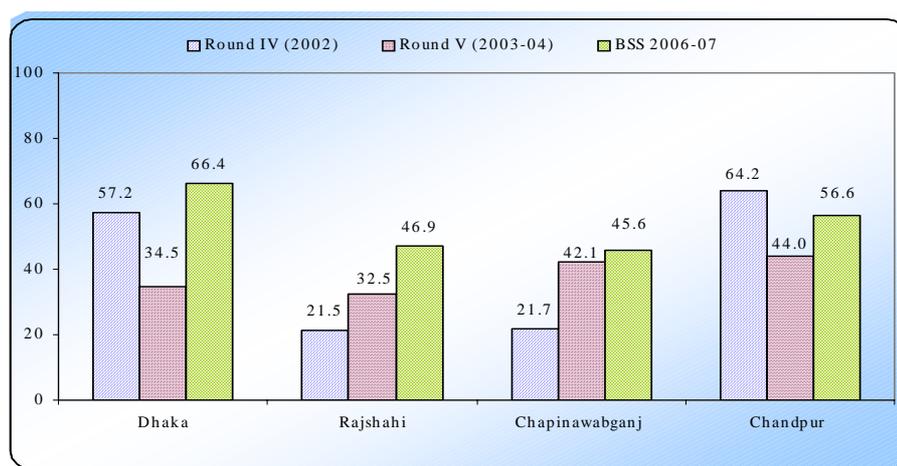
FIGURE 2: INTERCONNECTIONS AMONG THE GROUPS AT RISK OF HIV INFECTION SURVEYED IN BSS4 (2002)



Source: Government of Bangladesh, 2002

The data from BSS Round VI shows that the IDUs who buy sex has increased significantly especially in Dhaka (34.5% in Round V to 66% in the current round)

FIGURE 3: PERCENT OF IDU WHO BOUGHT SEX FROM FSW IN THE LAST YEAR

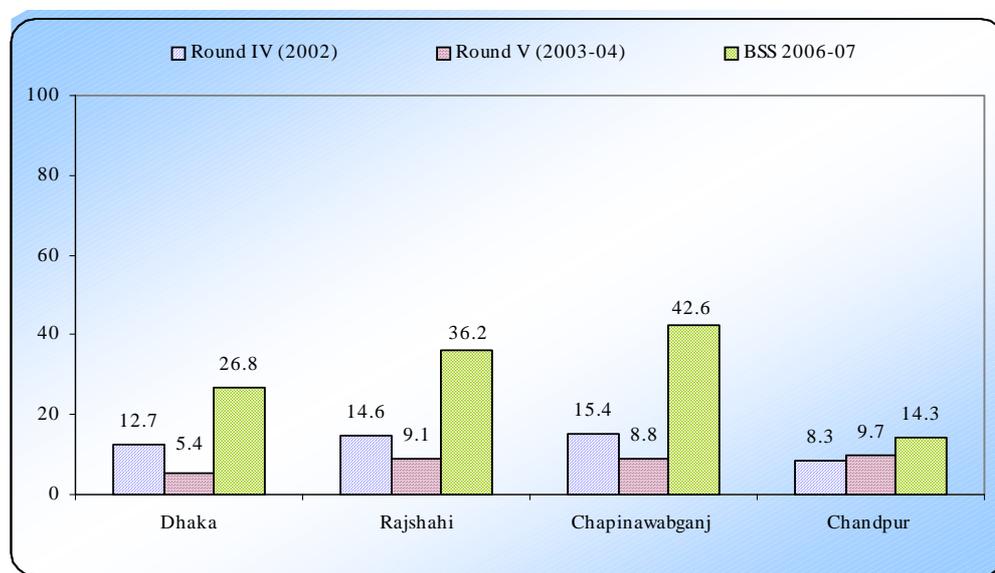


Source: BSS VII based on USAID and FHI 2007.

The report also shows that although there is an increase in condom usage in commercial sex, usage in last commercial encounter with sex worker is still only 41% in Dhaka. It varies in other places, but in

Chandpur for instance it is only 17%. Consistent condom use is even lower as seen in Figure 4. In Dhaka, for instance, it is only 27% and in Chandpur it is 14.3%.

**FIGURE 4: CONSISTENT CONDOM USE BY IDUs DURING SEX WITH FSW IN LAST YEAR**



Source : BSS VII based on USAID and FHI 2007.

IDUs on the average are reported to inject twice a day and almost 63% lend their needles /syringes. Considering the still high levels of unsafe behavior, the interventions need to be reviewed again. A research report (Foss *et.al.* 2006), which used mathematical modeling, indicated that the ongoing interventions, might be keeping the levels low, and there would be a prevalence of about 10 % but for these interventions. But, questions of intensity of coverage continue to arise.

More than 50% of female IDUs were found in the preliminary findings of the seventh sero-surveillance to have engaged in sex work in the last six months. In another recent study, 29% reported lending needles/ syringes. As for the sexual transmission risk, although 74% reported condom use, 15% reported anal sex and 70% reported serial sex with multiple partners. 60% also reported lifetime syphilis (Chowdhury *et.al.* 2005).

While this study is limited to look at female sex work population, from the point of view of overlapping network in the street-based situation, it is perhaps useful to look at MSM data 27% of them seem to buy sex from FSW and 54% of them report using condoms on last sex. Consistent condom however is only 31%.

The above analysis highlights how surges in any of these populations will need to be addressed through escalated interventions in all the populations. The current pattern of conceiving separate interventions

for each category by different organizations may not be so effective the situation underscores the need to design an integrated programme model

## **SITUATION AND RESPONSE ANALYSIS: HOTEL-BASED AND RESIDENCE-BASED SEX WORKERS**

Although hotel-based and residence-based are different types of scenarios they seem to have blurred boundaries as women move from one setting to another This section will talk first about the characteristics of the hotel-based population and then about the residence-based. What needs to be kept in mind is that most of them may not be exclusively in any one category. These patterns have existed before. What is new is the strong nexus between hotel managers and residence-based sex workers.

### **Hotel-based sex workers**

The closure of several large brothels and eviction of sex workers in 1999, resulted in the visibility of hotel-based sex work. Mapping conducted in 2001 confirmed that 55% (209/378) of hotels in Dhaka are involved in the sex trade with links to nearly 5000 HBSW (FHI 2007).

The estimate of hotel-based sex workers in Bangladesh has been difficult to arrive at. The Technical Working Group provided a range of 14000 to 20000. Interventions reported are only with 7090 (CARE 1517, FHI 5573) Residence-based sex workers covered by CARE are only 493, some of whom may also double up as hotel-based. By this calculation, it leaves 50% to 70% of hotel-based sex workers without coverage by any preventive intervention.

### **Entry factors and determinants of hotel-based sex work**

The entry into sex work could be primarily through the hotel setting or through the residential setting. The drivers are complex, ranging from personal life factors to developmental ones. But, there is a greater autonomy and choice involved here in the women's decisions to enter, stay in or re-enter sex work, than is envisaged typically in the victim paradigm of women coerced and sold into sex work.

