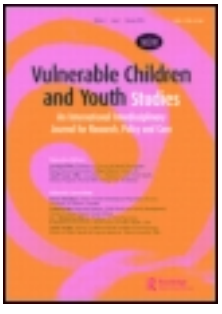

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The health and social well-being of female sex workers' children in Bangladesh: A qualitative study from Dhaka, Chittagong, and Sylhet

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The health and social well-being of female sex workers' children in Bangladesh: A qualitative study from Dhaka, Chittagong, and Sylhet

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Numerous studies have documented the health problems of sex workers; however, there has been limited research documenting the well-being of children of sex workers. Threats to the health and welfare of these children span their lives. Problems among infants may be more difficult to observe, but field observations by staff at NGOs, who operate drop-in-centers for sex workers in Bangladesh, suggest that older children of sex workers experience significant risks to their health and safety.

This qualitative study explored the threats to the health and welfare of children of sex workers through focus group discussions with sex workers and brothel madams in Bangladesh, all of whom were mothers. Risks to their children were explored from the time of pregnancy through adolescence.

Findings indicate that stigmatization of and discrimination against these children and their mothers are underlying conditions that compromise their access to safe housing, childcare, health care, education, and the protection of law enforcement. The threats they face may exceed those of other children in Bangladesh and include sexual exploitation, exploitive labor, trafficking for adoption, and forced entry into crime. In addition, many children of sex workers have reportedly been traumatized after witnessing police brutality against their mothers. While both sons and daughters of sex workers face similar barriers in altering their life trajectories, gender-specific challenges were also identified.

Additional research documenting trends among children of sex workers and their mothers is needed; however, much can be done immediately to mitigate potential harm by targeting family-based support to these mothers and children to meet basic needs and ensure their basic rights. Our recommendations are to strengthen health, social welfare, and other services to address protection and prevention needs; ensure access to basic services; and provide interventions that address the marginalization resulting from stigma and discrimination.

Keywords: children of sex workers; sex work; vulnerable children; child protection; Bangladesh

Introduction

There are limited studies on children of female sex workers (CFSW) (Beard, 2010). More than 20 years ago, Deisher, Litchfield, and Hope (1991) reported on the birth outcomes of infants of prostituted adolescents in the United States. Later, Willis (2002)

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produced the first study to estimate the public health impact of child prostitution, including birth outcomes to infants born to prostituted adolescents. In Bangladesh, Blanchet's (1996) anthropological study of children included daughters of brothel-based sex workers. More recently, Arefeen's (2006) study of street-based Bangladeshi sex workers also included information about their children.

There are many potential risks to the health and social well-being of CFSW in Bangladesh. Some of these risks are shared with other children in similar socio-economic situations; however, CFSW face additional threats due to stigma and discrimination as well as sex-work-related violence that other children do not experience.

The potential impact of these risks is significant: There are an estimated 30,700 street-based and 40,000 hotel- or residence-based sex workers in Bangladesh (Khan, 2008). The percentage of sex workers who are mothers and the number of CFSW in Bangladesh is unknown; however, one study (Mondal, Hossain, Islam, & Mian 2008) reported 96% of sex workers in Bangladesh were mothers with an average of two children.

Save the Children supported two nongovernmental organizations (NGO) – Bangladesh Women's Health Coalition (BWHC) and Durjoy Nari Shangha (DNS) – to provide a range of services, including HIV prevention, for hotel- and residence-based female sex workers at Drop-in Centers (DiC) in 52 Districts of Bangladesh. In 2010, Save the Children and another international NGO, Global Health Promise, partnered with BWHC and DNS to undertake a qualitative study of CFSW.

Methodology

NGO staff at DiC recruited sex workers and madams (women who manage local brothels) who were mothers, over age 18, who received services at the DiC. A total of 32 sex workers and 3 madams participated in 7 focus groups. During their focus group discussions (FGDs), respondents received childcare and compensation for travel expenses.

Focus groups were conducted in June 2010 at DiC in Dhaka, Chittagong, and Sylhet. Locations were selected according to logistics and the varied nature of sex work across the country. The lead researcher facilitated the focus groups using a series of open questions that focused on

(1) Health and social threats to CFSW.
(2) Access to basic services.
(3) Abuse and exploitation.
(4) Recommendations of mothers.

Staff from the NGOs were trained to translate during the FGD. Each FGD lasted between 60 and 90 minutes and were recorded and transcribed. Identifying information was removed to ensure anonymity. Deflective questioning was used for less threatening communication and to seek views on the experiences of other mothers and children known to the respondents.

