

## Chapter 17

### **HIV/AIDS and female street-based sex workers in Dhaka city: what about their clients?**

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#### **Abstract**

**SATHI (Sex Workers and Associates Training and Health Initiatives) is a small participatory action research project funded by the Royal Netherlands Embassy in Dhaka, Bangladesh, and implemented by CARE Bangladesh in close co-operation with the members of Durjoy Nari Shanga, an organization of female street based sex workers. The goal of the project is to develop proper HIV/AIDS strategies for targeting clients of female sex workers through active involvement of sex workers themselves. Combined qualitative and quantitative research shows that clients' knowledge, attitude and behaviour call for immediate interventions, which should probably first target the five major client groups: rickshaw-pullers, service employees, students, police and businessmen. Policy makers and implementers of HIV interventions need to be convinced that these are needed and feasible. The fact that lack of income is extremely important in the life of sex workers is another barrier to behavioural change. Fees and condom use decrease as the night progresses as a result of a changing 'market', probably because of the need for income. However, the largest barrier seems to be the very low status of women in Bangladesh society, particularly that of female sex workers. Violence against women, their own low self-esteem and the dominant role of men as policemen, pimps, local gangsters or clients, along with the growing number of HIV-positive people, make Bangladesh extremely vulnerable to a huge AIDS epidemic.**

In this chapter, results of a participatory action research project called SATHI, funded by the Royal Netherlands Embassy in Dhaka, are discussed, and a short overview of the situation in Bangladesh with regard to HIV/AIDS and prostitution is given. The background of the project, the methodology and some of the findings of the research are discussed. In the conclusion, future interventions are proposed.

AIDS is posing a threat to South Asia, including Bangladesh. According to UNAIDS (1999), by the end of 1997 there were an estimated 21,000 adults and children with HIV/AIDS in Bangladesh. More detailed and updated information collected through the Bangladesh National STD/AIDS Surveillance System in mid-1998 will be published soon. The percentage of HIV-infected people among sex workers is under one per cent and among injecting drug users more than two per cent; therefore Bangladesh is still considered a low-prevalence country. However, all high-prevalence countries were once low-prevalence countries.

Bangladesh seems to present an opportunity for all groups of people practising high-risk behaviour to be targeted for behaviour change. This chapter focuses on female sex workers and their clients.

Prostitution in Bangladesh is much more common than often acknowledged. Estimates of the number of sex workers in Bangladesh vary widely. There are estimates of 100,000 registered sex workers, but many of the estimations are without any foundation. Estimates are difficult because there are many different types of sex workers that may not always be recognized by the researchers: brothel-based (there are 18 registered brothels in all of Bangladesh), street-based, hotel-based, and they can be either females, males or *hijraj*<sup>1</sup>. Each of these sex workers has on average at least 3-4 clients per day and there is little condom use (CARE 1998).

In 1997, CARE Bangladesh in collaboration with the Marie Stopes Clinic did research with street-based sex workers of Dhaka City: these are defined as women who pick up their clients on the streets, but will not necessarily have sex with them on or beside the street. The sex workers themselves were responsible for making an estimation of the number of street-based sex workers by the capture-recapture method. In this way they calculated a total of 4366 street-based sex workers in Dhaka City (CARE 1998).

## Background

CARE Bangladesh developed a project called SHAKTI (Stopping HIV/AIDS through Knowledge and Training Initiatives) that initially started working among brothel-based sex workers in a town called Tangail, a two-hour drive from Dhaka. Peer educators and outreach workers (sex workers who are paid by the project) play a crucial role in this project, providing knowledge on sexually transmitted diseases, condom use and the distribution of condoms. The project also started with an intervention among street-based sex workers in Dhaka City, through similar strategies. Peer educators and staff outreach workers inform sex workers about sexual health and risk reduction, in order to motivate them and their clients to change their behaviour and to promote safer sex. Peer educators are trained and are working face-to-face and through group education with about 2000 sex workers.

The base-line study of street based intervention of SHAKTI indicated that there are a large number of locations in the city where the sex workers negotiate with clients and these locations include parks, railway stations, movie halls, street-corners, areas around office buildings and a number of residential areas. Many of these locations are also used by the sex workers to have sex with clients. The times they conduct their business vary depending on the locations and the characteristics of the women themselves. At some of these locations they can be found throughout the night and at others only during certain hours. Compared to the sex workers in a brothel, most of these women conduct their business independent of any centralized power structure. However, there are pimps and brokers who arrange clients for the sex workers, take money from them and exert a certain amount of influence over them. A quarter of the women are below 18 years of age and a large proportion of them are either divorced or separated from their husbands. Most of them have worked earlier in jobs not related to prostitution and about a fifth have been in a brothel before moving onto the streets. For most of them sex work is the only source of income. On laboratory examination TPHA<sup>2</sup> tests were positive for 52 per cent of them and VDRL<sup>3</sup> positive for 29 per cent; 53 per cent

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<sup>1</sup> *Hijraj*: eunuch. In Bangladesh many of these are not eunuchs but transvestites; however, all are termed *hijraj*.