Women enter sex work due to a variety of reasons, primary among them continue to be poverty and lack of livelihood security. If increasing lack of sustainable rural livelihood options is one reason, escaping from the severe restrictions imposed by conservative families is reported to be another. Many girls choose to come to the city, primarily to work in different small scale industries. However, the wages are not sufficient to support their living expenses, and many are gradually lured into sex work. Similar pathways of low wages, sexual exploitation and escape into sex work has been reported in the area of

domestic work.

Women report that being sexually exploited in workplaces, mostly by their supervisors is common. This exploitation, it is reported, is one of the factors which pushes them into sex work, as it makes them lose their inhibitions.

Women may also leave their families, due to family quarrels, dislike of stepmother, or husband's second marriage, desertion by boyfriend or lover and such reasons. Some women may follow their boyfriends to the cities, on promises of marriage.

Sex work is a relatively lucrative opportunity for women compared to other jobs in the unorganized sector, and this appears to greatly influence women's decisions to enter, stay in or re-enter sex work. The fact that casual sex reported among women is much lower than men (FHI 2007) it is not so much changing norms for multi partner sex as an income-generating phenomenon among women. The network of sex workers is reported to be definitely expanding. Young college going girls have been seen coming in to sex work. The money sex work brings in, appears to be a decisive factor. Many of the women do not want to leave the profession and avail the rehabilitation and livelihood services offered by the government, as those options do not pay much.

There are also instances where women accumulate enough money, or avail some rehabilitation amount from the government, leave the profession, and settle down in marriage. But they eventually return, after a couple of years, maybe in a different setting, when their accumulated capital has run out. Since they have already voluntarily or through coercion, transgressed the social norms governing sexuality and sexual relations outside marriage, it appears to be easier for them to continue or re-enter the profession.

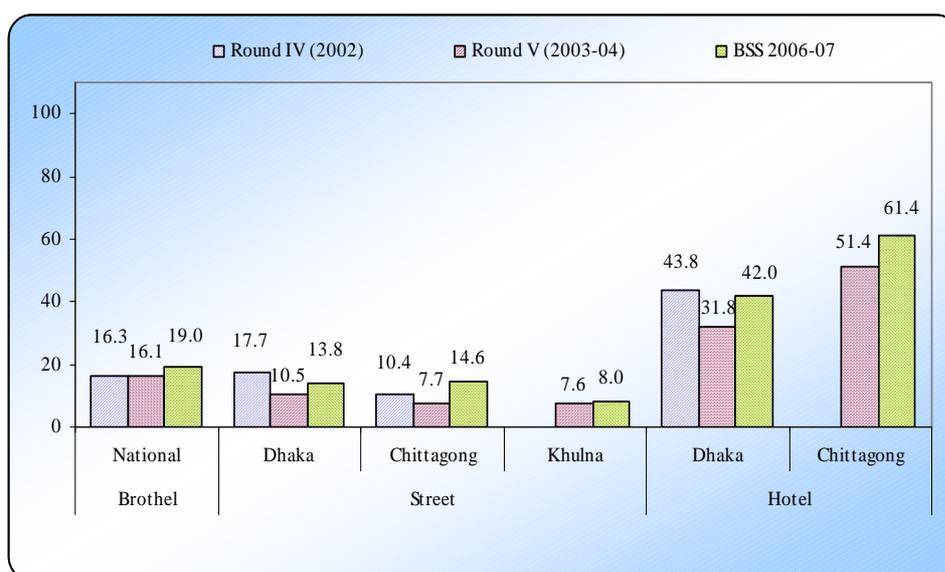
### **Risk profile in the hotel setting**

Eighteen – twenty one is reported to be the age for hotel-based sex work (Nessa, 2004). The FHI study (2007) actually found them to be even younger. Both studies found that these women also have the greatest mobility and seem to spend the shortest time in the same site as sex workers, between 12-24 months. Even during this time they change hotels frequently and even change 4-5 hotels per week. After this block of time, it is not clear whether they move into residence-based sex work and go back to their villages or get married.

The hotel-based sex workers also change hotels after 4-5 months, thus ensuring a steady supply of new clients but higher risk of STI and HIV transmission to the sex workers. This perhaps explains the situation of low STI prevalence in general population in Bangladesh, but prevalence among the female sex workers is extremely high.

Hotel-based sex work is largely voluntary, better paid, with a client turnover that is the highest in Asia. The recent rounds of BSS indicates that mean number of new/regular clients/week for hotel based sex workers in Dhaka and Chittagong were 42 and 61 respectively. As can be seen from the figure below (Figure 5), both the actual numbers as well as the growth in number of clients is far higher than any other category of sex worker. 80 % of those surveyed in Dhaka and 83 % of those in Chittagong reported more than 20 clients per week. The FHI study on HBSW reports an average of around 21 sex clients per week, some groups reporting up to 47 clients per week and up to 84% having symptoms of STI in last year. The majority of men do not use condoms in commercial sex encounters. These sex workers also report the lowest condom use in the region, with less than 24% using condoms with new clients (FHI, 2007). Added to this is the practice of group negotiation and serial partners. All this compounds the risks for the hotel based sex workers.

**FIGURE 5: MEAN NUMBER OF CLIENTS (NEW OR REGULAR) IN LAST WEEK**



Source : BSS VII based on USAID and FHI 2007

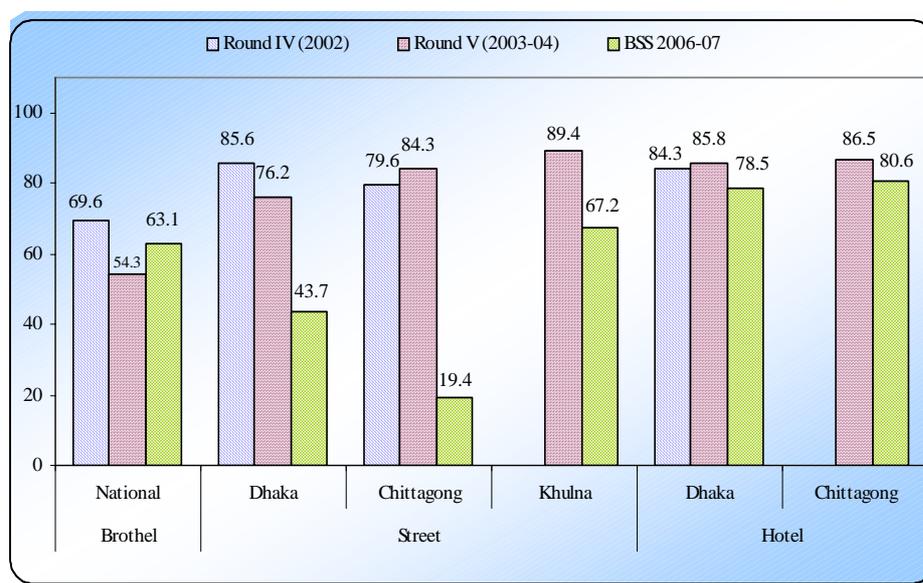
This tallies with the high level of lifetime non- marital sex in the general population reported in the *Assessment of Sexual Behaviour of Men in Bangladesh: a Methodological experiment* (FHI, 2006) : 27% of never married and 13% of ever married men sought sexual service. Although previous studies of smaller samples represent between 8% and 56% non-marital sex, this study had a larger and more representational sample. Although the commercial sex interactions reported cut across brothel-based, street-based and hotel-based sex workers, it still provides an indication.

