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Full Length Research Paper

Role of *Devadasi* brothel madams in the promotion of safe sex practices among sex workers in the brothels of Maharashtra, India

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In this paper we examined the role of *Devadasi* brothel madams in promoting safe sex practices among sex workers. Qualitative, in-depth interviews were conducted with twelve brothel madams as a follow-up of a larger cohort study that aimed to understand the patterns and determinants of sex workers migration from northern Karnataka to southern Maharashtra, in India. Our research identified that madams were ex- sex workers, who entered into sex work through the traditional *Devadasi* system and currently manage *Devadasi* sex workers in their own brothels. The social and kinship relations between the madams and the sex workers form the basis on which these brothels function. Brothel madam's role in the promotion of safe sex and their influence on sex workers in seeking health care is tied to reciprocal kinship relations, reveals an important area of opportunity for HIV prevention efforts to fully exploit these positive aspects of these relationships within intervention design and service delivery to achieve more desirable health outcomes and to effectively address HIV risk and vulnerabilities within the context of brothel environment.

Key words: Brothel madam, *Devadasi* system, India, in-depth interviews, sex workers, HIV/AIDS.

INTRODUCTION

HIV researchers and programme implementers have for many years recognized the importance of the relationship between social, structural, environmental factors and HIV/AIDS risk (Sweat and Denison, 1995) and programmes in India now include efforts to address these factors. Recent studies in Asia (Morisky et al., 2002a; Yang et al., 2007; Hong et al., 2008; Bo Wang et al., 2009; Swendeman et al., 2009; Blanchard et al., 2005; Basu et al., 2004; Jana et al., 2004) and the Dominican Republic (Kerrigan et al., 2003) identified environmental support as a significant predictor of HIV prevention behaviors (condom communication, consistent condom use with clients/ regular clients, HIV testing etc) among sex workers who work in organized settings. Therefore, to design specific interventions to promote HIV prevention behaviors among sex workers in organized settings, where the structural issues such as power imbalances, gender, poverty, violence influence safe sex practices, requires a comprehensive understanding of the structures and sex work operations in those settings.

HIV risk and interventions in brothels in India

Existing literature around HIV risk among brothel sex workers in India is inconsistent. A study by Dandona et al. (2005) showed that brothel sex workers adopt more protective measures than other sex worker. While, Ramesh et al. (2008) argue that the brothel sex workers are at the highest risk for HIV and STIs, despite high levels of reported condom use. Thus, the evidence on whether brothel settings enhance or diminish risk remains

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inconclusive.

In India, HIV interventions largely focus on health education, screening and treating of STIs, condom promotion (Singh et al., 1994; Jha et al., 2001) and rely on theories that overwhelmingly focused to bring changes at the individual level (Jana et al., 2004). However, Sonagachi HIV/AIDS Intervention Programme (SHIP) is an exception. SHIP focuses on empowerment and incorporates the social milieu of brothels into its efforts of HIV prevention. Through its unique approach, though SHIP is successful in lowering HIV rates among sex workers, the crucial role of brothels or key actors in the success is not documented (Ghose et al., 2011) under this programme. Therefore, an apparent gap in sex work research in India is to understand how brothel culture or structures could be aligned to intervention needs. To date, research on brothels sex work, with a couple of notable exceptions (Morisky et al., 2002b; Cornish and Ghosh, 2007) based solely upon the perception of sex workers and completely overlook the perspectives of other key actors (for example, brothel madams, establishment managers etc). The studies where madams have been the subject of research, have portrayed them through negative discourses of exploitation, emphasizing the economic interests of madams run counter to the autonomy, personal health and safety of sex workers (Cornish and Ghosh, 2007). Although, Cornish and Ghosh (2007) acknowledge possible benefits afforded through madam-sex worker relationships in terms of material and physical security, these relations are nonetheless represented as denoting power inequalities that need to be "balanced" by intervention specialists.

Without denying the possible exploitation of sex workers by madams across various cultural contexts, this case study of *Devadasi* brothel madams of Karnataka, now based in Maharashtra, examine madams' perceptions on health promotion and highlight a larger set of issues related to *Devadasi* system to be considered in intervention design. In this way, the authors attempt to provide a nuanced understanding of the relationship between brothel madams, sex workers and health promotion.

