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Improving Sexual and Reproductive Health among Street-based Female Sex Workers: Some Observations from Northern Bangladesh

Shah Ehsan Habib*

Sexual and reproductive health services are of central importance in addressing HIV prevention. Although some policymakers have pointed to the importance of targeting female sex workers (FSWs) in AIDS intervention, so far no studies have been undertaken in Thakurgaon. This study aims to investigate the extent of sexual and reproductive health risk behaviour of street-based FSWs, their STI/RTI experiences and risk perceptions to avoid HIV. A sample comprising 103 street-based FSWs took part in this study. A snowball sampling approach was used in the selection of sex workers in the sample. The results show that, on average, three-fourth of the sample used oral pills. One in four sex workers had experienced induced abortion – 80 per cent of which were accomplished in registered clinics. Sex workers had, on average, two clients with whom they performed either anal or vaginal sex during the previous working day/night. Nearly 21 per cent of sex workers in this study considered themselves not at risk of getting the HIV/AIDS virus, given the fact that 75.7 per cent of the sample reported having unprotected sex in the last episode of serving a client. The most frequent STI/RTI complaints were itching on the genital (39 per cent). Overall, the respondents' knowledge of AIDS was moderate, with 69.9 per cent having heard of the disease. Reaching this high-risk group early with effective sexual and reproductive health information and intervention is therefore vitally important in preventing the growth and spread of STI/HIV in Bangladesh.

Introduction

Commercial sex workers in Bangladesh experience well-documented increased health risk related to reproductive health (Azim et al. 2000, Nessa et al. 2005, 2004). Widespread consensus now exists that little attention has been given to the reproductive health and sexual behaviour of female sex workers (FSWs) in the past, but the shift towards the HIV/AIDS arena makes it important to explore the risks associated with all sexual behaviour. Rising trends in risk behaviour are seen among street-based FSWs engaging in unprotected sex, suffering from STI/RTI,

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in addition to having limited knowledge regarding HIV/AIDS and limited access to reproductive health services (Habib 2004, Barkat et al. 2000). According to the seventh round national serological surveillance data, the rate of active syphilis among street-based FSWs in Southeast – A region of Bangladesh – is 10.1 per cent (MOHFW 2006). Recent Behavioural Surveillance Survey (BSS) data also show that the high level of commercial sex continues with distressingly low levels of condom use (MOHFW 2004a). There is no other place in Asia where the documented levels of consistent condom use among female sex workers are lower than those in Bangladesh are.

Reproductive health-care encompasses a wide variety of issues like family planning, adolescent health, STI/RTI, HIV/AIDS, maternal nutrition, safe motherhood, abortion care and violence against women (Lau et al. 2007, Bruyn 2006, UNFPA 2003). The vision of reproductive health has proved controversial and has not been achieved to the extent hoped for by its proponents. A less controversial and more limited version guided the 1997 U.S. National Academy of Sciences report on reproductive health: (1) every sex act should be free of coercion and infection; (2) every pregnancy should be intended; and (3) every birth should be healthy for both mother and child (Tsui et al. 1997). Even so, no country has met these limited goals, and the problems are greatest in the low- and middle-income countries. In the newer views of reproductive health, a gender- and rights-based approach has been proposed by UNFPA that empowers women throughout their lives (UNFPA 2006, WHO 2003).

A bulk of literature has shown that a large majority of adolescents in Bangladesh (both married and unmarried) do not have information on sexuality, contraception, or STIs and HIV/AIDS (Khan et al. 2005, 2004, Barkat et al. 2000). To avoid the social consequences of unplanned pregnancy, transmission of STIs and HIV/AIDS, people need to be aware of their reproductive health (Neesa et al. 2005, Hossain & Chatterjee 2005, Qutub & Akhter 2003, UNFPA 2003). Nevertheless, reproductive health education has not been a part of the education curriculum, and the existing service delivery system is not catering to the needs of unmarried adolescents. A large section of population typically have unmet needs for reproductive health information and services but their reproductive health needs do not apparently draw the attention of health care service providers.