<sup>2</sup> *Trepanoma Pallidum* Haemagglutination Assay: test for syphilis.

<sup>3</sup> Venereal Disease Research Laboratory test for active syphilis.

were PCR<sup>4</sup> positive for gonorrhoea and 49 per cent for chlamydia. None of the tested women was found to be HIV-positive (CARE 1998).

The data from Bangladesh National Surveillance in mid-1998 show that active syphilis is present in 57 per cent and HIV in 3 per 1000 prostitutes on the streets of Dhaka city, but this included also the non-CARE areas (personal communication).

Despite the relative success of interventions like SHAKTI in Bangladesh, many issues related to female sex workers and their vulnerability to HIV have not been addressed. Underlying many interventions is the view that sex workers are a potential hazard for society and that they are multipliers in HIV-dissemination. Sex workers are often mainly regarded as contributors to HIV transmission by their frequent change of sex partners. Interventions often do not sufficiently reflect the needs and interests of these women and do not appropriately address their clients. For proper interventions to be developed, more information is required.

After several discussions with the peer educators, a participatory action-research proposal was developed. Sex workers and Associates Training and Health Initiatives (SATHI) was born. In Bengali the word *sathi* means friend. SATHI hopes to promote the concept that sex workers deserve respect, that they are not the cause of the HIV/AIDS problem, but are part of the solution. After the SHAKTI intervention had gone on for some time, the street-based sex workers formed an organization named Durjoy Nari Shanga (*durjoy* in Bengali means 'difficult to conquer'). This group received training on legal rights and human rights, leadership and organization development by partner organizations. It is with this group of women that SATHI is being implemented.

The goal of the project is to develop proper strategies for targeting clients of female sex workers through active involvement of sex workers themselves. Therefore the research itself is to identify the different clients of female sex workers in Dhaka city and their risk behaviour and perceptions, and to identify the views of female sex workers on the different clients and the different sexual relationships.

In this chapter, the data collected through the SATHI project are discussed. Different HIV - related risks are identified, and possible obstacles to change are shown. We try to look at the reasons why people do not or cannot change and what makes people get into risk situations.

## Methods

The research methods are both qualitative and quantitative. The quantitative research took place from 3 November until 15 December 1998; the qualitative research started on 14 January 1999 and ended on 22 February 1999. This research is a close collaborative effort of CARE Bangladesh and the members of Durjoy Nari Shanga with, as well as the specific research objectives, also the intention of strengthening this group of women.

### *Quantitative study*

During the mentioned period, the members of the *samity* (group of sex workers called Durjoy Nari Shanga) requested sex workers, their colleagues, to ask three questions of their clients during the coming night. The next day they would meet the sex workers again and gather the information on marital status of clients, regular or irregular clients<sup>5</sup>, and occupation of clients. The number and sequence of clients, number and type of sex acts with the different clients, condom use and fee per visit have been collected. The information was filled out on a

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<sup>4</sup> PCR: Polymerize Chain Reaction test for chlamydia and *Neisseria gonorrhoeae*.

<sup>5</sup> The women asked 'Is this the first time you go to a sex worker like me or do you go regularly?'

pictorial sheet developed in collaboration with the sex workers themselves through several meetings and discussion sessions. Thirty members of the Durjoy Nari Shanga interviewed five sex workers per day on seven different days. Every second sex worker they would meet was asked to join in the interview until the total of five per interviewer was reached. In total, information on 923 sex workers' events was collected with data on about 4654 different clients, who could have been double-counted. For most of the analysis for this chapter, we had to exclude one of the areas, because it is characterized by a large number of *hijraj* and our focus here is on female sex workers. Finally, these data were only collected in the NGO intervention locations, covering 2000 sex workers out of an estimated 5000 (using the capture-recapture method) street based sex workers in Dhaka city.