Ethical consideration

This study was approved by University of Manitoba's Ethics Review Board and St. John's Medical College Ethical Board, India. All participants underwent an informed consent process prior to the interviews and gave written consent.

MATERIALS AND METHODS

Study setting

Twelve *Devadasi* brothel madams who own brothels in four urban places (Mumbai, Pune, Sangli and Bhivandi) in Maharashtra participated in qualitative in-depth interviews. Traditional caste-based *Devadasi* system is practiced in the rural areas in northern region of Karnataka state. This cultural practice involves the dedication of young girls from impoverished communities to the goddess Yellamma for various reasons such as: to maintain cultural traditions, to overcome poverty, lack of a male heir, and to appease deities in times of misfortune such as sickness and drought (Orchard, 2007). Historically, *Devadasis* (dedicated women) served as concubines to men from higher castes. However, their sexual transactions have become commercialized in recent years (Patil, 1975; O'Neil et al., 2004; Orchard, 2007). Most *Devadasis* practice sex work in their homes or small lodges and brothels in rural settings and also migrate to outside the state particularly to the cities in Maharashtra (Blanchard et al., 2005) to work in brothels (FHI, 2001). Generally, few *Devadasis* after 40 years of age, transition to work as brothel madams.

Brothels in red light areas of urban Maharashtra are important economic destinations for sex workers from India and neighboring South Asian countries. In red light areas, brothels are located either in a large, multi-storied buildings consisting of 100 to 200 brothel houses or in a row of small houses along narrow lanes. In general, individual brothels are tiny without proper ventilation. In Mumbai and Pune, we found two categories of brothels: *banglows* (large houses) and *pinjaras* (small, cage-type houses with small windows through which women display themselves). *Banglows* are usually owned by "high class" madams, whereas *pinjaras* by madams of lower socio-economic backgrounds. In four urban places of Maharashtra, we estimated around 120 *pinjara*-type brothels that were owned by *Devadasi* madams from Karnataka.

Selection and recruitment of the brothel madam

We randomly selected 12 from a list of 120 *Devadasi* brothels for an in-depth ethnographic study of their operations and of their madams. Mumbai and Pune had the most brothels, thus selected 4 from each of these cities and 2 each from Sangli and Bhivandi. Out of the 12 selected, 1 was ill and 2 were uncomfortable with tape recording the interviews who refused to participate. Therefore, we selected additional 3 from the original list. All the 12 madams voluntarily consented to the study protocol and agreed to be interviewed.

Approach to data collection and analysis

A team of 4 community researchers (*Devadasi* sex workers) and 3 academically-trained researchers was led by the first author. Prior to the current study, the team had worked for one year (between January 2008 and November 2009) in the red light areas in Maharashtra for the *Payana* (meaning "journey" in the regional language, Kannada), a cohort study that aimed to understand the patterns and determinants of sex workers migration from northern Karnataka to southern Maharashtra (Becker et al., 2012). Under *Payana*, 643 brothel sex workers were interviewed with the support from madams. An extended period of data collection in the brothel environment had increased familiarity and mutual trust between the team and the brothel madams. Moreover, the research team consisted of members from northern Karnataka, who were able to communicate in Kannada, the regional language of Karnataka, and the native language of madams. Thus, the ability of the team to speak *Kannada* was vital to interact, build rapport with madams. As a result, team could easily approach madams to seek support and ask them to participate in the current qualitative study that was conducted in November 2009.

In this qualitative study aimed we aimed to understand madams' perceptions on the changes that have occurred in brothel environments over the past 10 to 15 years. We followed ethnogra-

phic approach and relied on in-depth qualitative interviews. A team of 2 spent nearly 3 to 4 h in the study brothels on the day of interview. Interviews comprised of open-ended questions, took an average of about 45 min to complete. Besides, for 1 to 2 h, the team engaged ourselves in informal chat with madams and sex workers, observed the social interactions between them. Basic demographic information of the madams was collected prior to the interviews.

