Geographies of HIV/AIDS in Bangladesh: Vunerability, Stigma and Place.

Paul, Alak

Geographies of HIV/AIDS in Bangladesh: Vulnerability, Stigma and Place

This Thesis Submitted for the Degree of Doctor of Philosophy

By

Alak Paul

Department of Geography
Durham University
Durham UK

June 2009

This thesis is dedicated to my beloved late mother who has been always inspirational to my studies and to the completion of this work.

Declaration

I declare that this thesis has composed by myself. The work presented in this thesis is based on original work and has not previously been submitted for any other degree or qualification. The nature and extent of my work is carried out by, or in conjunction with others, has been specifically acknowledged by references.

Statement of Copyright

Alak Paul
June 2009

Abstract

HIV/AIDS is one of the most complex health and socio-economic problems which leads to adverse impacts on individuals, communities and societies. It becomes increasingly concentrated mostly among marginalized populations in the developing countries like Bangladesh. In south Asia, Bangladesh is a predominantly Muslim country, where it might be thought that HIV (by sexual and drug use activity) is not likely to be a problem because of traditional and conservative mores. But different surveillance rounds results have show Bangladesh to be at risk of an HIV epidemic. There are many risk and vulnerability factors such as geographical location, trans-border mobility, poverty, stigma and discrimination etc. which favour the spread or transmission of HIV/AIDS. Most studies in Bangladesh on HIV are medical in approach and generally ignore the socio-economic, cultural or geographic linkages of HIV. Many research works have been carried out on sexuality, STDs, drug use and awareness related to HIV infection, but few investigations have contributed to understanding the 'lifeworlds' of vulnerable people, and stigma of marginalized communities. In addition, few research projects have attempted to see the role of place and mobility in relation to HIV risk in Bangladesh. This negligence has left planners poorly equipped to design and implement HIV prevention strategies. The present research intends to bridge this gap in understanding health risk behaviour in relation to prejudice, place and policy points of view by exploring the issues of vulnerable and marginal people's lives which put them at risk of infection and also their adopted coping strategies and how are these played out. Apart from this, the aim is also to gain an understanding of the local civil society, people and policy planners' perceptions in explaining the vulnerability of people to HIV and its mitigation measures.

This research takes a qualitative approach as a methodological research strategy which recognizes that people make a difference and places make a difference. In other words, the researcher has tried to explore the issue from a socio-geographic point of view along with health and policy planning in the field work in Jessore, Khulna and Dhaka. The location of both Jessore and Khulna has 'geographical value' as they have ports, brothels, opium dens, large transport terminals and slums. This research has been carried out on three social groups. First, I worked with people vulnerable and marginalized to HIV infection (i.e. sex workers, drug users, HIV positives and transport workers including Indian truckers). Second, I talked with local elites or people in civil society (i.e. journalists, NGO personnel and local government officials). Finally, I worked with key personnel and policy planners (i.e. high GOB and NGO officials) in

Dhaka. Regarding the sampling frame, beside the NGO beneficiaries, I managed this challenging work by developing contact with marginalised people through 'snowball' sampling. Despite it being a sensitive issue, this research did not negatively impinge on my respondents from any ethical or moral point of view. To fulfill the research objectives, the work is fully based on qualitative methods for data collection (i.e. in-depth interviews, focus group discussions, participant observation and naturalistic observation) and data analysis (i.e. discourse analysis and grounded theory). The researcher used flexible conversational techniques for questioning the participants in convenient places.

The evolving HIV/AIDS pandemic has shown a consistent pattern through which marginalization, discrimination, stigmatization, and, more generally, a lack of respect for human rights and dignity of individuals and groups heighten their vulnerability. In particular, due to this social, economic and legal context, sex workers and drug users are subjected to harassment which can increase their 'everyday' vulnerability to sexually transmitted diseases and make them 'victims' to violence. Most HIV positive participants felt loss of self image and self-esteem, uncertain and unpredictable future and distressing emotions. Discrimination against them has also been increasing. The qualitative information in this research demonstrates the real health risk to HIV/AIDS of the vulnerable people through their 'lifeworlds'. This research also managed to highlight or distinguish the geographically significant places like port areas of Bangladesh in relation to STD/HIV/AIDS. It makes a relationship between geographic space and health risk particularly with drug users and sex workers through 'risk bridging'. Apart from women trafficking and Indian truckers, this research has also found much evidence that many vulnerable people including sex workers, drug users and transport workers are falling into health risk due to their high mobility and the role of risky and non-risky places. However, a transparent and accountable mechanism is needed to ensure stronger coordination of activities on HIV and to ensure that commitments to HIV prevention and control are effectively translated into action. The government must formulate and implement programs to reduce stigma and discrimination so that people living with HIV, and particularly members of vulnerable groups, can access services for prevention, care and support. Hopefully, this research will ultimately lead to a better understanding of the social and geographical context of HIV/AIDS and provide a better foundation for health planning. In addition, this research develops a methodology of investigation for the study of a complex health and social environment in Bangladesh.

Acknowledgements

In preparing this thesis, I have incurred debts to a number of persons and institutions in UK and abroad. First, my deepest gratitude is extended to both of my mentors in the department of Geography, Durham University, UK. I could never have completed this work without help from Professor Peter J. Atkins who has stimulated my interest in the marginalized groups and guided me every step of the way. His unhesitating support, careful reading and comments in the early drafts, advice, and critique have enabled me to clarify my qualitative data, sharpen my ideas, and develop the organization of this thesis. I am indebted also to Dr. Christine E. Dunn for opening my eyes to contemporary concepts and theories in health geography and her critical review always directed me to read more literature. Her timely comments on some key issues of the research have also helped me to address and substantiate those issues. Special thanks are due to Professor Jonathon Rigg and Dr. Marcus Power for their valuable comments and suggestions in the concept and theoretical paper.

I am very grateful to Professor Dr. Md. Shahidul Islam, Department of Geography and environment, Jogonnath University, Bangladesh for his every encouraging word and support in my teaching life. I am also grateful to Professor K. Maudood Elahi, Jahangirnagar University for his kind affection towards me. I am especially thankful to Dr. Sk. Tawhidul Islam and Ms. Nandini Sanyal for their every help during the beginning of my work at Durham. As a part of my research work, I tried to collect some journal articles from different researchers by personal correspondence and in this regard I would like to show my thanks to Mary Shepherd (Johns Hopkins University), Dr. K. Sarker (India), Dr. Mahbubur Rahman (Japan), Dr. Matiur Rahman (ICDDR, B), Dr. Tapan K. Nath (Japan), Dr. Sreebash Paul (UK) for their assistance with this. Here, I would like to express my sincere thanks to the Chittagong University (CU), Bangladesh for allowing me the study leave and all members of teaching staff of the Department of Geography, CU.

My special gratitude to the 'marginalized' community of Bangladesh particularly sex workers, drug users and HIV positives who gave me enough time unexpectedly and shared their sufferings without hesitation which actually helped me to make this thesis today. They not only allowed me to tell their unspoken life story for my research but also thought me a friend and well-wisher. I am only hoping that those who read my thesis will understand their sufferings and hardships through my interpretations of their lives which I have come to understand. To be honest, I had no knowledge about their 'lifeworlds' before the study but had some mocking and unkind attitudes towards them. Now I can understand their hardship, sufferings, and society's behaviour towards them. I would like to salute to these fighters who have been fighting against the evils of the society in their everyday life. Here, my special thanks go to many NGOs, GOB officials and local people in Jessore and Khulna who acted as my local guides to make the 'bridge of friendship' with my respondents. My thanks go to Mr. Solzar Rahman, Mr. Nitish C. Mandol, Ms. Farzana Kabir for their involvement to facilitate my accommodation and research assistants. My thanks are also due to my research assistants for the way they have worked with me in the course of this research.

I express my sincere thanks to my friend at Durham, Simon McConway who always inspired me through frequent enquiry about my research. Here I also need to mention few more names like Rob lowe, John and Pauline Owen, Albert, George, Margaret, Smaran, Snigdho-Joyti, Jami, Mizan, Shukti who also shown their keen friendship in the long journey. Although I was often lonely during my four years living in Durham, I was always 'recharged' when thinking about the company of my Bangladeshi friends, including many senior friends. Among many I could mention some names are: Abid bhai, Maksud bhai, Maharu apa, Deypayon da, Saymol da, Salma bhabi, Litu da, Anjan da, Zakir bhai, Biplob da, Kanak, Subir, Mukul, Munni, Bilu, Taposh, Raju, Jobayed, Rassel, Hadi, Ranjit, Manik, Parvej, Mitu, Bappi, Papon, Anil, Ujjal, Titu and their lovely spouses.

I extend my indebtedness to my all family members including my father, all lovely sisters and their husbands and along with extended relatives who always gave me inspiration as well as blessings. My deepest thanks should go to my elder brother along with his family, whose dedication, on behalf, gave me moral support and made it possible to carry out this research work to complete without thinking about my lonely father.

This PhD research is made possible through the financial support received from jointly Overseas Research Students Award Scheme (ORSAS), University of Durham and Department of Geography which also gave me the opportunity to start my higher education in Durham University, UK and I am very grateful to all of them. In addition, I am also grateful to Geography Alumni Association, Sidney Perry Foundation, Charles Wallace Bangladesh Trust for their financial support for my field work and for completion the thesis. Finally, I bow my head down to almighty God for giving me the all opportunities to see a happy ending of this journey.

Alak Paul
June 2009

Contents

List of Figures

List of Tables

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
BAP	Bangladesh AIDS Programme
BBS	Bangladesh Bureau of Statistics
BDR	Bangladesh Rifles
BSF	Border Security Force
BSS	Behavioural Surveillance Survey
CAAP	Confidential Approach to AIDS Prevention
CDC	Centres for Disease Control
CSW	Commercial Sex Worker
Detox	Detoxification
DFID	Department for International Development
DIC	Drop-in-Centres
DU	Drug User
FGD	Focus Group Discussion
FHI	Family Health International
Fig.	Figure
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOB	Government of Bangladesh
HAPP	HIV/AIDS Prevention Project
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIV+	HIV Positive
HNPSP	Health Nutrition Population Sector Programme
ICDDR, B	International Center for Diarrhoeal Disease Research, Bangladesh
IDH	Infectious Diseases Hospital
IDI	In Depth Interview
IDU	Injecting Drug Use
IOM	International Organization for Migration
IVDU	Intravenous Drug User
KABP	Knowledge, Attitudes, Beliefs and Practices
KP	Key Personnel
KPI	Key Personnel Interview
LCS	Local Civil Society
LH	Local Healer
M&E	Monitoring & Evaluation
MR	Menstrual Regulation
MSM	Males Sex with Males
NA	Narcotics Anonymous
NAC	National AIDS Committee
NASP	National AIDS/STD Programme
NAT	National AIDS Trust
NGO	Non-Governmental Organization
NO	Naturalistic Observation

OI	Opportunistic Infection
Org-Int.	International Organization
PBD	Professional Blood Donor
PLWHA	People Living With HIV/AIDS
PO	Participant Observation
PO	Private Organization
PP	Project Proposal
RA	Recovery Addicts
RDS	Respondent Depend Sampling
Rep.	Representative
RP	Rickshaw Puller
RTD	Round Table Discussion
RTI	Reproductive Tract Infections
SD	Slum Dweller
SIV	Simian Immunodeficiency Viruses
SMC	Social Marketing Company
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TW	Transport Worker
UBINIG	Unnayan Bikalper Nitinirdharoni Gobeshona
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Chapter One

Background, Aims and Objectives, and Research Questions

Chapter One

Background, Aims and Objectives, and Research Questions

HIV/AIDS is one of the most complex health and socio-economic problems in the world at present, having adverse impacts on individuals, communities and societies. Over the last two decades it has become increasingly concentrated among marginalized populations in developing countries like Bangladesh. Apart from behavioural and bio-medical risk factors, HIV/AIDS has spread fast where there is widespread stigma and discrimination, along with poverty and illiteracy. In particular, stigma continues to remain a major barrier to treatment and this enhances vulnerability.

In much research, HIV/AIDS continues to be considered as a 'biomedical/behavioural level' problem, but Campbell and Williams (1999) suggest that it should be seen instead as a 'Bio-Psycho-Social' problem. In other words, epidemiological data alone cannot represent its multiple and complex social dimensions (Mann, 1987). The critical interacting factors of sexual and injecting drug-using cultures, together with the governmental and societal response to the HIV threat, shape the geographies of HIV/AIDS in particular settings (Ford et al, 1997). Being a third world country, Bangladesh is highly vulnerable to HIV/AIDS, not only as a medical challenge, but also in terms of its socio-cultural and geographical context. The country has a range of contextual factors that create and sustain this vulnerability (Bhuiya et al, 2004). A few researchers have focused on HIV/AIDS epidemiology, from a number of perspectives (for example, Motiur Rahman et al, 2000; Shirin et al, 2000; Hawkes, 2001; Gibney et al, 2002; Nessa et al, 2004 & 2005; Azim et al, 2004 etc.), but there is very little published from a social geographical viewpoint, and still less using qualitative methods. The present research is an endeavour to fill these gaps. The valuable qualitative field data will demonstrate the causes of HIV risk and vulnerability, and the thesis seeks a better understanding of the nature of the social and locational context of HIV/AIDS in Bangladesh and will therefore assist with health care policy planning.

The present chapter describes the origin and diffusion of HIV/AIDS, followed by a commentary on the global and South Asian situations. Bangladesh and its risk and vulnerability factors are discussed next. The aims and objectives of the thesis, along with the research questions come next, and the chapter then concludes with the ethical considerations of the research and a discussion of the approach to study area selection.

1.1 Origin, Diffusion and Transmission of HIV/AIDS

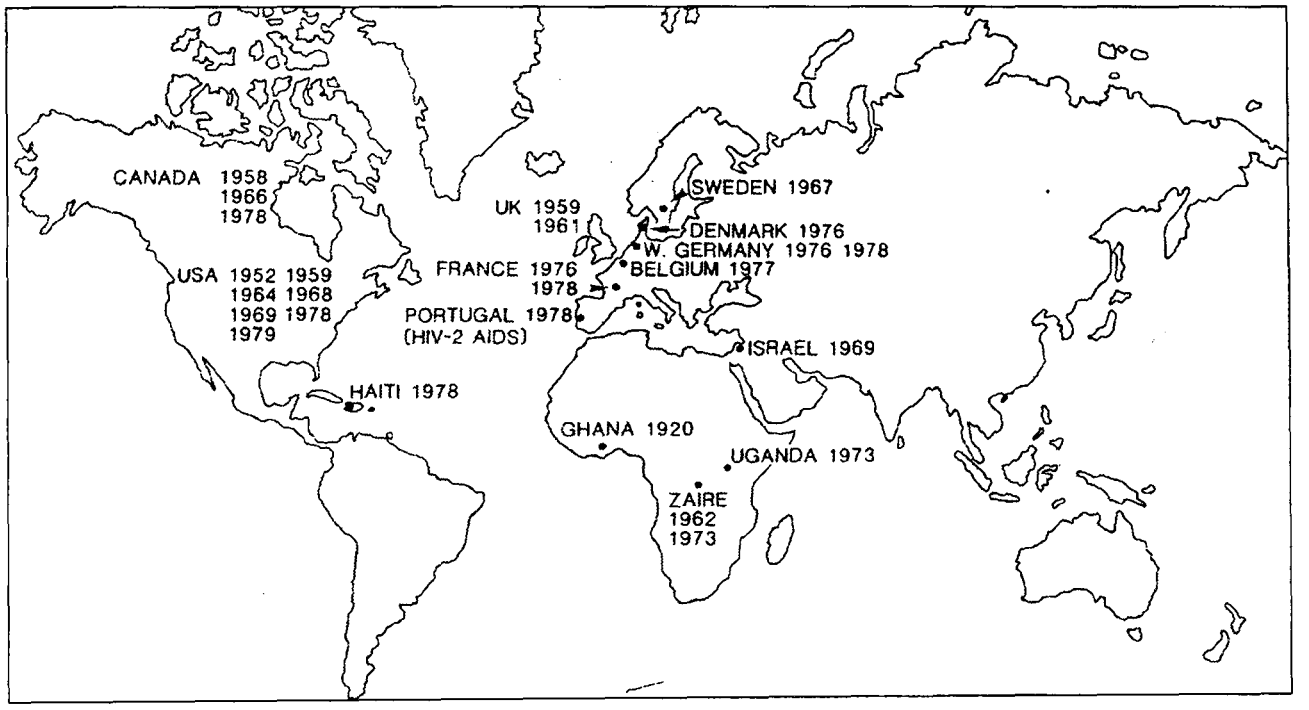
1.1.1 HIV origin theories

HIV is affecting people of both sexes and all ages, socio-economic backgrounds, sexual orientations and gender identities, directly or indirectly. The HIV/AIDS epidemic has been aptly named 'the slow plague' (Gould, 1993). There are two main sub-types of the virus: HIV-1 and HIV-2, the latter being harder to transmit and slower-acting. Both originate in simian (monkey) immunodeficiency viruses (SIV) found in Africa. The source of HIV-1 was chimpanzees in central Africa, while HIV-2 was derived in West Africa from Sooty Mangabey monkeys. How and when the virus crossed the species barrier continue to be matters of speculation and historical interest (Whiteside, 2008). We may never discover the origins of the HIV virus but there are three main theories (Sabatier, 1990). Following Sabatier, the first is that it has been around in humans for a long time but that we have not noticed it, perhaps because it has been confined to very few people (a small and isolated ethnic group), or perhaps because it has recently become more virulent. The second theory is that HIV was an animal disease (probably of monkeys or apes), and that it has only recently managed to infect and trigger an epidemic in humans through 'crossing over' (see also, Thomas, 2001; Whiteside, 2008). The third theory is that HIV is a human-made virus that was deliberately or accidentally manufactured in a laboratory.

AIDS is caused by the HIV, which probably occurred in the 1930s for the first time as isolated cases of infection (Fig 1.1) and the disease spread then accelerated in the late 1970s (Whiteside, 2008) and early 1980s in several widely separated locations, including Belgium, France, Haiti, The United States, Zaire and Zambia (Sabatier, 1990). But AIDS was publicly reported on 5 June 1981 by the Centres for Disease Control (CDC) in the USA (Whiteside, 2008). Though AIDS was first identified in the United

States, evidence points to a large region of central Africa, including the former Zaire, Zambia, Uganda, Rwanda, and the Central African Republic, as the possible location of the origin of the AIDS pandemic (Clumeck and DeWit, 1988). An HIV epidemic probably began in Zaire around 1959 (Gotlieb et al, 1981). Moreover, AIDS was almost certainly present in Central Africa throughout the 1970s but was diagnosed as a wasting condition known colloquially as Slim (Thomas, 2001).

Figure 1.1: Geographical Distribution and Date of Presentation of Suspected AIDS Cases Prior to 1981 (After Smallman-Raynor and Cliff, 1990)

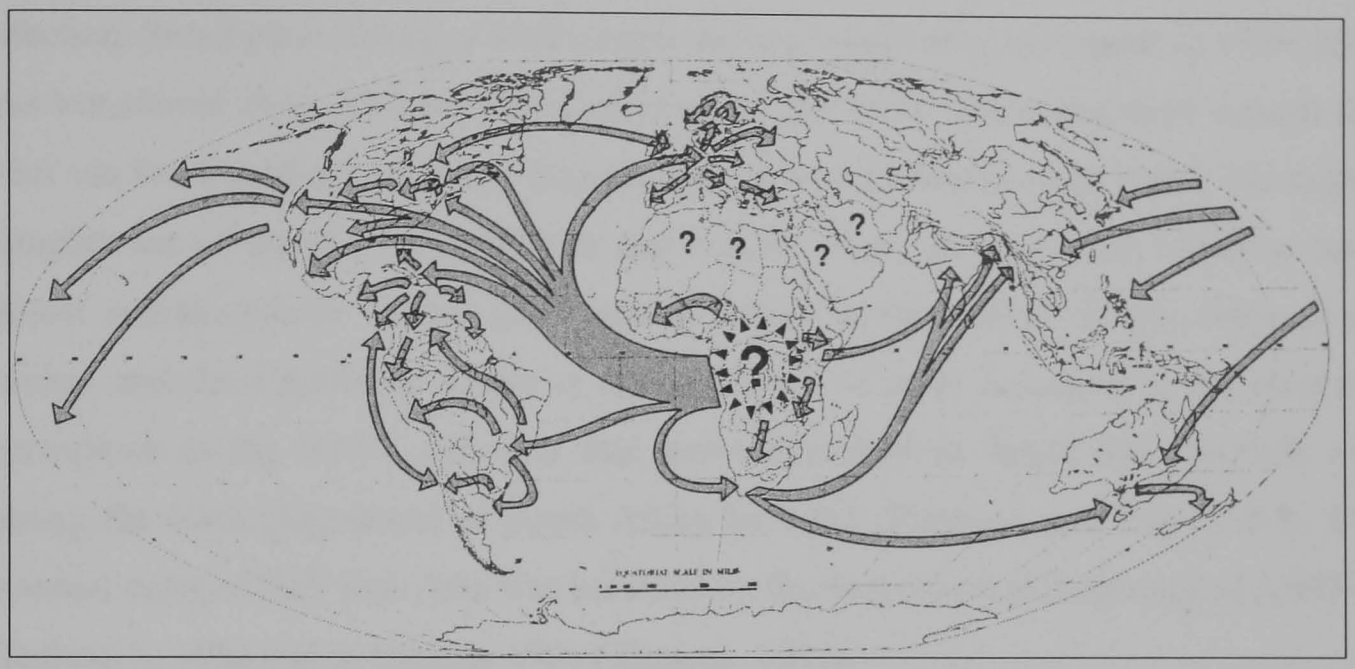


1.1.2 HIV/AIDS diffusion model

The specific geography of the origin and diffusion of HIV-1 remains incomplete, but a partial reconstruction of the spatial pathways is possible (Fig 1.2) utilizing information reported to the World Health Organization (Mann, 1987). The limited scientific evidence to support the hypothesis that HIV had been imported from Haiti into the USA led some workers to propose a reversal of the supposed direction of spread, namely that Haitians were infected by vacationing American homosexuals (de Cock, 1984). The only general model for the global spread of HIV-1, is that proposed by Robert C. Gallo, co-discoverer of HIV-1. Following the early work of Kanki and collaborators regarding the simian origin hypothesis, Gallo (1987) suggested that SIVagm entered the human race in the vicinity of lake Victoria, and that a 'series of mutations' yielded an 'intermediate' virus (HIV-2) before 'terminating in the fierce pathology' of HIV-1

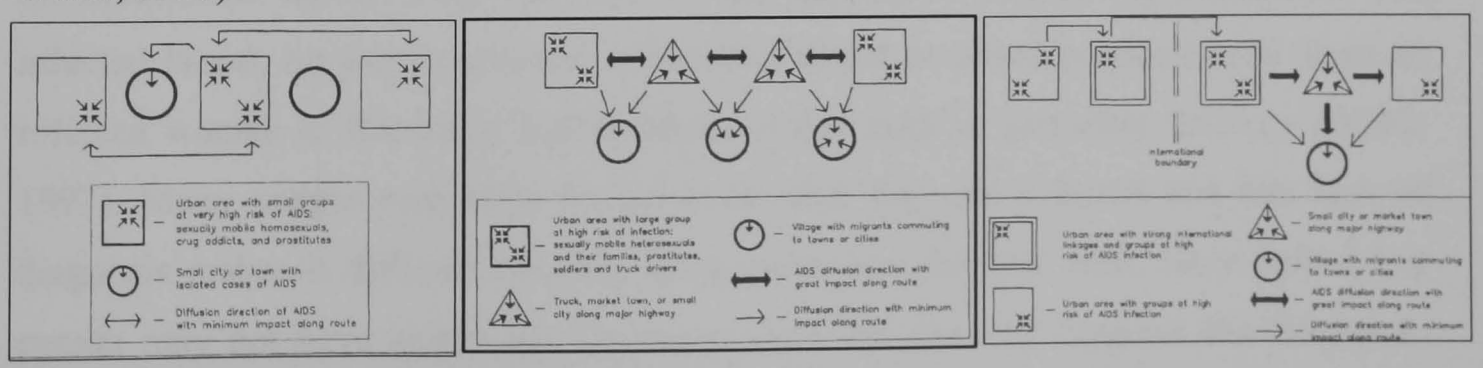
(Smallman-Raynor and Cliff, 1990). Three spatial models roughly correspond to the three patterns of world-wide transmission described by Piot et al (1988).

Figure 1.2: Postulated Diffusion of AIDS during the 1970s and 1980s (After Shannon and Pyle, 1989)



In their pattern-1 (mid 1970s to early 1980s) transmission primarily involves homosexual and bi-sexual men and intra venous drug abusers in the countries categorized under AIDS North. Pattern-2 (early to late 1970s) focuses on transmission among heterosexuals in AIDS South countries. Pattern-3 (early to mid 1980s) covers all other regions and continued transmission rates and did not depend upon sexual orientation but on levels of sexual activity in affected groups (Fig 1.3).

Figure 1.3: AIDS Diffusion Pattern (North, South and North/South Hybrid (After Wood, 1988)



Establishing the pathway for HIV/AIDS, however, has not proved to be easy (Shannon et al, 1991; Smallman-Raynor et al, 1992). One key date in this progression is the first clinical diagnosis of AIDS made in a New York hospital in 1979 (Thomas, 2001). The incubation period, however, indicates that HIV must have been present long before this diagnosis and many investigations have attempted to establish the prior history of the infection. Serological dating of viral strains has also established that, prior to 1979; HIV was transferred from Africa to the Caribbean by the early 1970s, and then entered the USA via San Francisco and New York during the mid-1970s (Li et al, 1988). Through a complex set of underlying conditions and transmissions, the infection seems to have almost simultaneously spread from central Africa to the United States, North West Europe and the Caribbean. There is also evidence of early infection in the southern hemisphere as the HIV-1 infection was well established in Brazil and Australia and among the black population of South Africa by 1982 (Shannon and Pyle, 1989). The eventual entry of HIV into Asia was heralded by the first recorded diagnoses of AIDS in Thailand in 1984 and in India in 1986 (Thomas, 2001).

1.1.3 HIV transmission and development

HIV/AIDS is not only a disease but also an economic burden of a nation, and a name that conjures death. As global phenomena, the Human Immuno-deficiency Virus (HIV) and Acquired Immuno Deficiency Syndrome (AIDS) are health risk factors of major significance. HIV is transmitted mostly through semen and vaginal fluids during unprotected sex without the use of condoms. Globally, most cases of sexual transmission involve men and women, although in some developed countries homosexual activity remains the primary mode. Beside sexual intercourse, HIV can also be transmitted during drug injection by the sharing of needles contaminated with infected blood; by the transfusion of infected blood or blood products; and from an infected woman to her baby: before birth, during birth or just after delivery (WHO, 1997). Many people with HIV do not know that they are infected and this lack of diagnosis makes it difficult to bring them under any form of care. Once infected, a person may not have symptoms for many years but can still transmit the disease to others. The virus multiplies in the body and eventually destroys the immune system. As a result, tuberculosis and other bacteria can cause opportunistic infections (OIs). Usually these organisms will not cause disease in healthy people.

The terminal stage of HIV infection, when patients suffer from OIs, is called AIDS. Approximately 50 per cent of HIV infected persons will develop AIDS after 7 to 10 years of infection. The average survival time for a person with AIDS may be only six months in developing countries and one to three years in developed countries. However, with the advent of new antiretroviral therapy, survival has improved dramatically in richer countries. These drugs, which are very expensive, are unfortunately beyond the reach of most patients in the developing world. World disasters report by International Federation of Red Cross and Red Crescent Societies, HIV/AIDS is the disaster that keeps on killing. UN officials caution that 70 percent of AIDS victims still have no access to medicines (Colum, 2008).

1.2 HIV/AIDS: A Global Disaster of Infection

HIV/AIDS is a global phenomenon but the dynamics and its consequences are played out differently across the world (Whiteside, 2008). Globally, the HIV/AIDS epidemic constitutes one of the most burning threats known to humankind, claiming over 8,000 lives every day (NAT, 2005). Since its discovery, more than 30 million have died. By 2010 it is estimated that approximately 100 million people will have been infected. Today's three leading infectious diseases, HIV/AIDS, malaria and tuberculosis, together are responsible for six million deaths each year. HIV/AIDS is now considered not only a health problem, but also a developmental problem and security threat. It can have an impact on a state's capacity and security because its impact is long term and indirect (Ostergard, 2007). Apart from the impact on national security from HIV/AIDS, it also reflects an unexpected intrusion into national life (Compton, 2007). In January, 2000 AIDS was addressed as a health issue for the first time in a session of the United Nations Security Council (Peterson, 2007). It no longer affects only high risk groups or urban populations, but is gradually spreading into rural areas and the general population. The epidemic is a disaster whose scale and extent could have been prevented. Ignorance, stigma, political inaction, indifference and denial have all contributed to millions of deaths. This global pandemic continues to grow unfortunately and there is concerning evidence that some countries are seeing resurgence in new HIV infection rates, which were previously stable or declining. According to the latest figures published in August, 2008, by UNAIDS/WHO and NAT, an estimated 33.0 million

people are living with HIV (Table 1.1). More than three quarters of AIDS-related deaths occur in Sub-Saharan Africa, and South Africa is now officially the country with the highest prevalence of HIV in the world.

According to the WHO, HIV/AIDS is the biggest single cause of mortality in the world, mainly because of unsafe heterosexual sex. The rate of development of new cases is highest in Africa, Latin America and Asia (UNAIDS, 2008). Currently, 22 million (66 per cent) of the 33 million people with HIV infection are concentrated in Sub-Saharan Africa, but epidemics elsewhere in the world are growing rapidly. According to UNAIDS, nearly 3 million new people are infected each year. More than 90 per cent of the HIV positive population resides in developing countries. About 14,000 adults are being infected daily of whom 40 per cent are women and over 50 per cent are in the 15-24 years category.