### ***Qualitative study***

The qualitative part of the study deals with both sex workers (209) and their clients (209) and these two groups were interviewed on topics such as prostitution, condoms, HIV/AIDS, STD, violence and drugs. This part of the study is especially important for understanding the clients' perceptions. The sex workers were again interviewed by the members of the Durjoy Nari Shanga and the male clients by male interviewers. The latter interviewers collaborated closely with the *samity* members to locate the clients and ask them to be interviewed. The interviews with the clients took place in the NGO intervention locations where most clients were found according to the quantitative data, and also in four locations where no NGOs had an HIV/AIDS intervention.

The sex workers' interviewers as well as the client interviewers were trained for several days on topics such as sexual activity, bias, how to ask questions, and sampling. They learned how to record their interviews on tape recorders. These tapes were later transcribed, translated and typed into a word processing program. These have been analysed using Atlas.ti 4.1, a computerized qualitative software program.

### ***Constraints in method and sampling***

Some of the constraints need to be mentioned that are of importance to put the data in the right context. The constraints of quantitative study can be divided into five broad areas.

We decided to use a short questionnaire, because our interviewers, the women of the *samity*, were not experienced interviewers. The questionnaire needed to be as simple as possible which might be important for bias in relation to the questions about condom use, clients coming in groups and the rate per visit. Both sex workers and clients could be double-counted. We also did not collect the characteristics of the sex workers during this exercise. In addition, using peers as interviewers might have biased the information on condom use, rate per client and type of sex act (Weir, Fox *et al.* 1998; Weir, Roddy *et al.* 1998). Lastly, we collected the data only in our NGO intervention areas, and therefore, we should be careful about generalizing this information for all Dhaka city.

The constraints of the qualitative study are important, because the data will also be used to put the findings of the quantitative study into the proper context. There has been very little research on clients, probably because it is more difficult to persuade clients to co-operate in an interview. Although a sampling procedure had been developed, in practice it was very difficult to stick to it owing to the unwillingness of the clients to participate. They often denied that they were at the contact points to look for a sex worker. Also the place and time of the interviews may have influenced our data set. When approached, the clients were looking for sex and were sometimes not in the mood to give an interview. Sometimes a proper place for the interview could not be found and this attracted outsiders, which created disturbance.

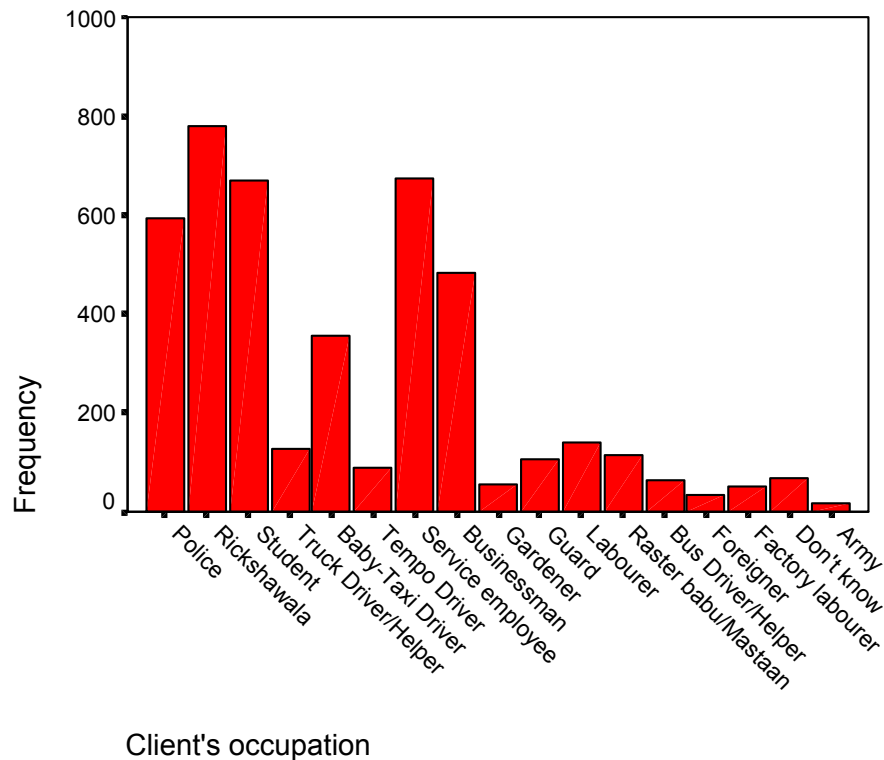
The best interviewers in the quantitative interviews were selected to do the in-depth interviewing of the sex workers. The fact that they were peers may have biased the data, although the selected six interviewers did the interviews in other areas than their working area, that is, where they do condom distribution as well as their own sex work.