The interviews were then translated to English for the analysis. Data was analyzed thematically. A careful reading of the transcripts resulted in the identification of several themes. Further analysis led to a thorough understanding of the themes, the context and the relation between them, which resulted in the formulation of two ideas for us to consider for writing, however, in this paper we focus only on one and that is, the relationship between the madams, sex workers and the health promotion. Contextual notes made following informal conversations and direct observations were utilized as the analytic backdrop.

RESULTS

Profile of brothel madam

The mean reported age of the madams was 46 years (range 40 to 60). All owned the brothel and had an average of 12 years (range 5 to 20 years) of experience as madams. Each brothel had an average of 4 sex workers (range 1 to 6).

Madams: Ex- Devadasi sex workers

All the 12 madams had previously worked as sex workers for an average of 9 years (range 5 to 15 years) in the brothels of Maharashtra. As indicated in the narratives below, they were initiated into sex work at young age through *Devadasi* system.

"I was left (initiated) as Devadasi when I was small (young). It was my mother's sister, who was also a Devadasi, took care of me when I was a child. We were poor, so my family left (initiated) me as Devadasi. Had they married me off, they would not have had money to live so, they made me Devadasi"

Another brothel madam, who grew up with her grandmother, who was also a brothel madam, said,

"I am a Devadasi and have been tied with 'muttu' (string of beads tied round the neck of the girl during initiation ceremony) and that is why I came here (to Pune) to work"

While explaining transition from sex work to brothel management, six madams claimed that they purchased brothel when they were around 40 years old, from their earnings from sex work and then continued to work as madams. One madam motioned that her lover gifted her brothel and made her stop sex work. The other five madams inherited brothels from their family. For example, the narrative below informs the involvement of two to three generations in sex work and the inheritance of brothel:

"*My aunt was … actually managing this brothel after my grandmother. We received this brothel from our elders. My mother, grandmother were Devadasis so, it (sex work, managing brothels) has been continued as an age-old tradition"*

Therefore, in the present context, madams were not random individual but, *Devadasis* of the past, who eventually stopped practicing sex work and became madams.

Madams as sex workers kin

Sex workers in the study brothels were all *Devadasis* from north Karnataka. No non-*Devadasi* women were found working in these brothels. Out of the 47 sex workers in the 12 study brothels, 16 shared kinship ties with madams and 31 were connected socially, as them and madam were natives of the same village in Karnataka. While narrating social- kinship bonds shared with sex workers, a madam said: *"All four women in my brothel are from my village, in fact from the same street (neighbors)".* An instance of how social ties signified trust and reciprocity between the madam and the sex workers was narrated by one of the madams as:

"They (referring to sex workers) are like our kids. They look after the brothel when I go home (to native village). They manage the brothel in my absence....I don't have to instruct them. They give me 50% of what they earn in my absence. I trust them and they are always with me (support me) in bad situation"

Devadasi brothels function mainly on social and kinship relationships unlike other brothels. Like others, *Devadasi* madams keep 50% of the sex worker's income and in addition sex workers are expected to pay for food, and share other utility expenses such as electricity, water and domestic help. However, the payments rules are not very strict in case of *Devadasi* brothels. According to madams, they waive off utility expenses for sex worker from poor background and provide free food, on the days when sex workers have no money to buy food. They also narrated the instances where sex workers supported the madams while they were in financial problems.

To our observations there were no signs of sex workers being trafficked or held against the will. We interacted with the families of sex workers who visited them on the day of our interview with madams. We noticed sex workers frequently communicating by phone with their families in the villages of Karnataka. Madams were observed spending time with and taking care of the

young children of the sex workers and at times some of them were busy in cooking food for everyone in the brothel. Thus, the social and kinship ties, reciprocal and less formal relationships between madams and sex workers make *Devadasi* brothels unique.

Madams as condom promoters

Condoms were readily available in the study brothels, provided by local organizations working on HIV prevention. Every brothel visited was littered with condom wrappers and had a "box" to keep the condoms and a "bucket" to dispose the used ones. Madams' perceived condoms as "health protecting" object. The following narrative exemplify madam's interest to support safe sex practices in her brothel:

"In my brothel, I tell them "not to go (to clients) without condoms" and "do not loose life for 5 min of pleasure (of having sex without condoms). Even though you are paid 300 rs (equals to 5.48 USD) instead of 100 rs (equals to 1.82 USD), do not go without condom, you must protect your health."