Table 1.1: Global Statistics on HIV/AIDS

People living with HIV and AIDS	33.0 million
Adults	30.8 million
Women	15.5 million
Children under 15	2.0 million
New HIV cases in 2007	2.7 million
Adults	2.3 million
Children under 15	370,000
AIDS deaths in 2007	2.0 million
Total HIV cases to date	60.3 million
Total AIDS deaths to date (since 1981)	25.0 million

Source: National AIDS Trust (NAT) and UNAIDS/WHO in July 2008/ Last Updated: August 2008

The consequences of HIV/AIDS extend beyond mortality; children are orphaned and entire economies can be affected. Current epidemiological data show that after Sub-Saharan Africa, South and South East Asia is the area with highest prevalence and it is considered as the epicentre of the HIV epidemic with regard to the rate of spread of the infection. Therefore the situation in Asia is a cause for much concern. According to an epidemiologist of Johns Hopkins Bloomberg school of public health in Baltimore, Chris Beyrer, the HIV/AIDS pandemic is 'very diverse' in where and how it is spreading. It is spreading fastest in Eastern Europe, central Asia and the former Soviet Union because

of increasing and widespread heroin availability (UNAIDS, 2002a). Chris Beyrer thinks that in first world settings, particularly in the United States, there are infections among gays and male bisexuals. For South Africa and its neighbours, labour migration, gender inequality, domestic violence are factors, and probably some biological factors, such as low rates of male circumcision, high rates of herpes simplex virus and low condom use (Cosmos Magazine, 2006). In South Asia, the focus is on sex workers and their clients, drug users and their sex partners, and homosexual men (The World Bank Report, 2006).

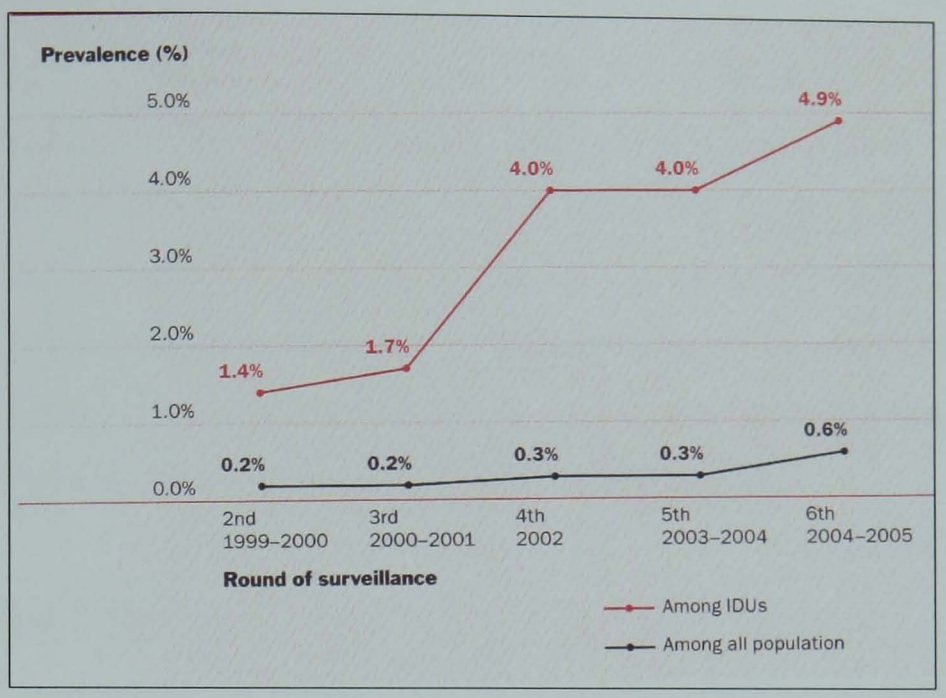
Epidemiological studies indicate that, unlike the western world and Africa, HIV is a relative newcomer to Asia (GOB, 2000). In South East Asia it was first identified in 1984 in Thailand. In India it was first reported in 1986, in Burma in 1987 and in Bangladesh in 1989 (NASP, 2004). It is estimated that the region had 7 million HIV infected persons in 2004. Exploratory sero-serveillance indicates an epidemic scale of HIV infection in Thailand, India and Burma, especially in population groups engaged in unprotected heterosexual sexual activities. In south west China, Vietnam and Malaysia, the mode of HIV transmission is principally Intravenous Drug Use (Chowdhury et al, 1995). Although socio-culturally the populations in this part of the world are not considered to be permissive, extra and premarital unprotected commercial sex is a tradition from ancient times. Commercial sex between men and women is without doubt one of the major drivers of the HIV epidemic in many countries of Asia (MAP Report, 2004). International travellers are primary hosts and the general public has access to the virus through them. Traditionally, Commercial Sex Workers (CSWs) in South Asia have been brothel-based. But, due to rapid socio-economic and cultural change, the commercial sex business has undergone significant change. CSWs are now available in hotels, restaurants, bars, street corners or inconspicuous houses in residential areas, massage and beauty parlours. In addition, intravenous drug use is high in Burma, Nepal and north east India, all of which are very close neighbours of Bangladesh. In South Asia, the HIV situation in India, Nepal and Burma is critical, in terms of the number of HIV patients and risk. With many people living with HIV/AIDS in neighbouring countries, what is the situation of a Muslim nation, Bangladesh? Although it is a predominantly a culturally conservative Muslim country, there are many social and economic, as well as geographical factors, fuelling the potential HIV risk in Bangladesh through insecure sexual activity and drug habits which in theory are 'visibly' prohibited.

1.3 Existing HIV/AIDS Situation in Bangladesh

According to the 8th International Congress on AIDS in Asia and the Pacific, 2007, Bangladesh has been recognized as one of the five countries in Asia where HIV/AIDS infections are increasing. A sero-epidemiological survey clearly indicates that an epidemic has already started. Different surveillance round results show risk of an epidemic and indicate that there is no reason for complacency (NASP, 2005a). Fortunately the country is still a low prevalence area, but this situation could rapidly change unless preventive measures are put in place.

Although there are only 1207 officially confirmed HIV-positive cases, national estimates put the number of people living with HIV closer to 7,500 but the real number could be several times higher. According to the National AIDS/STD Programme (NASP), the rate of prevalence is less than 1 per cent among the most at-risk groups (NASP, 2004). But HIV infection among IVDUs individually poses a significant risk, as the infection can spread rapidly within this group due to needle sharing (Fig 1.4). Recent sero-surveillance (2005) shows that HIV prevalence among IVDUs has reached a concentrated epidemic stage (Rahman, 2005). While still a low prevalence country for overall HIV rates, a small pocket of IVDUs (Intravenous Drug Users) under second generation surveillance has shown an HIV prevalence increase from 1.4 per cent to 4 per cent to 8.9 per cent (in one locality of Dhaka) in a recent period of three years (ICDDR, B Report, 2004). Another concern is the significant number of IDUs in the country who sell their blood professionally (Rahim, 2004). Among CSWs, HIV prevalence during the recent surveillance remained low (less than 1 per cent), as with the previous rounds, except in one of the border areas of the country, where the rate is 1.7 percent among casual female sex workers (ICDDR, B Report, 2004). Female sex workers in the border areas are mobile and sell sex across the border to India (Rahman, 2005). Hotel based sex workers are comparatively younger and have the highest number of clients among all female sex worker groups. Consistent condom use in female sex workers remains low in all groups.

Figure 1.4: HIV Prevalence among IVDUs and the General Population (After Panos, 2006)



HIV prevalence is low in males who have sex with males (MSM). Bangladesh has an established second generation HIV surveillance system (Biswas, 2007) consisting of sero-surveillance and behavioural surveillance components, but the biggest problem facing the country's HIV/AIDS prevention and control programme is scanty statistics. Moreover, significant underreporting of cases occurs because of the country's limited voluntary testing and counselling capacity and inadequate reporting systems. The serious social stigma attached to the disease is a further impediment to overcome the real threat of HIV/AIDS.

1.4 Risk and Vulnerability Factors for HIV/AIDS in Bangladesh

A stereotypical view of the people of Bangladesh is that they are likely to follow Islamic religious norms meticulously as it is a predominantly Muslim nation. There is a common misconception, for instance, that STDs, HIV and AIDS will not be health risks for them. But in reality there is evidence that all of the health risk behaviours related to HIV (e.g. pre-marital/extra marital sex, homosexuality, prostitution, intravenous drug use) are present, contradictory to the norms of the mainstream, conservative society (see Caldwell et al, 1999; Rahman et al, 1999). In addition, there are also many vulnerability factors (e.g. geographical location, trans-border mobility, low HIV/AIDS awareness, poverty, gender inequalities), which individually and collectively favour the spread or

transmission of HIV/AIDS (see Gibney et al, 2003; Rahman, 2005). Although Bangladesh is considered a low prevalence nation at present, from the epidemiological point of view, the HIV situation is evolving rapidly. Importantly, it is commonly assumed that some significant geographical locations, particularly the urban and border areas are channels for the 'transmission' and 'importation' of HIV into the country where Commercial Sex Workers (CSWs), Intravenous Drug Users (IDUs), and transport workers are highly mobile and sell sex and share needles. As a consequence, there are several key nodes for the diffusion of the disease across the whole country. In what follows, the existing risks and vulnerabilities including behavioural, bio-medical, social and structural, for HIV infection in Bangladesh are explained.

1.4.1 Behavioural risk

Sexuality: AIDS is overwhelmingly a sexually transmitted disease and sex is surrounded by taboos in nearly all human societies, including Bangladesh. Many research findings mainly by medical scientists and sociologists indicate that the incidence of extramarital sex is quite widespread in Bangladesh (CAAP, 1998). Prostitution is prohibited, but there are a significant number of female sex workers, particularly in the urban, border and port areas. Studies have shown that Bangladeshi society, long considered so conservative, is more footloose and sexually free than is commonly admitted (Khan, 2005). Aziz and colleagues (1985) found that 50 per cent of youths, mostly of the lower socio-economic class, have experienced sex before marriage. Folmer et al (1992) also found prevalence of premarital sex among their respondents with 29 per cent of them using condoms. Others researchers such as Islam (1981), Maloney (1981) and Begum (1976) reported similar findings in the significant proportion of their subjects and noted occurrences of induced abortions amongst unmarried girls. According to a World Bank Report (2006) a flourishing commercial sex industry is an important behavioural risk for HIV in Bangladesh. A few important academic works on behavioural risks, by Caldwell et al (1999), Caldwell and Pieris (1999) and Gibney et al (2003), found evidence which explained many anomalies regarding social issues on sexuality and also evaluated the prospects of an AIDS epidemic. They found that levels of premarital and extramarital sex among men including truckers are moderate by international standards but probably higher than the expectation in a socially conservative society. Apart from lower class men, recently it is

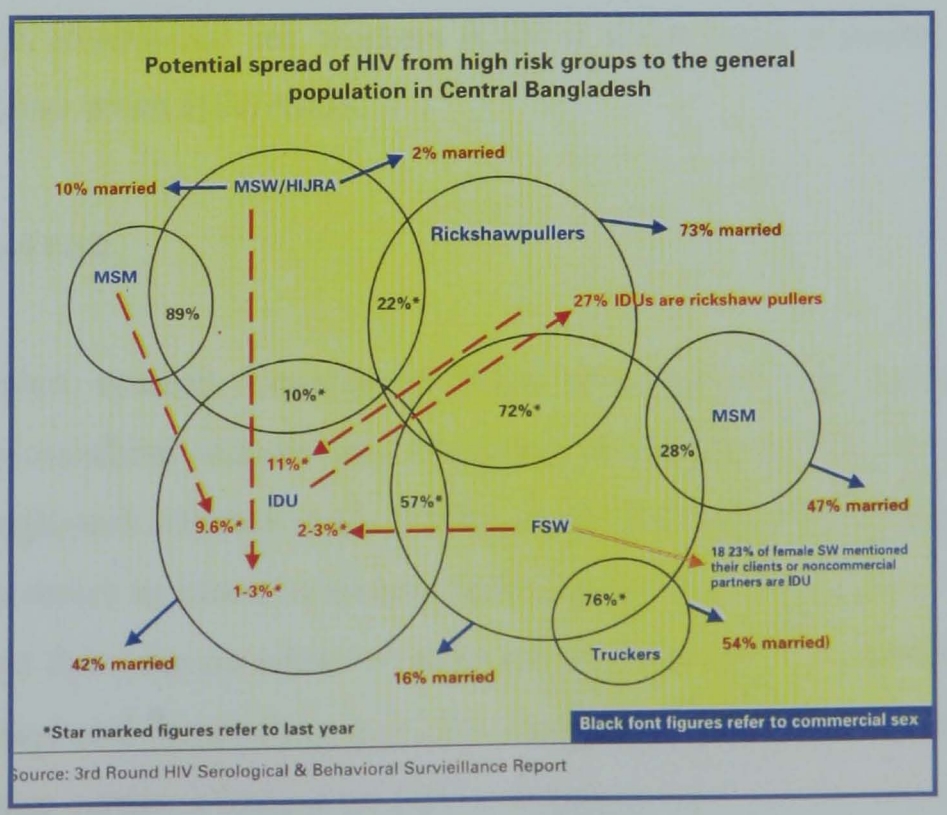
an open secret that many of the middle-high and high income people are frequently engaged with hotel/residence-based extramarital sex in the metropolitan city.

Deteriorating economic conditions in Bangladesh are leading more and more Bangladeshi women towards the sex trade (CAAP, 1998). They are generally non-literate, divorced or separated women and may be organized in brothels or may be 'floating' (Khan, 1999). Floating sex workers waiting to be picked up is a common nightly scene in many areas of big cities, including Dhaka and Chittagong. By comparison, MSM behaviour is largely hidden; it is, however, believed that it is more prevalent than previously thought (NASP, 2005c). There is some evidence of homosexuality among labourers, transport workers and boys. Particularly, rickshaw pullers and manual cart pullers have been reported as committing rape a certain group of child labourers who sleep in an open part of the market at night (Choudhury et al, 1997).

Illegal opiate use: Drug trafficking is the distribution of illicit drugs by large scale operations, which can, and often do, cross national boundaries, as well as the small-scale syndicates that distribute drugs at the local level (Bean, 2002). Afghanistan currently accounts for almost 75 per cent of the world's illicit opium supply (MacDonald and Mansfield, 2001). Much of the remainder is from the traditional growing region of the Golden Triangle (Burma, Laos and Thailand). Significant amounts, however, are grown elsewhere, such as in Iran and Turkey. Bangladesh is considered to be an important hub of illicit drug smuggling (Mahbubur Rahman et al, 2000). It is located between the 'Golden Triangle' and the 'Golden Crescent' opiate-producing zones, and has become an easily accessible market for opiates (i.e. Mahbubur Rahman et al, 2000; GOB, 2002). Informal reports claim that the number of drug users in Bangladesh has increased 300 per cent over the past few years (Farah, 1989; GOB, 1997). The problem of drug abuse has reached recognizably significant proportions today in Bangladesh (Islam, 2006) and it is linked to organized and petty crime (Muntasir, 2005). In general, most addicts are males. Frustration, curiosity and peer pressure are the most frequent reasons given for drug addiction. Illegal opiate use behaviour, which considered a lifestyle risk factor for HIV, is prevalent. In addition, a significant number of drug users are extremely marginalized and live on the streets and out of any social structure which puts them in more vulnerable situations.

Repeated rounds of surveillance have revealed that the rate of sero-positivity is highest among intravenous drug users (IVDUs) and the findings also confirm the presence of high levels of behavioural risk factors for the acquisition of HIV infection through needle sharing. Injecting drug use has steadily gained in popularity in Bangladesh (NASP, 2003). A considerable proportion of heroin users shared a needle/syringe during their last injection (ICDDR, B Report, 2004). Recent Behavioural Surveillance Survey (BSS) data indicate that the drug user population is well integrated into the surrounding urban community, socially and sexually, thus raising concerns about the spread of HIV infection. However, drug users are also sexually active with their married or unmarried partners. BSS data also indicate an increase in risk behaviours such as sharing of injecting equipment and a decline in consistent condom use in sexual encounters between drug users (including IVDUs and heroin smokers) and female sex workers. More than half of the heroin users had commercial and non-commercial female sex partners in the last year and those who did had multiple partners. Condom use, both in the last sex act and consistently in the last month, was very low with both commercial and non-commercial partners. This overlapping, as well as multiple relations between more vulnerable and bridging populations, makes Bangladesh vulnerable to HIV/AIDS (Fig 1.5).

Figure 1.5: Potential Spread of HIV from Vulnerable Groups to the General Population (After NASP, 2004)



Awareness of HIV/AIDS: Public awareness of HIV/AIDS is an important prerequisite for behavioural change (UN, 2002). Many people in Bangladesh have now heard the words 'HIV' and 'AIDS' as a result of intensive campaigns by different media and NGOs, but a significant portion still need to know how it is transmitted and that it can be prevented. The level of awareness among high risk groups, as well as the public generally, is surprisingly low (Khan, 2002). Educated people are better informed about HIV prevention than the poor (Rahman, 2005) but, as Bruce Caldwell and Indrani Pieris (1999) explain, the lack of openness with regard to sexual issues means that opportunities for improved knowledge are limited. Regarding awareness of STDs among married women of reproductive age, Khan et al (1997) found that women in rural areas are generally not aware of STDs, although their knowledge varied with their husband's occupation, and their own age and level of education. Bhuiya et al (2000) showed that awareness of HIV/AIDS among the general population, particularly villagers, is very low. The total number of non-marital sexual contacts as well as the low knowledge levels/exposure to HIV prevention information and programming suggests that community-wide awareness campaigns are needed (FHI, 2006). Epidemiological data, particularly on STIs and related complications among high risk behaviour groups, is limited in Bangladesh due to poor recognition of STIs as a major health problem; the stigma and discrimination associated with STIs; and the lack of coordination between service providers and the research community (Nessa et al, 2005). However, different surveys of long distance truck drivers revealed that most of them had contact with commercial sex workers (CSWs) about twice a month but that they mostly do not know about HIV/AIDS.

1.4.2 Biomedical risk

Blood transfusion system: Unscreened blood transfusions and commercial blood donation by professional donors are important bio-medical risk factors for HIV infection in Bangladesh. Gibney et al (1999b) shown that blood transfusion could be a potential risk in future as blood screening facilities are not good in most hospitals and blood banks, and there are no effective rules for commercial blood collection, testing, processing, storage and distribution (see also Hossain et al, 1996). The existing blood transfusion system carries a danger of HIV transmission. Currently, the country needs annually about 200,000 units of blood, which are largely (70-75 per cent) provided by

professional blood donors (GOB, 1997). Most professional blood donors (PBDs) sell their blood to raise money to feed their drug habits (Rahim, 2004), which can also fuel the danger of HIV transmission. It is suspected that approximately 20 per cent of PBDs are positive for Hepatitis B and syphilis (GOB, 1997). Recently, some PBDs have been identified as HIV positive in a border area of the country. Moreover, unsterile injections in non-formal and formal health-care settings can be one of the significant potential bio-medical risk factors for HIV infection in Bangladesh (Gibney et al, 1999b). It is a fact that disposable plastic syringes including needles are resold in shops and markets, adding greatly to the risk of spread of HIV/AIDS.

Sexually transmitted diseases: A high prevalence of sexually transmitted diseases (STDs) is a co-factor for HIV transmission among the 'most at risk' groups, and is associated with bridging to the general public if untreated or ineffectively treated. Bangladesh has a large commercial 'sex industry' in different forms. A diverse group of clients buy sex and only a few use condoms. Many believe that the low level of HIV/AIDS in the Muslim dominated society is a result of societal conservatism and religious teaching about immoral sex. But there are studies showing high levels of commercial sex and significant levels of STDs, thus presenting a situation more complex than the stereotype. Research confirms that there is a low level of condom use by sex workers (Khan and Arefeen, 1989; Sarkar et al, 1998). These CSWs are mostly non-literate and are organized in brothels or work casually in the streets (NACB, 1990; Khan, 1999) but condom use for commercial sex is the lowest in Asia (only 2 per cent) and the turnover of clients is high (averaging 44 clients a week) (Rahman, 2005). As a result, most CSWs have STDs, including syphilis and gonorrhoea (VHSS, 1993; Motiur Rahman et al, 2000; Nessa et al, 2005). A number of studies (Kabir et al, 1989; Choudhury et al, 1989; Wasserheit et al, 1989; Sabin et al, 1997; Bogaerts et al, 1997; Sarkar et al, 1998) also indicate the prevalence of STDs and RTI over a long period in the country. In addition, high rates of STDs also appear to be present among drug users. The existence of risky behaviour and high levels of sexually transmitted infections (STIs) among the 'core groups' indicates that the potential for a serious HIV/AIDS epidemic is great in Bangladesh (Bhuiya et al, 2004). However, transport workers are not necessarily regarded as a vulnerable group in terms of national surveillance. They are considered to be possible 'bridges' to the general population, potentially

transmitting HIV and STIs to their wives and to the population in general (Knight, 2006a).

1.4.3 Social and structural risk

Bangladesh has many contextual features, including widespread poverty, gender inequality, stigma and discrimination, violence, poor healthcare infrastructure, untrained health care personnel and low levels of literacy that are relevant to HIV risk and vulnerabilities. Poverty and gender inequalities have been playing an important role in transmitting the risk among marginalized people. Poverty is the primary cause of trafficking in the region and traffickers target their prey in the poverty-stricken rural areas. Due to poverty mainly, human trafficking into prostitution, stigmatization of these women, conservative social attitudes and huge migration flows (mainly rural to urban) exist (Mahmood, 2007). The HIV/AIDS epidemic in Asian countries has been strongly influenced by gender inequality and the frequent practice of men visiting sex workers. Women lack the power to refuse sexual activities due to a lack of economic empowerment and the cultural convention that wives are unable to refuse sex with their husband or demand the use of a condom (Rahman, 2005).

The biggest challenge to an expanded response to HIV/AIDS in Bangladesh is the government's limited funding capacity (Panos, 2006). There are limited care and support provisions for people living with HIV and AIDS (PLWHA) (NASP, 2004). Regarding health care, many health care personnel do not have appropriate training to handle the medical needs of people living with HIV/AIDS. Social and cultural barriers in risk prevention are formidable (Gibney et al, 1999a). Stigma and discrimination are problems, and public perceptions of PLWHA and members of vulnerable populations are negative (Panos, 2006). However, HIV/AIDS policy should not only emphasize medical and technological aspects, but should also be based on social and economic considerations. Human rights must be addressed in a comprehensive national policy (GOB, 1996). In all international declarations and the national policy on HIV/AIDS, reference is made to the need for a human rights framework. Human rights here include access to health care, information, confidentiality and gender equity (NASP, 2005c).

1.4.4 Geographical location and mobility

The geographical nature of Bangladesh, in particular its long borders with India and Burma (Fig 1.6), exacerbates the HIV/AIDS hazard (Gibney et al, 1999a; GOB, 2000; MAP Report, 2004; NASP, 2004). Bangladesh has a significant cross border trade in land ports and movements of population, including high-risk groups between Bangladesh and India. This trans-border mobility is high for various reasons, i.e. trade, education, religious exchange, recreation and some illegal activities (NACB, 1990). It is notable that India is in the phase of rapidly rising prevalence of HIV, with an estimated 4 million cases (Islam et al, 1999). Bangladesh has thirty border districts, twenty eight sharing a border with India and two with Burma (GOB, 2004; IOM, 2004). Most of the land frontiers are open with rivers running across. Bangladeshi trafficking groups have been able to build up powerful bases in the border districts of India in West Bengal and Assam, to the north and west, and these are now favourite transit points of trafficked people. Population increases, environmental crises and structural adjustments in Bangladesh have encouraged migration to India. An estimated 2000 Bangladeshis cross the border every day, including labourers, smugglers and trafficked women and girls (Knight, 2006a). Porous borders with economically poorer Bangladeshis (not needing a visa to visit India) aggravate the problem of cross border trafficking and the country has remained a source of women and children for some considerable time.

Figure 1.6: Bangladesh Map showing the Neighbouring countries

The environmental closeness of Bangladesh to Burma, and consequently the golden triangle drug trail, has made it a major transit route for drug smuggling. The HIV epidemic among drug users in Burma and Burmese heroin export routes has led to HIV epidemics in neighbouring countries (Chelala and Beyrer, 1999). Burma has been considered a primary contributor to the spread of HIV/AIDS in this region and 400,000 cases were estimated for HIV infection in Burma by the end of 2001 (Win, 2006). However, the constant movement is one of the major reasons for the transmission of HIV particularly among drug users in northern India, Afghanistan, Pakistan and Bangladesh. In addition, there is a high prevalence of HIV cases in two of India's north eastern provinces, Nagaland and Manipur, which have Burma as a neighbour. China is also facing a similar crisis along the stretches where it shares Burma's north eastern border (UNAIDS, 2006).

However, Bangladesh has a large number of overseas migrant workers who have gone in search of better job opportunities mainly to countries in the Middle East, or Malaysia and South East Asian countries (BBS, 2003; NASP, 2004). It is widely suspected that some of them come back after being infected with STDs and HIV from these countries. Most of the detected HIV/AIDS cases in Bangladesh are overseas migrant workers (GOB, 2000). In addition, there is a great deal of migration between rural and urban areas within the country (NASP, 2004), and Bangladesh hosts large communities of *Rohingya* refugees from Burma in the south east part of the country. The two major seaports also receive many foreign ships' crews the year round. Together, these population movements add to the risk of STDs and HIV/AIDS.

1.5 Aims and Objectives

Most studies of HIV/AIDS in Bangladesh have hitherto been medical in approach and there has been a neglect of social, cultural and geographic factors. The aim of this study is to explore those issues in vulnerable and marginal people's lives which put them at risk of infection and also their adopted coping strategies and how are these played out. In addition, the research aims to gain an understanding of the perceptions of civil society and policy planners with respect to vulnerability to HIV and the necessary mitigation measures. Within these general aims the study has five main objectives.

(a) To explore the everyday lives of marginalized communities. Here I will consider brothel and non-brothel sex workers, opiate users and HIV positives as marginalised groups because of their negative status, the hostility of mainstream society, and active discrimination by the state. I aim here to listen to stories of their lives, including their everyday practices, customs and emotions, which when combined play a role in putting them at health risk.

(b) To explore the identity 'crises' of the stigmatized groups and prejudices that impact them. This is an important target for the present study. The investigation of identity 'crises' and related consequences due to marginalization and stigmatization status will be helpful in measuring their potential risk of infection. Victimization processes will be explored in order to understand the negative societal attitudes in each study area.

(c) To identify the health risk behaviours, consciousness about HIV and coping techniques of the vulnerable people. Vulnerable people's perceptions about their risk behaviours and their impact on health will be of great help in revealing the real causes of risky behaviour in relation to HIV infection. Vulnerable people include sex workers, drug users, slum women, rickshaw pullers, and Bangladeshi and Indian truckers. In addition, their knowledge or consciousness about health risks, as well as their coping and adaptive techniques, will uncover their experiences of living with health risks.

(d) To analyze the role of place in risk transmission and the contribution of mobility in HIV channelling. The aim here is to consider the relationships between place and HIV risk by working in two geographically significant areas that are considered to be important nodes of health risk due to their location and economic significance. Relationships between risky and non-risky places and mobilities will be explored, and the channelling of HIV risk and potentiality of HIV risk in the future will be considered.

(e) To analyze the policy response to the human rights of marginalized groups and policies of HIV prevention that have been implemented from local to national level. Here I will focus on policy formulation and its practice in the field by

soliciting the opinions of relevant officials of government departments, NGOs, various international agencies in Dhaka, and different associations in civil society regarding plans, policies and implementation with respect to HIV prevention. This will help to identify the inherent policy weaknesses and assist in developing strong recommendations for preventing and mitigating this upcoming health disaster.

1.6 Research Questions

Empirical research is driven by research questions (Punch, 1998). It requires the linking of data to concepts; the connecting of a concept to its empirical indicators. It is the specific query to be addressed by this research that sets the parameters of the project and suggests the methods to be used for data gathering and analysis through a grounded theory approach (Strauss and Corbin, 1998). In order to fulfil the objectives, several related issues in the form of research questions need to be considered, i.e. what are the main research questions and why? The topic of this research is made timely by the current scientific interest in exposure to, and adverse social and health effects of, HIV in Bangladesh. Moreover, the role of geographic place and policy issues in this regard are also of major interest. To assess the whole picture of social, health, policy and structural impacts of marginalized groups' qualitative techniques were used for data collection. The main qualitative research questions are as follows.

(a) How do marginalized people lead their 'everyday lives'? This question covers answers relating to the everyday lives of sex workers, drug users and HIV positives. The study will explore how sex workers manage their economic uncertainties, their vulnerabilities in 'love traps' and their 'bad' identity. This question also uncovers how drug users face withdrawal symptoms, problems of managing money for drugs, and their recovery and relapse. In addition, what are the stigmas and why are addicts blamed? Furthermore, the question also addresses the HIV positives' emotions in the context of their marginalization. It will explore how they are 'outed' and face discrimination. This will help to focus on the policy response to reducing prejudice and the empowerment of marginalized communities.

(b) How are health risks around HIV/AIDS understood by 'core' and 'bridging' populations and what are the coping strategies they use? This question will explore the risk behaviours of vulnerable people. Here the 'core' people considered will be those who are believed to transmit the virus to others through body fluids while the 'bridging' people are those who visit the 'core' people and their partners. This study explores the sexual practices of sex workers, and drug addicts' and transport workers' understandings of health risk transfer as a bridging group. It will identify the level of knowledge about HIV/AIDS among the 'core' and 'bridging' people and what beliefs they hold. Finally, this question will also cover what the role is of 'traditional' techniques in 'minimizing' health 'risks' and coping with the 'environment'. I will also examine knowledge of risk and risk-coping techniques among these groups.

(c) What is the role of 'risky' and 'non-risky' places, or how does place affect health risk? This question allows the exploration of vulnerable people's concepts about 'risky' and 'non-risky' places for HIV transmission. Here, we will look at how drug users can bring stigma to a place and also at the roles of these places in making health risks. How do sex workers and transport workers see a place as safe or not safe? In addition, this study will uncover the invisible mobility of border women and open secret role of transport workers particularly Indian truckers in a border town. I will also find about the level of risk of Indian truckers and the possibility of them 'importing' risk into Bangladesh. Finally, this study investigates how the trafficking of women can play an extensive role in HIV risk transmission in Bangladesh from neighbouring India. Moreover, it will realize the hidden or 'unidentified sources' of HIV.