Like most countries in the South and Southeast Asian region, female sex workers and their clients in Bangladesh are at the heart of STI and HIV epidemics (Habib 2005, Hossain et al. 2004, Rahman et al. 2000, Sarker et al. 1998). Having multiple sexual partners and high prevalence of STIs form a "core group" that should be given high priority when

planning prevention interventions. Recent research in Bangladesh on socio-economic, cultural and behavioural factors indicates that sexual networking among men and women in the general population may facilitate the spread of STI/HIV (Habib et al. 2000-2001, Bogaerts et al. 2001, Gibney et al. 2001). For example, in the 2004-05 HIV sentinel surveillance across the country, the active syphilis prevalence rate was 3.4 per cent among high-risk groups – out of 11,029 individuals who had been tested for STIs, 376 had been identified having an active syphilis (MOHFW 2005).

Until today, no comprehensive studies have been conducted to get a better understanding of the sexual practices and reproductive health issues of street-based FSWs in northern Bangladesh. Various government and non-government agencies have conducted limited studies on FSWs, documenting their STI experiences, risk behaviour, social isolation and extreme marginalisation (MOHFW 2004b, Rahman et al. 2000, Ali 1998, Marcus 1993). Therefore, the present study is seen as relevant to the needs of these poor women – who work in the sex trade – in order to understand their reproductive health behaviour, especially the use of contraceptives, history of abortion, experience of symptoms of STI/RTI transmission and what is important to them. In Particular, in reproductive health intervention, understanding the target group's specific needs may be key to designing an effective intervention.

Thakurgaon is one of the northern districts of Bangladesh. It serves as a gateway to India (illegal movement of population), and large numbers of people use this district to cross into India for business purposes. While there is a large and growing literature on the sexual behaviour of FSWs in the central area of Bangladesh, much less is known about this group in Thakurgaon (Hossain & Chatterjee 2005, Rahman et al. 2000, Habib et al. 2000-2001, Habib et al. 2000). Learning more about the characteristics of this group, including their reproductive health, sexual practices and condom use, is important to the design of effective programmes to control STI/HIV transmission. Therefore, interventions focusing on the prevention of STI/HIV transmission among this high-risk group are likely to be the most effective and efficient means of preventing the spread of HIV infection where HIV seroprevalence rates in the general population are still low.

The overall goal of this study was to explore the reproductive and sexual health behaviour of street-based FSWs and to foster a supportive environment to address the problems faced by them. The specific objectives were:

- To examine the demographic and socio-economic characteristics of street-based FSWs.

- To describe sexual behaviours associated with risk of STI/HIV transmission among this group.
- To ascertain the history of reproductive health, particularly the history of abortion and contraception.
- To understand the HIV knowledge of the respondents and their self-assessment of risk.
- To collect data on the experience of symptoms of STI/RTI transmission.

Methodology

Study Site

The data for this study were drawn from a cross-sectional study conducted in Thakurgaon, Bangladesh. This town was selected because commercial sex is dominated by street-based female sex workers. The majority of street-based FSWs were migrant women – who are "family girls" or "housewives" operating either openly or secretly from their homes through a network of brokers in order to earn enough income for survival. Most sex workers were national highway based, as Thakurgaon town is across the national highway where transport workers come mainly to buy sexual services from them. Key informants identified a number of locations, although our independent enquiries subsequently established that some of these did not have an extensive problem with commercial sex. Finally, 5 locations were identified from 9 wards and 62 *mahallas* of Thakurgaon town.

Study Population

The subjects of the study were street-based FSWs working at Thakurgaon, who were included in this sample based on self-identification. Street-based FSWs are defined as those female sex workers who negotiate with clients on the street or any open public place such as parks, cinema hall, bus terminal, rail station, launch terminal or any other market place. The total number of street-based FSWs in the site was not known until the end of the survey. However, key informants estimated that this figure could be between 150 and 200 in Thakurgaon. During the field investigation, some key informants suggested that the number of street-based FSWs was lower because of strict law enforcement activities. Theoretically, all street-based FSWs were eligible for inclusion in this study.

The Sample

Owing to the impossibility of obtaining a list of the street-based sex workers working at Thakurgaon town, and the difficulty in locating these individuals, a non-probability sampling strategy was used. Traditional sampling methods were not suitable for examining the reproductive history and sexual behaviour, including risk behaviour and risk perceptions in this group. Network or snowball sampling has proved feasible and successful in recruiting hidden populations of sex workers in a variety of settings. It has also been used in several countries (e.g. Vietnam, Cambodia, India and Bangladesh) to collect both behavioural and biological data from sex workers and men who have sex with men (Simic et al. 2006, Habib et al. 2000-2001).