All data were analyzed in the same data set. Dynamics and interactions, often explored in focus groups (Wilkinson, 2004), were not considered for this study due to time constraints and translation; only narrative data were included. One author (IH) coded and searched data for consistently recurring themes (Silverman, 2000) using NVIVO® v.8 (produced by QSR International, Burlington, MA, USA), a tool for sorting, coding, and categorizing qualitative data (Bazely, 2007). Data were analyzed inductively, and two

authors (IH and BW) discussed emerging themes and ambiguities to ensure that interpretations were consistent and valid. Robust themes – using constant comparison and analytic induction – were identified as significant.

Ethics and consent

Data collection was consistent with ethical guidelines governing research in sensitive areas (Dickson-Swift, James, & Liamputtong, 2008) and with generic guidelines (World Medical Association, 2008 ratification). The study received ethical approval from the Centre for Global Health, Trinity College, Dublin, Ireland. Potential respondents were provided with an information sheet in Bengali, which was read to them by the translator. A consent form (also in Bengali) was provided to those who agreed to participate in the focus groups.

Findings

While mothers were not specifically asked to share experience of their own children, each reported their number of children (Table 1).

Health and social threats

Physical health

Respondents reported many newborns are ill and have birth defects, including cleft lips and palates and hydrocephalus. Nearly all respondents reported stillbirths and neonatal deaths among infants of sex workers, although the cause of death was generally unknown. According to respondents, many pregnant sex workers work into their third trimester ("up to the 11th hour"), use drugs and alcohol, are malnourished, and are infected with sexually transmitted infections (STIs), all of which may increase the risk of complications among newborns. In addition, the majority of respondents stated that sex workers do not breastfeed

Table 1. Children of sex workers: Demographics of the children of 30 sex workers attending focus groups in three locations.

Location and number of SW	Number of children	Average number of children per sex worker (mean)	Age range	Average age (mean)
All [30]	43	1.4	5 months to 14	8.6
Boys	27		1–14	5.3
Girls	16		5 months to 13	7.2
Dhaka [10]	22	2.2	1–13	5.9
Boys	17		1–14	5.4
Girls	5		5 months to 13	8.2
Chittagong [10]	13	1.3	2–8	4.2
Boys	10		2–8	4.2
Girls	3		4–6	4.3
Sylhet [10]	13	1.3	3–13	7.8
Boys	5		4–11	7
Girls	8		3–13	8.3

because they are away from their infants for many hours and instead give their infants other food:

> *If we can't breastfeed, we give canned milk, which is expensive. Sometimes we feel bad because we can't afford canned milk, so we give rice [FGD1].*

While respondents noted the risk of HIV, very few of them knew of any HIV-positive sex workers and therefore could not specifically address the risk of mother-to-child transmission of HIV.

Psychological well-being

Knowing their mothers are sex workers has a profoundly negative impact on children, especially sons who, according to two respondents,

> *Usually do not accept it. They have verbal fights with their mothers [FGD3].*
>
> *When a son knows his mother is a sex worker, he [often] enters criminal work and takes drugs [FGD2].*

There was one report of a son who committed suicide:

> *He learned his mother was a sex worker, [found her] hotel, gave the hotel manager money to care for his mother, and committed suicide [FGD3].*

While mothers try to conceal their work, most respondents thought that by 8 years of age, children suspected their occupation, which greatly distresses the mothers. Mothers often feel guilty about their children's situations and use drugs to deal with depression.

Access to basic services

Respondents reported a range of serious threats to their children, which they attribute to stigma and discrimination. Threats include abuse, exploitation, lack of protection from the police, and less access to health services, education, and social opportunities:

> *If [we disclose we are sex workers] we do not get services for the children – school and health care, or even a house for rent [FGD3].*

Safe housing and childcare

It is difficult for sex workers to obtain secure housing, without which they and their children often live and sleep on the street, where the children are at risk of being snatched. One respondent stated that as another mother slept in a mosque someone *stole her child [FGD1]*. Once sex workers do have housing, they must hide their occupation because disclosure may result in eviction:

> *After a landlord finds out they are sex workers they must leave with the child [FGD3].*

Police also reported staged "raids" on sex workers' apartments. The raids are traumatizing to CFSW.