(d) How are the government and NGOs addressing HIV/AIDS issues through policy for mitigation and prevention? As I talked with many people in local civil society in the field sites and with many policy planners in Dhaka, many policy-related matters were revealed, particularly with regard to future implementation. Here, the social and cultural barriers were explained to me, particularly in response to HIV prevention at field level. Different policy limitations in addressing HIV prevention discourse will also be discussed. Finally, the priorities for preventing the threat of HIV/AIDS will also be analysed.

1.7 Ethical Approach of the Research

Many ethical dilemmas arise in qualitative research (Bulmer, 2001) and all social research involves ethical issues. This is because the research involves collecting data from people, and about people (Punch, 1998) or the researcher needs to be involved inevitably in personal social relations 'with the researched' (Robson, 1997). This 'positionality' profoundly affects all aspects of research which involve interaction with other people, especially when researching the lives of people of a different class, race and culture from the researcher (Howard, 1997). 'Ethical research is commonly understood to be research that 'does no harm', which gains informed consent from, and respects the right of the individuals being studied' (Madge, 1997; p.114). Perhaps the most fundamental ethical question in development practice concerns the cultural identity of groups, populations and societies on the path toward development (Crocker, 1991). So, some key issues should be considered at the outset, including informed consent, right to privacy, protection from harm and informed consent (Denzin and Lincoln, 2000; Green and Thorogood, 2004). But project personnel may also confront moral issues, including sensitive ones. Research on sensitive topics 'addresses some of society's most pressing social issues and policy questions' (Sieber and Stanley, 1988; p.55). Sensitive research is important too precisely because it illuminates the darker corners of society. Researchers of sensitive topics may need to be more acutely aware of their ethical responsibilities to research participants than would be the case with the study of a more innocuous topic (Barnard, 1992; Lee, 1993). However, most development ethics neglect the practical side of survival and development in poor countries, the psychological aspects of human well being and some of the better things in life (Clark, 2002). The highest ethical standards must be upheld when collecting behavioural or biological data on STIs, HIV or AIDS. Because of the stigma and human rights issues around HIV/AIDS, study participants may experience psychological, social, physical or economic harm, even when precautions are taken.

As HIV/AIDS is highly stigmatized, a question may arise about the ethical issues of this kind of research. My work was about knowing the 'everyday lives' of participants and I was very careful to make sure that my research did not negatively impact on these respondents in any way. After approaching them, once I was confident that they were relaxed I asked for their patience and permission for recording. In the meantime I

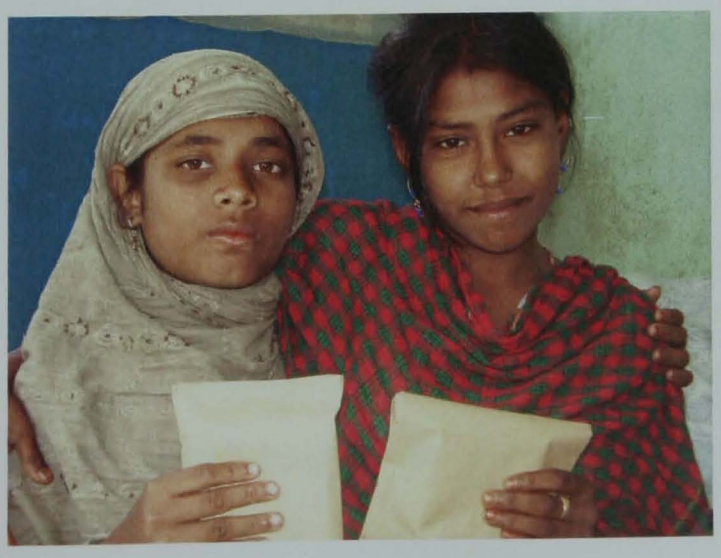
assured them about the confidentiality of their conversation. At the beginning of each research encounter I told my all respondents that they may face some shyness in replying to some 'sensitive' questions but I assured them that I would not ask their name and address. Particularly, some hotel or floating girls, or HIV positives had some worries as they are local residents. Sometimes they asked me "*what is your profit*"? or "*Why will you keep it confidential*?" Then I described more detail about my thesis objectives and anonymity issues. Although I had given my reply, one of them asked me, "*There are many issues, so why are you doing your research on this critical topic*"? Then I replied that it is an important issue for the country in the near future. I managed to get some initially quiet participants to be very vocal in the interviews or FGDs when I gave the assurance of confidentiality. After getting this assurance, many participants were willing to divulge details of their 'lifeworlds', including their risk and vulnerability. But there is an exception with one HIV positive. I thought that she felt too shy to speak anything about her HIV status and was trying to avoid my questions. Despite my assurance of confidentiality, she refused to give me an interview; giving the excuse that she had a headache. Then I stopped taping the interview and tried informal conversation instead and then she felt comfortable. But recently I have heard that she has died. As a final question in all interviews and FGD cases, I asked my participants whether my interview topic or any of my conversation has given them any distress.

In this thesis, I have changed all respondents' names in the text. I often provided a complimentary gift or food or money as a form of compensation for participants' time, patience and cooperation (Fig 1.7). For example, in most of the cases of sex workers and female slum dwellers, I gave some gifts (such as body lotion, shampoo, soap, or beauty cream) and offered food (ranging from light snacks to lunch). I gave some token money to the street girls who are very poor. For HIV positives, I gave energy drinks (e.g. Horlics) and fruit, along with some token money for transport costs since I interviewed some of them in NGO offices. All of them were very happy with this. I also offered some light snacks for the transport workers. In the case of drug users, I used different approaches. To some I gave money to help them buy food or sometimes I took them into a restaurant to offer lunch. Some begged money form me and many addicts broke down in tears when they took food or money. Though I gave them money for buying food, some may have used it for buying heroin. In one drug users' treatment centre, some of my FGD participants requested me to ask the officials to improve their

food. I always provided token amounts of money for the transport costs to NGO peers who brought or managed the participants. I also offered lunches and dinners for NGO officials in Jessore and Khulna for their help.

In many cases I took photographs (by myself and research assistants) during my research but only after obtaining participants' permission beforehand. Many addicts, TWs and some street girls were keen to have their photos taken with me. In some cases I gave them a photograph of themselves. But I never asked HIV positives for photos because of their high stigmatization. In Khulna, I faced a difficult issue with one street girl who had recently found herself pregnant and who begged some money from me. Because of my own concerns that she may have used the money to help pay for an abortion, I decided not to offer money.

Figure 1.7: Photos showing my Approach on Ethical Issues



1.8 Approach to Study Area Selection

The sampling plan and sampling parameters (settings, actors, events and processes) should line up with the purposes and the research questions of the study (Punch, 1998). There are varying accounts of principles applicable to study site selection but diversity also results from the main different methods of sampling (Curtis et al, 2000). Although the literature includes very useful reviews of 'sampling strategies' (Dixon and Leach, 1977; Patton, M. Q. 1990; Baxter and Eyles, 1997), the question of sample study sites selection receives less attention than methodological issues of data collection and data analysis. My reasons for selecting the study sites are mainly based upon 'purposive or theoretical sampling criteria' rather than a 'statistical probability approach'. The selection of study sites was primarily based on the conceptual framework of the HIV issues supported by the literature reviews, including a few published (mainly epidemiological) and unpublished (mainly newspaper clippings) materials. It is usually assumed that some important geographical locations, particularly the urban and border areas, are channels for the 'transmission' and 'importation' of HIV respectively within the country and from neighbouring countries. The study areas (Fig 1.8) are Jessore and Khulna, where many vulnerable people like CSWs and DUs are visible on the streets and many foreign and native truckers are present. Both places are therefore nodes of disease diffusion for the whole country. I initially had selected Jessore (as a main land port base) and Chittagong (as a main sea port) during fieldwork preparation. However, I subsequently modified my plans for three main reasons. Firstly, in Chittagong I didn't find any brothels. Secondly, during site checking in the field, I realized that it would be difficult for me to work in Chittagong as it has a very conservative social setting. Finally, as a resident of Chittagong myself, I felt that I could also have faced some personal problems as my work involved me with many stigmatized issues.

My main fieldwork period was from November 2006 to June 2007 and I worked firstly in Jessore district, which is in the south-western part of Bangladesh. Jessore is a frontier district with a long border with India and also has the largest land port of the country, namely Benapole. I choose this as a study site because of the boundary and the land port. In Jessore, approximately 35km from Benapole, I found a few brothels, hotels and a few residences where many girls have been involved in the commercial sex profession. I also found many street drug users in Jessore town. In Benapole, I worked

to find transport workers particularly Indians as well as Bangladeshi women who are used to crossing the border almost every day. In Benapole more than 300 Indian trucks approach every day and more than 500 Bangladeshi trucks arrive from different districts. Geographically Benapole is a strategic point for border trade between India and Bangladesh and it is the most important check post and busiest land port on the Indo-Bangladesh border. Benapole land port is also lucrative for Indian exporters because of its cheap service and equipment charges.[1] The second study area is Khulna, which is also geographically significant as an industrial and metropolitan city. Khulna is a port and a divisional border. Khulna's large urban area, along with its industrial and port setting made it an appropriate study site. I also found many identified HIV positive people in Khulna and this also persuaded me to select the place as my second study site. In Khulna, I went to Baniashanta and Fultola, the two local brothels. Finally, I also worked in Dhaka, the capital, to talk with policy planners on the HIV situation in Bangladesh.

Figure 1.8: Study Areas in Bangladesh

[1] See http://en.wikipedia.org/wiki/Benapole.

1.9 Concluding Remarks

HIV is one of the biggest social, economic and health challenges in the world. After sub-Saharan Africa, south and south-east Asia is the most vulnerable to HIV/AIDS. Bangladesh, a South Asian country, is engaged in fighting and preventing major diseases such as diarrhoea and tuberculosis and in the contemporary period HIV/AIDS is regarded as one of the diseases most likely to put the country's population at risk. Bangladesh has many epidemiological and social factors that could produce a devastating epidemic and may lead the country into a health disaster. The country has experienced a low level HIV epidemic for many years but the epidemic has recently entered the concentrated phase. Prevalence in injecting drug users has reached almost 5 per cent and it is almost 10 per cent in the capital city. From the social and cultural point of view, as a Muslim nation, people do not widely perceive HIV/AIDS as a problem Many believe that there is no scope for using opiates or promiscuous sex as Bangladeshis are chaste, pious and honest. In addition, they do not consider HIV/AIDS to be a threat to their conservative society, though poverty, discrimination, illiteracy, cross border trade, high population movements and unequal health access are very common. The transmission of HIV/AIDS is related to sexual and drug use behaviour, which are a domain of privacy and secrecy. Initial reaction to open discussion of sexual and opiate drug issues is characterized by fear, stigma and discrimination, leading to social rejection.

It is commonly believed that HIV/AIDS is still underreported in Bangladesh. People do not usually want to disclose their status and take treatment for fear of shame and embarrassment, or loss of social and economic security. Along with HIV positives, sex workers and drug users are considered to be the most at-risk group for HIV, and they have to bear a very bad image in the community and are often ostracized. Above all, these social repercussions and cultural barriers in risk prevention affect all aspects of the HIV/AIDS situation in conservative Bangladesh, which is a contribution to increasing the level of risk and vulnerability.

This chapter has mainly focused on the origin, diffusion and transmission of HIV/AIDS along with the global situation; risk and vulnerability factors in Bangladesh; aims and objectives, research questions, and selection procedures for the sample study areas. The next chapter will deal with the relevant literature on health geography in relation to HIV/AIDS and research gaps will be identified.

Chapter Two

Review of Medical/Health Geographic Literature on HIV/AIDS

Chapter Two

Review of Medical/Health Geographic Literature on HIV/AIDS

The global epidemic of HIV/AIDS has come under scrutiny since the 1980s and, particularly, from the beginning of the 1990s. As a topic of research, it has a strong pull because of the heavy toll of morbidity and mortality, and also because of the intellectual challenge of understanding its epidemiology. As the epidemic has unfolded, few regions in the world have remained free of the infection and a complex spatial and socio-cultural 'geography' of many overlapping epidemics has evolved (Clift and Wilkins, 1995). Geographers have contributed, for instance, by studying the distribution and diffusion of the HIV across the world and its impact (Kearns, 1996). They have also developed predictive models of future diffusion patterns and epidemiological changes across the regions (Takahashi, 1997). But there has been some critical reflection among geographers about a focus on mapping disease incidence, or showing the migration flows of people with HIV, without recognizing the social dimensions of the illness (Brown, 1995; Wilton, 1996; Craddock, 2000). This chapter is an overview of the focus and approaches of medical or health geography along with geographic studies related to HIV/AIDS issues. Required methodological approaches in health geography research, with special reference to HIV/AIDS are also discussed. Finally, a research gap in the geographies of HIV/AIDS in Bangladesh is elaborated, along with some concluding remarks.

2.1 Focus and Approaches in Medical Geography/Geography of Health

Different disciplines, including geography, offer varying perspectives on health and society. Over time, as for many other disciplines, fashions and emphases change in geography (Kearns and Moon, 2002). These changes have long been recognized as the development of knowledge and scientific thought (Kuhn, 1962; Lakatos and Musgrave,

1970). Thus, a quickening process of metamorphosis has shifted 'medical geography' from a minority concern and a 'confusing sub-variety' of human geography (Haggett, 1965), to a confident, recognized and distinct 'geography of health' (Rosenberg, 1998). Kearns (1993) was an initiator of the discussion in his attempt to position health geography within the wider theoretical debates. This helped the sub-discipline evolve from one dominated by a focus on disease and disease services towards a greater focus on well-being and wider social models of health and health care (Kearns and Moon, 2002). This focus draws attention to how different kinds of knowledge are co-constituted through particular places, embodied practices and technological artefacts (Davies et al, 2004). Many recent works in the branch of health geography have suggested that a shift from medical geography to the geography, or geographies, of health is more than a change in title. It also represents an epistemological shift that questions the grounds upon which medical geographical knowledge is based (Brown and Duncan, 2002; Gesler and Kearns, 2002). Pearce (2003) thinks that there has been a major change in the nature of research undertaken by geographers with an interest in health. In other words, distinctions are often made between medical and health geography, with medical geography dominated by biomedical models favouring intensive quantitative methods, whereas health geography relies more on socio-ecological models and often employs more extensive qualitative approaches (Mayer, 2000; Gesler, 2006).

2.1.1 Medical geography

The dictionary of human geography provides a simple definition of medical geography: 'the application of geographical perspectives and methods to the study of health, disease and health care' (Johnston et al, 1994; p.374). Medical geography does not have a long history. Jacques May, the 'father' of medical geography in the United States, initiated the sub-discipline (1950, 1954) and wrote a classic text, the *Ecology of Disease* (1958) (Meade and Earickson, 2000). Meade (1977) explains disease ecology as having numerous social, economic, behavioural, cultural, environmental and biological factors which create disease in specific places at specific times. Paul (1985) outlined a seven-fold classification of the multidimensional nature of medical geography, including disease ecology. Physician Finke, who first used the term medical geography in the late 18th century, was attempting to relate human diseases, cultures and lived environments

(Barrett, 1980). From the late 1960s to the early 90s, medical geographers were interested in the locations of disease occurrence, relationships within networks of health care delivery and, latterly, spatial relationships between individuals, places and institutions (for example, Shannon and Dever, 1974; Joseph and Phillips, 1984; Gregory and Urry, 1985; Johnston, 1991; Gesler, 1991). During the 1970s and 1980s, disease ecology and health services research were distinctive streams of work (Mayer, 1982; Jones and Moon, 1987) and the 'twin streams' model contrasted studies of disease distributions or diffusion with welfarist and largely empiricist studies of health care provision.

Medical geography, like many empirically focused subfields within geography, has a fascination with the unique and particular (Jones and Moon, 1993). Meade et al (1988) saw medical geography as a matter of spatial and ecological perspectives on disease and health care delivery. Medical geography addresses the tensions between the natural and social sciences in that it deals with both the physical and human elements which can affect the physical and mental health of human populations (Eyles, 1993) due to its traditional focus on the relationships between biomedical phenomena and the role of the environment (Mayer and Meade, 1994). Sui (2007) considers 'medical geography' as a big-tent concept that includes all geographic aspects of health and disease that have been studied by medical geographers, epidemiologists and public health researchers. Philo (2007) uses Canguilhem to press for some reorientation upon *medical* geography or, more accurately, upon the geographies *of* medicine and considers 'vitalism' and 'humanism' as its theoretical engagements. Both aspects of medical geography: the geography of disease/ill-health and the geography of health care, utilize similar methodologies, which derive from epidemiology, economics and behavioural research, where all dimensions of health problems are measurable and quantifiable in their characteristics.

Theoretical approaches: In recent years, there have been some new approaches added to reconceptualize the content of medical geography through explicit theorization by social constructionists rather than a biomedical or ecological view of the world (Gesler, 1990; Litva and Eyles, 1994). In social constructionist or social interactionist accounts (Aggleton, 1990), the emphasis is on the meaning of the illness or disease to the individual, and the researcher needs to uncover or interpret these understandings and

meanings that make it 'rational' to act in a particular way or, in other words, to see things from a particular point of view. For Litva and Eyles (1995) structural functionalism, the conflict theory approach and symbolic interactionism are key frameworks. Structural functionalism is particularly concerned with what happens when problems (i.e. illness/disease) arise and threaten the working order in society (i.e. Parsons, 1951). Structural functionalism uses a positivist approach which uses 'objective' (quantitative) methods to obtain 'facts' about the social world. There are a number of examples of health geography research using this approach (e.g. food contamination in central Africa, McGlashan, 1972). In the geography of health, the positivist approach is a matter of detecting areal patterns or modelling the way in which disease incidence varies spatially. This type of study relies on accurate measurement and recording and searching for statistical regularities and associations (Gatrell, 2002). Bennett, D. (2005) thinks that revisiting debates about philosophical approaches in medical geography suggests that logical positivism may have been prematurely discarded.

Like structural functionalism, conflict theory sees the function of power as integrative, thus ensuring compliance where there are reversed sets of norms and values in society. Fundamentally, this approach is based upon the work of Marx, who asserted that human thought and behaviour are the result of socio-economic relations, and that both thought and behaviour are alterable for human and social betterment. The conflict theory perspective has been used by several health geographers, in particular to look at health care systems (Eyles and Woods, 1983). Influenced by the writing of Blumer (1962) and Mead (1962), the symbolic interactionist approach emphasizes how subjective definitions of social reality are constructed and how this reality is experienced, negotiated and described by different social actors. This perspective on health and health care tends to focus primarily on the processes through which people come to understand themselves as being healthy, anxious or at risk. But Philo (1996) criticized this approach and commented on the remarkable possibilities thrown up by the recent attention being given by cultural, feminist and disability theorists to the whole question of 'what is the body'?, a question strangely absent from most of Litva and Eyles' (1995) paper. Moreover, Johnston's (1986) delimitations of 'positivism', 'humanism' and 'structuralism' were used to map out the theoretical contours of health care geography. Jones and Moon (1987) identify five distinctive theoretical approaches to medical

geography referred to as 'cartographic', 'modelling', 'behavioural', 'welfare' and 'structuralist'; and Curtis and Taket (1996) reviewed the history and current practice of medical geography under five different headings within two major groups of approach – the traditional and the contemporary. The first two of the five strands, spatial patterning of disease and death, and spatial patterning of service provision, are considered as 'traditional medical geography'. The other three strands, all labelled 'contemporary medical geography' adopt different epistemological stances, arising out of a variety of critiques of positivism and making more use of qualitative methods.

2.1.2 Geography of health

There is a long history of interest in place and health in the geography of health (Dunn and Cummins, 2007). The concept of place, and links between place and health, is pressing the developments in contemporary health philosophy. One such development is the emergence of a conceptual model firmly based on ideas of health rather than medicine (Kearns, 1993) in which a socio-ecological model of health (argument of White, 1981) involves an interactive set of relationships between a population and their social, cultural and physical environment. Kearns (1993) attempted to nudge the collective focus of medical geography towards a cultural/humanistic standpoint through the advocacy of 'post medical geographies of health'. This 'post medical' challenge sought to shift the sub-discipline from a concern with disease and disease services towards a focus on health and wellness, and this was inevitably not far enough for some (e.g. Dorn and Laws, 1994), but too far for others (Mayer and Meade, 1994; Paul, 1994a). Recently, the geography of health has emphasized the emergence of the theme of place (Mohan, 2000) for the sensitivity of difference. Health geographers have been most active in the analysis of smaller unit areas (Andrews et al, 2007) and they have turned to narratives as a way to engage with the everyday, situated experiences of people in place (e.g. Kearns, 1997; Parr, 1998). Curtis (2004) thinks that the geography of health is focused on the ways that the health of populations is differentiated between places and the range of factors that explain these differences. Based on a thematic evolution, Kearns and Moon (2002) argue that there are now three themes that characterize contemporary health geography. These can be summarized as social constructions of place; the utility and greater awareness of socio-cultural theory; and the evolution of a critical geography of health (see also Parr, 2004). Contemporary health

geography exhibits a particular geography of places reflecting the location of health geographers and their research sites. The epistemological underpinnings of this quest to read place have varied with researchers drawing on positivist, political economic and humanistic traditions.

The notion of therapeutic landscapes has been embraced by health geographers and yielded a significant, and growing, body of recent research (Smyth, 2005). Dyck and Dossa (2007) intend to contribute to the literature in health geography that is framed by recent work that seeks to investigate the role of everyday activity in producing meanings and experiences of space as 'healthy' or its converse (see Gesler, 2005; Smyth, 2005). Sense of place is one of the ways in which geographers have attempted to approach the complex linkages between people's well-being and residential location (McCreanor et al, 2006). Place is not only physical, but is deeply connected to the self (Wiersma, 2008). Place identity, according to Williams (2002) is the construction of the self and the relation to place and the environment. Health and medical geographers are not simply viewing place as a physical landscape, but meaning is increasingly being viewed as the key to the importance of places as 'it is the subjective experiences that people have within places that give them significance' (Williams, A. 1999; p.2). Geographers have long distinguished between space and place, emphasising that place is more than a physical location or container in which events unfold (Wiles et al, 2009). Rather, place could be thought of as a dynamic process invested with integrated physical, social, emotional and symbolic aspects which interact at a range of different scales (Massey, 1991 & 1999; Wiles, J. 2005). Smyth (2005) mentions that the physical, social and symbolic landscapes of therapeutic environments including places, spaces and networks serve to regulate and normalize certain kinds of behaviour.

Health geographers are primarily concerned with health and health-related results (Shaw et al, 2002) including behaviour (e.g. for HIV/AIDS, unprotected sex) and are interested in studying health in a particular place or in making comparisons between places and studying health events in a set of places (Gatrell, 2002). In a 'reformed medical geography', place is conceptualized as a multifaceted, complex and contested issue (see Gesler, 1992; Jones and Moon, 1993; Kearns, 1996; Brown, 1997; Milligan, 2000). As a result of challenges to positivist assumptions about place in medical geography (Mayer, 1992), the landscapes of health and health care are no longer theorized as static entities.

Rather, they are thought of as dynamic processes (Kearns, 1998; Del Casino, 2001). Del Casino (2001) argues about health care as 'constructed and reconstructed by individuals and organizations that negotiate their socio-spatial arrangement in relation to shifting epidemiologies and the power relations operating in and through particular places' (p.418). Importantly, geographers point out that discourses of health and illness are particularly powerful agents in the construction of places (for example, Kearns, 1993 & 1998; Asthana, 1998; Gesler, 1998; Kearns and Geslar, 1998; Craddock, 2000) as well as individual bodies (Dorn and Laws, 1994; Brown, 1995; Philo, 2000; Parr, 2002). Del Casino (2004) showed how 'local knowledge' is being replaced in the context of competing health care systems and practices. Elliott and Gillie (1998) described a qualitative analysis about health and health care in relation to place. Dyck and Dossa (2007) consider women's agency in producing 'healthy space' in a major immigrant destination city in Canada. They have focused on the embeddedness of their health practices in place, bringing to bear a conception of place that dismisses a notion of boundedness. Andrews and Evans (2008) think that health geography would benefit from broadening its current engagement with health care production through focusing future inquiry on workers, their workplaces and practices. The concepts from health geography enable a good view of context because they bring a more holistic perspective of place and process on the question of patterns of health (Cutchin, 2007). Their use also illustrates a way to collect information about place and landscape and then interpret how the processes that create and re-create them bring about the situation that an epidemiologist typically investigates (ibid).

2.2 Geographic Research on HIV/AIDS

The majority of existing epidemiological research on place and health has focused on a single spatial scale, generally that of local areas or 'neighbourhoods' (Cummins et al, 2007). Geographers have worked on infectious diseases such as cholera, malaria, influenza, measles and hepatitis for a long time (for example, Learmonth, 1952; May, 1958; Stamp, 1964; Pyle, 1969; Cliff and Haggett, 1988; Thomas, 1992) and are now making contributions to the geography of HIV/AIDS in the contemporary period. From the early years of the HIV/AIDS epidemic, it was apparent that international travel- for business and for pleasure- played a necessary, though insufficient, role in the geographical and social diffusion of HIV infection (Hawkes, 1992; Gould, 1993). HIV

is transmitted from person to person primarily by unprotected sex or through the sharing of injecting equipment. Kearns (1996) shows that geographers have focused basically on two related spatial dimensions of HIV/AIDS: distribution and diffusion. They have given their attention to the virus itself, developing diffusion models or recounting origins theories with no reference to the spatial-political implications of living with AIDS (Kearns, 1996). Or they have looked at the social context in which HIV gets transmitted and through which particular individuals become vulnerable. Both of these focuses are discussed in more detail below.

2.2.1 Quantitative approaches

Analysis of the geographic distribution and migration of HIV is an established field of study where mapping is the main element to show the origin of the virus and its diffusion over space. In 1989, Shannon and Pyle published a paper where they provided an overview of AIDS from the medical geographical point of view. They explored questions pertaining to the origin, aetiology and spatial diffusion of the disease by using available hypotheses, theories and data. The detailed work of Wood (1988) and Smallman-Raynor and Cliff (1990) is also in the tradition of quantitative medical geography. They looked at hypotheses of the origins of AIDS and its spread. Wood (1988) proposed three models of AIDS diffusion, namely AIDS north, AIDS south and AIDS north/south hybrid. Intra- and inter-urban infection within promiscuous groups happens in the AIDS north pattern. In the AIDS south pattern the urban population is affected and then the disease spreads rapidly into hinterland regions along marketing routes. The AIDS north/south hybrid pattern is relevant in third world countries with their internationally-linked primate cities and large numbers of young adults who regularly migrate between these cities and their home villages.

Gould (1989) discussed the geographic dimension of the AIDS epidemic on the basis of Wood's (1988) article and agreed with his spatial diffusion pattern of AIDS. According to Smallman-Raynor and Cliff (1990) 'when knowledge of the structure of HIV appeared, similarities between HIV and certain viruses found in African green monkeys were soon recognized. As a consequence, Africa emerged (replacing Haiti) as the main candidate for the hearth of the disease' (p.169). They described the Gallo (1987) model of major global spread of HIV-1 which hypothesizes major diffusion corridors from the

areas of endemic infection in west and central Africa to the rest of the globe between the late 1970s and mid-1980s. Cliff and Smallman-Raynor (1992) explored the geographical variation in the incidence of AIDS in Uganda and they considered three hypotheses in the context of spatial variation of the virus. Gould and Wallace (1994) have researched the spread of HIV by mapping the cumulative incidence of AIDS cases across the USA and they also analysed the number of reported cases in the New York region. Cliff and Haggett (1988) included AIDS in their book in relation to the complexity of its spread due to a long incubation period, its current lack of cure, its high virulence and because it results from one of the most basic urges of the human race. They discussed two reasons for non-reporting of the disease. First, variations in medical care between developed and developing countries, and different reporting conventions from country to country, result in missing data. Second, there are frequently political and social reasons for the non-reporting of a sexually transmissible disease.

Dutt et al (1987) performed a spatial analysis of HIV/AIDS in the United States by region, by patient, gender and age groups of the victims while Paul (1994b) examined the spatial pattern of AIDS distribution in Asia. He identified international travel as being the dominant mode of HIV transmission in Asia and compared the diffusion pattern as consistent with Wood's (1988) 'AIDS North model' to some extent. To explore the 'socio-geographic' network of HIV infection, Wallace (1991) suggested a useful model for the initial spread of HIV in a social or a geographic network where individuals are treated as nodes and relationships - as the connecting links between individuals. All of these works have emphasized mapping as a means of exploring the origin of the HIV virus and its diffusion. Pyle (1979) mentioned that disease mapping is one of the most meaningful yet controversial aspects of medical geography.

Many studies of migration and HIV/AIDS have shown considerable mobility among people with HIV and have identified key mobility (from urban to rural or rural to urban) factors, such as the need for social services, family support, changes in lifestyle, avoidance of high risk behaviours and the need to access to better health care (Tatum and Schoech, 1992; Cohn et al, 1994; Ellis and Muschkin, 1996). Recently a number of studies have been made to understand the impetus and reasons for migration among persons with HIV (Hogg et al, 1995; Wood et al, 2000a). In the context of sub-Saharan Africa, Oppong (1998) and Mayer (2005) have reviewed the spatial perspective of

HIV/AIDS. Geographers have also drawn attention to the impact of HIV on the individual behaviour and conditions of life from an ecological perspective while Aase and Agyei-Mensah (2005) highlighted the importance of place and gender. Kalipeni et al (2004) shifted the focus of work on HIV/AIDS in Africa from purely epidemiological approaches towards a social science perspective on the spread of the disease. Teye (2005) discusses a risk theory that argues that the individual is not a free agent when making choices due to constraints on a societal level. Piper and Yeoh (2005) described the HIV epidemic in Asia as more complex than that in Africa, involving a multiplicity of transmission modes. They also discuss the connections between issues of mobility, gender, (trans)nationalism and sexuality in understanding the HIV/AIDS challenges in the region. Moran (2005) worked on 'new wave' of HIV epidemics in Russia with transitional issues of risk and vulnerability. However, although much empirical research shows a connection between migration and HIV spread, few recent theoretical works have tried to connect the social and behavioural mechanisms (for example, Smith, 2005; Lindquist, 2005; Ming, 2005; Marten, 2005; Cheng, 2005) which play a role in shaping the geography of new HIV infections. All of the quantitative-based works have determined that HIV/AIDS has tended to cluster in certain areas and infection, diffusion and overlap can be expected between different population subgroups, even those who have not traditionally been at risk. This migration analysis is one of the best ways to anticipate how the epidemic will evolve and hence to direct the necessary steps to try and avoid further spread.