Most of the subjects were recruited from trucking-stand. Initially, the study subjects were recruited through personal contact and then networked. Before starting the survey, the team formed an idea about the FSWs and their spots through discussions and meetings with key informants and other current FSWs (who were contacted by key informants). This was important for planning the sample and interviews to execute. A total of 103 street-based FSWs were interviewed from this area.

The Survey Instrument

The survey instrument for this study was developed after consultation with researchers and planners and a review of other related research instruments. It was pilot tested with 10 subjects using the street intercept method, then revised to its final version. The instrument contained sections on demographic characteristics, current state of reproductive health, such as the history of abortion, menstruation regularisation (MR), use of contraception, frequency of sex and sexual acts with clients, reported condom use at last intercourse, STI/RTI experiences and AIDS knowledge and their self-assessment of risk.

Interview Procedure

The fieldwork for the study was carried out in two weeks from late September to early October 2005. Interviewers were young people with varying experience with reproductive health issues and commercial sex. In addition, the interviewers were assigned a field supervisor whose role was to ensure that they followed the correct procedures when interviewing. A total of 6 interviewers was employed, 4 females and 2 males. After verbal informed consent had been obtained from the study participants, they were interviewed by specifically trained interviewers

for approximately 35 minutes, using a standardised questionnaire. Each interview was conducted in a location determined by the subject in an attempt to allay any hesitation they might have about participating in the study. Interviews were conducted in public places such as in parks, truck terminals, backyards of shops and, on occasions in the Manob Kallayan Parishad (MKP) office. Subjects were guaranteed, both at the time of screening and interview, that any information they provided would be kept strictly confidential. Following an explanation of the purpose and procedures of the study, subjects were invited to give oral consent to participate. For all categories of subjects, retraction of consent at any stage of participation was allowed. Two respondents dropped out of the survey once they had started. All subjects were volunteers who were paid Tk.50 for their participation in the study. This method of remuneration was found to be preferable during the pilot test. It also encouraged respondents to sit down and concentrate on the interview in a relaxed fashion.

Focus Group Discussions (FGDs)

Four focus group discussions (FGDs) of 24 respondents (6 girls in 4 groups) depicting reproductive health issues; and high-risk sexual behaviour were also conducted to supplement the survey findings. FGDs, comprising approximately six people in each group, were conducted to examine a number of issues in a group setting. A field investigator facilitated the discussions, which took place in fields. A member of the research team worked as a note-taker, observing and recording significant verbal and non-verbal details. The FGDs mainly focused on: (a) estimating the number of street-based FSWs in the sampled town; (b) exploring the high-risk activities for initiation into prostitution; and (c) examining the sexual behaviour and their assessment of risk related to HIV.

Data Processing and Analysis

Data were analysed using SPSS (version 11.5) on a personal computer. The focus of analyses was descriptive. Statistical testes were unlikely to be useful due to the small sample size. Most data were categorical and reported as percentage, mean and frequencies. Missing values were excluded from frequency tables so that frequency percentages only relate to those who answered the question. Discussions in the FGDs were tape recorded to maintain accuracy and preserve the respondents' own words. These were transcribed from audiotapes and transcripts were cross-validated against the tapes to ensure accuracy. All transcripts were coded manually for common themes that emerged across the data. Data were

ordered in relation to the research questions and structured analysis condensed the mass of data to identify trends and patterns.

Results

Socio-Demographic Profile

The socio-demographic features of the respondents are illustrated in Table 1. The study population consisted of 103 sex workers who were recruited from streets. The women averaged 26.6 years of age (range 14-37 years). The majority (51.5 per cent) interviewed were aged between 25 and 30 years. Of the respondents, a small number (n=6, 5.8 per cent) were under 18 years of age.