Among hotel-based sex workers, a study among 400 hotel-based sex workers in Dhaka (Nessa *et.al.* 2004) reports that 228 of the women suffered from symptomatic infections, while 172 were

asymptomatic. A total of 86.8 % were positive for at least one RTI or STI, which included 43 % positive for *N. gonorrhoeae*, 43.5 % were positive for *C. trachomatis* and 4.3 % were positive for *T. vaginalis*. A total of 8.5 % had syphilis, 34.5 % were positive for HSV 2.

The lower rates for syphilis might be due to the fact that most hotel-based sex workers studied had been in the profession for a year or lesser. There was a 57 % prevalence of *T. vaginalis*. It must be noted however, that the study sample was drawn from the population of hotel-based sex workers, who had been covered by an NGO intervention. The BSS reports indicate that STI load is high in Bangladesh, but is also declining significantly in the areas covered by interventions (Reddy, 2007).

**FIGURE 6: PERCENT OF FSW COMPLAINING OF STI SYMPTOMS IN THE LAST YEAR**

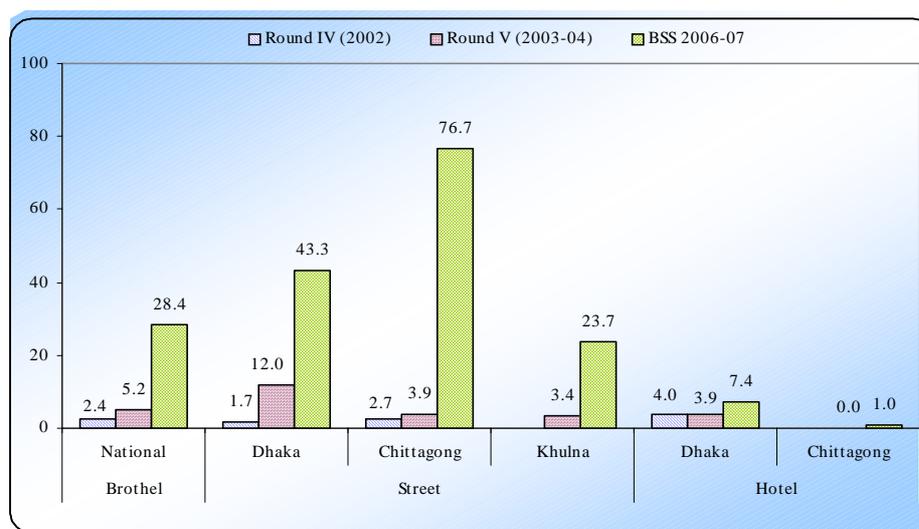


Source : BSS VII based on USAID and FHI 2007

The BSS data on hotel-based sex workers in Round V is alarming. The condom use with new clients is much lower than street-based sex workers in the same cities. Dhaka street-based sex work report 81% condom use with new clients, as against only 40% by hotel-based sex work.

Given the number of mean clients per week, the risk is very high. Chittagong, which has shown such progress towards risk reduction among Street-based sex workers, reports just 36% condom use during last sex with new client among its hotel-based ones. The same pattern is seen in condom use in last sex with regular clients being 25.7 % and consistent condom use being 1 %. This correlates with the high prevalence of STIs reported and poor programme coverage.

FIGURE 7: CONSISTENT CONDOM USE WITH REGULAR CLIENTS OVER THE ROUNDS



Source : BSS VII based on USAID and FHI 2007

Sex workers have more autonomy and more mobility in hotel-based work. An important finding from the FHI study on hotel-based sex workers has been the significant decrease in physical and non physical coercion over time. This may be due to increased confidence in women,

However this dispersion the sex workers has resulted in some changes in the power structure, though this has not always been in their favor. In many cases, the network of hotel managers and pimps exert power over the sex worker, just like the *Sardarni* does in the brothels. They are even less concerned about the women than the *Sardarni*. Key informants repeatedly reported that there was poor access to condoms and STI services among hotel-based sex workers in many places and that was due to the indifference of the hotel managers and intermediaries associated with hotel-based work. Their primary focus is the client and client satisfaction, not the women. This is a new power structure that is emerging

## Residence-based Sex work

On this group, there is a lot of anecdotal information available from key stakeholders and the women themselves in various towns, but no enumeration process has taken place. In fact, there is no data available even on a mapping or estimation exercise and in the absence of these, accurate information is lacking. There is a growing concern among key stakeholders and experts that this population is not getting captured in the surveillance. The challenge has been on several counts:

1. The residence-based sex workers are not "open" populations like brothel-based or street-based sex workers.

2. Many of them have other identities, which they will lose (like wife, mother) if their practice of sex work is known, and so they really like to remain hidden. Often, they are partially hidden, using the identity of a job, but their sex work identity is known to a closed circle.
3. Many are part time, and do other work such as in garment factories or beauty parlours.
4. Many of them are married, and only around 10% of those, practice with the knowledge of their husbands.
5. Quite a few service "high society" clients who would not go to them if their identity were known publicly. The reason they go to them and not to hotels or brothels is that they too want it to be hidden.
6. 4-5 sex workers are said to operate in each residence having close links with hotels. Many operate not through pimps or brokers but through informal networks of their own that function through mobiles and the internet. This makes it difficult to trace them for interventions.
7. One recent trend among the residence-based sex work is the emergence of some kind of co-operative enterprise, which seems to manage the services. A group of about 10 women come together, practice sex work, and manage it like a small business.

The difficulty has been that this is a fluid group that defies categorization. They may work in hotels on some days and service clients at the residence on other days. There is also an indication that not all is sex work in the strict sense of the word; there is also some small element of casual and unpaid sex. The key factor is that a lot of it is hidden and part time. There is also a report of sex work in slums. This is also home-based, but services a socio-economically poorer clientele. Some of them, IDUs themselves or partners of IDUs.

In Dhaka and Chittagong, the trend is towards residence-based sex work as hotels are under watch of the authorities. It is reported that the Rapid Action battalion of the government raids the hotels often forcing sex work to go underground. But, police sensitization under NASP and support from district collectors is reported to have helped in reduction of harassment of sex workers. It is reported that residence-based sex work is on the whole lower in small cities.