## **Results**

Through the quantitative pictorial sheet, it was found that the five major occupation groups in the selected 23 locations are rickshaw pullers (17.7%); service employees including government staff, private staff, non-government organization staff, private car drivers, salesmen, hotel staff, and cinema hall staff (15.3%); students (15.1%); police (13.4%); and businessmen (10.9%) (see Figure 1).

The qualitative interviews in six of the 23 locations confirm these findings. The non-intervention areas show a similar picture, except for one area that includes a truck stand which resulted in more truckers as clients. Indeed, the quantitative data show that in some geographical areas, some occupations are more prevalent: servicemen near an army base and foreigners in the richer residential areas. Therefore, it was not surprising to find more truckers as interviewees in one of the non-intervention areas. Looking at the main five client groups, we were especially interested to find out more through in-depth interviews about the service employees and the businessmen. Sex workers in the in-depth interviews said that their clients were mostly people working in offices, either government or non-government. In these interviews service employees are often mentioned when talking about the type of clients who visit them. In-depth interviews with clients showed that many were service employees. However, the policemen were not sufficiently represented, as they were very difficult to approach. The in-depth interviews give more detail about businessmen, who are mainly small and moderate businessmen such as tea-shopkeepers, *pan* (betel-leaf) sellers and fruit sellers. One-eighth of clients interviewed belong to this group.

**Figure 1**  
**Division of clients by occupation**



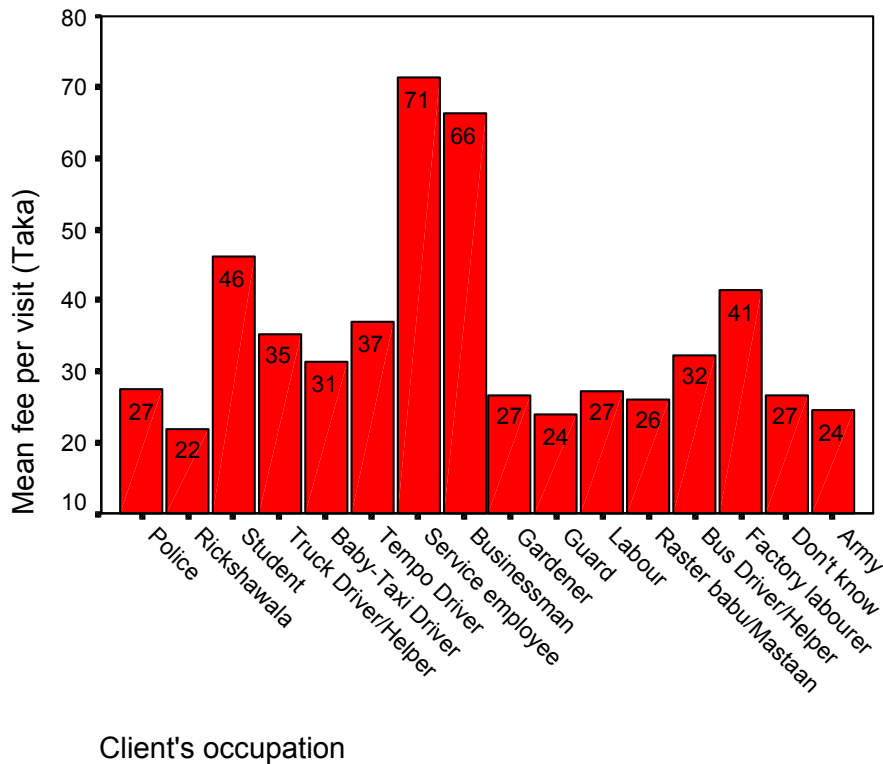
There are large differences in the number of clients in the different areas. We expected that identifying a client and persuading him to participate in our research would not be easy, so we chose the areas with the largest number of clients in the CARE intervention areas and with a similar representation of occupations in all 23 locations together. The four non-intervention areas were chosen after the mapping exercise and in consideration of the potential for new interventions with both clients and sex workers after the research.

The fee that is received on average differs significantly according to occupation, for example service providers give 70 taka ( $\pm 83$ ) (about US\$1.50)<sup>6</sup> and rickshaw pullers 22 ( $\pm 12$ ) taka (see Figure 2). The in-depth interviews made it clear that the fee paid is related to the income level of the different client groups. The sex workers told us almost unanimously that they prefer businessmen and service employees because they pay more. Foreigners are most profitable but only a small proportion of the women, those working in certain locations where foreigners live, have them as part of their clientele. Businessmen bring the women to their residence if possible or otherwise to hotels, then they hire the women for the whole evening or night for parties during which often alcohol is consumed. The women earn more during these events, but are also more vulnerable to violence and unsafe sex, and have to perform varieties

<sup>6</sup> US\$1 = 48 taka.

of sex acts other than conventional vaginal intercourse. It is likely on these occasions that the sex workers have to entertain more clients than initially agreed upon, often for no more money.