Table 1. Socio-Demographic Features of the Participants

Feature	**Number (n=103)**	**Percentage**
Age (in years)		
Under 18	6	5.8
18-24	25	24.3
25-30	53	51.5
31-35	16	15.5
36 and above	4	3.9
Mean age = 26.6, SD = 5.9, Range = 23 (14-37 years)		
Marital status		
Married	45	43.7
Unmarried	14	13.6
Separated	6	5.8
Divorced/Widowed	12	11.7
Abandoned	31	30.0
Education completed		
Illiterate	68	66.0
Primary incomplete	12	11.7
Primary complete	10	9.7
Secondary incomplete	12	11.7
Living arrangements		
Lives with husband/family	72	69.9
Lives alone	27	26.2
Other	4	3.9
Occupation other than sex work		

Table 1. *(Continued)*

Employed	4	3.9
Business	21	20.4
Housemaid	31	30.1
Agriculture	6	5.8
Sewing	4	3.9
Other	4	3.9
Mean number of children = 1		
Mean income from sex work in last working day = Tk.85.60		
Mean weekly income from sex work = Tk.497.73		
Mean duration of sex work = 4.4 years		

The largest proportion of women were abandoned (30 per cent), divorced (11.7 per cent) or separated (5.8 per cent). Conversely, a much higher proportion (43.7 per cent) reported being currently married. Most participants (66 per cent) had no education. Only 10 (9.7 per cent) of the respondents were educated up to primary level, 12 (11.7 per cent) could not complete primary level. A similar proportion (11.7 per cent) of respondents did not reach secondary level. More than half (69.9 per cent) of the respondents had been living with their husbands/families. The remaining lived alone. Some women reported additional sources of income, most of which came from housework and small businesses. Nearly one-third (30.1 per cent) had been working as housemaids, in addition to sex work. However, a significant proportion (20.4 per cent) had small businesses. The proportion of other occupations, illustrated in Table 1, was insignificant. On average, the women had one child. The average daily income of the FSWs (from clients) in the last working day/night was Tk.85.60 (range = Tk.10-500), which can be considered a good earning for women living in a semi-urban area, with their relatively low level of education. The income reported for the previous week averaged Tk.497 (range = Tk.35-2,500). The women averaged 4.4 years of working as a sex worker on the streets. The duration of a FSW's sex work ranged from less than 1 year to 12 years.

Respondents' Self-assessment of HIV/AIDS Risk

Table 2 summarises the AIDS knowledge of the respondents and their self-assessment of risk. Overall, the respondent's knowledge of AIDS was moderate, with 69.9 per cent (n=72) having heard of the disease. Respondents were also asked to assess their personal risk of acquiring HIV/AIDS (Table 2). In the sample, 9.7 per cent considered themselves at moderate risk, a similar per cent at low risk. None of the respondents

stated that she was at extremely high risk of acquiring HIV. However, nearly one-fourth (20.4 per cent) of the sample said they have no possibility at all in relation to getting HIV. In the sample, the most frequent response was "don't know" at 60.2 per cent. Respondents were also asked to give reasons for the risk. More than half (60 per cent) of women thought they were not at risk following their hygienic practices. Confidence (not being at risk) was also reflected for a substantial proportion of women (n=9, 45 per cent) who stated that they use condoms all the time during sexual intercourse. Responses in relation to other categories were not frequent.

Table 2. Respondents' Self-Assessment of Risk Related to HIV/AIDS

Questions Asked	Number	Percentage
Have you heard of HIV/AIDS? (n=103)		
Yes	72	69.9
No	31	30.1
Are you at risk of AIDS? (n=103)		
Extremely high	–	–
Moderate	10	9.7
Low	10	9.7
No possibility at all	21	20.4
Don't know	62	60.2
Reasons given for being at low/moderate risk (n=20)*		
Maintain hygienic practices	12	60.0
I always use condom during sex	9	45.0
I sometimes use condom during sex	3	15.0
Due to sex only with partner/husband	3	15.0
Partner not having any disease	3	15.0
Other	1	5.0

Note: Dashes (–) indicate that data were not available.

*Multiple response.

History of Reproductive Health

Asked if they ever had any menstruation regularisation (MR)[1](Table 3), only 19 (18.4 per cent) of the female sex workers said that they had had MR. When asked about their MR related information, one-third had used government hospitals and about one-third said they used private clinics/hospitals as well as traditional methods–31.6 per cent each.

[1] In Bangladesh, menstrual regularisation may be performed legally within the first three months of conception. After three months from conception it is considered abortion and it is illegal.

During her lifetime, on average, each woman had MR performed three times. More than half (63.2 per cent) of the women had had at least one MR and 36.8 per cent had MR performed three times.

In this sample, 25 (24.3 per cent) respondents stated that they had had an abortion, with all having done this once. The table also shows that ever abortion is higher compared with MR among this group. Government hospitals and private clinics/hospitals were most frequently reported (40 per cent each) as the place of abortion.