### *Casual sex workers in border areas*

There are increasing anecdotal reports of sex work in the rural areas, but not enough documented evidence. There is high mobility of casual sex workers in the border areas to neighboring India and sometimes Myanmar (BSS VI). 85.8 % of sex workers studied in one border area crossed the border to India, of which 82.5 % sold sex. In another border area, 14.5 % crossed to India, with 89.7 % of them selling sex. Crossing to Myanmar was relatively lesser, with 8.7 % crossing over, of which 46.2 % sold sex. However there is no indication of the extent of condom use in the sexual contacts.

## **Risk Profile of Residence-based sex workers**

It is the hotel-linked residence-based sex work in bigger towns, which is reported to be on the rise. The use of technology in the form of internet and mobiles, gives women greater autonomy and control in the choice of clients and client numbers as well as a greater control over earnings, but it does not have a protective element for condom negotiations, as they are in a hidden setting and so remain vulnerable. What is alarming is that this is a group, which is outside the influence of programmes. Given the very high STI levels and low condom use in settings, which have not been reached by adequate interventions or influenced by peer advocacy, this is alarming.

It is also a cause for concern that the high commercial sex activity reported in Bangladesh is changing contours and moving into hidden, poorly defined areas, which can escape interventions. The sex worker as well as the client profile seems to be reflecting an upward mobility as well. In the emerging scenario, both women in sex work and their clients appear to be rather young. The women are mostly below 21 while 50% of men having non- marital sex all seem to be below 29 years (FHI, 2006).

Some of the entry pathways of residence-based sex work are similar to the hotel-based sex work, but it could also be drawing in women from the mainstream, who are looking for some additional income to improve their quality of life. Many of the residence-based have more than one regular partner. This pattern of concurrent partners, including marital partners puts them and their partners into extremely high risk given the low use of condoms, typically seen with long term partners. It is obvious that with this level of risk, when HIV enters these sexual networks, it will move very fast.

The following table gives socio-demographic characteristics of respondents who reported non-marital sex in the male reproductive health survey (FHI 2006). As can be seen, respondents from diverse socio-economic backgrounds reported non-marital sex, underscoring the complexity of sexual networks.

**TABLE 4: PERCENTAGE OF RESPONDENTS WHO HAD NON-MARITAL SEX BY SOCIODEMOGRAPHIC CHARACTERISTICS**

Demographic characteristics	% of respondents					
	Face to Face Interviews		Modified Ballot Box Method		Total	
	n	%	n	%	n	%
Study Area						
Dhaka	624	16.6	603	17.7	1227	17.2
Chittagong	634	15.5	610	19.3	1244	17.4
Bogra	621	15.9	582	24.3	1203	20.0
Faridpur	527	13.8	528	19.3	1055	16.5
Cox Bazaar	602	17.4	595	24.6	1197	21.0
Rajshahi	615	13.9	581	19.2	1196	16.5
P value		0.35		0.01		0.01
Age (years)						
<=19	337	26.2	340	23.7	677	24.8
20-29	1398	21.8	1352	24.8	2750	23.2
30-39	1107	11.0	1047	15.5	2154	13.2
>=40	781	7.2	760	11.1	1541	9.1
P Value		<0.01		<0.01		<0.01
Marital Status						
Never Married	1106	26.5	1140	27.2	2246	26.8
Ever Married	2517	10.7	2359	14.9	4876	12.7
P value		<0.01		<0.01		<0.01
Schooling (Years)						
0	901	14.5	821	20.7	1722	17.5
1-4	575	18.9	603	23.7	1178	21.4
5-9	1133	17.8	1097	22.4	2230	20.1
>=10	1014	13.4	978	12.0	1992	12.7
P value		0.5		<0.01		<0.01
Religion						
Islam	3269	16.3	3150	19.6	6419	17.9
Others	354	12.0	349	13.8	703	12.9
P value		0.12		0.04		0.02

Source : FHI 2006

## The increasing trend towards residence-based sex work: the implications

Residence based sex workers live in apartments well linked with hotels - equipped with internet and mobile communication. Some continue the link with hotels as the workplace, but do not live in them, while others use hotels to build their own clientele and then operate out of their residences. These residence-based set ups can become mini brothels along the way. They are smaller, decentralized, non- stigmatized, connected by an invisible network of operators. They constantly shift location to escape disclosure. The demand for them is reported to be very high, with the supply not so high. This means large number of re-infection among women due to large number of clients.

Some of the women the researcher met were completely comfortable with their new income generation measures and were not bogged by moral or ethical dilemmas of the earlier generation. It appeared to be a sexual liberation of sorts. These raise a lot of questions. Not just in the realm of health and safety, but in the psychosocial and developmental spheres as well.

In a society, which still accepts multiple partner activity in men and not in women, being a married, hidden sex worker takes its own toll on the women's mental health. Fear of disclosure, leaves them vulnerable to several elements of coercion. They lack the protection and solidarity which the sex worker movements have given sex workers in other settings, who are open about their profession. The hidden nature of sex work also calls for alternate approaches to interventions, which is different from the traditional peer based model. Interventions need to acknowledge and accept the hidden nature of the women's practice of sex work, respect the women's desire to remain hidden and anonymous, and not be actively engaged in activities with other women, who have accepted the identity of sex workers.

## Empowerment processes and new dilemmas

In many ways, these residence-based sex workers are a product of the liberalization brought about by the rights discourse within sex work, '*Shorir aamar shidhanto aamar*' (my body, my decision). The empowerment process and fighting for their rights by the women in sex work over the decade has led to a greater acceptance of this as a profession. Whatever their mode of entry, once they are in it, many are comfortable. A group of them take a house together and operate from the home. Some housewives join for the extra income.

While the women do not seem to have personal moral dilemmas about being in a marriage and also in sex work, the fact that they need to keep it hidden is a denial. It is a denial of the rights perspective and sex work as work. It also shows that society is not yet ready for it. Within the sex work identity, segregated from the world of families, it could be acceptable, but as a profession open to all - not yet.

Another aspect that needs to be examined is how “voluntary” are these choices? How distressing are the social conditions that make them choose sex work? Are there enough community mechanisms to deal with marital or family conflict, are there alternative support structures? The worldwide debate on choice versus consent in sex work needs to be looked at.

The role of violence and marginalization of women in HIV vulnerability is becoming increasingly evident. The disempowerment, loss of agency and inability to protect oneself in varying circumstances spans social economic and sexual vulnerability. For women in sex work this is compounded by the stigma surrounding sex work and settings of exploitation.

## Development and Sex work

The serious question, however, is developmental. The National policy and the National Strategic Plan have spoken about addressing vulnerability.