**Figure 2**  
Mean fee per visit by occupation (excl. foreigners)



The money that has to be paid also depends on the price of the woman herself which is closely related to the way she looks and her reputation as a sex worker. However, this seems to be less important than the rate the client is willing to pay, especially as the evening progresses. We found that a sex worker earns on average 228 taka<sup>7</sup> per night; it should be borne in mind that most of them do not work every day. The money ranges up to more than 5000 taka, for sex with an average of 5.1 clients ( $\pm 3.1$ ), although two of the respondents had sex with a total of 20 clients. The sex workers have to pay money to the pimps, police, guards and *mastaans* (local Mafia) to be able to keep working in the area.

<sup>7</sup>  $\pm 262$  Taka, median 175 and mode 100.

A few of the clients (3.1%) do not pay at all, and they are mainly the police and *mastaans*. From the pictorial sheet it was not possible to find out if this could be considered as rape or not, but the qualitative data give much more insight into this issue. Although very few clients admitted to being violent or failing to pay for the services of the sex workers, a majority had seen others do this.

A married pimp and *mastaan* of around 40 years old:

Sometimes I paid, sometimes I did not. Sometimes I have beaten some of them, instead of giving money, as they did not behave well. *Have you seen other people not paying or beating ?* No. *What do you think about not paying?* I think it is bad. Because those [girls] who do it, do it for earning bread, for [buying] cloth, for [taking care of] their children. If some one does not pay because girls do not have any prestige, I feel very bad about it.

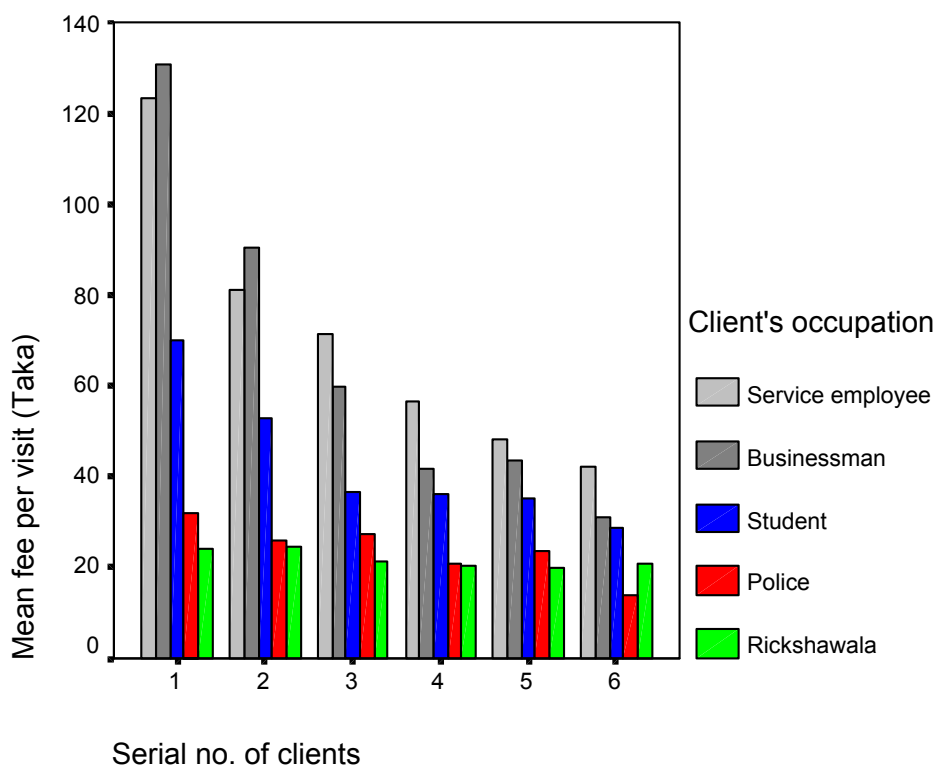
Despite the regret this person claims to have, later in the interviews he says:

Anyway I asked the girl [for sex], but she called me bad names. I went back with a friend of mine and took her. At night we took her in a 'baby-taxi' [motor-tricycle]. We asked her: 'Would you like some wine?' She said yes. Then we offered her hard drink [and she got drunk]. There were four of us. We compelled her to do oral sex, we went through the urinary passage [vaginal sex], and we went through the anus. We compelled her to do that. She did not want to do it. So, we have beaten her. And then we did not pay her. [We] did not pay because she called me names. That's why.