2.2.2 Qualitative approaches

Although a large body of literature currently exists on HIV/AIDS in general, rather less research has explicitly considered the geographical dimensions of living with HIV/AIDS. In other words, geographical studies focusing upon the experience of people with HIV/AIDS are limited. In the 1990s, geographers began to make contributions to an understanding of the AIDS epidemic in the form of mapping to illustrate the origin of the HIV and its diffusion at global, national and local levels. These contributions of spatial diffusion of the virus in the geography of AIDS are valuable and important but provide only a 'single and partial geography of AIDS' (Wilton, 1996; p.70) Relatively little attention has been paid to the socio-cultural, economic and political dimensions of the disease or to the ways in which individual risk behaviours are related to non-spatial

processes in particular geographical settings (Asthana, 1998). Craddock (2000) shows that there has been a strange silence in the geographical literature on AIDS concerning the investigation of risk and its geographic variables.

In this regard, alternative geographies have started to document the appearance of HIV, its progression to AIDS, and its manifold complications, which undoubtedly affect the geography of HIV-positive people's daily lives. One promising response to this research gap is Wilton's (1996) ethnographic study of the daily life experiences of Los Angeles men with symptomatic HIV/AIDS. This work disaggregates the social, physical and psychological dimensions that help him to show how place matters in the lives of these men. Here, space is important in terms of material conditions for people living with HIV/AIDS in the development of their daily paths and their shifting social networks, where people's daily worlds and routines changed after diagnosis. In his subsequent paper, Wilton gives a framework of qualitative research with a critique (1999). Brown (1995) also carried out ethnographic work on gay men's experience with HIV/AIDS and argued that geographers' preoccupation with the spatial diffusion of the virus threatens to reduce gay men's bodies to biological hosts, a subject of interest only to the extent that they are able to transport HIV across space. In another piece of empirical work that included a distinctively ethnographic approach to health, Brown (1997) looked at the local politics of AIDS in Vancouver, Canada, and tracked the location of political engagement with the AIDS crisis. Craddock (2000) proposed a framework which combines a realist approach to mapping vulnerability with feminist and post-structural approaches that focus more attention upon the role of social identities and cultural framings of diseases particularly calculations of disease risk. The primary intention of this paper is to posit a model of risk that can be modified to suit other diseases and other places. This article shows a good relation in the 'entitlement packages' of Nobel laureate economist Amartya Sen (1981).

A combination of these approaches would result in a more effective framework for evaluating vulnerability and subsequently for generating effective disease prevention strategies. Browne and Barrett (2001) discussed the 'moral geographies' in different campaigns in the context of HIV prevention in Africa. They have raised the question of how states define and represent norms of sexual morality and, in this case, the AIDS pandemic has forced states to redraw the 'moral boundaries' of consideration and

acceptability for public consumption. Sabatier (1996) conducted interviews with migrant women from southern Africa, examining their vulnerability to HIV infection together with the mechanisms they adopt for coping with the infection. Asthana and Oostvogels (1996) carried out ethnographic work with commercial sex workers regarding their problems and prospects for participation in HIV prevention while Kesby (2000) used qualitative diagramming techniques to explore gender relations for HIV patients in rural Zimbabwe.

Geographers have begun to explore the nature and extent of the impact of HIV/AIDS on health services, and on diverse aspects of the daily lives of people living with HIV and AIDS (for example, Murray and Robinson, 1996; Takahashi and Smutny, 2001; Del Casino, 2001; Young and Ansell, 2003). This research on the experience of people living with HIV has provided a further illustration of the way in which health status is the product of more than health care alone, a theme which has received considerable attention in discussions about the evolving structure of 'medical geography' (Kearns, 1993 & 1994; Dorn and Laws, 1994; Hayes et al, 1994). Some studies of the social construction of HIV/AIDS also include exploration of the stigmatization of HIV/AIDS, a central component of the developing literature, a key concern of this thesis and discussed in further detail later in this chapter. Alonzo and Reynolds (1995) noted how stigma shifts during the life course after diagnosis, resulting in changes of identity and social acceptance. The construction of stigma surrounding HIV/AIDS is also constituted and mediated through spatial relations (Dear et al, 1997). The spatial dynamics of HIV is described by Patton (1994) and termed 'sexual geography' because 'HIV has achieved its geographic mobility in the bodies of infected people' (Patton, 1994; p.21; see also Knopp, 1992). The spatial relations of HIV/AIDS as migration, daily paths, social networks and locations have largely been explored through the infected bodies.

Discourses around health care, sexuality, gender and migration related to the epidemiology of HIV/AIDS, and local processes involving individual and community response are much argued about by geographers, anthropologists and others. These concepts are also related to class, gender, sexuality, culture and politics (Patton, C. 1990 & 1994; Brown, 1995; Kearns, 1996; Takahashi, 1997; Takahashi and Dear, 1997). Moreover, despite a growth of studies in different areas addressing questions of risk and its social context, the dominant paradigm of 'risk groups' and individual behaviours

continues to be a key focus (Craddock, 2000). The concepts of 'risk group' and 'risk behaviour' are well established in public health research as well as by geographers to identify the determinants of healthy lifestyles as well as chronic ill-health. The nature and intensity of risk varies by gender, race, ethnicity and class and in addition, the risk group idea moves in the direction of peopling the virus (Kearns, 1996). In this way, geographers have been constructing 'new geographies of HIV/AIDS', which are alternatives to the epidemiological approach.

2.3 Required Methodological Approach in Health Geography

Research in the geography of health needs to be sensitive to spatiality and temporality (Jones and Moon, 1993). Health research needs to be comprehensive enough to understand a complex interplay of forces, yet sufficiently focused to obtain valid and meaningful results. I have sought a methodology that recognizes that 'people make a difference and places make a difference' (Gregory, 1985; p.74). People should not be reduced to generalizations. We need micro- and macro-scales, structure and agency, intensive and extensive approaches, and qualitative and quantitative methods (Strange and Zyzanski, 1989; McKinlay, 1992) but they all need to be considered together. Although a significant amount of empirical research on health and place has applied extensive, quantitative methods and techniques for statistical modelling of a general 'contextual' effect on the health of populations (Cummins et al, 2007), some recent studies have used qualitative methods to research individuals' experience and perceptions of place and what these mean for health (ibid). Andrews and Evans (2008) think that medical geography maps aggregate supply and demand features and the geography of health focuses more on consumption and social and cultural contexts.

In recent years, health/medical geographers have challenged the dominance of a bio-medical discourse and have demonstrated the inherently social and political nature of health and health care (Wilton, 1999), a growing new geographical research feature of qualitative methodology. Traditionally, medical geographers represent a strong quantitative emphasis along with statistical hypothesis on disease incidence or prevalence spatially which provide clues to disease aetiology. Medical geographers also traditionally identify social or environmental factors associated with disease and high risk location (Meade et al, 1988; Yiannakoulias et al, 2005) and pursue their research

using spatial statistics, mapping and recently GIS technologies (Jones and Moon, 1993). Recently, GIS has been used to conceptualize and measure place identity and place attachment (Mason, 2007). It has provided new sets of very powerful tools to medical geographers for exploring both disease patterns and health services (Sui, 2007). The literature on GIS and medical geography has predominantly focused on how GIS can be applied as analytical and visualization tools to examine the geographic aspects of disease and health services (ibid). Ferguson and Morris (2007) highlight the roles of 'vulnerable places' in HIV transmission and the attitudes of vulnerable groups on the trans-Africa highway. They found an explicit spatial dimension through the use of GIS that facilitates the identification of 'hot spots' of increased HIV transmission. In addition, Participatory GIS encourages individuals and social groups to participate equally in spatial analyses, knowledge production and communication of data (Townley et al, 2009). Dunn (2007) explores Participatory GIS in the context of local and indigenous knowledge, scale and scaling up, web-based approaches and some potential future technical and academic directions. However, the emphasis on quantitative analysis has begun to wane and instead, the infusion of feminism and other critical social theory and the move toward a new geography of health have had profound implications for medical geography (Kearns, 1993) with the development of more holistic and contextual conceptions of 'health' and 'health care' as well as the exploration of the social and spatial construction of illness and disability issues (Litva and Eyles, 1994 & 1995; Dorn and Laws, 1994; Hayes et al, 1994; Butler, 1994; Kearns 1996; Dear et al, 1997). These developments and changes of emphases have been accompanied and facilitated by methodological shifts from quantitative to qualitative which, in Kearns' (1995) emphasis, is 'recasting of the subjects of research as persons rather than as patients' (p.252); using participant observation, in-depth interviews, focus groups, storytelling and autobiography as methods (Kearns 1995 & 1997). Wilton (1999) stated that 'in health geography, qualitative research may involve talking with people who are dealing with poor health, with the social stigma attached to certain conditions and who are otherwise in potentially vulnerable situations' (p.262). He also gave importance (1999) to recognizing the direct involvement in people's lives that qualitative research implies.

Moreover, in health geography, quantitative spatial data analysis typically involves one or more of three tasks. Firstly, visualization involves spatial patterning or visual

evidence of an association with social or environmental factors. Secondly, there is exploratory spatial data analysis that engages graphical and statistical methods to explore the data. Thirdly, modelling involves testing a hypothesis. Recently, there has been work at the individual level (spatial arrangements of point patterns of individual disease) by quantitative analyses (Gatrell, 2002). But the danger is that these analytical methods give little attention to what the points or dots on the map really represent: 'The dots are not inanimate objects; they are real people, and while the ways in which they are arranged spatially may shed some light on disease causation...[quantitative analyses] give no consideration at all to the feelings, experiences, beliefs and attitudes that the individuals have' (Gatrell, 2002; p.78). In other words, medical geographers have been keenly concerned with the paradoxical side of a map (Sui, 2007) which suggests bogus concentrations and false trails while revealing distinctive patterns for a particular disease (ibid). Yiannakoulias et al (2005) think that geographers must pay particular attention to the diagnostic inconsistency of the representation of health statistics in spatial variation.

Both Geographic Information Science and medical geography are moving away from the dominant positivistic paradigm to a more inclusive outlook (Sui, 2007) where there is plenty of room to integrate a critical GIS approach with complex, multidimensional issues in medical geography (for example, McLafferty, 2005). Despite its potential, GIS remains largely underutilized in behavioral science research (Townley et al, 2009), and GIS and medical geography can be bridged (Kwan and Knigge, 2006; Kwan and Aitken, 2007) to form a new hybrid geography (Kwan, 2004). On the other hand, qualitative studies are valuable because they provide insights that show us how conditions in particular places are thought to influence health and health related behaviour, and they are powerfully suggestive of causal pathways relating environmental factors to individual health (Cummins et al, 2007). Qualitative approaches may help us to explore in greater depth some of the findings of these less quantifiable influences on health (Smyth, 2008). Mykhalovskiy et al (2008) offer an expository discussion of an approach to qualitative health research that draws on the normative politics of immanent critique. Qualitative research in the geography of health focuses less on measurement and more on the interpretation and understanding of ill-health, disease and disability of individuals or groups in the context of place (Gatrell, 2002).

Downing (2008) explores the ways in which individuals living with HIV/AIDS interact with their home environments. In symbolic interactionism, or more simply 'interactionism' (Hewitt, 1994) social action is based on shared meanings and negotiations between people. Language is central to this process because it provides common definitions and meanings which allow individuals to see their behaviour in the same ways as others do (Field, 1997). Qualitative research aims to understand how the lived experiences and meanings associated with health risk are influenced by different social, cultural and economic contexts (Rhodes, 1995) through everyday interaction and experience (Rhodes and Quirk, 1996). Qualitative research thus proceeds on the assumption that it is possible to gain an insight into the factors producing social behaviour, primarily through engaging with participants themselves (Agar, 1980). Qualitative health research aims to answer 'what' 'how' or 'why' questions about social aspects of health, illness and health care (Green and Thorogood, 2004). Smyth (2008) explores recent contributions to the continuing debate on the relative importance of context and composition in explaining health research particularly in health inequalities. Much of the understanding of health inequalities has been advanced by researchers using quantitative methodologies and has focused upon the role of context rather than upon composition (ibid). The predominance of quantitative methodologies and concerns with contextual effects has perhaps contributed to a general reluctance by qualitative researchers to engage with a subject area fundamental to medical and health geographies (Smyth, 2008). Hemming (2008) argues that mixing qualitative methods can be beneficial for gaining deeper and more complex understandings of social processes, but a reflexive approach is required in order to deal with the challenges of combining different methodological approaches. Triangulation is a technique that emerged as a response to criticism of qualitative approaches from positivist researchers (Hemming, 2008), particularly the charge that such approaches lack appropriate validity (see Blaikie, 2000). Denzin (1978) argued that using triangulation could improve the validity of research findings by directing a range of different methods at the same problem, and checking whether or not they all returned similar results.

The countries of the global South that are facing major HIV/AIDS problems, including Bangladesh, have varied forms of health risk depending upon their contingent circumstances. I have found that writing this thesis has helped me to learn about the

generic aspects of health risk, coping strategies, health facilities and health care for HIV/AIDS. I have also read widely about methodological and theoretical aspects and this has helped to plan the various dimensions of my research. But, practically speaking, I am aware that the situation on the ground in Jessore and Khulna is very different from the papers I have read about Africa or North America. Therefore, I built a framework for my work that is both aware of this HIV/AIDS work elsewhere but that is also geared towards the particular cultural, social and economic circumstances of my field area. It is mentionable that my research is totally based on 'lifeworlds' of marginalized people - those who are vulnerable to HIV. Stigma and rights issues are looked at in this study as well as dimensions of risk and place, rather than adopting a medical perspective. The research also pays attention to relevant policy issues related to HIV. Considering the preceding methodological and conceptual discussion, I have adopted qualitative methods for data collection and analysis.

2.4 Research Gaps and Target Areas

The HIV epidemic has brought new dimensions of risk to third world countries like Bangladesh. It has also brought many changes, not only in the health sector, but also in social and economic issues. These changes have occurred in the everyday lives of the individuals and communities who are highly vulnerable or affected by the HIV threat. Over the last 25 years, around the world many geographers, sociologists, anthropologists, psychologists, epidemiologists and medical scientists have had an increasing interest in HIV and AIDS and its related subjects. In Bangladesh this influence has been very limited. Most of the research on HIV has been performed by public health scientists and epidemiologists. Very little academic research on HIV has addressed the socio-economic or socio-geographic issues of the marginalized and stigmatized communities who are considered as the 'risk group' for HIV infection in Bangladesh. Although most epidemiological research (for example, Sarkar et al, 1998; Gibney et al, 1999a & 1999b; Caldwell et al, 1999; Hosain and Chatterjee, 2005 etc.) has hinted at the necessity for doing intensive study on geographically significant places like the border towns of Bangladesh, there has not been significant academic research in this area. Furthermore, there has been no work on HIV positive people and their 'lifeworlds' in conjunction with HIV policy issues in Bangladesh. Figure 2.1 shows the main academic research trend or emphasis on HIV related issues in Bangladesh and the current gaps in research. This section identifies these research gaps by exploring and reviewing the relevant literature on HIV related issues in Bangladesh concerning risk behaviours, prevention measures and levels of awareness.

Figure 2.1: Showing the Existing Research on HIV in Bangladesh and Present Study

Existing Research and Issues

Etiological Research on STD/HIV

- Gibney and colleagues (2001)
- Sarkar and colleagues (1998)
- Nessa and colleagues (2005 & 2004)
- Motiur Rahman and colleagues (2000)
- Sabin (1998)
- Wasserheit and colleagues (1989)
- Azim and colleagues (2000; 2002; 2004; 2008)
- Islam and colleagues (2003)
- Bogaerts and colleagues (2001)

Study on HIV Awareness

- Mahbubur Rahman and Zaman (2005)
- Hosain and Chatterjee (2005)
- Ullah (2003)
- Mehrab Khan and colleagues (1997)
- Tajul Islam and colleagues (2002)
- Asaduzzaman Khan (2002)
- Rahman and colleagues (1999)

Assessment on HIV Risk (Behavioural/ Bio-medical)

- Gibney and colleagues (1999; 2002; 2003)
- Mahbubur Rahman and colleagues (2000)
- Shirin and colleagues (2000)
- Caldwell and colleagues (1999)
- Bloem and colleagues (1999)
- Caldwell and Pieris (1999)
- Jenkins (1999)
- Gazi and colleagues (2008)
- Blanchet (2003)
- Mercer and colleagues (2007)
- ICDDR'B Bulletin (2007)

Research on HIV Prevention

- Hosain and Chatterjee (2005)
- Hawkes (2001)
- Chan and Khan (2007)
- Jenkins and colleagues (2001)
- Jenkins and Rahman (2002)
- Sarkar and colleagues (1998)
- Mamtaz (1999)
- Islam and colleagues (1999)
- Mehrab Khan and colleagues (1997)
- Gibney and colleagues (2003)
- Mahbubur Rahman and colleagues (1999)

Geographies of HIV/AIDS in Bangladesh: Vulnerability, Stigma and Place

Present Research and Issues

Everyday life, Stigma and HIV Vulnerability

Main issues

- Everyday life and rituals
- Daily sufferings
- Differing dreams and frustrations
- Identity crisis and its impact
- Stigmatized people's blamed life
- Negligence towards vulnerable people

HIV Risk Behaviour and Coping Techniques

Main issues

- Risk behaviour of vulnerable people
- Knowledge and realization about risk
- Health risk 'coping' practice

Place Mobility and Channelling of HIV Risk

Main issues

- Place as 'safe' or 'risky'
- Role of mobility and border town
- Indian truckers and women trafficking
- Many 'unidentified' source for potential HIV risk

Addressing HIV issues from the national to local

Main issues

- 'Contradictory programs' in HIV project
- Limitations in 'Behaviour change' discourse
- Low HIV prevalence 'mystery'
- Assessment of GO, NGO and Donor role in HIV prevention
- Problems in planning and coordination

Most HIV related research in Bangladesh is based on epidemiological and public health perspectives. This public health research has investigated some common themes. A significant number of works (for example, Azim et al, 2000 & 2004; Shirin et al, 2000; Mahbubur Rahman et al, 2000 & 2005 etc.) are taking place in Dhaka on the 'most at-risk' groups, particularly on IDUs. Among sex workers, many research projects (for example, Jenkins, C. 1999; Nessa et al, 2005 etc.) are carried out with brothel based sex workers. Very little work has been covered on residence and hotel girls around the country. Some research (for example, Bloem et al, 1999; Motiur Rahman et al, 2000 etc.) can be seen in relation to street girls but most is based in Dhaka. To date, almost all published research on risk factors for HIV in Bangladesh has focused on behavioural risk factors, i.e. high-risk sexual practices by Bangladeshis (Sarkar et al, 1998) at home and on trips abroad, as well as the increasing levels of intravenous drug use (Begum, 1991). Much of the literature has also focused on public awareness of HIV/AIDS, particularly with respect to behavioural risk factors for transmission of the disease (Gibney et al, 1999a). Little academic research (for example, Hawkes, 2001; Ara, 2005) has been carried out from the social, geographical or policy point of view. In this section, I will divide the existing literature on HIV in Bangladesh into four categories: aetiological research, assessment on HIV risk, studies on HIV awareness and research on HIV prevention.

There is a vast literature on epidemiology and aetiology for the most at-risk groups. These reports have looked not only at HIV infection but also at STDs and hepatitis. Firstly, most work (for example, Sabin, 1998; Gibney et al, 2001; Islam et al, 2003; Nessa et al, 2004 etc.) has assessed risk through blood testing. Secondly, much research (for example, Caldwell and Pieris, 1999; Gibney et al, 2003; Rahman and Zaman, 2005 etc.) has assessed risk behaviours for HIV prevalence of sex workers and drug users as well as truckers. A few works (like, Gibney et al, 1999b) have also looked at the biomedical issues of HIV risk in Bangladesh. These above mentioned studies have tried to show the potentiality of the future HIV threat to Bangladesh from the behavioural as well as the biomedical point of view. Thirdly, there are a good number of papers (for example, M. Khan et al, 1997; Rahman et al, 1999; Khan, 2002; Islam et al, 2002 etc.) which have focused on the assessment of awareness of HIV/AIDS among the different stakeholders, especially the most at-risk groups for HIV. Finally, all the above categories of work discuss some relevant preventive efforts in their concluding remarks.

Figure 2.1 focuses as some of the important works on HIV or related subjects which were published in different well reputed academic journals.

With a dominant biomedical and epidemiological framework many studies of HIV in Bangladesh frequently ignore the explanatory issues regarding the prejudice against marginalized and vulnerable people, health risks, unhealthy places, and policy, all of which can be investigated by utilizing qualitative methodologies. Following Mann (1987), epidemiological data alone cannot represent the multiple and complex social dimensions of HIV/AIDS. According to him, the pandemic has been conceptualised as consisting of three separate phases: an epidemic of HIV infection, an epidemic of AIDS and an epidemic of social, cultural, economic and political responses to AIDS. The third of these has been the most explosive, characterized by denial, stigma and discrimination. However, the substantial literature supports the notion that the HIV/AIDS epidemic is determined by a combination of structural, social/cultural, and individual factors (UNAIDS, 1997; Parker et al, 2000; Mac-Phail and Campbell, 2001). The AIDS pandemic is now extremely complex, consisting of a number of smaller and constantly changing epidemics which affect individuals, communities and nations in a multiplicity of different ways. But in Bangladesh, many arenas of research in the HIV field have not been covered equally. It has been found in this review that there has not yet been any in-depth research concerning the socio-cultural and geographic impacts of the HIV disaster in Bangladesh. Almost all of the literature shows HIV as an epidemiological problem rather than investigating it from a social or cultural point of view. This thesis will explore some of these issues in the context of health risks and will also investigate how HIV-vulnerable people can benefit from better planning for mitigation and prevention.

'Lifeworlds' issue: Apart from a few studies assessing the prevalence of STDs/HIV, only a few academic research works have addressed the 'lifeworlds' of marginalized people in Bangladesh, such as sex workers and drug users. Most work has tried to cover the lifestyle of a particular group, but most has only incomplete views of their whole lives. Among the works, Khan and Arefeen (1992), Ahsan and colleagues (1999), Irshad Kamal Khan (2000), Karim (2004) and Rahman and colleagues (2004) are notable. In reviewing the existing literature, it can be seen that there is a lack of information on social issues of HIV vulnerable people. A small number of newspaper articles point out

some social problems, but there is no detailed or in-depth work into how these social problems are related to economic uncertainty and daily vulnerability. In this thesis I will detail the 'lifeworlds' of marginalized communities in terms of their everyday practices or customs, along with their emotions and aspirations. Their monetary uncertainty and everyday suffering are covered in detail. Their anger and expectations from society are also discussed. Conducting this research required an extended period of time to be spent with the marginalized communities to obtain the views about 'lifeworlds' through in-depth interviewing, focus group discussion and naturalistic observation.

Identity and stigma: There is much research on sex workers' and drug users' risk of HIV, but no detailed work could be discovered on their social status or the stigmatization or rights issue. A limited literature has addressed the role of social, cultural and behavioural practices in explaining marginalization and vulnerability of HIV. Although there are a few recent works on sex workers identity (Reshmi Chowdhury, 2006), rights (Zinat Ara, 2005) and harassment and suffering (Hasan, 2007; Ullah, 2005), no major academic works have approached drug users' and HIV positives' marginalization and stigmatization except a Human Rights Watch Report (2003). There is no information on how HIV-affected or HIV-prone people in Bangladesh live with social hazards. Still less research in Bangladesh has focused on the way in which these social and psychological factors affect people's everyday lives. The present empirical research has been devoted to the task of studying the socio-geographical and psychological aspects of having HIV or living in close proximity to people with HIV.

Risk behaviour and coping: There are rich descriptions of HIV risk behaviours, including behavioural and bio-medical approaches to HIV transmission, but there is a serious lack of qualitative information on the pattern and nature of risk in Bangladesh. There is a gap in the literature on coping strategies of vulnerable people to HIV infection and risk. In this research, 'risk' is discussed in the light of the implications for understanding how everyday norms influence the ways in which people perceive risk and act in response to risk. There is an examination of how 'risk' is perceived among sex workers, drug users and transport workers, and how their 'norms' influence individual attempts at 'risk behaviour' change, as coping strategies. By utilizing

qualitative methods, this research has attempted to explain risk behaviours and their impact on people's everyday lives.

Place concern: The Bangladeshi academic literature ignores the role and importance of place in 'contributing' to health risks, particularly HIV. Some publications (for example, Chowdhury et al, 1995; Islam et al, 1999; Gibney et al, 2003) have alarmed public health officials about the dramatic rise of HIV infection in Bangladesh's neighbouring countries, especially in India. But there is an absence of major work (except Caldwell and colleagues, 1999; Gazi and colleagues, 2008) examining the role of significant places like borders, people trafficking zones and port areas in transmitting the potential source of HIV infection in Bangladesh. Apart from sexual networking and its related impact, there is no research on place as a source of stigma for vulnerable people and their health risks. Again, very little research has been done on the changing condition of brothels and the impact on transmission-related risk, except for Jenkins and Rahman (2002). There has also been very little research on destitute women or slum women, except for Gibney (2001) and Sabin's (1998) work. Similarly, with regard to border girls, there is little research (except Paul and Hasnath, 2000; Blanchet and colleagues, 2003) on their role in the transmission of HIV. It is notable that many NGO reports can be found on the issue of women trafficking as a whole, but not on the trafficked girls themselves. My research has examined places from different points of view, such as those that are thought to be safe, risky, or stigmatized. Through interviewing border girls and foreign truckers, I have covered the role of mobility of vulnerable people and the role of border towns in transferring the potential risk. Moreover, I have also looked at the issue of probability of HIV risk for Bangladesh through trafficking and other unidentified sources.

Policy and practice: Policies and institutional practices can make certain populations vulnerable to disease. Specifically, poverty, gender disparity, and discrimination have been identified as structural factors facilitating health risk particularly HIV transmission worldwide (Parker et al, 2000). However, social and cultural factors including socioeconomic status, norms, values, beliefs, and ideals of a population are often intertwined with health behaviour among a population (Last, 1998). A number of publications discuss different prevention measures but there is no information on the 'contradictory programs' for HIV prevention in Bangladesh, 'standard awareness

campaigns', stigma and discrimination for HIV positives, NGO politics and donor policy, and the role of the government. Very little detailed research has explored HIV policy, policy implementation or the components of HIV prevention strategies in Bangladesh.

2.5 Concluding Remarks

The global AIDS pandemic is recognised worldwide as a substantial public health problem. This thesis has been planned to look at the current threat of HIV and its adverse health and social effects, as well as public policy and practice in Bangladesh. This chapter has explored the health geography literature and other geographical discourses related to health risk particularly HIV. In reviewing the geographic and HIV literatures of Bangladesh, I have found a conceptual and theoretical (including methodological) framework for developing the thesis. In this regard, this qualitative research among marginalized and vulnerable people, such as drug users, sex workers, HIV positives and transport workers of Bangladesh aimed to investigate their 'risk' and 'vulnerability' through their 'lifeworlds' and stigmatized life. This qualitative research points to how health risks, particularly in relation to HIV, are seen by these marginalized and vulnerable groups as relative concerns. In the context of everyday injecting drug use, heroin inhaling or everyday commercial sexual activities, HIV risks associated with injection or commercial sex may be seen to be less immediate or important than other risks, such as stigma and identity crises, discrimination and criminalization, and risks such as drug overdoses.

This chapter has addressed the conceptual and theoretical aspects along with HIV issues from several types of literature. The investigation will be advantageous in measuring the health risk from social and geographical points of view. The next chapter (Chapter Three) will mainly focus on the data collection procedures and the data analytical procedures used to fulfil the research objectives.

Chapter Three

Data and Methodology

Chapter Three

Data and Methodology

In assessing the health, social and geographical influences on HIV/AIDS risk among vulnerable groups in Bangladesh, it is important to ask what data are needed and which methods should be adopted for data collection, analysis and theory building. As the present research objectives are to explore in-depth information regarding the challenges facing marginalized people in Bangladesh, this information is bound to be sensitive, covering many emotional and personal themes. Many of the stigmas, uncertainties, lack of awareness and unhygienic practices that place marginalized and vulnerable people's health at risk are difficult to quantify. However, much recent epidemiological research indicates that qualitative research is needed for insights into the risk behaviours of the most vulnerable population for HIV transmission and the circumstances of high risk behaviours. Considering these factors, my study objectives have been best addressed through qualitative methods. Different qualitative techniques have been employed for this research for data collection and analysis. This chapter is divided into seven sections which will describe the methodological approaches, field survey planning and design, sampling procedures, data collection techniques, methods for analyzing data, limitations and, finally, concluding remarks.

3.1 Methodological Approach

3.1.1 Introduction

From the beginning of human history there have been differences in opinion on how research should be conducted. Over recent decades, philosophers such as Kuhn (1962 & 1970), Foucault (1972 & 1980) and Habermas (1978) have argued about the four concepts of research: ethics (axiology), epistemology, ontology and methodology

(Guba, 1990). Here ethics asks, how will I be as a moral person in the world? Epistemology asks, how do I know the world? Ontology raises questions about the nature of reality and the nature of the human beings in the world; and methodology focuses on the best means for gaining knowledge about the world (Denzin and Lincoln, 2000). To clarify these issues, it is essential to distinguish between two different ways in which theory and observation are related, the one 'inductive' following the arguments of Bacon (1561-1626) and the other essentially 'deductive' derived from the ideas of Leibniz (1646-1716) and more recently Popper (1968 & 1976) (Haines-Young and Petch, 1986). In the process of research, researchers might consider a general picture of social life and then research a particular aspect of it to test the strength of the theories. This is known as deduction, where theorizing comes before research. On the other hand, researchers might examine a particular aspect of social life and derive their theories from the resultant data. This is known as induction, where research comes before theory and researchers seek to generate theoretical propositions on social life from data (May, 1997). Apart from these 'theory comes first' and 'theory comes last' aspects, Mason (2002) mentioned, thirdly, that theory, data generation and data analysis can be developed simultaneously in a dialectical process.