*The ultimate goal with regard to prostitution should be to offer women, men and children realistic alternatives, so that they will not be induced into prostitution neither by a person, nor economic nor by social circumstance. (National Policy on HIV/AIDS/STD, 1985)*

*The National Strategic Plan recognizes that HIV/AIDS is not just a health problem but that it is largely a development issue that is inextricable linked to cultural social and economic determinants that demand a wide and exhilarated response. (Government of Bangladesh, 2004)*

*Poverty is endemic in Bangladesh and the gap between rich and poor is one of the widest in the world. Services for the poor are inadequate in the face of great need, and there are inadequate quality services for the poor at the field level to meet the high level of need. The link between poverty and HIV is clear.*

In fact Bangladesh has been one of the few countries with low prevalence to be thinking of risk and vulnerability. However, these appear to have stopped at awareness creation. There have been many schemes for women's development. But they have been unable to meet the needs and aspirations of all. Why else would women who are part of savings and credit groups which gives them access to capital and crisis funding still move to the city. The linkage between loss of traditional livelihoods and migration to the cities will have to be examined.

Key informants strongly felt that poverty and economic reasons (desire for better life style) was the main driver. Rural-urban migration was the main reason. The capital city of Dhaka, which is the most highly

urbanized district has a decadal growth rate of 565% (Reddy, 2007). Not enough jobs were available. Both supply and demand factors operated for this choice. The development partners have all been very conscious about the link between HIV and development. The *Human Development and HIV* 2005 report of UNDP clearly points to it

However the focus has continued to be on risk. From 2001, there have been programmes, which have addressed the vulnerability of youth. Some of these programmes have gone beyond awareness to life skills building. Yet vulnerability reduction efforts will need to be looked at in relation to entry into sex work as well.

## Conclusions and Recommendations

1. The HIV prevalence in Bangladesh has remained low so far. However, the risk and vulnerability have not reduced adequately despite more than a decade of efforts.

1.1 High levels of non-marital and commercial sex is reported in the general population, a large part of it is unprotected. Eight percent of the general population surveyed reported symptoms of at least one STI in the last year. Condom use is very low, and consistent condom use is even lower. The client turnover is very high especially among hotel based sex workers and is reported to be the highest in Asia.

Added to this is the fact that the most women across all categories of sex work are reported to have more than one long term regular partner. As it is increasingly evident that this concurrency in multiple partners is what leads to a rapid increase in transmission rates, this adds to the risk profile.

Other factors that exacerbate the risk include the fact that there is still a fair amount of coercive sex, although it is reported to be declining in many areas. The very young age of girls (mostly below 18) adds to their biological risk of acquiring the virus. The fact that they are often trafficked/ sold/ bonded and the violence accompanying the entry of this group into sex work in the early years compounds the risk.

1.2 The other pathways to sex work also enhance vulnerability. Workplace conditions such as low wages, violence and abuse- often sexual, disempower women; stripping them of dignity, self worth and agency. Therefore, many women who migrate to the cities in search of employment and drift into sex work enter the profession in a very vulnerable state – not with a sense of control which can help them demand or negotiate safe sex.

The growing economy has increased communication and mobility and higher spending power in men. While it creates a demand for commercial sex and creates new client markets where women can negotiate better, in practice it takes a different form. This mobility also extends to young women coming to towns to work, but the circumstances are unequal.

The majority of the hotel-based and residence-based sex workers are “hidden” sex workers, that is, they have other identities besides sex work and those are their public identities. Forced by socioeconomic circumstances to migrate from safe environments of home and community to towns, they do not have enough support structures. To hide their identity they often operate either individually or in small networks through the internet or mobiles and are at the mercy of

hotel managers, pimps and clients. They do not access protective mechanisms that have evolved in many brothel and street based locations : neither support in crisis, nor even ensuring access to basics like STI services or condom access. Sex work, especially in hotels or residences adds an immense threat to their physical and psychosocial well-being. Given that the current estimates of hotel-based sex workers is almost three times that of brothel-based sex workers, and these estimates are likely to be far lower than the actual numbers, and given the fact that there is no reliable estimate of the number of residence based sex workers, this is a major vulnerability area.

- 1.3 Care needs have already started surfacing, even if they are not so visible given the small numbers. Although the HIV prevalence is low, services are still inadequate. Voluntary testing and counseling is still not adequately decentralized and access to treatment education, opportunistic infection prophylaxis and CD4 testing and ART still need to scale up.

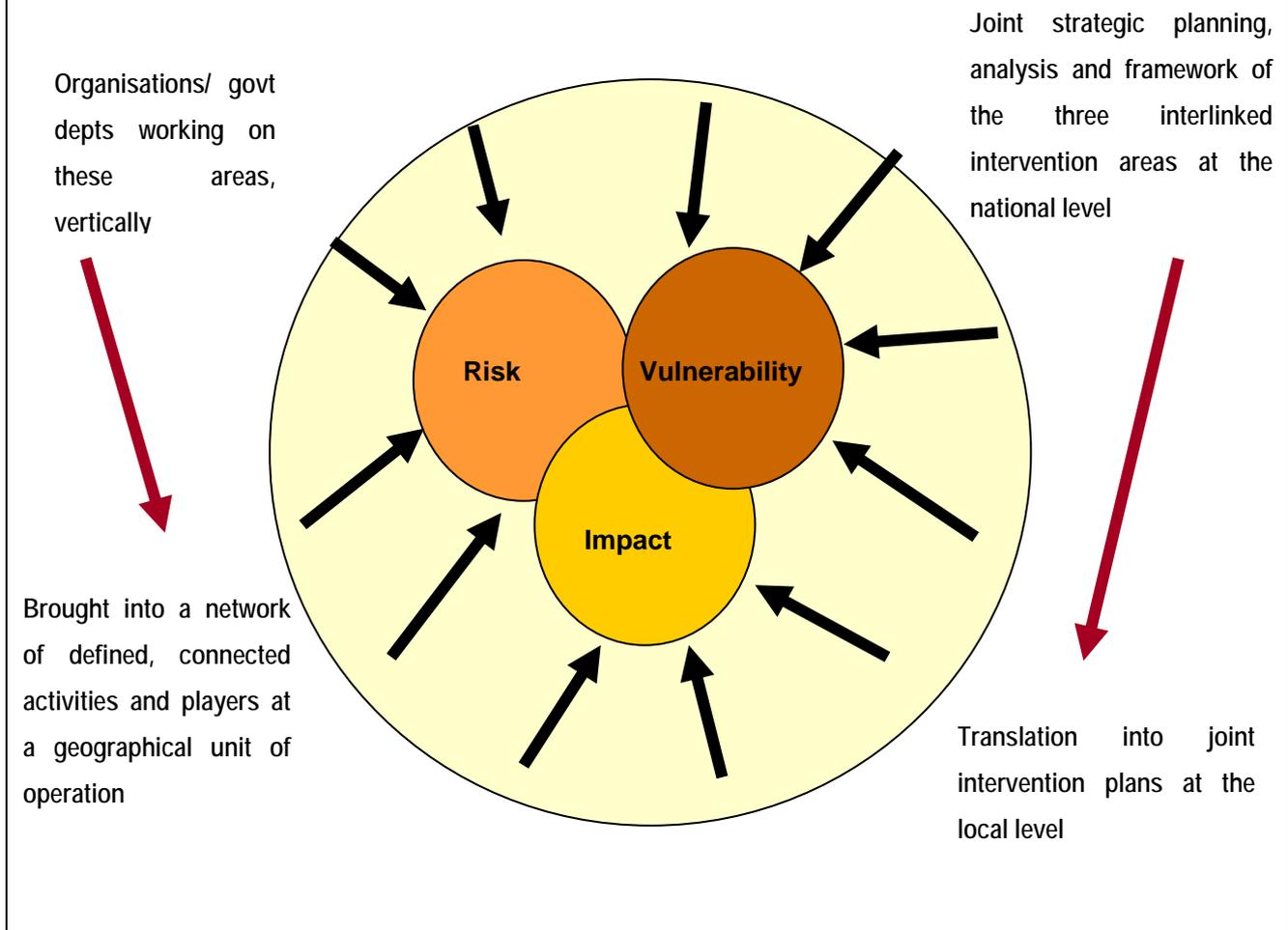
The potential for the nascent epidemic to expand is there and the response has to address risk, vulnerability and impact concurrently and aggressively.