For all client groups the fee decreases when the first client is compared with later clients. For example, if a service employee is the first client, he pays on average 122 taka (see Figure 3). However, if he is the second client of a sex worker he pays 80 taka, third, 70 taka, fourth, 56, fifth 49 and sixth 43. This trend is found for all 23 locations and, although it is an issue that has not been covered in the in-depth interviews, it has been discussed in the feedback sessions (see discussion).



**Figure 3**  
**Mean fee per visit per client number**



During the quantitative data collection it was found that almost all sex acts are vaginal (94%). Only a small percentage is anal (4.1%), intercrural (3.6%), manual (1.2%) or oral sex (1.1%). However, as already discussed, the non-vaginal sex acts may be underreported owing to the stigma attached to them. In the in-depth interviews with the sex workers, it is very often mentioned that the clients want to have oral sex with them, but that they would never perform this. Only a very few admit to performing this type of sex if requested by the client.

A 25-year-old, unmarried sex worker:

Many customers tell us to take [the penis] into our mouth but we feel that our mouth is a very holy thing ... we pray to Allah .... Allah is the greatest to us in this world .... then our mother ... our father ... isn't it ... if we do not want to take [it] into our mouth..... then they beat us .... many boys say: Take it into the *pasha* [anus]. I tell them: Why will I take [it] through my *pasha*?.... don't we have a place in front?.... No.... if I do not give in they beat me, they torture me a lot.

The women present at a feedback session agreed that a lot of girls have oral and anal sex, because they receive more money than usual. Sometimes they are forced to do it, especially when they are with a group of clients. Moreover, it is important to realize that sex workers do not want to admit that they are doing it, even among themselves.

One of the sex workers at a feedback session:

We will never admit that we are doing oral sex, only when you will see us doing it. However, we will deny it again afterwards.

If one finds out from another that she has been performing oral sex, she will call the other 'chushni' (sucker) which puts a negative label on the woman. Some of the interviewed sex workers had other reasons for not agreeing to oral and anal sex.

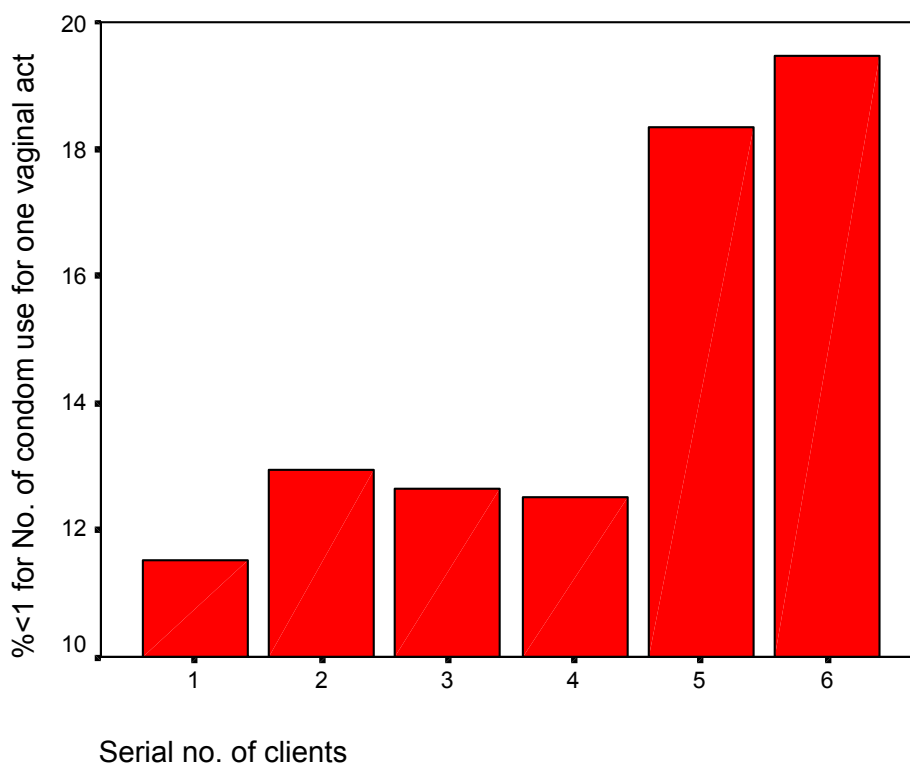
Another 25-year-old married sex worker:

Then they said: you will have sex with me in this way, but I did not want to, because I do not do these things. Then he slapped me. *What did he say?* He told me to take it [penis] into my mouth or otherwise he would...He said: I will not do it this way [vagina] but I will do it the other way [anus]. I did not agree with him, I did not give in. Then he slapped me and after that I went back from there. *Well, sister, is there any problem, if you do the things these people want? How? What you said, taking it in the mouth, in the pasha, is that a problem?* It is a problem for me. *What type of problem?* It is a problem because AIDS may occur from this. *You also get pain?* I get pain, but that does not matter. Sufferings are not a big deal, if I get 'AIDS' disease from this, that is a big deal.

Interviews with the clients show that especially those who look at pornographic films and magazines tend to experiment not only with the different types of vaginal sex, but also with anal and oral sex. However, they also told us that most of the women do not agree to these acts.

We also found that condom use per vaginal sex act decreases when the first client is compared with later clients (see Figure 4). Controlling for client occupation group it is only significant for rickshaw pullers and students. The qualitative data show that condom use is especially difficult to maintain with rickshaw pullers and students. Rickshaw pullers are not very popular as clients, because they always want to bargain. Students are often known to be violent. It has not been specifically discussed in the in-depth interviews why these barriers become more difficult as the evening progresses, but we did find that the availability of condoms is problematic later in the evening.

**Figure 4**  
Trend of condom use per vaginal sex act per client number



## Discussion

The findings of the study show possible barriers for reducing the HIV/AIDS risks within the context of street prostitution in Bangladesh.

There are clients who pay less than the market price, that is, less than other clients pay to a particular sex worker, for example the police and rickshaw pullers. As mentioned above, the fee asked and received per client is related to the income level of the client. As a result, the rickshaw puller pays little, and in addition, he always wants to bargain. However, sex workers are indeed not in control over the rate with certain clients, especially police. When looking at the qualitative data we see that violence is most common with students, police and the *mastaans*; the latter two are the clients who often pay below the market price. We discussed some of the quantitative results with the members of the *samity* and we asked them about our finding on the police paying below the market price. One participant told us (while showing a scar on her ankle): 'I tell the police: then just give me five taka only, but please do not beat me'.

The finding that condom use decreases while the night progresses is similar to findings in other countries (for example, Pickering *et al.* 1993 in Gambia). However, we found that the decrease in fee seems to accompany a decrease in condom use. Figures are not available for the number of clients that come in groups and have sex one after the other. So it

is not possible to check if the decrease in amount paid and in condom use as the night progresses is due to the increase in clients that come in groups. However, in interviews clients said that many of them indeed go for the first paid sex experiences with their friends in a group, but after that not any more.

Client who is a painter and is 22 years old:

I was influenced by my friends going there. *So you were influenced by your friends?* Yes on a holiday when I finished my work, my friends said: 'Let's go somewhere'. I asked them 'Where?'. They replied 'It's that place [a brothel]'. *There?* R: Then, I had sex there.

Client who is a transport worker and 20 years old.

*Later, when you went ..... did you go alone or with your friends?* The first three or four times I went with my friends, and thereafter I went alone.

Further, it seems that even clients who like going in a group, do not wish to do so when going to street-based sex workers, as opposed to going to a brothel with their friends. Clients as well as sex workers mention that during 'parties' group sex does occur, although most of the time this is not a group act, but a serial event in which they will have sex with the same girl one after the other in separate rooms; it is still high-risk behaviour. However, only sex workers in certain areas, especially those women who work in areas with limited space for sex acts, have experience with these parties. Many of the women do not want to go to these parties for fear of violence and group sex.

The most plausible explanation for the decrease in fee and condom use, is the changing market situation in the course of the evening and the decreasing availability of condoms when it gets later. The participants of the *samity*, asked about this trend, said:

In the beginning of the evening there are many clients, but the number of sex workers is not that many as yet. When bargaining about the price the woman is in a good position and can really ask what she is worth. However, as the evening progresses, there are fewer clients and more sex workers. At that time, we do not only want the client. We want him at any cost.

While talking about the decrease of condom use, the sex workers also mentioned other reasons:

The condom availability is less later in the evening and further our vagina gets very dry after a number of clients, and as we do not have access to lubrication, we prefer to have sex without condoms.