Basic research aims to contribute to fundamental knowledge and theory (Patton, M. Q. 1990) but developing theory is a complex activity (Strauss and Corbin, 1998). Theories are derived from the field work process, are refined and tested during field work and are gradually elaborated into higher levels of abstraction towards the end of the data collection phase (Bryman, 1996). Human geographers have been involved in such debates and, there are a number of schools of thought on the best way to approach the relationship between society, space, place and environment (Kitchin and Tate, 2000). Unwin uses Habermas's taxonomy of the different types of science to structure his discussion of approaches within geography, and I follow his lead (Table 3.1). Habermas (1978) divided science into three different varieties: empirical-analytical, historical-hermeneutic, and critical. These differ fundamentally from each other in a number of respects in relation to how knowledge and human action is mediated. He suggests that knowledge within each type is mediated through a series of interests (technical, practical and emancipatory), developed within differing social media (work, language and power), and expressed through different forms (material production, communication and relations of domination and constraint) (1992). At the broadest

Table 3.1: Methodological Approaches Adopted for this Research

Research Approach (Type of Science)	Main Methods (School of Thought)	General Description	Importance in HIV Research	Data Collection Procedures	Data Analysis Procedures	Target Covered
Qualitative Approach (Historical-hermeneutic)	Phenomenology	It refers to the 'people-centred' form of knowledge of an object based in human awareness, experience and understanding (Pile, 1993). It reconstructs the meaning of phenomena and objectives in the worlds of individuals to understand the individual behaviour without drawing upon supposed theories (Kitchin and Tate, 2000). It rejects the scientific and quantitative approaches of positivism. It seeks to disclose the original way of being prior to its objectification by the empirical sciences (Pickles, 1985).	To understand the HIV impact, it is suggested that we need to reconstruct the world of marginalized people who are HIV positive and also vulnerable to HIV. We need to try and see the world through the eyes of vulnerable people of HIV. This might be attempted by taking to them about their life experiences.	In-depth Interviews, Focus Group Discussion, Ethnography	-Discourse analysis -Heuristic approach -Grounded theory	'Lifeworlds' of Marginalized and Vulnerable People to HIV/AIDS
	Existentialism	It is based on the notion that reality is created by the free acts of human agents, for and by themselves (Johnston, 1986). It focuses upon how individuals come to create and place meaning to their world and how they subscribe values to objects and to others.	Health risk particularly HIV is understood by trying to gain insight into how people who vulnerable to HIV come to know, ascribe meaning and interact with the world.	In-depth Interviews, Ethnography, Participant Observation	-Grounded theory -Ethnographic approach	HIV Risk Behaviour and Coping with Threat
	Pragmatism	It suggests that rather than focusing on individuals, attention should be paid to society and the interaction of individuals within society. By exploring the lives of people within a community, it is hoped that the nature of the beliefs and attitudes, which shape society, will be uncovered (Kitchin and Tate, 2000).	HIV threat is understood by observing how individuals of vulnerable people interact to produce conditions which sustain destitution, for example, examining whether marginalized and vulnerable people remain in risk because of their marginalization and stigmatization etc.	In-depth Interviews, Ethnography, Focus Group Discussion	-Grounded theory -Hermeneutical approach	Identity, Stigma and Prejudice of Marginalized Community
	Idealism	It posits that the real world does not exist outside its observation and representation by the individual. Idealism views reality as a construction of the mind. It seeks to explain patterns of behaviour through an understanding of the thoughts behind them (Kitchin and Tate, 2000).	Health risk is understood by trying to gain insight into how vulnerable people think about risk and the world they live in, for example, examining vulnerable people on what it feels like to be risky, why they think they are risky.	Participant Observation, Naturalistic Observation, In-depth Interviews	-Grounded theory -Narrative analysis	Relationship of HIV Risk and Place
Critical Research	Realism	It refers to the investigation of underlying mechanisms and structures of social relations, i.e. identifying the 'building blocks' of reality. It concerns the identification of how something happens (casual mechanism) and how extensive a phenomenon (empirical regularity) is (Unwin, 1992).	Potential HIV disaster is understood by determining the mechanism underlying how society operates, for example, examining whether HIV disaster exists because of the uneven social and political attitudes.	In-depth Interviews and Secondary Data	-Narrative analysis -Grounded theory	Policy and Practice in HIV Mitigation

Idea Adapted after Kitchin and Tate, 2000/ Note: The methodology of this research is covered mainly the qualitative objectives.

level, science is concerned with the pursuit of truth, which Tolstoy termed 'an abstract idea' (Unwin, 1992) and it is concerned with the formulation of hypotheses derived from observations, testing, and theories and laws (ibid). It is an invention of the human mind, which once created takes on the status of absolute truth. This means that we need to have some understanding both of what truth is, and also of the method by which it is pursued (Russell, 1961; Popper, 1968; Harvey, 1969; Kuhn, 1970; Habermas, 1978). In social research, there are three major ingredients: the construction of theory, the collection of data and the design of methods for gathering data (Gilbert, 2001). Social theory, along with social research, is of central importance in the social sciences (May, 1997).

3.1.2 Qualitative methodology

Methodology in social research refers to the techniques and epistemological pre-suppositions that contribute to how information is identified and analyzed in relation to a research problem (Filstead, 1979; Innes, 2001). The quantitative researcher adopts the posture of an outsider looking in on the social world. Quantitative research is typically taken to be exemplified by social surveys and by experimental investigations (Bryman, 1996). On the contrary, knowledge and theory are generated from empirical data in qualitative research (Bunne, 1999) and oriented toward exploration and discovery (Patton, M. Q. 1990). Qualitative methods can be used to explore substantive areas about which little is known (Stern, 1980) like people's lives, experiences, behaviours, emotions and feelings (Strauss and Corbin, 1998).

The quantitative research designs of most HIV-prevention studies do not measure accurately the intimate practices of vulnerable people (Bourgois et al, 2003). Most research studies, particularly those of an epidemiological or quantitative slant, are unable to describe how risk behaviour is understood (Rhodes, 1995). Instead, the advent of AIDS brought about major shifts in the substantive interests of qualitative researchers, as well as methodological innovations more generally on risk behaviour (Lambert et al, 1995; Wiebel, 1996). Qualitative understandings of the social context of risk behaviour are paramount in understanding HIV infection, and HIV-related risk

behaviour, as a product of the particular 'risk environments' in which they occur (Rhodes et al, 2001). In addition, qualitative research techniques are now a commonly used and accepted means of social inquiry, particularly the case among 'hidden' or 'hard-to-reach' populations - such as sex workers or drug users - where there exist practical and methodological difficulties in the use of large-scale quantitative surveys and representative sampling designs (Aviles et al, 2000). However, qualitative research approaches are increasingly recognized for their importance in the geography of health and health care (Curtis et al, 2000).

Qualitative research fundamentally depends on watching people in their own territory and interacting with them in their own language, on their own terms, and this method has been seen to be 'naturalistic', ethnographic and participatory in social science (Kirk and Miller, 1986). Qualitative research, which played an important and distinguished role within the social sciences throughout the 20th century (Hartnoll, 2000) may be defined as an attempt to obtain an in-depth understanding of the meanings and 'definitions of the situation' (Wainwright, 1997). It refers to techniques which seek to generate, collate and analyze primarily 'qualitative' rather than 'quantitative' forms of data (Rhodes et al, 2001). Qualitative data can be summarized as information which is based on speech, text or observation and which is made available to analysis in textual rather than numerical form (Punch, 1998; Table 3.2). The various methods of qualitative research are oriented towards understanding how people perceive their lives and construct them as being meaningful (Agar, 1980 & 1997; Carlson et al, 1995). Qualitative research seeks to adopt an 'inductive approach' in an attempt to 'make sense of, or interpret, phenomena in terms of the meanings people bring to them' (Denzin and Lincoln, 1994; p.2). It is a 'method of discovery' (Fielding, 1993) and it works on the basis that the life or behaviour under study 'becomes meaningful, reasonable and normal once you get close to it' (Goffman, 1961; p.9). In geography, qualitative methodologies span a wide range of empirical work and different philosophical and epistemological underpinnings (Dwyer and Limb, 2001).

Table 3.2: Aims and Techniques of Qualitative Research

Aim:	to describe the social meanings actors attach to their actions
	to describe actors' 'lived experiences' and lifestyles
	to describe the social environments in which action takes place
Data:	textual
Data collection:	observation, interviews, focus groups, diaries, written biographies,
	oral histories, photographs
Data analysis:	inductive, hypothesis generating, systematic case comparison

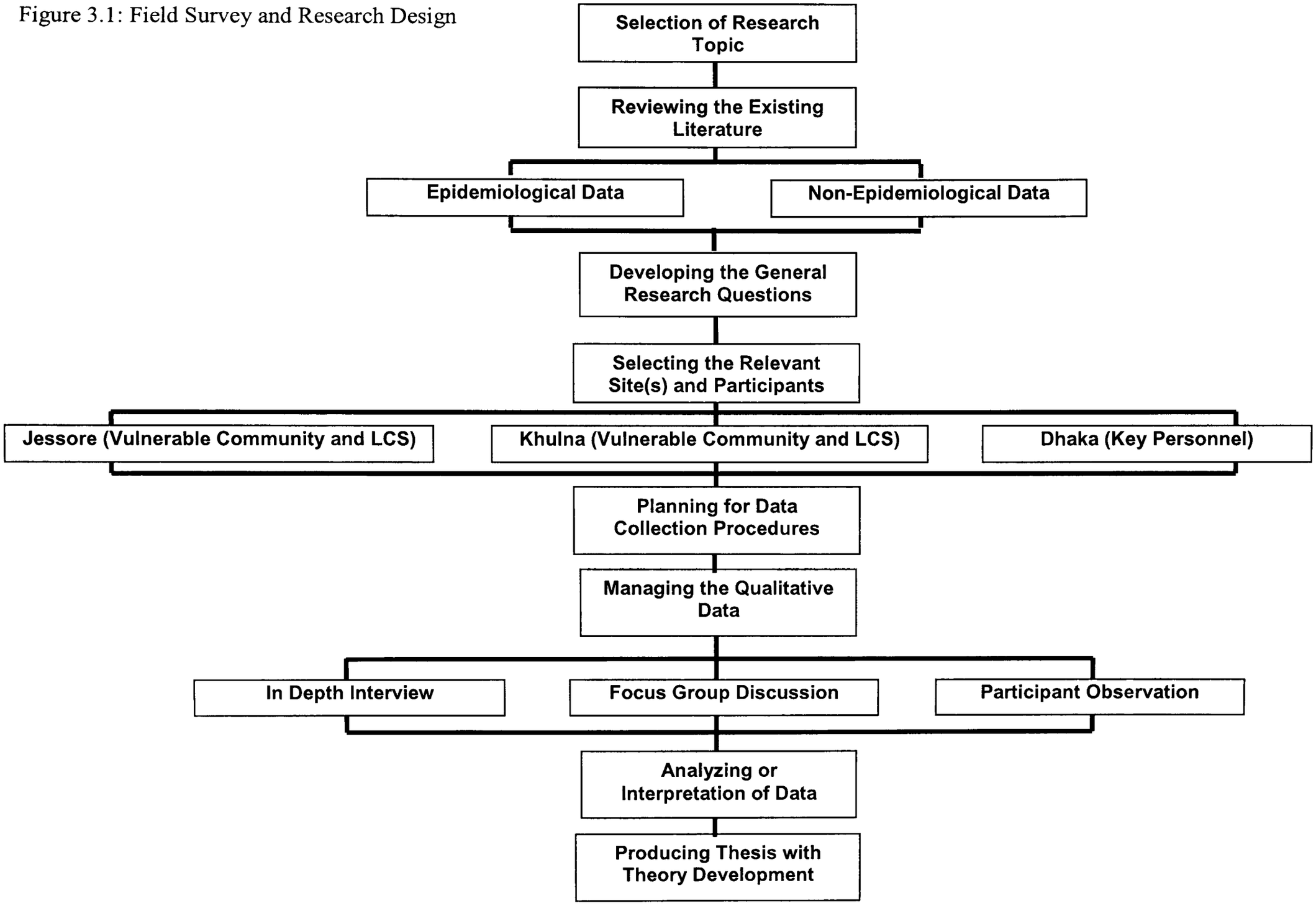
Source: After Rhodes et al, 2001

3.2 Field Survey Design and Problems in the Field

A research design provides a framework for the collection and analysis of data (Bryman, 2004) and a coherent argument for answering the research question (Green and Thorogood, 2004). Qualitative research methods have the capacity both to inform survey designs and to complement survey findings (Aviles et al, 2000). Qualitative design demands that the researcher stays in the setting over time and the researcher must have the ability to observe behaviour and must sharpen their skills for observation and face-to-face interviews (Jenesick, 2000). The researcher does not attempt to manipulate the research setting (Patton, M. Q. 1990). As qualitative methods are rather similar to the interpretive procedures of our everyday life (Maanen, 1983), including sensitive topics, the researcher may face problems and issues that arise at each stage and which take a variety of forms. Sensitivity potentially affects almost every stage of the research process from the formulation of a research problem, through the design and implementation of a study (Lee, 1993); qualitative design incorporates informed consent decisions and is responsive to ethical concerns (Jenesick, 2000). In addition, sensitive research often has potential effects on the personal life, and sometimes on the personal security, of the researcher (Brewer, 1990).

The survey design was organized as a data collection procedure to address the 'lifeworlds' of marginalized communities and also looking at the risk factors for HIV/AIDS infection (Fig 3.1). Data have been collected from both primary and secondary sources. At present it looks as if very little health risk data regarding HIV/AIDS in Bangladesh exists, not only for the study areas but also for the whole country. The author therefore needed to collect his own data. Respondents were selected on the basis of a convenience sample design. All discussions used a semi-structured interview guide in local dialect (in Bengali). Participants were given the choice of both time and venue for interviews or discussions.

Figure 3.1: Field Survey and Research Design



3.2.1 Research planning and experiences

As the HIV/AIDS issue is stigmatized in Bangladesh, the selection of specific interviewees and focus group discussion participants was very carefully planned. I stayed in the field for more than seven months for this research (Table 3.3). Different socially marginalized communities like CSWs, DUs and vulnerable groups like TWs, were considered as research participants in order to understand their exposure to risk, their coping strategies and their 'lifeworlds'. However, I also managed to develop contact with local civil society participants and officials of national and international agencies to elicit their views about the issues, plans and future policies on HIV/AIDS in Bangladesh. In many cases, I obtained NGO permission from the head office for accessing their office and stakeholders at the local level. As it was a challenging job, what security measures did I take? I thought carefully about personal safety. Before starting field work I had regular communication with local civil administration high officials including District Commissioners and high police officials of the districts mentioned since I worked with some groups who are usually termed 'dangerous' by local people. Many locals advised me to keep in regular contact with the police to avoid potential dangers or harassment from drug users, sex workers or others. The police high officials reassured me and I was given relevant mobile telephone numbers for emergency contact. Moreover, I developed good relationships with local influential journalists and local university and college teachers as well for references. In most cases I visited these people personally after getting an appointment by mobile phone.

Table 3.3: Time Schedule for Field Work (Week wise)

Nature of Work Schedules	**Field Weeks (1-31)**										
	1	**2-4**	**5-7**	**8-12**	**13-15**	**16**	**17-19**	**20-21**	**22-25**	**26-29**	**30-31**
Arrival and readjustment											
Contact with NGOs & Related people											
Pilot study for Q theme check (KL & BP)											
Work starts at JE											
Work starts at BP											
NO and RTD in BP											
Work starts at KL											
Work continues at KL (PO)											
Work in DH (Key personnel interview)											
Secondary data collection (from GOB/NGOs)											
Preparation for return to Durham											

DH: Dhaka, JE: Jessore, BP: Benapole, KL: Khulna

Regarding my interview approach, I told everyone about my PhD project and my objectives in detail, at the beginning. When they agreed to participate, I started my interviews or group discussions. Some felt embarrassed or were afraid to talk with a stranger. When I met them in an 'open field' (street corner or transport terminals or abandoned house etc.) or in a closed room such as an NGO office, I found some to be very nervous. I tried to make them feel relaxed at first by asking 'ice-breaker' questions and engaging in normal small talk. In the FGD format, at first I introduced myself to my participants (who ranged in number from 5 to 8), then I explained my research topic - but not in elaborate detail, otherwise they might think it as a problem for them. Finally I gave them an assurance of anonymity. Fortunately in most cases my interviewees felt reassured because it was not so much a formal interview as a normal conversation, and I found them to be easy, relaxed and flexible. I did not always finish my question schedule because interviewees wanted to continue their life story or history of their suffering. If the participant stopped contributing on any point then I usually asked another question derived from his or her previous conversation. When I could not find anything special, I changed my interview style and asked them some 'light' questions. Sometimes I asked the same question twice at different times in order to assess the authenticity of the answer. In the event of a discrepancy, I tried to help them recall their previous answer to work out what the truth was. However, when I asked participants to talk about facts, a few were worried about confidentiality. In these cases I gave categorical assurances about anonymity. To see the group dynamics and participants' psychology, the whole research team including my assistants observed each discussion which was held in brothels, NGO offices or in field sites, and in each discussion I played the role of moderator to facilitate the conversation.

Before starting data collection, I checked the question themes to make a few IDI and FGD with these mentioned groups as a part of a pilot study. Then I modified the question themes accordingly (Please see Appendix-1.1/ 1.2/ 1.3/ 1.4/ 1.5). Moreover, I kept in regular contact with my supervisors during field work as some of the question themes needed to be changed. By making an appointment schedule, I regularly communicated with the NGOs peer educators and other sources who had good relationships with project participants.

3.2.2 Problems faced during fieldwork

As my research issue is considered 'sensitive' and I worked with some socially marginalized and vulnerable people, I faced a number of problems during field work, as described below.

1. I faced abusive language during an interview at a Jessore brothel and was forced to leave the place due to an interruption from an influential woman. I was interviewing a '*chemri*' (bonded sex worker), when suddenly a lady approached and shouted rude language at both of us and I was compelled to stop the interview at an incomplete stage.
2. Some respondents assumed that I came from a daily newspaper, so they were very cautious. At Fultola brothel, one girl willingly allowed some photos to be taken by my assistant, but next day when we arrived she asked me not to publish the pictures in any local daily newspaper. She became confused and shouted at us to delete her pictures. I became very concerned to see her sudden outburst, but some local NGO workers solved the problem on our behalf.
3. In Jessore and Khulna, some LCS participants missed appointments several times, which hampered my schedule. Most of the times, when I phoned to confirm the schedule they cancelled the appointment and gave another time. Also, during the interviews with LCS people, many of them received phone calls, which interrupted the flow of conversation.
4. A few addict interviewees were selected by NGO workers who then refused to talk to me. A few even denied their drug addiction. NGO workers explained that this was because people felt scared, but it did waste time.
5. I requested an NGO to organize a programme to show me its operation in the field. But unfortunately the NGO was unwilling to agree to this. They gave some poor excuses for not organizing this, but I think they wanted to avoid seeing me to conceal this area of their weakness.
6. When I was talking with addict respondents beside the road or in a residential area, it was common for local people to interrupt or become curious to listen. Sometimes these onlookers stubbornly refused to move on. Sometimes they tried to blame the addicts as an anti-social element and even asked me to arrest them, which ultimately interrupted the conversation.

7. There were a few technical problems with data collection. For example, on some occasions at the start of a FGD or interview, the digital voice recorder failed to operate properly and I was required to make written notes.
8. One addict respondent sought money from me for heroin. When I refused he became angry and told me that he would go to sell his blood and refused then to continue his conversation with me.
9. I introduced myself to one street girl near Khulna railway station and started to talk to her sitting on the footpath. When we were talking, many people on the street were looking at me strangely and may have considered me to be a punter. When we had just started our interview, I discovered that the girl was feeling shy about responding. Her husband was sitting beside her and he gave me advice not to ask any questions which might bother or embarrass him. I was confused to hear that the woman's age was 35 but her so-called husband was 22. The woman was clearly not free to talk with me about risky behaviours and I felt threatened by her husband, so I decided to stop the interview, giving the excuse that it was a noisy environment.

3.3 Sampling Strategy: Principles and Approaches

Among qualitative researchers there is a strong urge to 'get close' to the subjects being investigated - to be an insider (Bryman, 1996). Sampling is important in qualitative research (Silverman, 2005) and is often one of the primary aspects in project planning (Arber, 2001). Sampling decisions are required not only about which people to interview or which events to observe, but also about settings and processes (Punch, 1998). The sampling strategy should be relevant to the conceptual framework and the research questions addressed by the research (Miles and Huberman, 1994; Punch, 1998). Sampling in qualitative research aims at achieving as much information as possible about the issue studied (Bunne, 1999). But the question of sampling often seems to receive less attention in methodological discussion than issues of data collection and analysis (Curtis et al, 2000). Purposive sampling, with some purpose or focus in mind, is the dominant strategy in qualitative research (Patton, M. Q. 1990). Purposive samples are ideal when developing interview schedules and other research instruments (Arber, 2001). They allow the researcher to choose a case because they illustrate some feature or process of interest (Silverman, 2005). Many qualitative

researchers employ purposive sampling methods that are not random. They seek out groups, settings and individuals where the processes being studied are most likely to occur (Denzin and Lincoln, 2000). 'Theoretical sampling', often treated as synonymous with purposive sampling is also used in qualitative research as a sampling strategy (Glaser and Strauss, 1967).

During my field work, I worked with three social groups. First, I worked with people vulnerable to HIV infection: commercial sex workers (including hotel, residence, floating, brothel and street based); drug users (including heroin smokers and intravenous drug users); transport workers (including Indian and Bangladeshi truckers and rickshaw pullers); and female slum dwellers and people living with HIV and AIDS (PLWHA). Second, I talked with local elites (people in civil society): journalists, NGO personnel, local government officials, international agency people, teachers, physicians, local elected representatives and religious persons. Both of these groups were interviewed in Jessore and Khulna. Finally, I worked with key personnel and policy planners for HIV in Dhaka, including Bangladeshi NGO high officials, international agency officials and members of funding organizations. I also joined in a round table discussion (RTD) with transport workers at Benapole. None of this was easy to do because no database exists at present on HIV/AIDS in the study areas and it was therefore difficult to anticipate the sampling frame and size of sample. It was necessary to select a sampling strategy for collecting the qualitative information (Table 3.4). In terms of finding interviewees to take part in the study, participants were contacted through institutions or through snowballing.

Table 3.4: Statistics of Sampling Frame

Groups	**Jessore**			**Khulna**			**Dhaka**
	FGD	**IDI**	**PO**	**FGD**	**IDI**	**PO**	**KPI**
With CSW	5	28	-	6	44	-	25
With DU	8	15	3	5	32	1	
With TW	3	18	-	-	2	-	
With LCS	1	35	-	-	30	-	
With HIV+ and others*	-	2	-	2	18	1	
NO	For CSW, DU and TW			For CSW, DU and HIV+			
Total No	**17**	**98**	**3**	**13**	**126**	**2**	**25**

* Others mean slum dwellers, local healers etc.

3.3.1 Finding and selecting suitable participants

Sampling becomes more difficult the more sensitive the topic (Lee, 1993). One important aspect of interviews dealing with sensitive topics is that there should be no fear on either side and it is vital to ensure trust between interviewer and interviewee (Brannen, 1988). In definition, Sieber and Stanley (1988) focus on the consequences of research, while Farberow (1963) equates sensitive topics with those areas of social life surrounded by taboo. Networking is one of the major strategies which can be used, singly or in combination, for sampling 'special' populations which are scarce and/or 'deviant' in a way (Rock, 1973); or where no adequate list exists to use as a sampling frame (Arber, 2001); the researcher builds up 'layers of contacts' and trust (Valentine, 2005). Network sampling, also known as 'snowball sampling', is based on a number of initial contacts within the culture of a particular group who are asked for the names and addresses of other people (Sudman and Kalton, 1986; Kemmesies, 2000; Kitchin and Tate, 2000; Bryman, 2004). Here generalization is not really legitimate, mainly because there is no idea of the size of the population (May, 1997). This sampling does have advantages in cases where those being studied are members of a vulnerable or highly stigmatized group (Lee, 1993). Bias is an almost inevitable feature of snowball samples because the social relations which underpin the sampling procedure tend towards reciprocity and transitivity (Davies, 1986). In addition, the main obstacle to recruiting informants from organizations is often knowing who is the most appropriate person to talk to (Valentine, 2005).

As the issue of HIV is a sensitive matter, I was very careful about the selection of my interviewees and FGD participants. I found some local NGOs who are working with vulnerable groups in Jessore and Khulna by using 'snowballing'. I took their help to get access to their stakeholders and also to discover and communicate with the respondents initially through their (NGO) peer educators, who worked at the field level, so that they could help me to find drug users, sex workers and transport workers in the 'open field'. Though I managed many interviews in the closed rooms of NGOs, others were arranged in open places like steamer terminals, tea stalls, transport terminals, residential streets, beside the highway or in rickshaw garages. I visited these different places on my own and used the snowballing technique to find them, particularly street sex workers and

drug users. For instance, I discovered an addict in an area of Jessore that is known as a drug selling point. I introduced myself and we started our conversation in an open field sitting beside a coconut tree. Using the snowball sampling technique, I managed to develop relationships with some members of the marginalized community and find more participants from these groups. For transport workers, particularly Indian truckers, snowballing was less effective because nobody trusted me or wanted to speak about their personal lives in front of another friend. Here, a few former NGO peers assisted me to identify participants for interviewing and organizing an FGD. Firstly these peers approached them to know whether they had spare time to spend talking to me. If anybody agreed then I explained my purpose and importantly confirmed to him that I didn't come from any intelligence branch, as most of them feared. After introductions, I boarded the driver's truck or sat beside the truck in the terminal area for the interview. Most days I used the afternoon period when they have free time. Most of them felt free to speak me when they observed that I didn't ask their name. So they trusted me and talked about their sexual life which is usually considered to be a very secret matter. Sometimes they thought I was a doctor though I clearly stated my qualifications. For the FGD with Indian truckers, I was helped by an interpreter for the Hindi speaking drivers in Benapole terminal.

Apart from snowballing, I used NGO offices for interviews and for organizing FGDs with DUs, CSWs (mainly brothel-based) and HIV positives. For example, in the brothel, I used some NGOs' offices inside the brothel as my interviewing place. When I requested NGO managers in the field level to suggest participants for my research, they chose them from different perspectives according to my instructions. Most participants were not taking any visible benefits from that NGO, but had contact with the local NGO peers. Participants' ages ranged from 15 to 60 years. I wanted to carry out most interviews in the 'open field', but when I tried this I faced many problems from different corners. Most importantly I observed that CSWs and DUs are difficult to organize in a group format in the open. But they were in a controlled environment when I talked with them in a separate room of an NGO office. They were very attentive to my questions and articulate in their replies, which is absent in the 'open field'. And most importantly, due to the location, they were away from any physical threat. Both the inside and outside facilities provided by the NGOs enhanced the speed of my project. But there is a question that may arise out of an NGO's involvement with these

participants for interviewing. Although I took the NGO's help, they had no influence on my research participants. I always assured my interviewees that I was not an NGO official, so they could easily share their views and I found this to be beneficial. In addition, many other prominent local people in both study areas and policy planners in Dhaka gave interviews in their offices.

3.3.2 Earning interviewees' trust

Research on a sensitive topic is not easy to present and the researcher must decide whether or not the topic of the interview should be described in detail at the outset (Lee, 1993). Qualitative research emphasizes the importance of getting close to the people and situations being studied in order personally to understand the realities and minutiae of daily life (Patton, M. Q. 1990; Denzin and Lincoln, 2000). Trust is essential between the researcher and the people being studied to facilitate the disclosure of sensitive information (Lee, 1993). Empathy develops from personal contact with the people interviewed and observed during fieldwork in qualitative inquiry (Patton, M. Q. 1990). In some cases, respondents feel grateful for the opportunity to express their feelings and, over time, this may lead to a growing closeness (Brannen, 1988). During each interview, I needed to earn the trust of the interviewee to get information. I came to understand that many marginalized people, particularly sex working girls, often do not want to share their emotions and feelings even with NGO peers. On reflection I feel privileged because I think that I was able to explore many of their 'lifeworlds', although it is difficult to draw firm conclusions from an hour long interview. Many people tried to assess 'up to which level they would trust me', then some of them told me real facts since they considered me to be trustworthy. I adopted no authoritarian or patronising attitudes in my approach to them. Many addicts and TWs thought me to be a detective police officer at the beginning. Sometimes my attempts at consolation also induced them to share stories of their suffering in the 'banned life' or stigmatized life of a hidden sex worker, drug user or HIV positive. During my interviews I was sympathetic; good behaviour and simplicity, and sometimes some emotional expressions, also influenced them to share their untold stories. It is difficult to say what should be the real academic query style with these marginalized groups, but I found that if I could understand their sorrows and if they could see it in my eyes, they would tell their facts. I never showed any aggressive or hostile attitudes in my questions and did not ask about any issues that

they might consider disrespectful. I never tried to exploit these people in any way. I always tried to keep myself as quiet as possible, which helped them to trust me rapidly. I showed all of my respondents a high level of respect. If they received phone calls during the interview I advised them to receive the call. I never asked them to switch off their phones because many of them received calls from paying customers. On the other hand some girls were annoyed to receive calls during the interview and switched off their phones willingly. Some wanted to continue talking with me after more than an hour had passed, so I reminded them of the time so that they would not suffer by losing customer. Sometimes I wondered why they were so interested in giving up their time to talk with me. I think that one reason is 'sharing'. They cannot share their life with anyone because they have no trustworthy friends. They considered me as a friend, which also helped my research findings. One hotel girl, who shared her life story with me without hesitation, told me that there are some issues of life which she did not share even with her husband. She said, "*I feel very happy that I could share many of my sufferings with you. There are some things which I don't talk about with my husband because he might get angry or be sad to hear my feelings. Now I feel light from my heart after sharing many things with you, but I don't know what you think of me.*"

3.3.3 Emotional involvement

The overriding characteristic that many qualitative researchers find most crucial is flexibility. They must learn to be responsive to new data, unexpected data and unwelcomed data (Ely et al, 1991). This flexibility is needed during fieldwork, when unforeseen questions and issues emerge (Power, 2000). In addition, interviewing about sensitive topics can produce substantial levels of distress in the respondent and can also be stressful for the interviewer (Brannen, 1988). However, the ability to maintain a sense of humour in the face of minor adversity is a tremendous asset for qualitative researchers (Ely et al, 1991). The fieldwork was by no means all plain sailing. Although I had some bad experiences with these 'inaccessible' communities, I had a lot of good experiences, including the willingness of people generally to talk and to share their life stories with me. I will mention a few of these in the following.