**Recommendation 1: A multi-sectoral response of relevant agencies at the national and local levels should be developed, which included engagement of relevant ministries of Health and Family Welfare, Home Affairs, Social Welfare, Women and Children’s Affairs.**

Risk, vulnerability and impact reduction need different approaches and may need different agencies. Yet, they are interwoven parts of the dynamics of transmission and cannot be separated in response. These need to have a common framework that charts out the different sectoral responses at the national level. This could be then taken up by each sector but a co-ordinated effort is required at the geographical unit at the local level. The mechanisms may descend vertically from the interventionists’ point of view, but for affected communities they simply lie on a single continuum

This multi sectoral response has already been mentioned in the NASP. It needs to be given priority and more body, going beyond education on HIV. Poverty alleviation and sustainable livelihoods, rural development, women’s development, youth affairs, education, transport and tourism, labor and industry, just to name a few sectors may need to come together for the common strategic plan. This mainstreaming of HIV will need again need to go beyond awareness generation into risk and vulnerability reduction. Many of the interventions will therefore need to structural.

## Strengthening the multi-sectoral approach



2. Risk for women in sex work is still very high as seen in the previous paragraphs, and the coverage does not seem to be adequate.
  - 2.1 Even with brothel-based sex work, where the population is well defined and interventions began almost a decade ago, there seems to be a drop in coverage. This has clearly shown a co-relation to increasing risk. Street-based sex work has done well on coverage, wherever interventions have been intensive. Hotel-based has a coverage of less than 50% and possibly as low as 30%, despite being at the highest risk.
  - 2.2 High commercial sex activity is changing contours and moving into hidden poorly defined areas, which escape prevention interventions. Hotel linked, residence-based sex work in bigger towns is reported to be on the rise. For hotel and residence-based sex work, current methodologies to address to reach dispersed, individually operated, hidden sex workers do not appear to be adequate. This also applies to mobile, rural sex workers.
  - 2.3 Across the different categories of sex work, there needs to be consistency in funding support for

interventions. This sudden withdrawal /reduction of funds for a sustainable prevention programming undermines all previous efforts and is a major barrier in efforts of prevention of HIV transmission.

- 2.4 Bangladesh's concentration on risk reduction has to some extent paid off with reference to the HIV prevalence in women in sex work. However, given the dynamic nature of sex work and the fact that women in sex work stay in the location and profession for a maximum of 6 years on an average (among brothel-based sex workers) and less than two years in hotel based settings, programmes have to work beyond individual behavior change to community norm change. This means that as individuals keep changing, reaching each new generation or cohort of sex workers intensively will be an on going process. For sustainability of change, there has to be transfer of learning between overlapping cohorts of sex workers, till self care such as safe sex and health seeking behavior become community norms. This would take a minimum of two decades of very concentrated efforts.
- 2.5 The Government of Bangladesh has been proactive in raising resources for the National AIDS Prevention Plan. These efforts need to be continued. The Government should also ensure continuity of interventions and coverage by having a co-ordinated plan with all donors.
- 2.6 For instance, while vulnerability reduction and risk reduction is equally important, one is not a substitute for the other. Working with youth in the area of life skills building is a highly desirable complementary activity, but is not a substitute for focused interventions with people at high risk. There should also be an effort not to lose precious intervention time by changing intervention partners frequently.
- 2.7 If funding is withdrawn from what has taken years of financial and human resources to build, it appears to be a loss of all the prevention achieved earlier, as it will not sustain. Mathematical modeling predicts a minimum of 2 decades to stabilize an epidemic. However, if the sex worker and client population is dynamic, it may need longer.

**Recommendation 2: Consistency in funding for all interventions with populations at higher risk is critical and should be a priority. Interventions to reduce vulnerability are equally critical. These two should be seen as complementary, not replacing each other.**

**Recommendation 3: NASP's management capacity requires planned enhancement without further delay so that it can truly function as the hub of all collaborative efforts at interventions by national and international agencies in women at sex work.**

This should be on the lines of the 3-ones proposed by UNAIDS, one national framework for

implementing programmes by all stakeholders, one national AIDS authority and one country level monitoring framework. This will bring the developmental partners to support a long term plan. Donor priorities will then have to bow to the national strategic plan.

**Recommendation 4: For residence- based sex workers, an in depth situational assessment (rapid ethnographic survey) and mapping for both estimation and enumeration is needed to understand needs, dynamics and current coverage; and to design appropriate interventions.**

**Recommendation 5: Interventions with residence- based sex workers have to change from the current peer-based, high frequency, face to face contact models being used with other groups of sex workers to a staff and peer mixed, less intrusive, more service linked ones.**

As many of the sex workers are part time and are reported to be married and wanting to retain the family identity and life, their needs are different. Interventions and support networks that allow them to remain hidden and that can link them to services and products, are likely to find favor. Activity centres with a health or cultural slant also tend to draw women voluntarily into geographical spaces of intensive interventions.

3. The sex worker movement in Bangladesh has been able to successfully involve the larger women's movement in their struggle for a right to dignity, work and life as equal citizens in society. This is the medium which could provide support to the hundreds of women in sex work who are hidden and at risk. Even more important it could address gender- based violence and other pathways of vulnerability.

**Recommendation 6: Involvement of the women's movement to deal with the larger issues of and discrimination of women in sex work and stigma, increasing their access to services and life in the mainstream, and to deal specifically with intimate partner related violence.**

4. The increasing difficulty in identifying client groups in fitting them into neat intervention categories means a scale of coverage that point to entirely different approaches.