To watch over their children, sex workers often rely on neighbors, other sex workers, and madams, some of whom abuse the children. For example, respondents reported other sex workers have sex with their sons and some madams verbally, physically, and sexually abused CFSW. In one case:

> *One sex worker left her child with another sex worker. But when the mother didn't pay for 6 years, the woman kept the child [FGD1].*

Health services

Stigma and discrimination seem to impact access to health services for children when providers know the mother is a sex worker. Respondents stated that they and their children are often insulted and generally receive less care than other mothers and children. One mother said:

> *There is no problem getting vaccines for our children, as long as we don't disclose [we are sex workers] [FGD3].*

Education

If the mother's identity as a sex worker is known, her children might not be admitted to a school, and if they are in school, they are often harassed by other students. According to one mother:

> *If a friend of a sex worker's child doesn't know identity of mother there's no problem. But if their identity is disclosed, no one will tolerate the child [FGD3].*

Protection from law enforcement

Respondents reported that if a sex worker's child is stolen, and the police know the mother is a sex worker, police will suggest the mother simply have another child.

Abuse and exploitation

Sold and stolen children, false adoptions, and trafficking

Respondents reported cases where infants were given away, stolen, sold, or "adopted." In one case, a mother with 11 children reportedly *gave three children away* due to lack of funds to support them [FGD4].

Though respondents confirm that very poor sex workers give their children to childless couples, mothers sometimes receive up to Taka 3000 (approximately US$40) per infant. The majority of respondents opined that daughters were purchased for sex work or to be used as maids until adolescence, when they may be forced into sex work. Sons were reportedly trafficked to be camel jockeys or for other forms of labor. Purchasers preferred children without birth registration to prevent future tracing. When children are stolen, the police seldom assist sex workers. In one case, the police told the mother: *Why worry about the child? It is better the child is stolen* [FGD2].

Sexual exploitation of daughters

Mothers report that nearly 100% of daughters are forced into sex work. Many of the daughters become pregnant and have an abortion:

> *One sex worker had a 14-year-old daughter, who got pregnant. She tried a self-abortion, but then the mother took the girl to a "quack". She is now 15 years old and very sick [FGD4].*

However, according to respondents, where daughters do give birth, the infant is usually sold to the madam.

Many respondents stated that sex workers want their daughters to marry but that it is difficult to arrange if the mother's occupation is known:

> *How can I give my daughter in marriage? I don't know the solution [FGD2].*

Where the daughter does marry and her husband or his family later learns the mother is a sex worker, the daughter is at serious risk of abandonment or divorce, and may be *forced into sex work* [FGD2].

Recommendations for service – the mother's view

Sex workers were asked what NGOs should do to help CFSW. Most of the respondents focused on the need for food, shelter, and education:

> *We need to feed, dress, and give shelter. Then we then need education for the children [FGD3].*

Respondents suggested that programs promote *shomaj prothishta* (society's respect) to improve the children's inclusion into the community and that "mainstreaming" of their children into society is important.

Discussion

We only identified two studies from Bangladesh that directly address the situation of CFSW. Blanchet's (1996) study included children of brothel-based sex workers while Arefeen (2006) focused on homeless sex workers in Dhaka. Our study appears to be the first to focus on children of hotel- and residence-based sex workers. As in Arefeen (2006), our respondents reported that CFSW are at risk of being stolen. In addition, our study indicated that CFSW are also at risk of being sold, sometimes through fraudulent adoptions that may result in their sexual exploitation.

Respondents reported many pregnancies ending in stillbirths. This has not been previously reported from Bangladesh but has been reported from the United Kingdom where the stillbirth rate among infants born to sex workers was 50/1000 versus 5/1000 for other women (Jeal, 2004).

In addition, respondents clearly recalled numerous neonatal deaths among newborns of sex workers. However, as in studies from the United States and India, the cause of death among newborns of sex workers in Bangladesh was unknown (Deisher et al., 1991; Wayal et al., 2011).

Based on respondents' comments about the health of pregnant sex workers and the barriers to breastfeeding, such poor birth outcomes and neonatal deaths would be expected,

yet most of these are entirely preventable. This underscores the need for antenatal health services to pregnant sex workers.

Very few of the mothers mentioned concern about the risk of HIV. This may reflect the fact that Bangladesh currently has a low prevalence of HIV – estimated at <1% among sex workers (World Bank/UNAIDS, 2009) and respondents did not know many sex workers with HIV. However, sex workers are at greater risk of HIV infection than the general population. If the HIV rate greatly increases, it could be devastating for these mothers and children. Both sex workers and their children must be treated as key affected populations, and daughters in particular must be considered as among most at risk populations for HIV.