When I heard about the sorrows or discrimination in the family of the HIV positives or marginalized people, I felt very sad and sympathized with them. For example, one of

the HIV positives appealed to me to arrange the marriage of her daughter after her death. When one of my HIV positive participants was crying, I tried to give her some consolation. I emphasized to keep her confidence and reminded her to trust in God. I hinted to her that some good opportunities might come up in the future. Another HIV positive was telling me about her husband's love affair with tearful emotion - which was a really emotional moment for me. In addition, I visited an HIV positive baby in hospital when he has been suffering from some opportunistic infections. I took some fruit and chocolate for him. I encouraged his HIV-positive father and advised him not to be anxious. They were all asking me to do more for their welfare in future. Many HIV positives invited me to visit their house or village. One of them was so enthusiastic that she had been waiting for me to call her as an interviewee. She said, "*I was waiting for your interview call. I thought that as I cannot speak Bengali language* [she is a foreigner] *you will not call me. But I was very willingly interested to hear from you*". Now I feel that I can also play a positive role for their welfare. Moreover, as many drug addicts considered me an NGO high official, they requested me to admit them into an NGO treatment centre after the interview. They were telling me that they wanted to be cured. I approached an NGO on behalf of a few addicts and finally they got the chance of admission into the treatment centre. However, other respondents made jokes with me and asked about personal issues such as my marital status, religion and home address. One participant told me that I did not look like a university teacher because I looked very 'young' in their eyes. One sought a job from me and another thought that I would give them a prize on the basis of their knowledge of HIV after the interview. In an FGD session with addicts, they wanted to sing a song on drug addiction and its vulnerability. I was encouraged to hear it as it was a melodious song which described the vulnerability of addiction. In addition, I asked almost everybody what they understood about my study or research. However, regarding the issue of positionality, many respondents asked questions about their risk behaviour after the interview or FGD when they became close to me. These participants thought that I was a practising medical doctor and wanted to learn from me about health risks. They also anticipated that they could obtain prescriptions for medication from me. In most cases, I tried to give answers to their questions and so increase their awareness of HIV risk. I advised those participants who showed me their physical problems to visit a doctor immediately. I believe that my research helped many vulnerable people to get involved with safe practices - particularly in terms of needle sharing and condom use.

3.3.4 Diversified sampling frame

In order to produce credible findings, qualitative researchers need to address questions of reliability, validity and generalisability (Green and Thorogood, 2004). In order to assess the validity of self-reported data from respondents, there are a number of different sources for validation including other information obtained from within the interview itself or collateral reports from family members, partners and friends (Bateson, 1984). There are many ways in which interviewers can affect the validity of the responses they receive (Bradburn, 1983). To enhance the understanding of the researcher and thereby the quality of the research, Severyn Bruyn (1966) thinks that time, place, social circumstances, language, intimacy and social consensus play a vital role. Apart from specific marginalized and vulnerable people, I also interviewed their family members to understand the social context and family opinions. In order to know and understand addicts' attitudes and behaviour, I undertook interviews with mothers and wives. In order to follow up on case verification for the addicts, I went to some of their houses and met with their family members, whilst keeping confidentiality or making a phone call to inquire about the addict's present condition. In most cases, family members, particularly wives, did not want to admit to their husband's heroin addiction due to the social stigma, but a few wives confessed and told me about their troubles with their addicted husbands. I also met with some recovering addicts' family members and, in a few cases, I used the opportunity of having both parties present to question the former addict and the rest of the family together about their experiences.

In addition, I met with a recovering addict who was the former representative of *Union Parisad* (smallest unit of local government). I also arranged a few interviews with HIV positives' families, and, in this regard, I selected a NGO worker (not as LCS people) who deals with HIV positives and knows their emotional world. I decided to talk with her to assess the HIV positive's different demands from the NGOs. Some NGO outreach workers (former CSWs and DUs) who give support to their peers, helped to assess all of my respondents' information authenticity. I interviewed them to get their ideas about how NGO accessibility can improve. In a few brothels, I was privileged to meet some customers along with their sex partners. I asked some questions related to HIV to understand their knowledge. Finally, I undertook a few interviews with local

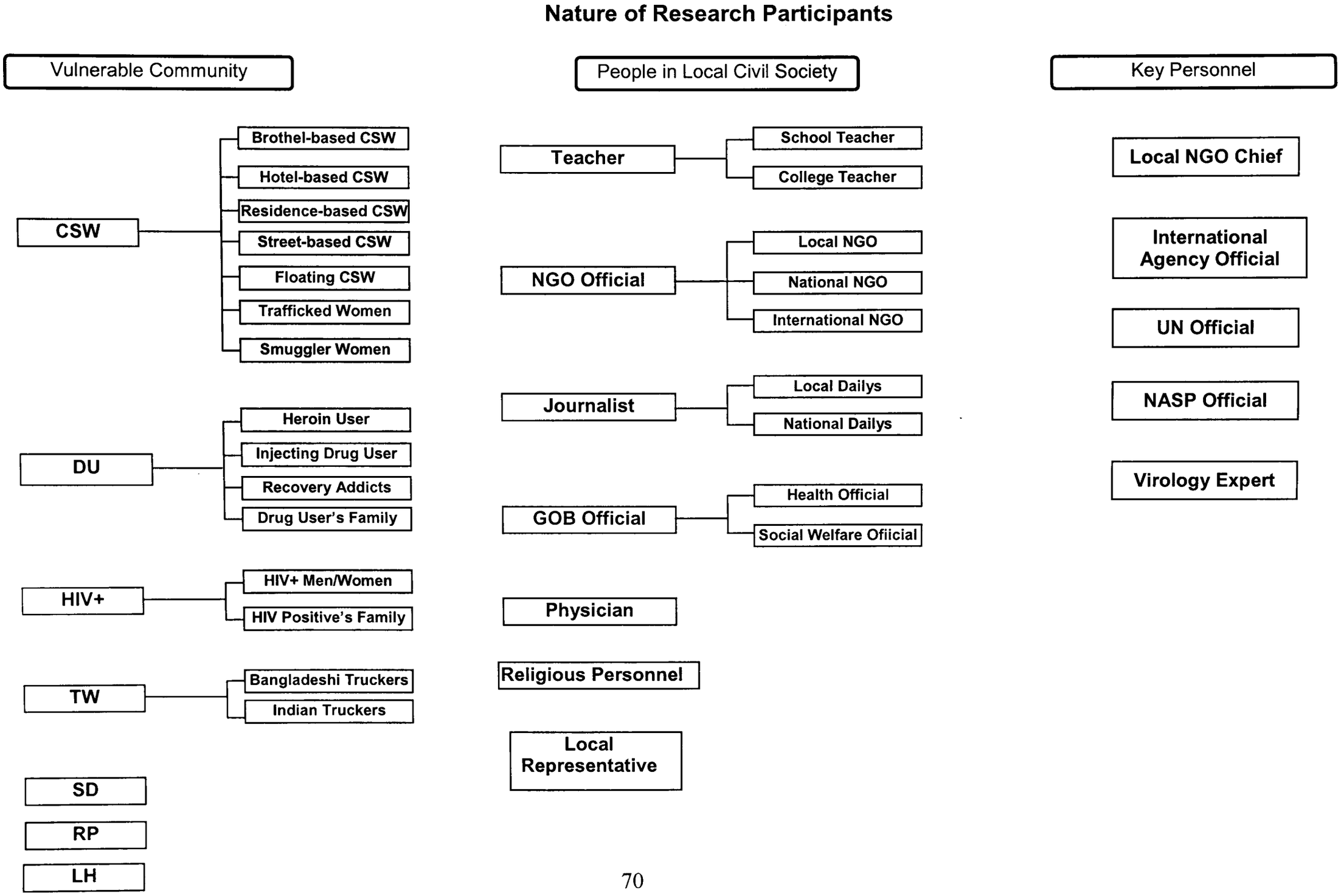
healers in Benapole and I also visited CSW's children's house to get an idea about their lives.

3.4 Data Collection in the Qualitative Approach

Qualitative research is a situated activity that locates the observer in the world (Becker, 1986) and is inherently multi-method in focus (Flick, 1998). The domain of qualitative inquiry offers some of the richest and most rewarding explorations available in contemporary social science (Gergen and Gergen, 2000). Qualitative design is holistic and it looks at the larger picture and begins with a search for understanding of the whole (Jenesick, 2000). The methods of qualitative inquiry are for studying and understanding people in whatever settings and under whatever circumstances one encounters them (Patton, M. Q. 1990). The data we collect and act upon in everyday life are of the same sort a qualitative researcher explicitly attempts to gather and record (Maanen, 1983). Qualitative field data are linguistic in character: observations, texts and interviews - all focus and rely on language (Silverman, 1993).

I used in-depth interviews, focus group discussions, participant observation and naturalistic observation (Fig 3.2). I used a digital voice recorder for recording data and a written diary was used on an everyday basis. Observation reports from research assistants and photographs were also used in the research. The research assistants received a week of intensive training before the data collection started. I also collected secondary materials like published books, annual reports, NGO working maps and documents, and posters and leaflets. Figures 3.3a, 3.3b, 3.4 and 3.5 are reproduced to illustrate my data collection points and approaches.

Figure 3.2: Participants in the Present Qualitative Research



3.4.1 In-Depth interviews

The interview is one of the main data collection tools in qualitative research (Punch, 1998) that generate useful information about lived experience and its meanings (Denzin and Lincoln, 2000). It has a strong claim to being the most widely used research method (Fielding and Thomas, 2001) in a wide variety of forms and a multiplicity of uses (Fontana and Frey, 2000). Each interview varies according to the interests, experiences and the views of the interviewees (Valentine, 2005). Interviews are generally unstructured or semi-structured. Semi-structured interviews come in between- the researcher has some predetermined topics and questions, but also leaves space for following up interesting topics when they arise (Rugg and Petre, 2007). In-depth interviewing produces information (Lee, 1993) that is defined as a short-term, secondary social interaction between two strangers with the explicit purpose of one person obtaining specific information from the other (Neuman, 1994). An in-depth interview is a one-to-one research encounter in which a respondent answers the questions of a researcher. In this study, different questions were asked of individuals to elicit their understandings about the issues of HIV risk.

Field experiences: As a technique of in-depth interview, I approached some brothel girls in different brothels when they had finished their 'business' with the customer. Most non-brothel girls were anxious about recording the interviews. For drug users, I found many addicts when either they had already taken drugs or were waiting to take drugs. Most of them gave their in-depth interview in the open. I did not observe any fear or shyness about giving interviews from the addicts. Transport workers showed their reluctance to be interviewed concerning their risky behaviour. I found most truckers for interviewing - including Indians - in the terminal areas of Benapole land port. In the case of HIV positives, I found them through different NGOs and interviewed them in the NGO office. Many gave long interviews and with much emotion. On the other hand, some respondents replied only briefly to my questions. Interviews with slum dwellers, rickshaw pullers, and local healers were undertaken at convenient times and places for them.

Figure 3.3a: Researchers' Action in In-depth Interviewing with Vulnerable People

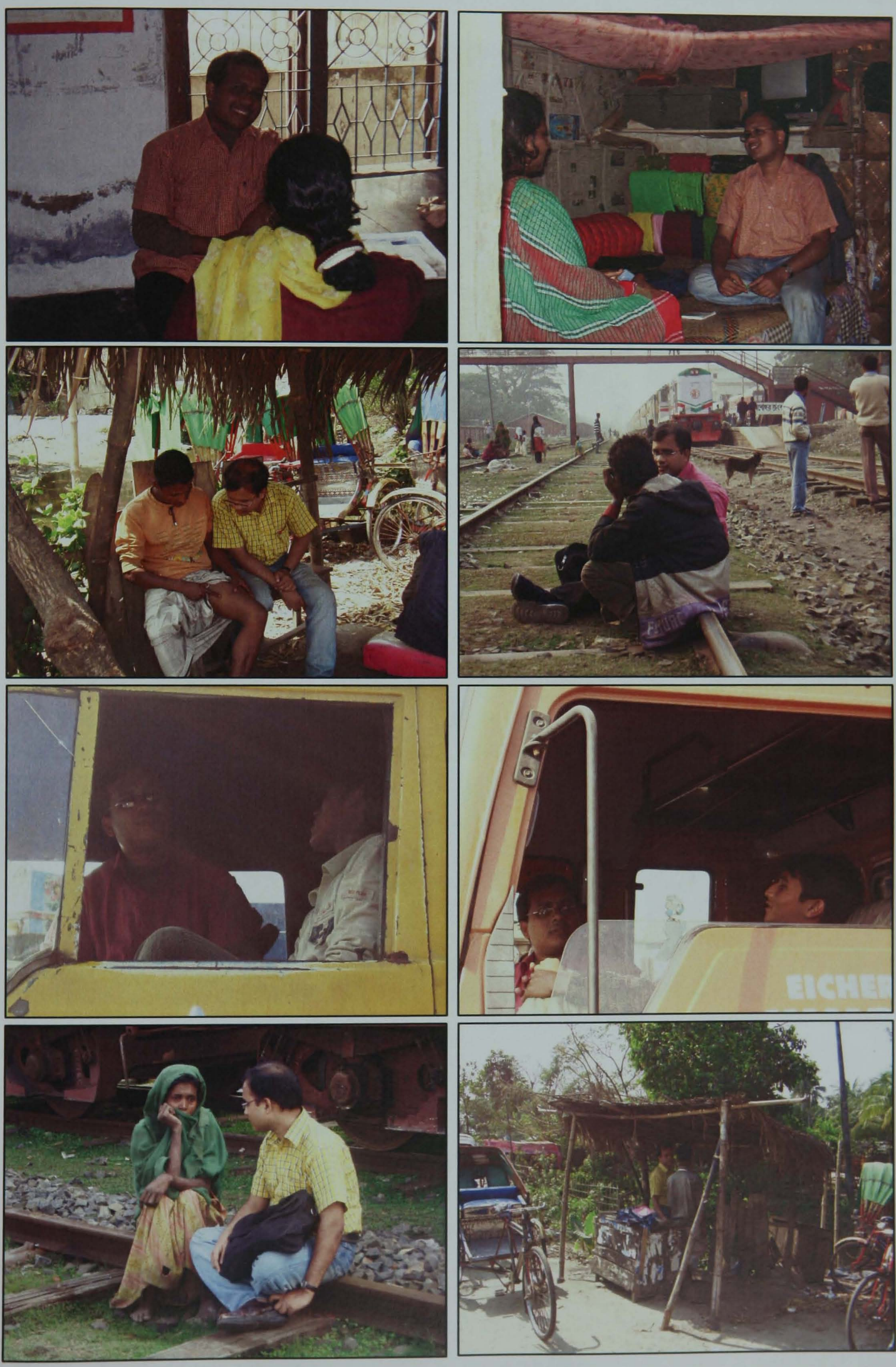


Figure 3.3b: In-depth Interviewing with People in Local Civil Society at Jessore and Khulna

3.4.2 Focus group discussion

The use of focus groups has become a key method for the collection of qualitative data (Krueger, 1998). Fundamentally, a focus group is 'a way of listening to people and learning from them' (Morgan, 1998; p.9). A focus group discussion consists of a small group of individuals who meet together to express their views about a particular topic

(Patton, M. Q. 1990) in a focused manner (Cronin, 2001) and the emphasis is upon interaction within the group and the joint construction of meaning (Bryman, 2004). The group interview relies on the systematic questioning of several individuals simultaneously in a formal or informal setting (Denzin and Lincoln, 2000). A general design principle in setting up focus groups is one of intra-group homogeneity (Conradson, 2005). Well facilitated group interaction can assist in bringing to the surface aspects of a situation which might not otherwise be exposed (Punch, 1998). A common complexity of FGDs is that two people may answer the same question using different words (Krueger, 1998). However, there can also be problems associated with group culture and dynamics, and in achieving balance in the group interaction (Fontana and Frey, 1994). FGDs have proved to be a useful tool for gathering information and attitudes about topics that are sensitive, intensely private and culturally taboo (Lee, 1993; Denzin and Lincoln, 2000; Conradson, 2005). The group situation can also stimulate people in making explicit their views, perceptions, motives and reasons. The FGD method was adopted in this thesis since the study of HIV issues in marginalized communities was complex and was thought to benefit from participants interacting with each other.

Fieldwork experiences: It was really difficult to organize and conduct group discussions with the sex workers and addicts but I was able to organise 30 focus groups in total. I found the people in many FGDs to be different with many interesting issues with their group dynamics. For example with addicts, I was required to mix with them in different ways and to listen to their emotions with more attention. Sometimes I observed that when I was listening to one addict's voice or opinion, the others wanted to speak against that. Some participants thought that I would give them money for heroin or would provide opportunities for treatment. Different individual characters like addicts in a group discussion are very difficult to manage. In a FGD with brothel sex workers, I found that the girls wanted to withdraw from the discussion after a while. Apart from their 'business' time limitation, the main reason behind is that some of the girls do not wish to discuss their life stories or other issues in front of their colleagues. In the FGD, some of them seemed to be very vocal and others very quiet. When I tried

to break their silence, sometimes I could but sometimes they laughed. Sometimes they carried their baby along and when the baby cried, they were forced to leave the session. However, although addicts were very willing to speak or discuss sexual matters in a group format, many TWs were embarrassed to speak about sexual issues. Among FGD participants, many transport and addicts wanted to show me or talk to me individually about their sexual infections.

Figure 3.4: Researchers' Action in Focus Group Discussion with Different Groups

3.4.3 Participant observation

The primary method of ethnographers is participant observation (Patton, M. Q. 1990) which means engaging in a social scene, experiencing it and seeking to understand and explain it (May, 1997). The stance of the participant observer is basically to carrying out naturalistic research (Ely et al, 1991) in unstructured ways (Punch, 1998). Wolcott

(1988) distinguishes three different participant-observer styles: the active participant, the privileged observer, and the limited observer. During participant observation, some informal interviews are done 'on the hoof' when the time is available and the spirits are amenable (Ely et al, 1991). In addition, dimensions of the research setting, interactions, relationships, actions, events, and so on are immersed (Mason, 1997). The role of the researcher changes from detached observer of the situation, to both participant in and observer of the situation (Punch, 1998). In participant observation the researcher seeks to observe events and the behaviour of people by taking part in the activity themselves. As an observer, I adopted many dynamics during my field work. I visited drug addicts' treatment and rehabilitation centres, and drop-in centres of NGOs as a participant observer to see how people are living life or passing their time. And sometimes I asked their opinions about life there.

Case-1: Participant observation in a commercial drug treatment centre gave me many different experiences during field work in Jessore. This is a treatment centre where I did not find a doctor or any trained person for the addicted patients. It seemed like a prison to me, where I found few living rooms and one toilet and bathroom for all the patients. After getting permission to observe activities, I stayed there for one day and tried to talk and follow their everyday life or daily routines. I took my food with the patients.

Case-2: I decided to visit an addicts' rehabilitation centre, though they didn't allow me to do so at the outset. I stayed in that centre for the whole day from morning to evening. My assistant and I tried to follow the addict people's life skill training by observing and talking with them through the use of voice recorder, camera and diary writing. I held an FGD with a few patients and a few recovering addicts in the rehab centre during their leisure time or in between two sessions.

Case-3: I also visited an NGO treatment centre for addicts where I was allowed to see the patients' activities and talk with them about the nature and cause of their addiction and also how they sought remedies from the treatment centre.

Case-4: I visited an HIV positive's house in Khulna in order to see her life with other family members. I took my lunch with the all family members to show my integrity. I stayed with them for more than six hours and inquired about different issues,

particularly whether HIV is affecting their everyday and social life in any way. I brought sweets and some energy drinks for them.

Figure 3.5: Researcher's Action as Participant Observer

3.4.4 Naturalistic observation

Observation has been characterized as 'the fundamental base of all research methods' in the social and behavioural sciences (Adler and Adler, 1994; p.389). Going into a social situation and looking is another important way of gathering materials about the social

world which is called an observational method (Denzin and Lincoln, 2000). Technically, a 'qualitative observation' identifies the presence or absence of something, in contrast to 'quantitative observation', which involves measuring the degree to which some feature is present (Kirk and Miller, 1986).

As a naturalistic observer I visited some parts of the India-Bangladesh border which are considered to be a 'trafficking zone' and drug smuggling point. During that trip, I took a local man with me to show me how the trafficking of women takes place. He showed me some points of the border where 'syndicate' people from both countries work together for human and drug trafficking. In that land port area, I saw many issues of the truckers, including Indians. In order to see the addicts in both my data collection areas I visited many places which are known as drug selling points. Most are located beside the transport terminals and slum areas where population mobility is high. In addition, I also visited drug taking points to see how addicts take their drugs and to understand how long they take them and their reaction after taking the drugs. In the case of sex workers, I visited places in both towns, Jessore and Khulna, where the floating, street-based sex workers can be found. I saw many girls in places such as busy street corners and beside the cinema, waiting until midnight looking for customers. At all the brothels I visited, I found potential customers waiting in the street outside the brothel entrance.

3.5 Data Analysis in Qualitative Research

Qualitative research concentrates on the study of social life in natural settings (Punch, 1998) and aims at exploring and describing human phenomena with a view to developing new concepts and theories to explain the described phenomena (Bunne, 1999). Qualitative modes of analysis recognize the primacy of the subject of inquiry (Rich and Ginsburg, 1999), which is largely an inductive, open-ended process (Lofland and Lofland, 1995). It involves systematic, rigorous consideration of the data through description, classification and making of connections between the data (Dey, 1993) in order to identify themes and concepts that will contribute to the understanding of social life (Gilbert, 2001). Qualitative researchers study spoken and written records of human experience, including transcribed talk (Denzin and Lincoln, 2000) and usually emphasize words or meanings rather than quantification in the collection and analysis of data (Lee, 1993; Dey, 1993; Bryman, 2004). The qualitative analysis in this research is

based on the interpretation of text and observations to uncover and understand what lies behind social, health and geographical influences on HIV risk among marginalized and vulnerable groups in Bangladesh about whom little is yet known.

Qualitative research involves almost continuous and certainly progressive data analysis from the very beginning of data collection (Ely et al, 1991). There are a number of approaches, multiple perspectives and practices to analysis in qualitative research (Silverman, 1993; Miles and Huberman, 1994; Kitchin and Tate, 2000; Green and Thorogood, 2004) because there are different questions to be addressed and different versions of social reality that can be elaborated (Coffey and Atkinson, 1996). Some modes of analysis consider the data to be present thorough comprehensive descriptions of the phenomena under study known as 'thick' description (Denzin, 1978). Description focuses on *what* is the case, whereas explanation focuses on *why* or *how* something is the case (Punch, 1998). Some analytical approaches focus primarily on language, and the construction and structure of talk, text and interaction (Ritchie and Lewis, 2003). On the other hand, grounded theory and some other forms of analysis are mainly concerned with capturing and interpreting common sense, substantive meaning in the data (Strauss and Corbin, 1990 & 1998). This thesis aims to combine some of these approaches for exploring and presenting rich descriptive narratives by developing new concepts of HIV risk in Bangladesh through translating the Bengali speaking interviews into English. The qualitative modes of analyses are mainly discourse analysis, narrative analysis, ethnographic analysis, hermeneutical and the grounded theory approach discussed in the following.

3.5.1 Discourse analysis

Discourse analysis is the study of the rhetorical and argumentative organization of talk and texts (Bryman, 2004; Silverman, 2005). It can include analysis of media and all other documentation of a written or visual nature (Grbich, 2007). Discourse analysis is not a unified body of theory, method and practice. Rather, it is conducted within various disciplines, with different research traditions (Punch, 1998). Discourse analysis can be characterized as a way of approaching and thinking about a problem (Hassan, 2003). It does not provide absolute and tangible answers to a specific problem, but it enables us to access the ontological and epistemological assumptions behind a specific problem. It

is an important development in qualitative research, starting as it does from the assumption that there are discourses at all levels, including individual people's accounts (Gee et al, 1992). During my field work, I asked the same questions of the same groups of people many times concerning my research objectives, and got different answers at different times. But, I gained insights based on continuous debate and argumentation from people vulnerable to HIV/AIDS. There is always remaining an element of interpretation.

3.5.2 Narrative analysis

Narrative analysis is a term that covers quite a wide variety of approaches that are concerned with the search for and analysis of the stories that people employ to understand their lives and the world around them (Riessman, 1993; Bryman, 2004). It is an understanding of human motivations, perceptions, and behaviour by interpreting the stories of the people and their experiences. Narratives and stories are valuable in studying lives and lived experiences. Coffey and Atkinson (1996) describe formal approaches to narrative analysis, where the focus is on identifying the structural features of narratives and their arrangement. In narrative analysis, form and content can be studied together, and a concern with narrative can illuminate how informants use language to convey particular meanings and experiences (Punch, 1998). It is the study of an individual's speech (Ratcliff, 1999) and focuses on stories told by participants. There is an underlying presumption that much of the communication is through stories and that these are revealing of experiences, interpretations and priorities (Grbich, 2007). Narrative analysis is designed to take up the challenge of interpreting and understanding layers of meaning in interview talk and the connections among them (Wiles et al, 2005). It enables us to move away from forms of analysis and interpretation that seek to nullify the ambiguities of talk (Hoggart et al, 2001). Narrative is both a mode of representation and a mode of reasoning, shaping our perceptions of ourselves and impacting our lives, culture and society in general (Richardson, 1990; Berger, 1997). Narrative analysis is a valuable tool for geographers and others who are striving to interpret the 'in place' experiences of different individuals and groups, and how they understand and attach meaning to situated experiences, and produce the places in which their experiences occur (Wiles et al, 2005). This analysis gives insights into how individuals structure communication for effect and how they construct meaning from their experiences. In

this approach, the story is what a person shares about the self. In some cases for this thesis, in-depth interviews and case studies were analyzed and interpreted with the narrative approach to get real understandings about the lives of marginalized and stigmatized people.

3.5.3 Ethnographic analysis

Qualitative researchers routinely describe the data deriving from ethnographic work as 'rich' and 'deep' (Bryman, 1996) through focusing on the question 'what is the culture of this group of people'? (Patton, M. Q. 1990; p.67) The denotation 'rich' is generally indicative of the attention to often intricate detail which many qualitative researchers provide. Ethnography seeks to understand the world as it is seen 'through the eyes' (Kitchin and Tate, 2000) of the participants. It can explore the full extent of their subjects' accounts of a variety of phenomena. Philosophically, ethnography utilizes unstructured interviews and different levels of observation, ranging from simple description to full participant observation (Kim, 1993). The purpose of the ethnographic interview is to discover cultural meanings which exist within a social group, emphasizing interaction, social context, and social construction of knowledge (Lowenberg, 1993). This approach emphasizes the role of the investigator in the construction of the meaning of and in texts. There is an emphasis on allowing categories to emerge out of data and on recognizing the significance for understanding the meaning of the context in which an item being analyzed and the categories derived from it appeared (Bryman, 2004). In this thesis, some accounts of participant observation were interpreted and explained with ethnographic analysis to focus the insights about the lives of addict patients in particular.

3.5.4 Hermeneutical approach

Hermeneutics is a theoretical approach that can inform qualitative inquiry. Hermeneutics asks, 'what are the conditions under which a human act took place or a product was produced that makes it possible to interpret its meanings'? (Patton, M. Q. 1990; p.84) It is concerned with the interpretation of various forms of communication, including speech, dramatic performances, written texts, art and events (Grbich, 2007). The central idea behind hermeneutics is that the analyst of a text must seek to bring out

the meanings of a text from the perspective of its author (Ratcliff, 1999; Bryman, 2004). Historically, hermeneutics emanates from the interpretation of biblical texts and it emphasizes an interpretative element in analysis (Bunne, 1999). In this thesis interview conversations were constructed into theoretical concepts. Hermeneutical analysis in this thesis is used to make sense of the whole, and the relationship between marginalized people and their real situation.