Table 3. MR and Abortion in the Study Population

History of MR/Abortion	**Number (n=103)**	**Percentage**
Have you ever had any MR? (n=103)		
Yes	19	18.4
No	84	81.6
Places where MR was done (n=19)		
Govt. hospital	6	31.6
Private clinic/hospital	6	31.6
Traditional method (*kabiraj/hekimi*)	6	31.6
Mid-wives	–	–
Other	–	–
Frequency of MR in lifetime (n=19)		
1	12	63.2
2	–	–
3	7	36.8
Have you had an abortion? (n=103)		
Yes	25	24.3
No	78	75.7
Places where abortion was done (n=25)		
Govt. hospital	10	40.0
Private clinic/hospital	10	40.0
Traditional method (*kabiraj/hekimi*)	5	20.0
Mid-wives	–	–
Other	–	–
Frequency of abortion in lifetime (n=25)		
1	25	100.0

Note: Dashes (–) indicate that data were not available.

Sexual Activities and Condom Use

Table 4 illustrates respondents' history of sexual activity and condom use with their clients. Women were asked about the number of sex partners they had in the last working day. During the previous working day/night, sex workers had, on average, two clients with whom they performed either anal or vaginal sex. Based on the number of sex partners in the last working day/night, most sex workers had at least a client. They were also asked how many vaginal sex acts they performed in the last working day/night. During the previous working day/night, vaginal/anal sexual intercourse was performed on average 2 times (not in the table). Participants were asked if they had used any condoms during the last working day/night. The FSWs' sex experiences with condoms are summarised in Table 4. Examining condom use in all penetrative sex acts (anal or vaginal) in the last working day/night shows that only 23.3 per cent (n=24) of sex workers had used condoms.

Table 4. Self-Reported Sexual Activity and Condom Use in the Last Working Day/Night

Sexual Activity and Condom Use	**Number (n=103)**	**Percentage**
Number of sex partners in the last working day/night (anal/vaginal sex)		
1	68	66.0
2	19	18.5
3+	16	15.5
Frequency of sex acts in the last working day/night (vaginal sex)		
1	41	39.8
2	41	39.8
3+	21	20.3
Frequency of condom use in the last working day/night (vaginal sex)		
0	78	75.7
1	12	11.7
2	6	5.8
3+	6	5.8

Note: Dashes (–) indicate that data were not available.

It is not uncommon for groups of men to hire a woman for serial sex. In serial sex, one person has sex with different persons one after another and not concurrently. Evidence shows that serial sex appears to be more

common with street sex workers than in brothels. Table 5 shows that almost all the workers (91.3 per cent) reported having no serial sex during the sexual encounter. Of the 103 women sampled, only nine said they had multiple partners during sex. Only six women reported having performed sex only once in the last month preceding the survey.

The FSWs' previous experiences with condoms in serial-sex activities are also summarised in Table 5. When asked whether they use condoms with these sex partners, only 3 (33.3 per cent) reported that they sometimes use condoms, 6 respondents (66.7 per cent) stated that they never used condoms with clients.

Table 5. Serial Sex Activity among the Participants

Sexual Activity	Number	Percentage
Any serial sex in the last month (n=103)		
Yes	9	8.7
No	94	91.3
Frequency of serial sex in the last month (n=9)		
1	6	66.7
2	3	33.3
Frequency of condom use during serial sex in the last month (n=9)		
All the time	–	–
Sometimes	3	33.3
Never	6	66.7

Note: Dashes (–) indicate that data were not available.

Experiences of Sexually Transmitted Infections (STIs)

Information about the symptoms of STIs is useful as it is a marker of unprotected sexual intercourse and also a cofactor for HIV transmission. Table 6 illustrates the respondents' knowledge about STIs. Asked if they had current experience of any health/STI related problem, nearly 70.9 per cent (n=19) acknowledged having had such a problem (Table 6). Although this study did not measure current prevalence of STIs among FSWs, their reports suggest the prevalence to be high.

Table 6 summarises the symptoms of STIs of the respondents. The table shows that itching in genital was reported as the most frequently (39 per cent) citied symptom of STI, followed by burning sensation during urination (22 per cent). Some of the respondents (15.3 per cent) reported having pain during sex. Other types of responses commonly made by the respondents include: having genital lesion (11.7 per cent), having abnormal vaginal discharge (11.7 per cent), having pain in the

lower abdomen (6.8 per cent), and getting pus and blood from the anus (6.8 per cent). A small proportion of women (3.4 per cent) reported symptoms of current STIs, such as having pain/pus during menstruation. The table also shows that many women (42.4 per cent) did not have any recent symptoms frequently associated with STIs.