**Recommendation 7: Larger communication based interventions along with intensive workplace interventions will need to be considered. These may also need to be mainstreamed. The two risk factors of unprotected sex and concurrent multiple partners and across different networks should continue to be key reiteration areas.**

5. Overlapping sexual networks between different populations at risk means that surges of prevalence among IDUs in some pockets of Central Bangladesh, increases risk for women in sex work, MSM, transgender and male sex work populations. Findings that there are a significant number of female IDUs

identified with 50% selling sex compounds that risk.

**Recommendation 8 : All interventions will need to be stepped in those pockets in the context situations of overlapping sexual networks. Tight linkage between the interventions would be necessary.**

6. Bangladesh has done significant work in the area of sex worker rights. The sex worker organizations are led by independent sex workers who are fully aware and articulate. Among the two categories of “open” sex workers (brothel- based and street-based) who have collectivized under a rights based approach, the challenge is to keep focused on risk reduction, as the CBOs go forward to meet the emerging needs of their communities. While the rights based approaches enhance prevention efforts, there is a real danger of felt needs of communities moving away from risk reduction as a priority. The strong message is that risk reduction is still necessary and critical even as the rights of sex workers are being ensured. We cannot afford intervention fatigue.

6.1 The SWOT exercises of the sex workers’ CBOs also throw up a critical need: to look at sustaining existing leadership and building alternative ones. There is a crucial need to invest in institution building and leadership development. It is also necessary to take stock of the organizations’ ability and motivation to continue with the HIV prevention efforts. While sex worker empowerment efforts and HIV prevention programmes did intersect at a very crucial time in their history, and mutually benefited from each other, it is possible that they will progress on different paths in the future. Larger empowerment movements may not wish to be tied down to programmatic goals and objectives. However, there has to be a dialogue on future prevention efforts.

6.2 What contributes to CBOs’ moving away is also sudden withdrawal /reduction of funds for prevention programming. This leads to a loss of the rich experience and the momentum, which can make all the difference to HIV prevention. If funding is withdrawn from what has taken years of financial and human resources to build, it appears to be a loss of all the prevention achieved earlier, as it will not sustain. Mathematical modeling predicts a minimum of 2 decades to stabilize an epidemic. However, if the sex worker and client population is dynamic, it may need longer.

6.3 At the same time NGO interventions are taking over some of the existing programme areas as well as the new growth areas of the CBOs that have evolved. What will be strategic partnership between Government, NGOs, CBOs and donors for sustained interventions till the risk is reduced, will need to be decided.

**Recommendation 9 : Organisations of Women in Sex Work have a critical contribution to make in reducing HIV risk as well as vulnerability in their constituency. There has to be a significant Institution building and leadership development in these organizations.**

7. The ease with which migrating for work, gets converted to trafficking both internally and across borders, is of great concern. The great vulnerability of women when they leave homes invokes two responses, to stop their mobility through law or to accept the consequences of sexual exploitation and violence as a necessary evil. Neither is acceptable, as both have implications of freedom, justice and life with dignity. Mechanisms are thus needed that provide safer choices for women, not just resigned consent. Great beginnings have been made by different groups working with adolescents and youth awareness generation and life skills programmes have been taken up in certain areas to bring in these perspectives. This needs to be scaled up.

7.1 However, vulnerability reduction is a very complex affair that will need to go beyond awareness raising. In the context of a rapidly globalizing environment, many get left behind. Among them developing livelihoods for women that can meet their personal and social aspirations in addition to providing a sustainable livelihood are important.

7.2 There is also a need to aggressively address entry of children into the trade. There can be no compromise that while we must accept sex work as work; we have to stop bonded sex work. Laws can enable, but this can only be stopped if the sex worker movements take this on as an ethical priority. Only movements have the power to fight commerce. Strengthening and nurturing of the sex worker movements is a priority

**Recommendation 10: Vulnerability Reduction among in women before and after they enter sex work needs to be an important objective of the new national programme with specific focus on age of entry, coercive entry and livelihood related vulnerability .**

Based on data from various surveys on age and pathways of entry into sex work, interventions can focus on addressing entry of young girls into any form of work as it is anyway against child rights. It can also look at providing support for abuse and crisis in these pathways. What would also help would be a review of wages to women in certain industries

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## Annexure 1 Persons met during the Field Trip to Bangladesh

Sr.No.	Person	Organization
1.	Dr. Mahmudur Rahman Director, Institute of Epidemiology and Disease Control and Research	IEDCR
2.	Dr. Imtiaz Ashraf Chowdhury Curator, Institute of Epidemiology and Disease Control and Research	IEDCR
3.	Dr. Tasnim Azim Scientist, Head, HIV/AIDS, ICDDR, B	ICDDR,B
4.	Dr. Sarful Islam Khan, Associate Scientist, Medical Anthropology, ICDDR, B	ICDDR,B
5.	Dr. Nizam Uddin Ahmed Director, HIV/AIDS Sector & South Asia Program Advisor, Save the Children	Save the Children
6.	Dr. Robert Kelly Country Director, Family Health International	FHI
7.	Dr. Amala Reddy Data Synthesis Specialist, Family Health International	FHI
8.	Dr. Munir Ahmed Team Leader, HIV Program CARE Bangladesh	CARE
9.	Dr. Mozammel Haque Advisor, HIV/AIDS Program UNODC	UNODC

10.	Dr. Rebeka Sultana NPPPP, HIV/AIDS, UNFPA	UNFPA
11.	Ms. Hazira and Ms. Chumki Street Sex Workers' Network, Durjoy Nari Sangho	Durjoy
12.	Dr. Khayrunnessa Amin STI Doctor, Durjoy Nari Sangho	Durjoy
13.	Dr. S.M. Asib Nasim Health Manager, Health and Nutrition Section, UNICEF	UNICEF
14.	Mr. Mahboob Aminur Rahman, Monitoring & Evaluation Advisor UNAIDS	UNAIDS
15.	Dr. Lazeena Muna Social Mobilization and Partnerships Advisor, UNAIDS	UNAIDS
16.	Ms. Farida Husain, Consultant, UNAIDS	UNAIDS
17.	Dr Julia Ahmed, Dy Exec. Director, Bangladesh Women's Health Coalition	BWHC
18.	Dr. Gayatree Saha, Centre Manager, BWHC, Tangail	BWHC

19.	Ms. Akhi, President, Nari Mukti Sangho, Tangail	Nari Mukti Sangha
20.	Dr. Rowshanara Lily, Executive Director, Rural Poor Development Organization	RPDO
21.	Dr. Jahanara Birani Project Officer, HIV/AIDS STI Prevention Project, RPDO, Tangail	RPDO
22.	Dr. S.M. Mustafa Anower, Director, CME & Line Director, NASP Govt. of Bangladesh	NASP Ministry of Health & Family Welfare
23.	Dr. Md. Hanif Uddin, Programme Manager, National AIDS/STD Programme, Govt of Bangladesh	NASP Ministry of Health & Family Welfare
24.	Dr. A.S.M. Habibullah Choudhury, Programme Coordinator, Social Marketing Company, Bangladesh AIDS Programme	Social Marketing Company
25.	Dr Mahmudda Islam Member, AIDS Commission	AIDS Commission