3.5.5 Grounded theory approach

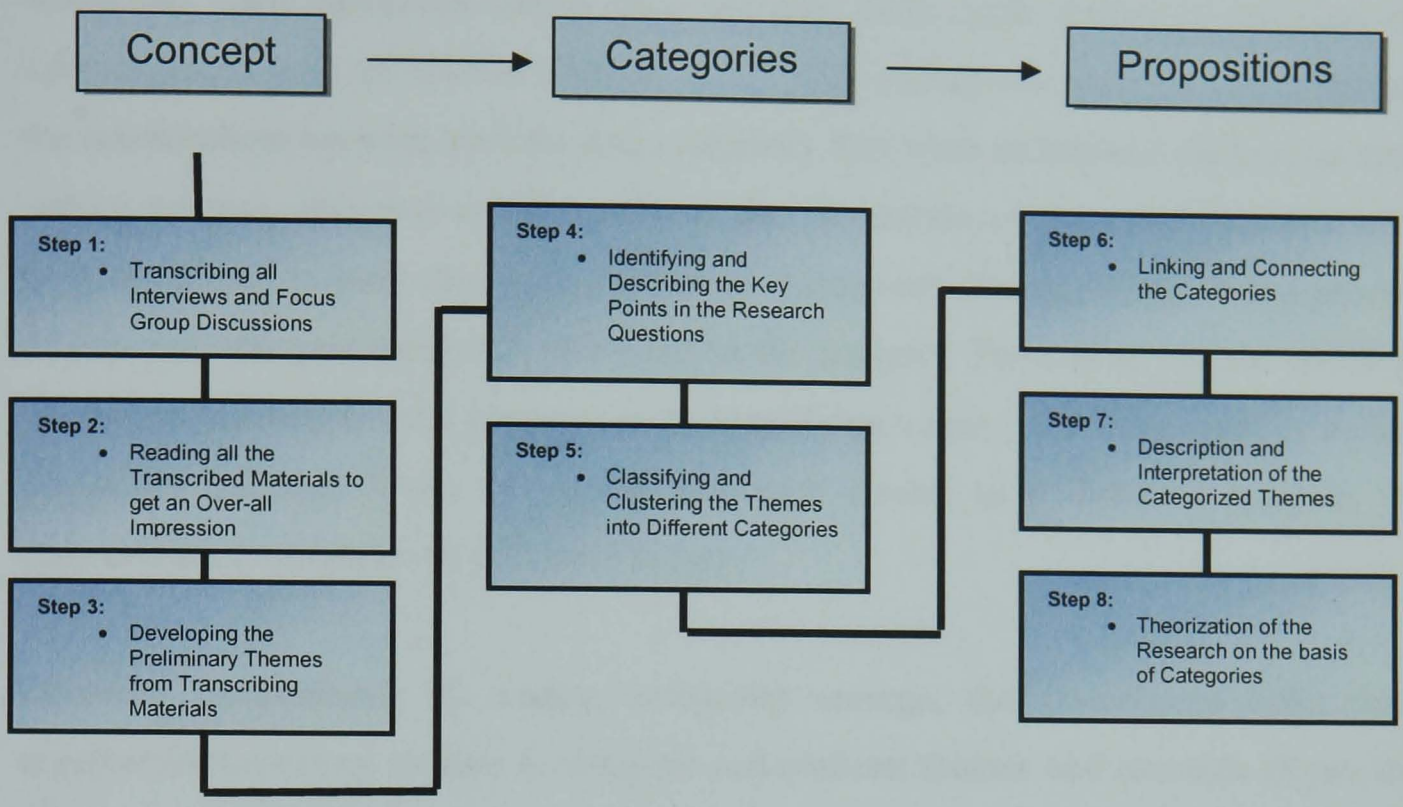
Grounded theory is a qualitative research approach that was developed by Glaser and Strauss in 1960 (Glaser and Strauss, 1967). It is a method, an approach and best defined as a research strategy, whose purpose is to generate theory from data (Punch, 1998). 'Grounded' means that the theory will be generated on the basis of data; the theory will therefore be grounded in the data (Strauss and Corbin, 1990). Grounded theory uses the inductive approach which relies on observations to develop understandings or empirical phenomena and ultimately aims for construction of substantive and formal theory (Lindberg, 2000; Grbich, 2007). Grounded theory is now a widely used framework for analyzing qualitative data in the social sciences and a methodological literature has developed to accompany its use (Annells, 1996; Barnes, 1996; Benoliel, 1996; Strauss and Corbin, 1997). There are two versions of grounded theory: Straussian, which has a focus on fragmentation of data through a three-stage coding process; and Glaserian, which is closer to field-based or hermeneutic qualitative research with a lesser emphasis on coding (Grbich, 2007). The strengths of grounded theory methods lie in a) strategies that guide the researcher step by step through an analytic process, b) the self-correcting nature of the data collection process, c) the methods' inherent bent toward theory and the simultaneous turning away from a contextual description, and d) the emphasis on comparative methods (Denzin and Lincoln, 2000; Charmaz, 2000). However, 'Grounded theory' has been criticized for its failure to acknowledge implicit theories which guide work at an early stage (Silverman, 1993). The grounded theory approach was extensively used in this thesis for analyzing qualitative data. This approach was used as a form of field-study that systematically applied procedural steps to develop an explanation about the social, geographical and policy aspects of HIV risk in Bangladesh. The vulnerable people's perceptions concerning the risk of HIV on their social and health conditions were fitted into a grounded theory approach in focusing on

the realities of a situation. In this thesis, the goal of grounded theory is to seek a new concept that is compatible with the field evidence concerning HIV/AIDS risk.

Outcomes of grounded theory: This approach uses a 'systematic set of procedures' (Strauss and Corbin, 1998) to develop richer concepts and models of how the phenomenon being studied really works (Ryan and Bernard, 2000). The grounded theorist's analysis tells a story about people, social processes, and situations (Denzin and Lincoln, 2000). The theorist collects verbatim transcripts of interviews and reads through a small sample of text (usually line by line). Sandelowski (1995) observes that analysis of texts begins with proofreading the material and simply underlining key phrases 'because they make some as yet inchoate sense' (p.373). They want to identify categories and concepts that emerge from the text and link the relationships between them (Ryan and Bernard, 2000; Ritchie and Lewis, 2003).

The three basic elements of grounded theory are concepts, categories and propositions (Pandit, 1996). Following Glaser and Strauss (1967), grounded theory involves three stages: a) an initial attempt to develop categories which illuminate the data, b) an attempt to 'saturate' these categories with many appropriate cases in order to demonstrate their relevance, and c) developing these categories into more general analytic frameworks with relevance outside the setting. The first step in theory building is conceptualizing. A concept is a labelled phenomenon and an abstract representation of an event, object or action that a researcher identifies as being significant in the data (Strauss and Corbin, 1998). In conceptualizing, we are abstracting. Data are broken down into discrete incidents, ideas, events and acts and are then given a name that represents or stands for these which also known as substantive codes (Punch, 1998). The second step in theory, categorizing the data, allows the classifications of concepts in terms of relations of similarity and difference which are characterized according to their location along various dimensions (Dey, 1993; Miles and Huberman, 1994; Urquhart, 2000; Bryman, 2004). This is called theoretical coding, which connects these categories (Punch, 1998). The third is to conceptualize and account for these relationships at a higher level of abstraction and it is called a core code, which is the higher-order conceptualization of the theoretical coding, around which the theory is built (ibid). It indicates that the generation and development of concepts, categories and propositions is an iterative process (Fig 3.6).

Figure 3.6: The Steps Involved in Qualitative Data Analysis



Tools of grounded theory: The following are the tools of grounded theory: Coding, Constant comparison, Theoretical sampling (Bryman, 2004).

Coding: In grounded theory, coding is the analytic processes through which data are fractured, conceptualized, and integrated to form theory (Strauss and Corbin, 1998). It tends to be in a constant state of potential revision and fluidity. It entails reviewing transcripts and/or field notes and giving levels (names) to component parts that seem to be of potential theoretical significance and/or that appear to be particularly salient within the social worlds of those being studied (Bryman, 2004). Charmaz (1983) thinks that codes serve as shorthand devices to label, separate, compile, and organize data. Strauss and Corbin (1990) drawing on their grounded theory approach, distinguish between three types of coding practice:

Open coding is the process of breaking down, examining, comparing, conceptualizing and categorizing data (Strauss and Corbin, 1990). This process of coding yields concepts which are later to be grouped and turned into categories. As the data were collected, I applied a system of open coding in looking at the database pattern and for identifying, naming and categorizing the essential ideas found in the data. In this coding

process a very shallow structure of initial categories was first set up, based on research questions and expected themes. *Axial coding* is the name given to the second stage, where the main categories which have emerged from open coding of the data are interconnected with each other (Punch, 1998). This coding was used for understanding the relationships between various data categories that were determined during the open coding process. *Selective coding* refers to the integration of the categories that have been developed to form the initial theoretical framework (Pandit, 1996). It is a process of selecting the core categories identified in the analysis. The coding process develops the theory that best fits the phenomena by identifying a story. The three types of coding are really different levels of coding and each relates to a different point in the elaboration of categories in grounded theory.

Constant comparison: As coding categories emerge, the investigator links them together in theoretical models to compare and contrast themes and concepts (Ryan and Bernard, 2000) that are referred to as the 'constant comparison method' (Glaser and Strauss, 1967). In qualitative analysis the most useful strategy is finding patterns, making comparisons, and contrasting one set of data with another (Krueger, 1998). In grounded theory it is often referred to as a significant phase by practitioners, but that seems to be an implicit, rather than an explicit, element in more recent writings (Glaser and Strauss, 1967). It refers to a process of maintaining a close connection between data and conceptualization, so that the correspondence between concepts and categories with their indicators is not lost. In this thesis, data were analyzed by the grounded theory approach for much diversity of themes. The constant comparative method is able to identify the over-riding and integrating conceptualizations of higher order and lower order themes in comparing incidents in each category and integrating categories with properties. This method allows the theory generated by the analysis to be grounded in the interview data and is not constrained by pre-defined, abstract categories.

Theoretical sampling: Theoretical sampling is a defining property of grounded theory and is concerned with the refinement of ideas, rather than boosting sample size (Charmaz, 2000). According to Glaser and Strauss (1967) theoretical sampling 'is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them' (p.45). Theoretical sampling is a particular kind of purposive sampling in which

the researcher samples incidents, people or units on the basis of their potential contribution to the development and testing of theoretical constructs. The process is interactive: the researcher picks an initial sample, analyses the data and then selects a further sample in order to refine his or her emerging categories and theories. This process is continued until the researcher reaches 'data saturation' or a point when no new insights would be obtained from expanding the sample further (Ritchie and Lewis, 2003).

3.6 Limitations of the Study

A number of limitations ranging from data collection to data analysis have been identified in different stages of this thesis which I explain in the following.

Some of the participants arranged by NGO people for my research were motivated by NGO peers. When NGOs brought participants in the office, sometimes peers shared my research interest with the participants, which seemed to me to be one of my research limitations. Participants considered that I was there to evaluate their HIV knowledge so when I asked a question they irrelevantly replied that they 'know everything about HIV'. To some extent dependency on NGOs for choosing the participants from the field hampered the standard of my requirements.

During the first few interviews I missed some opportunities to explore more important themes from the respondents because of my excitement. During data collection, I became very emotional after listening to the suffering of the respondents, which to some extent stopped the flow of the interview or hampered my attempts to acquire the best information. However, I did not fully understand their (CSW and DU) language, tone and eye contact, though I learned the meaning of their language after a certain time.

In FGDs, sometimes I was uncomfortable asking the respondents difficult questions regarding their sexual behaviours. Sometimes I asked them questions which irritated them, causing some hesitation for both of us. My observation is that people feel embarrassed discussing sexual matters. When I asked any relevant question to them, they replied very briefly, rather than as I expected. I was required to ask many questions to understand their level of risk. They sometimes felt shy and embarrassed.

I had some preconceived notions from the surveillance report of the Bangladesh government that most potential drug users would be injecting drug users (IDU). But in both of my field areas I found that most drug users were actually heroin smokers. I did not find many IDUs, which hampered my understanding of their risks. Also, I was unable to make contact with anyone in the Males who have Sex with Males (MSM) group. If this had been possible it would benefited my picture of health risks.

For key personnel interviews, I tried to question the highest ranked officials, but in some cases I experienced that they were reluctant to keep the appointment and referred me to other officials. This also happened at the field level, where government officials avoided this responsibility. In some cases, high officials told me many issues only when I switched off my recorder. They talked about 'sensitive' matters of government as well as their own organization which they insisted had to be 'off the record'.

The data on health risks, particularly sexual activities and drug habits were collected through self-reports in interviews which are always a matter of validity and reliability and recall problems despite the researcher's efforts.

As the present study is a qualitative study and the data collected are exploratory and thematic in nature, there are no quantitative comparisons. This might have contributed to missing some more positive ideas in the research because the qualitative approach has some limits about the generality of the findings.

3.7 Concluding Remarks

Qualitative methodologies reflect particular understandings of social life and meanings. My qualitative research aims to develop an explanation about the social, health, geographical and policy aspects of HIV risk in Bangladesh. Here qualitative data were used to understand the interactions between health risk and stigma, place and policy. In addition, the qualitative methods in this thesis examine how people lead their 'everyday lives' when they are marginalized or stigmatized in the society in the context of HIV vulnerability. The qualitative techniques for data collection include in-depth interviews, focus group discussions and participant observation, along with naturalistic observation

of the risk sites. The narrative approach, discourse analysis, hermeneutics, ethnographic approach, and grounded theory approach were used as techniques for analyzing data.

Along with different field experiences, this chapter has mainly focused on the methodological approach, sampling frame, data collection and data analysis techniques under the framework of field survey and research design. The next chapters will deal with the outcomes of different issues regarding stigma, place, and policy following the aims and objectives as well as the research questions.

Chapter Four

'Lifeworlds' of Marginalized People in HIV Discourse

Chapter Four

'Lifeworlds' of Marginalized People in HIV Discourse

The term 'lifeworld' ('lebenswelt') is used by Habermas (1987) to describe the collection of behaviours, expectations, norms and communicative acts (Wilkie, 2001) that comprise everyday life and serve to link individuals. The study of everyday life in social research involves 'the necessity of subjecting one's own activities to practical knowledge and routines whose heterogeneity and lack of systemicity is rarely theorized' (Featherstone, 1995; p.55). Theorists such as Schutz and Berger and Luckman recast the individual as an active agent in the construction of meaning in everyday life (Bennett, A. 2005) in their social context or meanings (Ortner, 1998; Morgan, 2004). In this approach, the significance of everyday life is inseparable from the indexical meanings ascribed to it by individual actors (Gardiner, 2000). This interpretation of everyday life is further developed by Erving Goffman through his application of a dramaturgical model of everyday interactions (Bennett, A. 2005). Thus, argues Goffman (1959) through gaining a 'practical experience' of everyday life characterized by the internalization of social roles, individuals also learn how to manage and negotiate those roles through the creation of 'front-stage' and 'back-stage' selves. In doing so, individuals' creativity manipulates the everyday, making it tolerable through creating spaces for the subversion of conformity. Goffman's approach to the everyday suggests an inventory of performances spatially arranged across the geography of everyday life (Highmore, 2002; Karner, 2007). Chaney (2002) assumes everyday life to be the forms of life we routinely consider unremarkable and thus take for granted. The reality of habitual experience is provided in the routines or rhythms of occupations, relationships and residences. Geographers are of interest as they focus on the individual, the short term and small-scale, pointing out the routine nature of everyday life, a 'chronogeographical' analysis pioneered by the Lund geographers (Holloway and Hubbard, 2001). In an essay, John Eyles (1989), on his 'the geography of everyday life'

follows similar arguments in suggesting that it is desirable that geographers examine the everyday. Though he contends that such a sensitivity to the common place is necessary for the development of a human-centered geography, few (for example, Watts, 1991; May, 1996) could dispute that geographical analysis of the everyday offers a way of thinking about the relationships between individuals and their surroundings in a period of rapid time-space compression. Seamon (1979) was concerned with how individuals' phenomenological immersion into a geography of everyday life constructed their 'lifeworlds'. To explore people's 'lifeworlds' he argued that it is necessary to consider the relationships between people's behaviour (what people do in places) and their experiences of place (Holloway and Hubbard, 2001).

The evolution of the HIV/AIDS pandemic has shown a consistent pattern through which marginalization of individuals and groups heighten their vulnerability to HIV exposure. Marginalization engages the formative influence of economics and politics in contemporary life, including their increasing interaction with the environment (Atherton, 2003). This chapter looks at the everyday geography of marginalized people's daily rituals, physical discomfort, sorrows and anger, dreams and frustrations, all of which fuel their vulnerability. In order to know how marginalized people lead their 'everyday lives', here I consider brothel and non-brothel sex workers, opiate users and HIV-positive people as marginalised groups because of their negative status in and neglect by mainstream society, and discrimination by the state. I have tried to hear the distressful 'stories' of their life. From these stories, I have reconstructed their everyday rituals, physical vulnerability, and frustrations.

4.1 Female Sex Workers' Everyday Life and Rituals

The centrality of women's role in everyday life, ironically, gets intertwined into the fabric of social relations and social structures in ways that create women's subordination and unequal position (Heyzer, 1986), especially in patriarchal societies like Bangladesh (Osmani, 1997) where life expectancy for women is lower than for men (Kumar et al, 1997). Men are usually dominant in the allocation of scarce resources and this structured inequality has a major impact on women's health (Doyal, 1995; Khan and Khanum, 2000). Poverty, illiteracy and traditional customs often make women vulnerable to HIV infection (UNAIDS, 2002b), and this has now become a major threat

to women, especially those involved in the commercial heterosex industry around the world (Berer and Roy, 1993). The term 'sex worker' is sometimes used in place of the word 'prostitute', and tends to obscure the harm of prostitution; it legitimizes commercial sexual exploitation but offers no dignity or safety to the person in prostitution (Farley, 2001). Women's entry into prostitution is characterized by an act of resistance to the experience of relative poverty or threat of it (Townsend, 1979). Prostitution, a world-wide phenomenon (Pullen, 2005) is often a response to poverty, financial hardship, need, homelessness and unemployment (O'Neill, 1997; Kempadoo and Doezema, 1998), and a result of women's marginalization (Barton, 1999). A study by Chant and Mcllwaine (1995) also shows that women often have to turn to sex work in order to support their children, and some are in the position of having to help parents and siblings as well. Since prostitution is a direct outcome of women's gender subordination, such links should be recognized by AIDS programmes, and ways found to combat such traditions (Goddard, 1993). In Bangladesh, Khan and Arefeen (1989) found that the majority of prostitutes were not abducted but had chosen the profession in the face of limited alternative options and perceived the trade to have major economic advantages. Khan (1988) and the UBINIG Report (1995) also show that a network of brokers and middlemen exists throughout Bangladesh who tempt girls and women from poor families with the promise of lucrative jobs, and it seems that dowry-related violence is a push factor (Barton, 1999). Hammond (2008) mentioned that poverty and other social and cultural factors related to gender-based exploitation are the main reasons for entering brothels. The number of sex workers in Bangladesh is difficult to judge. There are estimates ranging from 150,000 to 200,000 brothels, streets, hotels and residences (see also, Gibney et al, 1999a). Brothel closure in many locations is one important reason, along with social and economic factors, for the recent explosion in the numbers of non-brothel-based sex workers. This section will look at how sex workers lead their lives at the brothel along with their different rituals. It will also touch on those aspects that are playing a role in the uncertainties of brothel and non-brothel sex workers' income and physical discomfort.

4.1.1 Life at the brothel

Although the legality issue of prostitution prevails in most countries, from the view of mode of operation, prostitutes may be categorized in three broad groups, from those

who are relatively independent workers, those who work through linkages with a variety of operators, to those who fall under the control of organized and stratified institutions (Heyzer, 1986) like brothels. Literally a brothel is 'a house of prostitutes' and a brothel constitutes premises at which clients can view, select, arrange and execute a transaction with prostitutes (Davidson, 2006). There are 15 registered brothels in Bangladesh (Hosain and Chatterjee, 2005) where 38,000 sex workers are registered. Technically, residentially brothel status is neither legal nor illegal. Prostitutes are authorized to pursue their trade by having an official document stamped by a magistrate (Blanchet, 1996). Prostitution particularly in a brothel without a licence is illegal and carries a sentence of two years imprisonment or a fine (Baden et al, 1994).

Sex workers, a marginalized community as they are socially isolated, lead everyday lives that are very different from those of 'straight' women. Generally all women in Bangladesh perform certain predictable activities regardless of season (Wallace et al, 1987) but a brothel girl's life is a matter of everyday 'business'. Following Featherstone (1992), I can describe the brothel girls' everyday lives as a matter of reproduction, maintenance, common routines, receptivity and sociability. Their day starts early in the morning and continues until late evening, with some breaks. After taking a shower and breakfast they go to the 'gate' for a customer (Fig 4.1). Their rule is that they have to stand in line so that everyone will eventually get a customer, although some girls have regulars. In many brothels girls take their main food (lunch and dinner) in a mess system (Fig 4.2) and live in a house together sharing their rent, food costs, electricity bills and night guard bills. When a customer comes the others wait outside. On average each gets 2-5 customers during the day, but no customers are allowed to stay at night in many brothels. Usually the girls do not go outside except in emergencies. In such an inward-looking environment, quarrels are common and sometimes turn into physical assault. Brothel sex workers' main form of entertainment is Bangladeshi and Indian romantic movies. Moreover, in almost every house they have a cassette or CD player to listen to music. One Fultola girl, Nazma told me about her everyday life:

"I get up in the morning at 7.30, then go to the toilet and wash my face, clean the house, and collect water and take a shower. Then I eat and afterwards go to the gate and collect a customer. After a lunch of fish and vegetables I take a rest. A customer may come in the meantime, and if he says my name at the gate then he will be able to come to me. If the customer comes after lunch, then I will not take a rest. In the evening I

roam around in the gate area for more customers, chatting with other girls, then come to my room and cook something and watch TV. After taking dinner, I go to sleep. It's everyday life. I take a break when it is my 'period', and at that time if any customer comes for me then I will give him to another girl and collect some money."

Figure 4.1: Brothel Girls' 'Serial' System for Customer Collection

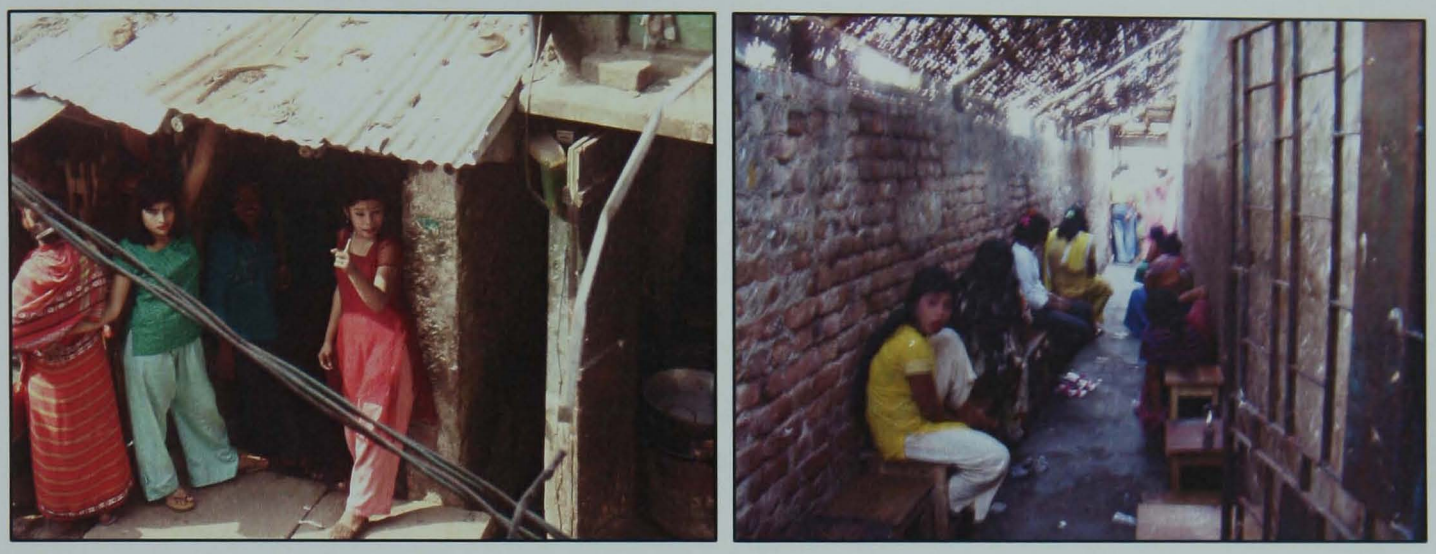
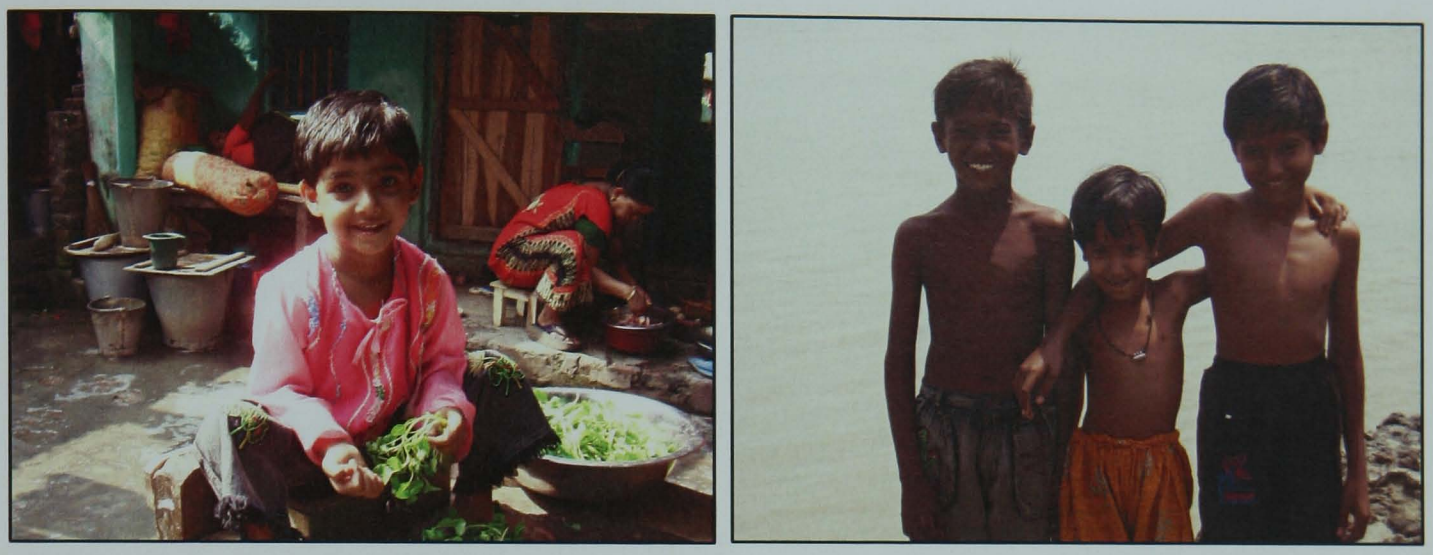


Figure 4.2: Brothel Girls' Everyday Cooking

Many brothel sex workers want their own or adopted children with them, partly to satisfy their emotional needs for attachment and partly to ensure an income when aged (Jenkins, C. 1999). I found that many brothel sex workers keep their children with them (Fig 4.3), although it seems that there are psychological effects due to the mother's profession. In addition, the children's presence can cause embarrassment and sometimes hampers earnings. In Baniashanta brothel Santa told me that she has been facing a problem with her little son, who becomes upset. She says "*sometimes my son shows anger when I talk to any man or any customer comes to my house and he stands at the closed door and cries, and asks me to open the door. Sometimes the other girls help me by taking him to their room.*" Some sex workers send their babies to an NGO shelter

house, as they cannot give the appropriate care. Some girls like Parul keep her child in a house in the adjacent village and pays monthly for food and board.

Figure 4.3: Children in Brothel



When comparing their present life with the past, many girls become very emotional and nostalgic. In Baniashanta, one former sex worker, Nargis told me that she had enjoyed her life with many pleasures like drinking alcohol with customers, songs and dancing every weekend but now the flow of customers is less and there is no alcohol shop in the brothel. She thinks that previously the brothel was a place of enthusiasm and girls were affectionate to each other but now nobody cares about the others. During religious festivals like Ramadan or Eid, most of the brothel girls usually stay indoors. Although most do not follow religious fasting due to their own sense of 'impurity', they try to celebrate the festivals by cooking special dishes, wearing good clothes and sharing food with their 'private' customers (regular or close customers) or neighbours. Girls have to fall back on their savings during Ramadan because there are few customers at that time. In Baniashanta the girls live a life at risk of natural disasters such as cyclones, tidal surges and floods because their settlement is very close to the Bay of Bengal. The brothel is sometimes called 'death valley' as many girls were washed away during the 1988 cyclone and tidal surge. Sometimes they try to go to the nearby village shelter, but they are not welcomed by the local villagers and for that reason some girls pay to stay in another family's home in the village when disaster threatens. Moreover, they face riverbank erosion every year which forces the relocation of their houses at great cost for such poor women.

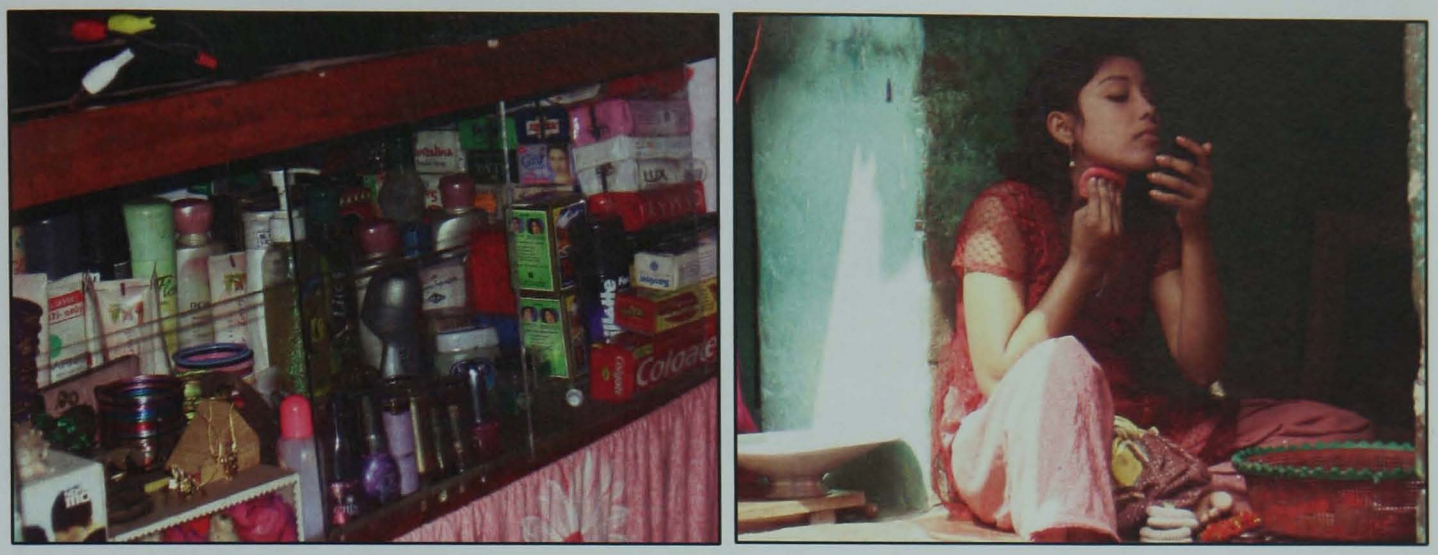
4.1.2 Income (un)certainty

A sex worker is a person who is exploited sometimes for money in a commercial sex business (Farley, 2001). Among the sex workers in Bangladesh, many non-brothel based sex workers like street and floating girls lead their everyday lives in miserable conditions. They do not know how much they will earn in a day and some have no income on many days. In a study with street based sex workers and their clients in Dhaka, Bloem et al (1999) found that the girls' income uncertainty is an important barrier for their behaviour change in HIV prevention. Thus, without legal protection under Bangladeshi law, girls and women involved in this profession have to struggle daily for their survival.