Among ever-married women, nearly three-fourth (72 per cent) have used contraceptive method at some time, and more than three-fourth (78 per cent) have said that they have used oral pill (Table 7). The next most commonly used method is injections (37 per cent), followed by condom (12 per cent), IUD (9 per cent) and female sterilisation (8 per cent). Very few women report having ever used male sterilisation (0.3 per cent).

The survey also shows that overall 70 per cent of married women are currently using any contraceptive method, with nearly a quarter (30 per cent) of the sample have discontinued using their method. In this survey, information was also collected concerning discussion about family planning between spouses. In order to achieve sustained use of contraception and to facilitate family planning method, discussion between husband and wife is an important step. More than half (60 per cent) of the women reported that both husband and wife took decision about which method to use.

Table 6. Respondents' Experiences of Symptoms of STI Transmission

Symptoms	**Number (n=103)**	**Percentage**
Itching on the genital	23	39.0
Burning sensation during urination	13	22.0
Pain during sex	9	15.3
Genital lesion	7	11.7
Abnormal vaginal discharge	7	11.7
Pain in the lower abdomen	4	6.8
Pus and blood from the anus	4	6.8
Pain/pus during menstruation	2	3.4
Smelly discharge	–	–
Sore on the vagina	–	–
Other	4	6.8
No symptom	25	42.4
Mean duration of main symptom in the body = 6.9 months		

Note: Dashes (–) indicate that data were not available.

Multiple response.

Table 7. Ever Use of Contraceptive Method by Age

Age (inYear)	Pill	Injectables	Condom	IUD	Norplant	Female Sterilisation	Male Sterilisation
<18	66.7	11.1	22.2	11.1	10.2	–	–
18-24	77.6	26.5	14.3	8.2	3.5	–	–
25-30	84.7	40.0	11.8	2.4	4.7	3.5	–
31-35	77.6	47.1	10.6	9.4	5.3	7.1	–
36+	73.7	42.1	10.5	15.8	2.5	26.3	–
40+	70.0	25.0	7.5	17.5	–	20.0	2.5
Total	78.0	36.9	11.5	8.7	4.9	7.7	0.3

Note: Dashes (–) indicate that data were not available.

Social Context of Sex Work in Thakurgaon

With the presence of street- and home-based sex workers in some locations (e.g. Old Bus Stand, Court area, Kalibari) of Thakurgaon, visiting sex workers is common among diverse segments of the male population in this area. In Thakurgaon, much of the commercial sex is concentrated in the truck stand (across Panchagar road) and Court area. As with many areas in Bangladesh, sex work is illegal in Thakurgaon, however, street-based sex workers can operate without fear of arrest. Subsequently, two forms of sex work occur: street- and home-based. However, since commercial sex is not tolerated throughout the society, the law is periodically enforced in Thakurgaon by token arrests of home-based FSWs. Clients of sex workers have not been subject to arrest or harassment however. Sex workers serving clients include mainly two groups in Thakurgaon. The first group, who typically charge low prices, includes women who work either in public areas such as the bazaar, truck terminal, open fields, the rail station, etc. or in small, low-price hotels in town. The second group, FSWs who charge mid- to high prices, includes women who work in houses, where clients come to meet sex workers, or sex workers visit clients' houses. These women may also be called to a hotel when clients request a sex worker from a hotel employee.

In a FGD, 6 FSWs participated – all classified as part-time street-based sex workers. Most of the FSWs were in their mid-thirties and were illiterate, although two had some primary education. The FSWs shared the view that they came from poor socio-economic conditions, and almost all of them had become involved in this profession due to economic necessity. Other reasons reported by the FSWs were sexual violence perpetuated by previous partners or lovers, being cheated by

someone in the past or history of abuse in their childhood. Some of them reported having husbands who are aware of their profession.

Several sex workers in the FGD explained that "the need of money" makes it difficult for them to insist on condom use with their clients. Such narratives indicate that even where sex workers want to use condoms, they have fewer options to negotiate safe sex with clients. Key informants that participated in our field research explained that sex workers have also unprotected sex with brokers and police. It appears that coercion, dominance and power make it difficult for sex workers to negotiate condom use with clients.