## Annexure 2 Guide for Focus Group Discussion With Sex Workers

No	Probe Areas	Domain and Instructions
	Profile of the respondents	
	<p>1. Ask the respondents to introduce themselves and record the profile (Probe if introduction does not include Age, Education, Religion and Caste, Language and occupations)</p>	General profile of the Key Informant
	Profile of the sex workers	
	<p>2. Can you give me some details about the sex workers in this area/town</p> <ol style="list-style-type: none"> <li>a. Age group of the sex workers <ul style="list-style-type: none"> <li>• What is the age at which they come into the profession?</li> <li>• What is the age at which they stop sex work?</li> </ul> </li> <li>b. Educational qualifications?</li> <li>c. Religion and Caste?</li> <li>d. Languages?</li> <li>e. Marital status (Probe for currently married, widowed, separated/deserted, unmarried)</li> <li>f. Economic status – Poor - %, lower middle - %, Middle - % and Upper middle - %</li> </ol> <p>% of sex workers heading the family</p>	profile of the sex workers – socio-demographic data
	Types and Patterns of sex	
	<p><b>Type</b></p> <p>3. Can you give me some details where do they solicit sex – bus stand railway station, park, hills, farm, forest, workplace, temple, church, hotel /dhaba, brothel, hospital, their home, someone else's house? (Probe for the percentage of each type, rank)</p> <p>4. Are there any new types of soliciting emerging in the recent days <b>Prompt with clue</b> – contacting clients/sex workers through mobile phones</p>	Do all ranking exercises after the group discussion ends

No	Probe Areas	Domain and Instructions
	<p><b>Patterns</b></p> <p>5. What are the other occupations that the sex workers in this area take-up (<b>free-list and rank</b>)</p> <p>6. Are there women who practice sex work part time? If yes, what is the percentage of part time and full time sex workers in the town</p>	
	<p><b>Mobility</b></p>	
	<p>7. Do the women (sex workers) travel to other places from this town for any work/sex work? If yes, <b>Probe for</b></p> <ul style="list-style-type: none"> <li>• Place: <ul style="list-style-type: none"> <li>a. Within the town</li> <li>b. Outside</li> <li>c. Cross border</li> </ul> </li> <li>• Frequency of the mobility – Daily, weekly, monthly, seasonal,</li> <li>• Duration of stay <ul style="list-style-type: none"> <li>- in the place traveled to.</li> <li>- at this place between two trips</li> </ul> </li> </ul>	<p><b>Movement - Type of Movement (Intra/inter/cross border)Duration</b></p>
	<p><b>Sexual Networks</b></p>	
	<p>8. How do the new women enter into the profession (%)</p> <ul style="list-style-type: none"> <li>• On their own</li> <li>• Influenced by peers/existing sex workers</li> <li>• Through Intermediary persons</li> </ul> <p>9. By seeing the last five years, is there any change in the number of women coming into the profession? If so why? <b>(Free list and rank)</b></p> <p>10. How do the women get clients?</p> <ul style="list-style-type: none"> <li>• Through Direct contact</li> <li>• Through Intermediary persons – Brokers, etc</li> </ul> <p>Through a structured network – Madams, Lodges, Superiors at workplace</p>	

	<b>Health and Risk Awareness</b>	
	<p>11. In your opinion, are the sex workers aware of:</p> <ul style="list-style-type: none"> <li>• STI – Symptoms, treatment, prevention</li> <li>• HIV – Modes of spread, how to prevent</li> </ul> <p>12. In your opinion, are sex workers in this town at risk of HIV? Why? <b>Probe for</b></p> <ul style="list-style-type: none"> <li>• Unaware of condom use</li> <li>• Forced by the clients not use condoms</li> <li>• Condoms are not available</li> <li>• Sex workers indulged in IDU</li> <li>• Any other reasons</li> </ul> <p>13. <b>Condom</b></p> <ul style="list-style-type: none"> <li>• What is the % of women know condom use</li> <li>• % of women use condom <ul style="list-style-type: none"> <li>– with all the clients and regular partners</li> <li>– with all clients but not with regular partners</li> <li>– with a few clients only</li> </ul> </li> </ul> <p>14. What could be the reasons for the women for not using condoms?</p> <p>15. Are sex workers aware of safer sex practices</p> <ul style="list-style-type: none"> <li>- consistent condom use</li> <li>- reducing penetrating sex</li> </ul> <p>- condom negotiation skills with difficult clients and partners</p>	Awareness of STI/HIV transmission/ prevention/

	<b>Channels for communication</b>	
	<p>Can you name any channels of information that communicate to sex workers about STI/HIV/AIDS? (Probe in terms of media habits, exposure to any NGO activity, government activity, posters/hoardings, TV, Radio, Print, etc. (Free list and rank)</p>	Communication Systems

	Current Programmes	
	<p>16. Are there any HIV intervention programmes for sex workers? If yes, How are these programmes addressing issues of:</p> <ul style="list-style-type: none"> <li>• Reaching sex workers</li> <li>• STI – Treatment, partner treatment</li> <li>• Condom promotion – distribution channels</li> <li>• HIV – Testing, OI treatment, ART</li> </ul> <p>17. What is the percent of sex workers accessing these services.</p> <ul style="list-style-type: none"> <li>• Reaching sex workers</li> <li>• STI – Treatment, partner treatment</li> <li>• Condom promotion – distribution channels</li> <li>• HIV – Testing, OI treatment, ART</li> </ul> <p>18. What are the difficulties in accessing existing services? Probe for</p> <ul style="list-style-type: none"> <li>• Distance</li> <li>• Lack of confidentiality</li> <li>• Any other reasons</li> </ul>	
	What are the areas to improve the HIV situation among sex workers?	

## Annexure 3 Interview Probe Matric for Information on People Engaging in Risk Behavior

For use with the following Key Informants: Police/ Brokers/ Madams/ STI doctors/ NGO reps						
Country:		Location:		Date:		Key Informant:

S. No	Item	
1	Profile of the key Informant ; Police/ Brokers/ NGOs (Specify )	
2	Kind of groups / subgroups engaging in risk behaviour	
3	Principal Occupation	
4	Engaging in casual, transactional / commercial sex	
5	Socio demographic characteristics - age group, gender, caste, religion, economic status	
6	New Trends? New demands, new profiles of sex workers?	
7	Locations / sites where these individuals can be contacted (normally found (residences, aggregation, workplace)	

8	Mode of contact for sex work ; direct or through intermediary	
9	Additional risk factors( prompt only if necessary client, substance use, violence, no support)	
10	Access to basic services – health / communication / peer support/ intervention	