Respondents' comments about barriers to health services are consistent with studies from other south Asian countries. In Nepal, for example, nearly 20% of sex workers had never accessed services at a health clinic while other women reported discrimination and negative attitudes of health workers, similar to reports from our study (Ghimire & van Teijlingen 2009).

We did not explicitly inquire about mental health problems among the CFSW and few of the respondents specifically mentioned psychological conditions the children experience. However, many respondents were explicit about the distress some children, especially sons, experienced when they learned their mothers were sex workers and the trauma they experienced when they saw their mothers abused by the police and other people. The lack of specific responses about expected mental health conditions, such as depression, could reflect the failure to ask about these conditions and to a Bengali term for depression.

The situations of CFSW in this study are similar to those described by Blanchet (1996), who noted that, in Bengali society, daughters of sex workers must accept their mothers' decisions about entering sex work. Our study confirmed that, according to respondents, 100% of the daughters of sex workers who live with their mothers in the cities are forced into sex work.

According to respondents, sex workers who are mothers must take more clients and often engage in more high-risk sex in order to earn enough to care for their children:

> *Since sex workers are always under more pressure to get more money for their kids, they [have to] take more clients, and don't use condoms [FGD3].*

This finding is consistent with Mondal et al. (2008), where street-based sex workers with children had the highest rates of STIs and among sex workers in Kenya, where mothers are 3.1% more likely to seek clients and 21.2% more likely to have high-risk sex when a family member, usually a child, is sick, when compared with sex workers who do not have children (Robinson, 2011).

STIs among sex workers who are mothers may also be related to other barriers, as has been found in Nepal, and requires further research (Ghimire, Smith, van Teijlingen, Dahal, & Luitel, 2011).

Although there is some awareness about the situation of daughters of sex workers, little is known about the situation of their sons. Based on our preliminary research, sons of sex workers also have bleak prospects and are at significant risk of being sold, trafficked for labor purposes – specifically as camel jockeys – and encouraged to engage in criminal activities. Like daughters, sons of sex workers encounter similar exclusion from education and other training opportunities so will have fewer options for employment as they enter adulthood.

Recommendations

Based on these results, a larger scale quantitative study of the risks to CFSW in Bangladesh is needed. This study should also include specific questions on their mental health status, the situation of sons, and the risks to children in their mothers' villages.

To protect CFSW from birth defects and other birth-related complications, antenatal services must be accessible for sex workers. In addition, barriers to breastfeeding and good nutrition must be addressed.

Interventions are needed to ensure that CFSW receive basic health services, including physical and mental health, safe-housing and childcare, and education. Programs should ensure effective mainstreaming of CFSW into schools and the rest of society. Lack of birth registration, which limits access to education, social services, and other legal protections to CFSW, must also be remedied.

Preventing daughters from being forced into prostitution is critical. Sons will need similar programming to address the threats of exploitation to them.

To improve the success of interventions, suggestions from sex workers who are mothers should be solicited and programs must support the needs of sex workers who are heads of households.

Finally, the situation of CFSW in Bangladesh must be viewed from the perspective of a rights-based approach. Birth registration, education, and protection from sexual exploitation are rights that are largely unfulfilled.

Limitations

The majority of respondents were residence- or hotel-based, and therefore the responses may not reflect the problems of children of brothel- and street-based sex workers.

Many sex workers have children in their villages before entering sex work, where the mothers indicated that they were safer; however, our questions did not specifically ask about children in the villages.

Conclusion

Children born to and raised by sex workers in Bangladesh are extremely vulnerable to numerous threats to their health, safety, and well-being. These threats are compounded by stigmatization and discrimination against them and their mothers, resulting in marginalization and barriers to meeting basic needs and accessing services.

While additional data are needed to better understand the threats to CFSW, measures can be taken now to ensure access to basic services such as health, nutrition, and education. At the same time, the profound threats these children face from unsafe child care, abuse, forced sexual initiation, exploitation, stigma, and discrimination require urgent attention with comprehensive child protection. In addition, many mothers and their children likely need psychosocial intervention due to physical and emotional trauma they experience and witness.

Daughters of sex workers face very high risks of trafficking and pregnancy, indicating need for protective action and services. Although this study revealed less specific information about the threats to sons, their needs must also be met.

In addition, while HIV rates among sex workers in Bangladesh are low, HIV prevention programs for sex workers must continue to receive support, and when appropriate, include their children.

Based on our data, it does not appear that the situation of CFSW has improved since Blanchet's (1996) work. Rather, these FGDs again raise very serious concerns about the

health, education, safety, welfare, and human rights of CFSW in Bangladesh, all of which require urgent attention.

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