Sex workers' own health needs often go unmet – constrained by the economics of losing wages, inaccessible services, and socialisation to prioritise children and partners' needs over their own. If they do seek treatment for their ailments, it is usually as a last resort and through private providers that include quacks and neighbourhood pharmacists. Group discussions with sex workers and interviews with key informants revealed that sex workers do not use public sector facilities (such as government hospitals) because of poor quality of care and discriminatory treatment by providers.

Discussion

This study is the first of its kind in Thakurgaon that attempts to investigate the history of reproductive health, AIDS knowledge, risk behaviours and STI/RTI experiences of street-based FSWs in the town. It begins to address a severe dearth of information, particularly on high-risk sexual behaviour among this group of population of the country. The main objectives of the study were to document and analyse the extent of sexual and reproductive health risk behaviour of street-based FSWs and to understand their risk perceptions to avoid STI/HIV. The ultimate aim is to identify ways in which the reproductive and sexual health of these street workers can be improved most effectively.

The results show that commercial sex is common in Thakurgaon, and there is an active group of street-based FSWs serving clients. The FSWs come from various areas of the town and many are engaged in commercial sex work in other parts of surrounding districts (i.e. Dinajpur, Panchagar). This survey using a snowballing technique identified a group of women best described as part-time sex workers. They are described as part-time sex workers because the majority are self-employed in some form of small business and sell sex to supplement their small income. Small businesses often include selling foodstuffs,

vegetables, and in some areas agriculture. Among the street-based FSWs covered in the study, most of them are married (43.7 per cent) with low level of education. The majority of literate workers had received only primary level of education. The level of income is very low, and more than half of the sex workers live with their family.

In this study, an effort has been made to explore the experience of abortion and MR, and steps taken to deal with this unwanted pregnancy among street-based FSWs. An experience of abortion and MR is quite significant among this group. Among the FSWs, one in every three girls (18.4 per cent) had at least one experience of MR. Apart from that, one in four girls (24.3 per cent) reported that they had an abortion in their lifetime. A government hospital or private clinic was the most reported place for obtaining abortion services for these street working girls. There are similar proportions of girls in this sample who sought abortion services from unqualified personals such as *kabiraj* or *hekim*.

The most frequent STI/RTI complaints were itching on the genital – reported in 39 per cent of the respondents. Burning sensation during urination, pain during sex, genial lesion and vaginal discharge were also frequent in the FSWs – reported in 22 per cent, 15.3 per cent, 11.7 per cent and 11.7 per cent of FSWs respectively. The results of this study are similar to those of a study of FSWs in Dhaka, conducted by Nessa et al. (2004), in which chlamydial infection is the most prevalent STI among hotel-based sex workers in Bangladesh, though it is mostly asymptomatic and detected in screening programmes. Recently, the prevalence of STI/RTI has become more widespread and extended to general people. The Bangladesh Demographic Health Survey (BDHS) 2004 shows that one in five currently married women reported having had each of the problems: itching or irritation on/around genitals, urinating problem, and abdominal pain with discharge (NIPORT et al. 2005). Women who are engaged in commercial sex work, should, therefore, be encouraged to be screened routinely by laboratory tests, treated properly, and received preventive education.

Information concerning family planning methods was collected from the respondents by asking if they had ever used any of this. The data show that use of family planning method is widespread in the sample – almost all women over 25 years of age know of at least one method of modern family planning method that can be used to delay or avoid pregnancy. On average, three-fourth of the sample used pills, with the next method of family planning being cited injections, condoms, IUD and female sterilisation. Male sterilisation was rarely mentioned as a family planning method in this sample.

HIV/AIDS awareness and knowledge is the most widely used indicator of risk and a tool for tracking behaviour change (Habib 2002, Hawken et

ordered in relation to the research questions and structured analysis condensed the mass of data to identify trends and patterns.

Results

Socio-Demographic Profile

The socio-demographic features of the respondents are illustrated in Table 1. The study population consisted of 103 sex workers who were recruited from streets. The women averaged 26.6 years of age (range 14-37 years). The majority (51.5 per cent) interviewed were aged between 25 and 30 years. Of the respondents, a small number (n=6, 5.8 per cent) were under 18 years of age.