We noticed several such positive condom messages were expressed in our interviews with madams. This illustrates madams' interest to promote safe sex practices in their brothels. However, their role was not restricted to advice sex workers on condom use, often they supervise sex workers to know whether they actually use condoms or not. Like for instance a madam, who was explaining about how she supervises sex workers to ensure safety, said:

"*If women use condoms or not we can make out. If they do not use, the bed sheet will have stains. Based on the condom wrapper, used condoms thrown in bucket, we make out whether they are safe or not"*

However, consistent condom use according to madams is a challenge. Two factors that inhibited the use of condoms were: first, clients that offer more money to buy condom-free sex and second, the difficulty to negotiate condoms with intimate partners. Statements such as: *"four out of ten men refuse to use condoms and they go away. They go to those women who let them do sex without condoms"* suggest the client's demand for condom-free sex. However, the madams did not seem to be concerned about losing clients if they were insisted on to use condoms. One madam said: *"I tell men to get lost if they refuse to use condoms and I return their money*".

The madams were consistently assertive about unsafe sex practices between sex workers and their intimate partners. Frequent episodes of violence faced by sex workers in these relationships were mentioned as matter of concern. There were few instances, where madams helped sex workers to get over the abusive relationships. A madam, who holds a negative opinion about sex worker's intimate partnerships, said that she often advises sex workers to keep their partners away from work place to avoid the possible financial exploitation, which is indicated in the narrative below:

"*Do not make lovers, if you like to have one, have a lover in the native (village). Do not trust men here (in Pune), because they beat and take away money from you*"

Providing a space in the brothel to store condoms (unused) and to dispose the used ones, encouraging sex workers to use condom, managing clients who refuse to use condoms, monitoring condom use among sex workers suggest the critical role of madams in structuring the brothels to protect sex workers against HIV.

Madams shape health seeking behaviors among sex workers

In our study we found that madams perform a critical role in connecting sex workers to health services. All the madams interviewed preferred private hospitals over the public (government) hospitals and the clinics of the non-government organizations (NGOs) that target sex workers to prevent HIV transmission. Lack of confidentiality, experiences of discrimination and negative attitudes of health care providers towards sex workers at public hospitals were cited as the main reasons for preferring private clinics. Referring to the judgmental attitude of health care professionals at the public hospital, a madam said:

"*At the government hospital, if doctors get to know that the girl is from "Budwar pet" (name of the sex work locality in Pune), they immediately say that she has disease even before doing any tests, therefore we do not go there"*

As far as NGO clinics were concerned, the madams felt concerned that "anybody" in the brothel locality could access their health records as the clinics were located in the brothel area. They perceived that the women who go to NGO clinic are often detected as having disease. The following narration reflects madam's perception about an NGO clinic and suggests how her perception stops her and sex workers accessing services from NGO clinic:

"We do not go to the clinic run by the organization (NGO). Whether they give good or bad treatment is not my concern. It is just the suspicion that I have, that they might say something bad (bad = having disease)! Many women who went there had disease!", so we do not go there.

Only one madam, who held positive opinion about the NGO services said:

"Once in 15 days girls go for a check-up (at the NGO clinic). Before, this clinic was not there. Then we would go to the private hospital. Now women (peer educators) from NGO give us health information, which is good. So, i send my girls for a regular health check up."

Our interactions with madams on the subject of health care suggests that, they influence the sex workers to seek health care from the private clinics, as they perceive private clinics to be better than others.