Another explanation could have been that certain types of sex workers of certain areas are responsible for the general trend, but analysis by area shows that in almost all cases, the same trend can be observed. We did find that HIV/AIDS knowledge is higher in the CARE intervention than in the non-intervention sites, even for the clients. This latter group told us that they had heard it from the 'sisters of CARE', referring to the peer sex worker educators trained by CARE.

The finding that oral and anal sex probably occurs more often than admitted by both the sex workers and the clients in the study, even by the trained peer educators of CARE, because of the stigma, is a reason for concern. If certain issues are difficult to admit, it will always be difficult to develop the correct prevention strategies.

The finding that there are differences between the client groups in the different areas is important for effective and targeted client intervention. For example, truck drivers are only seen in limited areas of Dhaka city, although this group should also be targeted because of its mobility throughout the country and even beyond the borders of Bangladesh.

Violence against the sex workers is a huge problem, as can be seen from most of the above statements by both sex workers and clients. The beatings, forced sex, arrests and other types of harassment increase their HIV vulnerability. In addition, analysis of the qualitative data shows that the female sex workers themselves have internalized a low self-esteem that seems to be very difficult to overcome. In all our interviews, the women talk about themselves as being bad women and only among the women who have been members of the Durjoy Nari Shanga for a longer time, is this attitude less common.

A sex worker of 29:

When I became *kharap* (bad) there were not many girls at Gulshan or Banani [two residential areas in Dhaka], there were only four girls in Gulshan and in Banani there were four or five. And now people cannot walk around in Gulshan or Banani any more, because of the huge number of girls. As the population has increased, also the number of *kharap* people has increased. Normally, one should be able to handle a bad boy easily but [at present] he cannot be managed because of the fault of girls. A girl misbehaves with men. It happens only because of girls. Although boys also have faults.

It will not be surprising that we came across comments from the clients about sex workers in line with the above.

A business man of 30 years old:

*Now except for paying do you not have any girl friend for sex? Without paying money it is not possible in Dhaka city. There are friends [who do this] but that is not correct. To spoil a good girl is not good. Do you have sex with them? I never spoil the good girls.*

## Conclusion

The finding that young active men (students) are the third largest client group is of great importance for any future intervention in Bangladesh, where young people have been greatly neglected by the HIV/AIDS interventions so far. Only recently have several initiatives for addressing young people been started. However, the incorporation of sex education in the school curriculum (mentioned in approved HIV/AIDS policy 1997) is still to be implemented (GOB 1997). Also interventions for the police, being also in the top five of clients, have not taken place as yet. Comprehensive interventions for clients have only taken place in a very scattered way. Client interventions are often considered too diverse and difficult to handle, and are neglected because it is not known where to start. This study shows clearly that a start has to be made and should focus in Dhaka city on the five major client groups; the problem will be to target these occupation groups without stigmatization. Certain clients, such as the police, seem to be difficult to approach, but they can be approached, especially with commitment from high-level authorities.

In short, the data show that very specific interventions need to be developed in order to reduce risk behaviour on the streets of Dhaka city. However, one huge resistance that needs to be tackled is the gender issue. Women have a very low position in Bangladesh society and the position of female sex workers is even worse. Violence against women, women's own low self esteem and the dominant role of men as police, pimps, local Mafia or clients, along with the growing number of HIV-positive people, make Bangladesh extremely vulnerable to an AIDS epidemic.

The above described attitudes and behaviour of the clients are not uncommon among clients of street-based prostitutes (Plumridge *et al.* 1996). This chapter offers further evidence that it is also important for community education programs to address men's failure to accept

responsibility for condom use when seeking the services of sex workers (Pyett and Warr 1997).

Also the income issue seems to be a major barrier to behaviour change that can only be tackled through community organizations. However, organizing sex workers, especially in a street situation, is not easy.

CARE Bangladesh HIV/AIDS prevention efforts, through SHAKTI and SATHI, together with partner organizations mobilizing the street-based sex workers of Dhaka city in the form of Durjoy Nari Shanga, are proving that it is possible to reduce the HIV vulnerability of women.

Looking at the HIV/AIDS-related risks and the possible obstacles to change identified in this paper, we question what makes people change their behaviour and start having safer sex. Putting our data into perspective, there are three approaches for the development of HIV/AIDS interventions targeting female sex workers and their clients: human rights, people's vulnerability and people's individual behaviour. The human rights approach leads to advocacy work to draw attention to the deplorable situation of sex workers in Dhaka. The vulnerability approach leads to community interventions like empowerment through community organizations like Durjoy Nari Shanga, and improvement of their economic circumstances through alternative income sources; while the risk aspect leads to more individual interventions like health education and care, such as access to lubrication.

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