Table 1. Socio-Demographic Features of the Participants

Feature	**Number (n=103)**	**Percentage**
Age (in years)		
Under 18	6	5.8
18-24	25	24.3
25-30	53	51.5
31-35	16	15.5
36 and above	4	3.9
Mean age = 26.6, SD = 5.9, Range = 23 (14-37 years)		
Marital status		
Married	45	43.7
Unmarried	14	13.6
Separated	6	5.8
Divorced/Widowed	12	11.7
Abandoned	31	30.0
Education completed		
Illiterate	68	66.0
Primary incomplete	12	11.7
Primary complete	10	9.7
Secondary incomplete	12	11.7
Living arrangements		
Lives with husband/family	72	69.9
Lives alone	27	26.2
Other	4	3.9
Occupation other than sex work		

traceable to the cross-sectional study design. First, the possibility of self-selection bias influencing findings must be considered. Reviews of strategies for commercial sex data collection have recommended purposive or network sampling for descriptive studies of sex workers when probability sampling is not viable (Simic et al. 2006). The current study used a purposive sampling technique whereby particular locations were sought out as being places where street FSWs would be likely to frequent. There was no list of all possible sites from which a random sample of sites could be drawn. Consequently, the proportion of sites used and the representativeness of the chose sites are unknown. Similarly, there was no list of street-based FSWs from which a random sample could be selected so the representativeness of the sample is not known.

Second, the data collection methods in this study relied on self-reports of behaviour which are susceptible to response biases. Given the social sanctions for admitting continued engagement in commercial sex and high-risk sexual behaviour among FSWs, the data may underestimate the rate of risk behaviours practised by this sample. In light of these limitations, however, the current findings offer implications for designing interventions for women engaged in sex trade who continue high-risk practices.

Conclusion and Recommendations

This study has highlighted aspects of commercial sex work in Thakurgaon that are of critical importance in terms of current and future risks of increase in STI/RTI infections, including the entry and spread of HIV. This study has shown that substantial proportion of street-based FSWs engage in risky sexual behaviour. Multiple partners, irregular use of condoms, low use of contraceptives, occurrence of unsafe abortions are common. Despite high-risk behaviour, relatively few sex workers considered themselves to be at risk of getting STIs or HIV/AIDS.

In view of the insights provided by this and other studies regarding causative factors in the spread of STIs and the potential danger of HIV/AIDS epidemic, further attention must be given to preventive and promotive interventions (Murshed & Ullah 2000, Abdul-Quader 1998). There are interventions of proved efficacy in decreasing STI and HIV incidence in sex workers, such as peer education and condom promotion. In designing such interventions, it is important to target part-time sex workers, who, because of the part-time nature of their work, may

otherwise be overlooked. The low use of condoms, incomplete knowledge of HIV and STI, the high prevalence of reported STI in this group emphasise a great need for intensive STI and HIV prevention programmes in this hidden population and particularly in those in the younger age group.

Since peers were most preferred source of getting information on reproductive and sexual health among the sex workers, peer education and outreach can be an effective channel for disseminating reproductive and sexual health information among these group of people. Reproductive and sexual health information should be provided through appropriate channels. In-depth discussions during FGDs have shown that fear of disclosure particularly prevents girls from seeking appropriate and timely care for a variety of sexual and productive health needs. Therefore, it is essential to provide confidential and gender sensitive sexual and reproductive health care services to street working girls.

A few suggestions regarding reproductive health programmes and policies can be derived from the results of the analysis. A positive outcome from prevention programmes among this high-risk group may be possible through a wide range of activities. The activities of the reproductive health and STI/HIV related health service delivery need to include the following:

- Basic sexual health information on STI and HIV/AIDS prevention treatment could be provided to these groups by launching programmes in Thakurgaon.
- HIV/AIDS awareness programmes need to introduce for sex workers in this area. For example, awareness meetings could be held for these groups once a week.
- Management of STIs and condom promotion also needs to be provided in the vicinity of Thakurgaon town.
- Promote empowering sex workers to raise their voices against any discrimination and harassment they may face.
- Introduce HIV/AIDS outreach work in Thakurgaon with sex workers and other vulnerable groups, including peer-driven approaches. Ensure that the police or *mastans* do not arrest or harass the outreach workers.
- Provide sex workers with access to training and counselling for the pursuit of alternative careers.

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