DISCUSSION

Our research offers a contrasting perspective on a group of brothel madams who have been seen to facilitate sex work solely in an exploitative fashion (Orchard, 2007) and brings out their salient participation in the health promotion for sex workers from their community. The supportive and advisory role played by brothel madams around safer sex, their influence on sex worker health seeking practices is tied to reciprocal kinship relations, reveals an opportunity for HIV prevention efforts to fully exploit these positive relationships within intervention design and service delivery to achieve more desirable health outcomes. Condom promotion and management of the clients who refuse to use condoms (Ghose et al., 2011) indicate that the condom use is not perceived as threat to client satisfaction or to their business as found in an earlier study by Asthana et al. (1996). Madam's observation, that sex workers do not use condoms with lovers, correspond with the findings of quantitative studies that showed the low rates of condom use between brothel sex workers with their lovers (Albert et al., 1998; Ramesh et al., 2010). Likewise, the prevalence of intimate partner violence (Beattie et al., 2010) was also indicated by madams.

Unsafe sex practices and the intimate partner violence among sex workers is associated with HIV risk (Panchanadeswaran et al., 2008) and perhaps these two factors increases HIV/STI risk for brothel sex workers. Even though programs achieve higher condom use rates between brothel sex workers and their clients, without addressing intimate partner violence and the unsafe sex practices between brothel sex workers and their partners, it is difficult to prevent HIV transmission in brothel setting, which currently is a serious problem in India, more so in the areas where the present study was conducted (Mainkar et al., 2011); therefore, exploring the possibility of addressing these issues with the involvement of madams and the sex workers is one of the key areas for future research.

Our research indicated that madams are highly influential in shaping the health seeking practices of sex workers. Madam's preference for private hospitals is associated with the confidentiality and non judgmental attitude of physicians towards sex workers (Asthana et al., 1996; Mony et al., 1999; Bhave et al., 1995). Similarly, negative attitude about the public health facility is tied to discriminatory attitudes of the services providers, however, perceived lack of confidentiality about the services offered by NGO clinics is a matter of concern because, with this perception madams influence sex workers, which eventually affects sex workers participation in NGO clinics which are setup exclusively for sex workers to provide comprehensive HIV prevention and care services. Since, no or lesser participation of sex workers in these clinics may negatively affect to achieve the desired health outcomes the programmes should work closely with the madams, change their negative perceptions regarding the services that are offered in NGO clinics and aim to increase sex workers participation in HIV prevention programs.

Conventionally, HIV prevention programs consider madams as barriers to reach out and deliver services to sex worker and hence, their negotiation with madams is only to gain an entry into brothels to provide services to sex workers. However, this study suggests that brothel madams are, in fact, key players, who could be instrumental to re-structure the risk environment as they were in case of Sonagachi HIV/AIDS Intervention Programme (Ghose et al., 2011) and Thailand's 100% condom promotion campaign (Hanenberg et al., 1994). However, madams in other non-*Devadasi* brothels may also have contributed to the HIV prevention efforts, but there are no evidences or documentation of same to recommend, involving them in the intervention design. Without denying the power imbalances that may exist between sex workers and madams, the potentially positive and mutually beneficial effects of sex worker and madam relationships should be further explored in different cultural contexts to fully address the challenges surrounding safer sex and pro-active healthcare in brothel settings.

Study limitations

Limitations of this study relate to the sample size and to the type of brothels examined. Twelve interviews may appear to be small to influence the HIV programme planners and implementers to take further actions based on our findings. We assert 12 interviews were quite adequate in this research because we interviewed a homogeneous group of individuals who barely, differ in background characteristics or why in which function, thus we could achieve the information saturation very early, that is, by 5th interview (Guest et al., 2006), however we continued and completed 12 interviews to ensure that we have representative samples from all the 4 urban places. Moreover, the extensive time spent in brothels talking to

madams and sex workers, observing them in their natural environment and understanding social dynamics meant that we were able to establish trust and uncover multiple layers of meaning (Geertz, 1973). In short, the ethnographic approach allowed us to view any disjuncture between what madams said versus what they actually did in relation to health promotion and protection. Thus, this approach provided considerable opportunity to re-confirm and validate findings.

With respect to the type of brothels examined, the findings may be transferable to other similar contexts where social- kinship networks forms the basis of sex work operations. However, this case study is useful to question commonly held negative assumptions about madams and sex worker relationships and reveals possibilities that may be overlooked in relation to the participation of brothel madams in HIV prevention.

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