Although brothel sex workers depend on regular clients for a predictable income (Jenkins and Rahman, 2002), many non-brothel women's daily income depends on their health, place of operation and 'physical appearance' (Khan, 1988), and may be as low as 50¢ (U.S.), or as high as about $33 (U.S.) (Ara, 2005). Women who are usually prostituting in the street tend to stand on street corners, where they find a large supply of potential clients for whom anonymity is important. As they have no established or fixed places to engage in their work, they are considered floating prostitutes. Most of them are independent, although some rely on pimps for help in finding clients. Bus terminals and stops, railway stations, cinema halls and river banks are the usual locations where the contract is negotiated, from where they go to cheap hotels, buildings under construction, dark parks, and, sometimes, the client's own house. The stereotypical picture of their clothing and cosmetic use are sometimes in evidence. Some consciously dress provocatively while others choose to dress neatly. They have to wear very heavy make-up, otherwise they will not attract customers (Fig 4.4).

Regarding income, many street girls have no fixed rates like the brothel girls. For their survival or consistent livelihood they are forced to work for as little as 10 taka (equivalent to about eight pence). Occasionally they find a new client whom they term a '*dhur*' (a gullible person who has just arrived from the countryside), but most of their customers are low income clients like labourers, transport workers, migrant people or uniformed personnel and they pay as little as they can. Sometimes these girls need to

Figure 4.4: Everyday Cosmetics and 'Make-up'



have sex with their regular known customers without being paid as one of their techniques to get them regularly. Most have very poor living conditions think little about the importance of sanitary facilities, showers, or hygienic practices. Only a few street-based workers are able to rent a room where they sleep and where they can use sanitary latrines. Many of them have no specific home to sleep in or to take food. They bathe in public ponds, ditches or rivers. Usually they sleep on the street or in bus or railway stations, in parks and take their food in street hotels. In both Jessore and Khulna, I found many street girls who have no access to shelter or hygiene practices. One of them named Subarna in Jessore, who sleeps near the town hall, bathes in the stadium pond and has been living this life for the last 7-8 years with a variable everyday income but fixed expenses. Every day she faces harassment from the police.

A few floating girls solicit independently, which provides them with some economic advantage due to not having a broker. They can control their own working rate and working days, but at the same time, the level of violence against such floating girls is high. So they have to be conscious about risk and they know very well that prostitution is stigmatized. On the other hand, I also talked with some casual sex workers or call girls who rely solely on intermediaries for their customers. If they do not get a call from a broker or a customer, they may have to take out loans to meet their basic needs. Their income is also unpredictable because their customers are very irregular (Fig 4.5). As a result, their lives are high risk because debt and desperation take over. Customers wanting sex without a condom, and offering above the normal payment, are then difficult to refuse. Such uncertainty puts such girls in a more vulnerable situation with regard to STDs and HIV.

Figure 4.5: Everyday Income Uncertainty

4.1.3 Physical discomfort

Sex work itself may have a negative impact on health (Seib et al, 2009). This negative impact might be because of the work involved or might be associated with social stigma or the emotional cost attached to working in the sex industry (ibid). In Bangladesh, women's poor health experiences during the course of their lives relate to both physical and mental factors (Payne, 1991), which are influenced by ambiguities and uncertainties (Miles, 1993). Commercial sex workers' health status is a combination of pain and discomfort. They suffer from illnesses and experience real pain from the circumstances often forced upon them. In Bangladesh, a significant number of women do not live in brothels, but engage in commercial sex work under the guise of other professions, such as workers in the garment industry (Ara, 2005). They are vulnerable to life-threatening disease and violence because of the absence of control over their own bodies and the surrounding environment. The equation is that customers are paying money, but the girls suffer violence, exploitation, degradation and ill-health. These in turn may hamper their availability for further work, which initiates what we might call their cycle of vulnerability.

Most of the women that I interviewed have faced problems of Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs) for a long time due to their use of unhygienic clothing during their 'period', along with unprotected sex. The effect of these infections may persist for their whole life. Most poor women, including sex workers, repeatedly use the same clothes to absorb the waste of menstrual discharge and keep it in a dark place without maintaining proper hygiene due to attitudes of stigma in conservative families. Most of the women that I spoke to who are involved in

commercial sex work suffer from abdominal pain, urinary problems and vaginal discharges. They often feel weak, with irregular menstruation and always the fear of pregnancy because of unprotected sex. In the brothels, they may have several customers in a day. Their uterus can become swollen, with associated aches and pains, sometimes even loss of sensation in the legs. Moreover, as sex workers, particularly brothel girls, use the many skin creams and other cheap cosmetics to enhance their attractiveness, many of them face harmful impacts on their body in the long term.

As sex workers are deprived of their rights, so they are very vulnerable to violence. Regarding residence-based sex workers, some customers misbehave, biting and causing bruising. In almost all cases, customers take alcohol or other stimulating drugs before the start of sex and they become emboldened or aggressive. One girl, Lota told me that "*we cannot predict the behaviour of drunks or bad customers. They like biting and some enjoy beating us, shouting and causing pain and suffering. They stay a long time.*" I found some street girls at Khulna rail station who are very young. One of them, Jorna who is only 13 years old told me that "*I feel pain during intercourse.*" They all need to tolerate these sufferings silently because customers have hired them with money. Most of the girls, particularly street and floating sex workers, have to face two further problems. They told me that customers want to copy what they see in pornographic films. They want to fulfil their desires but do not consider the girl's capacity or her suffering. This may involve bleeding, burning and pain from group sex and anal sex. Such experiences are unpredictable and may involve threats that she will be reported to the local police or '*mastaans*' (muscle men). As many girls cannot ensure condom use, they use female contraceptives to prevent unwanted pregnancies but they become very confused about their proper use. Many of them face numerous difficulties with the various types of birth control methods. As they are poor women, they cannot afford to buy these contraceptives from local markets or clinics, so they use cheaper pills and do not follow a doctor's prescription. They tend to follow their clients' or friends' advice but, after a certain time, when they see that their menstruation becomes irregular or non-consistent or varies in quantity, they become anxious. However, most girls/women soon experience severe side effects, such as headaches, abdominal pain, lethargy, eyesight problems and general weakness. After a while, most workers switch to either a Depot injection or a Copper-t or Intra-Uterine Contraception Device (IUCD) or they develop a preference for condom use rather than pills or injections.

4.2 Drug User's Daily Vulnerability

Drug abuse is defined as taking a drug to such an extent that it greatly increases the danger or impairs the ability of an individual to function or adequately cope with his or her circumstances (Irwin, 1973). Experts in this field agree that although no factors actually cause substance abuse, there are several that contribute to its gradual development (Lex, 2000). Generally, a person with serious life stresses, or major depression, or a tendency to curiosity and experimentation, may be at increased risk, but is not fated inevitably to become a substance abuser. These drugs may relieve pain, induce sleep, and stop diarrhoea, but tolerance and dependence sometimes develop at therapeutic dosages. Psychoactive drugs are found in three major groups: depressants, stimulants and hallucinogens (Whelan, 2004). The use of drugs and spread of drug cultures are reflective of these everyday tendencies toward opposition to 'rationalistic' and 'regulation', and the embrace of indulgence in dionysiac activities and the 'carnivalesque' (South, 1999). The health consequences of illicit psychoactive substance use are numerous and diverse and are not only related to the direct action of the drugs themselves, but to the mode of administration and associated lifestyle factors (South, 1999; Lex, 2000; Sutherland, 2004). All over the world, drug users have been characterized as leading 'unstable' and 'chaotic' lives (Singh et al, 1996; Williams et al, 2000) as indicated by lack of permanent housing and/or employment, involvement with the criminal justice system, absence of ongoing relationships, and/or reliance on public entitlements. Drug abuse is a significant problem in Bangladesh, where the majority of addicts are thought to use the mode of inhalation. Although no scientifically rigorous surveys have been carreid out, it is estimated that there may be as many as 4.6 million Bangladeshis who abuse drugs of which 91% are adolescents/youths (Sharma et al, 2006). While the vast majority of drug users are male and heroin smokers there are at least 20,000-40,000 injecting drug users in Bangladesh (ibid). There is general agreement that socially and economically marginalized groups are more prone to drug use and its more serious form- problem drug use. Other than commercial sex and needle-sharing, many street-based drug users take other risks, such as sleeping on the streets or in other dangerous places where accidents occur. They take risks like theft to raise money for drugs, and face a beating if they are caught. Moreover, a good number of drug users have a tendency to switch from one drug addiction to another, particularly

from heroin to injecting drugs or vice versa. This mainly depends on cost and availability of alternatives and the withdrawal symptoms suffered in switching. This section aims to focus on the drug addict's everyday suffering from withdrawal symptoms and the many negative impacts on the body by drug abuse and drug switching. However, their desperation for drug money and its consequences will also be addressed.

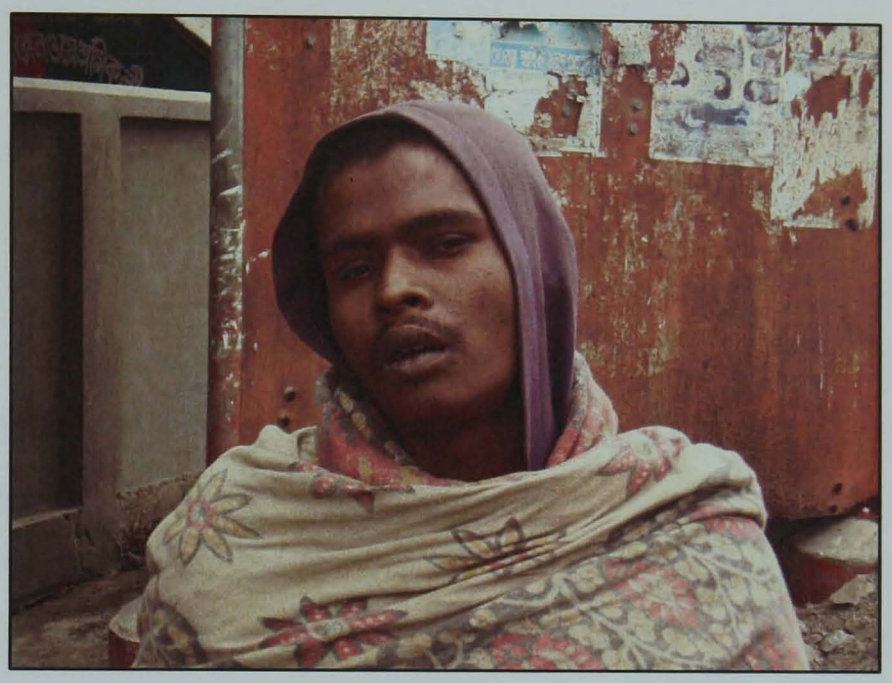
4.2.1 Everyday sufferings with withdrawal symptoms

Psychoactive drugs like heroin and morphine are regarded as 'miracle drugs' that have the ability to 'kill all pain and anger and bring relief to every sorrow' (McCoy, 1972; p.2). But the phenomenon of withdrawal, or the production of abstinence symptoms, is often considered the most important feature of addiction (Elster and Skog, 1999). Withdrawal symptoms, depending on the drug, generally start from 12 to 24 hours after the drug is no longer used (Brownell et al, 1986) and it progresses with additional signs and symptoms (Jaffe, 1990). There are some physical symptoms of withdrawal syndrome such as aching limbs, a runny nose, and shaking. Mental symptoms, such as disturbed sleep and anxiety can last much longer. There are some well-observed pathways to heroin addiction like sniffing (snorting), inhaling heroine vapour (chasing the dragon), smoking, skin-popping or intravenous injection (shooting up) (Tyler, 1986). In Bangladesh, chasing the dragon is popular, along with injecting. To inhale heroin, a dose is placed inside a strip of foil paper, such as that found inside cigarette packets, and a flame is run underneath it. The heroin heats up and turns to vapour, which is then sucked up into the nostrils via a tube. Those drug users who prefer to take morphine through injection, target the large veins in the forearms, thighs, buttocks and stomach.

Drug users suffer physical and psychological symptoms if they cannot obtain drugs (Fig 4.6). Most addicts have to take them on a daily basis and it becomes a way of life for those addicted. When an addict's withdrawal symptoms or '*bera*' appears, they go to collect or raise money for buying drugs, and, after taking drugs they become 'calm'. Without taking drugs they avoid normal food and find no taste in it. Some users take drugs three times a day, rather like breakfast, lunch and dinner. They take heroin as a stimulant, and then sedatives for sleeping. In Jessore, one heroin-user, Shapon told me his story:

"If you don't take heroin or other drugs timely, then a hundred types of sufferings will appear in the body, like fever, cold symptoms, body pain, coughs, sneezing, headache, diarrhoea, insomnia, burning sensations and itching in the whole body, drowsiness and red eyes, stomach ache, a weak heart, emphysema, bleeding gums, and many other physical problems. After taking heroin we go to another world, where there is no tension, no thought for this world, and everything is fine."

Figure 4.6: Withdrawal Symptoms and Hopeless Addict



When a person starts heroin inhalation or other drug taking s/he experiences some feelings which normally continue for a few weeks, but when this stage finishes, they need to take more drugs to remove the bad feelings or get rid of withdrawal symptoms. Some heroin smokers believe that the heroin presently available is not like previous batches in purity. They say that it has been contaminated by dishonest dealers in order to increase their profit. Due to contamination, they say they now need to take many times the previous quantity to support their body, instead of just one dose.

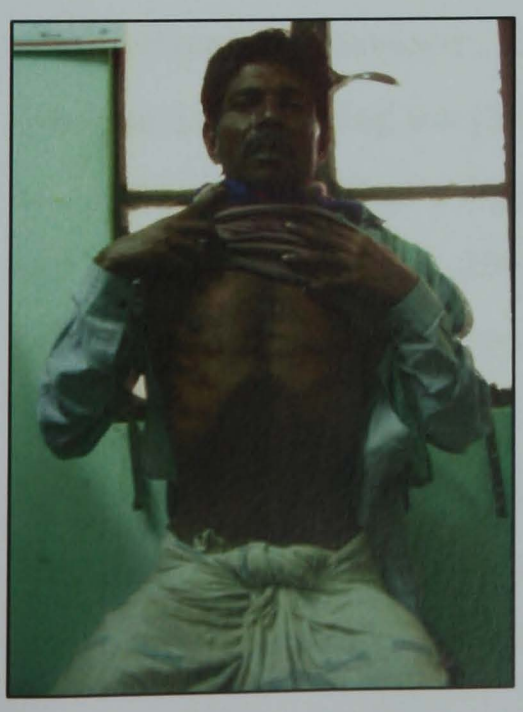
4.2.2 Negative impacts of addiction on the body

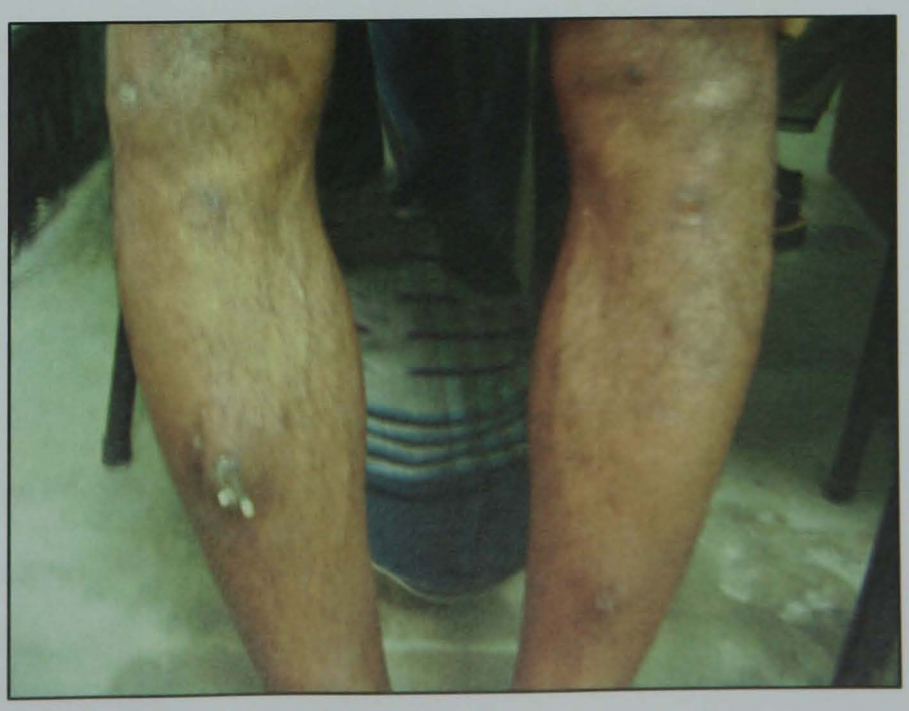
Opiate drugs like heroin have the capacity to alter mood, perception, cognition and behaviour. These drugs can produce two major groups of harm; first, toxicity (intoxication), and second, dependence (Whelan, 2004), and it has been called 'the most dangerous substance on earth' (*New York Times*, 1972). Indeed, heroin is a powerful narcotic. Several times more potent than morphine, it suppresses both respiratory and cardiovascular activity, and has strong analgesic effects and a high addiction potential. According to Robertson (1987), the main medical disorders listed as 'complications of

heroin dependence' are depression, blood vessel infection, nerve damage, pneumonia, fungal infection of the heart and brain damage. Once in the bloodstream, opioids are distributed throughout the body, with accumulations in the kidneys, lungs, liver, spleen, digestive tract and muscles, as well as the brain (Maisto et al, 1995). Depressants, like sedative/hypnotics, alcohol and heroin are drugs that slow down the activity of the brain. Depending on the dose, these drugs produce relaxation or drowsiness, emotional depression, or loss of consciousness. In particular, heroin is especially likely to cause coma by depressing an individual's breathing.

I found some drug users who had bronchitis and severe coughs. It is usual for drug users to have multiple physical problems due to serious and continuous involvement in addiction, and most of them face negative impacts on their bodies in the long run (Fig 4.7). Among the commonest complaints are lack of strength, respiratory problems, weight loss due to lack of appetite, kidney damage and scabies. In Jessore rail station, I found one drug addict, Giash who had been suffering gangrene in his leg. He has no family or relatives and so he has to manage on his own to get drug money. He shows his gangrene infection to passers by to get sympathy and begs for money in the name of treatment. He does not take any medicine and instead spends the money on drugs. However, I did find one addict in a FGD at Khulna named Raju who managed his drug money in legal ways. He thinks that drugs usually 'eat' the addicts, but in his case drugs are not able to eat him. He said "*I can work because I take the drug and food simultaneously on time, I bathe regularly and, because I have no tension like others for drug money, so it doesn't hamper my activities.*"

Figure 4.7: Physical Sufferings for Addiction





One reason that addicts feel weak and anaemic is that selling their own blood is their last option to raise drug money. I found a former rickshaw puller and heroin addict who had recently sold his blood and was left feeling so weak that he could not walk and was in fear of his life. But I also found many drug users cum professional blood donors who sell their blood frequently, maybe twice a week, and believe that if they take a vitamin tablet, their blood will recover and they will be fit again. From my observation in Bangladesh, drug users feel well at first but after a few months to a few years they become depressed. Their level of hygiene and intelligence goes down, and this starts many physical problems. Most drug users' prevalent health problems are malnutrition, protein and vitamin deficiency, and anaemia. In general, they neglect themselves because many of them lose interest in their appearance and also in social conventions. As they cannot afford a proper diet, weight loss is a common consequence of heroin misuse. Skin problems like itching are also common due to a combination of poor nutrition and infrequent bathing. These can increase discomfort and may cause general ill health. Indeed, injecting drug users commonly face abscesses and other skin problems which are usually the result of a failure to inject the substance completely into the vein. However, many addicts seem to face bronchitis or asthmatic problems, perhaps due to living on the streets as well as cigarette smoking. Moreover, many addicts are susceptible to respiratory diseases, infections of the urinary tract, and kidney problems.

4.2.3 Drug switching and needle sharing

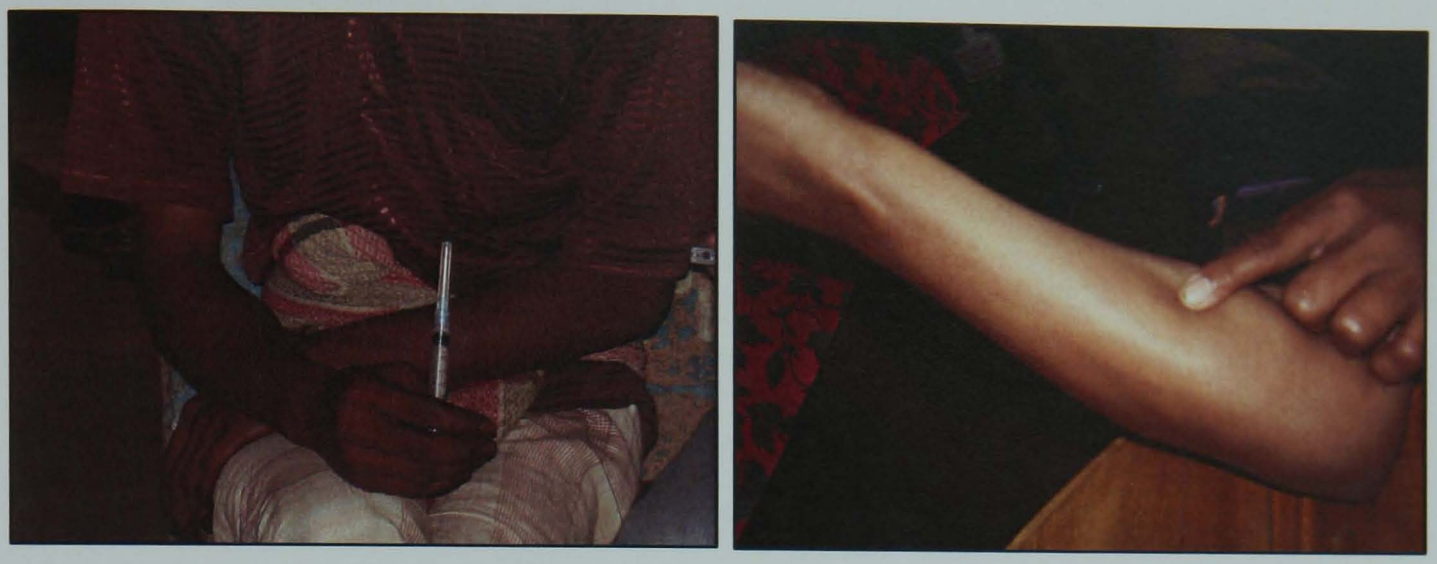
Heroin users are at high risk of polydrug abuse and dependence. They may find their tranquilizer supply interrupted and then use other drugs to continue or enhance the opioid effects (Westermeyer, 1982). Injecting drug use generally involves greater health risks than non-injecting use (Sutherland, 2004). Evidence shows that some of the influx to injection drugs is due to drug users switching to injecting after taking other drugs for four to ten years (NASP, 2003). The most common injected drug in Bangladesh is buprenorphine that produces opiate-like euphoric effects and dependence (Koester et al, 2005). To estimate the prevalence of Hepatitis B and C, and HIV infections among drug addicts in Dhaka, Shirin et al (2000) found the HCV infection was significantly higher among the IVDUs who are associated with the sharing of needles and a longer duration of injecting drugs. On the other side, the sero-prevalence of HBV infection was

significantly higher among the IVDU and non-IVDUs who had a history of extramarital or premarital sex. Mahbubur Rahman et al (2000) also found some HIV related risk behaviours particularly needle sharing among drug users in Bangladesh.

There are many reasons for 'switching-over' from one drug to another. For example, when there is a heroin shortage in the market, its price increases; as a result, poor addicts switch over to injecting drugs, which are comparatively cheap. This is a recent phenomenon because, until a few years ago, these were pioneer opiates until heroin came onto the illegal drug market and addicts jumped into it from injectable drugs due to its low price. For example, one ampoule of pethidine costs more than 100 taka, whereas heroin comes at 50 taka (a small wrap) a fix. Injecting drug users (IDUs) usually share their needles with their close friends. In that case, place, time and money are mainly responsible for needle sharing among the addicts. Addicts cannot wait to acquire a clean needle, so they share. One IVDU named Rakib told me that "*sometimes we share the same injection syringe; ampoule sharing also happens. We use the same syringe among our friends when the shop closes, and we cannot delay.*"

One serious drug addict in Khulna, Rafiq told me of a rule that, if any of his friends manage to get any drugs, there is an expectation that he will share. He also said that they use the syringe to take some blood from their own bodies, and then hand over to others to inject, so that they can get a high. It is a significant risk factor in the spread of HIV, Hepatitis B and C and other blood-borne infections because of the common practice of sharing needles. Repeated injections can cause vein collapse or loss. Drug users inject directly into their veins rather than their muscles because of the faster reaction. But they may subsequently face the problem of finding a vein because of their frequent use of needles. One showed me his vein shrinkage and I could not see any veins in either arm. He was concerned because he had heard that his vein problem might prevent him from working. As a result, some addicts inject a finger or penis due to the disappearance of veins in other parts of the body, or they inject drugs into muscles rather than veins (Fig 4.8). These injecting drug users suffer abbesses and intermittent bleeding. Moreover, they lose sensation in parts of the body.

Figure 4.8: Needle Sharing and Vein Shrinkage Problem



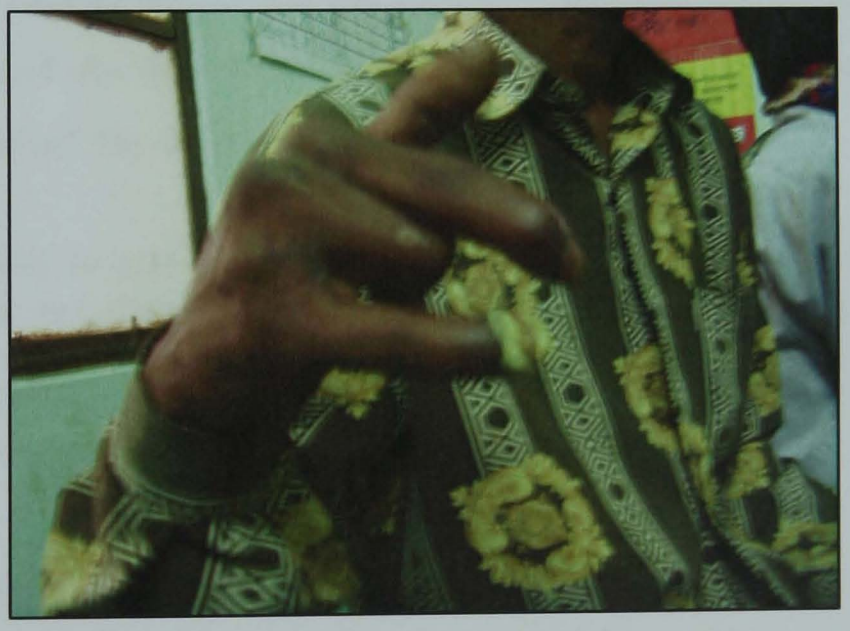
4.2.4 Stealing and facing retribution

'H' is for heaven; 'H' is for hell; 'H' is for heroin. In the life of the addict, these three meanings of 'H' seem inextricably intertwined (Chein et al, 1964). The relationship between drugs use and crime may be more profound than simple causality (Harris, 2007). Most drug users lack the funds to purchase sufficient heroin on a regular basis, however, and users may therefore commit crimes prior to the use of heroin in order to obtain the agent (Anglin et al, 1981; Nurco et al, 1988). Victimization is the understanding of the processes associated with the impact of crime (Walklate, 2007). Many addicts have to make choices about selling their favourite possessions or family heirlooms like jewellery or wrist watches to purchase heroin or other drugs (Westermeyer, 1982). Heroin addicts and other drug dependents manage their drug money on a day to day basis. Rahman et al (2004) found that the average per person cost of drugs was US$ 707-1135 per year, which is much higher than the per capita income of Bangladeshi people. Most drug users supplement their income by pick pocketing, thieving or selling their blood (Knight, 2006b). The abuse of drugs in Bangladesh is closely associated with other social crimes such as theft, robbery etc. (Hossain, M. 2005). Drug users follow many strategies, ranging from begging to stealing. Some collect rubbish (old papers, aluminium jars, and animal bones) from residential areas and sell it. Some beg by showing any infection they have on their body, or by presenting themselves as destitute, or any other tactic to collect money or rice.

Sometimes people identify them as heroin addicts and refuse to give. When they cannot manage to acquire money in a legal way (mainly from family, rubbish collection or begging), then they are prepared to steal. If they are caught they may be beaten up and sustain serious injuries (Fig 4.9). Often addicts carry a blade in their mouth or in their pocket when they go to steal. If faced by an angry mob the addict cuts his hand and people are scared off by seeing the blood. He may even get some sympathy. Saju told me about his technique for collecting drug money:

"*When I go to any house, and if there's no-one there I take anything I can carry. If I'm caught then they will beat me and I have many fractures in the body. Look, many joints of my body are already broken due to beatings. I bring stolen goods to certain shops in the railway station that are willing to buy, and the money goes on heroin. Sometimes I beg by showing my broken leg or hands. Some people can understand this and if I get, say, 3 kg of rice I sell it and use the cash for drugs.*"

Figure 4.9: Addict's Stealing Character and Facing Retribution



The evidence indicates that drug abuse is associated with an increasing number of people who commit crimes and, as a result, many addicts suffer from physical assault. Some experts claim that drug use is a mental illness to some extent and that there is a close relationship between mental attraction and drug use along with physical symptoms. As many drug users are unable to mix in mainstream society, they always live in a sense of depression, which makes them frustrated and anxious. In most cases, due to substance use, many drug users fall into a pattern of victimization.

4.2.5 Drug users' sexual 'pleasure'

The behaviour, social adjustment and medical problems encountered among opioid abusers are surprisingly varied (Trad, 1995). Rahman and Zaman (2005) found an intertwined relationship between drug use and unsafe sexual behaviour among male drug users in Bangladesh (also in Hassan, 2005). When people, particularly married men, indulge in heroin, one reason is that they have heard that it prolongs sexual 'pleasure' due to long intercourse. Some reported that their wives accused them of a kind of sexual torture as a result, and, rather than risk discovery of their drug addiction, they find release elsewhere for what they claim to be a boosted 'sex power'. The new sex partner may be the source of or a victim of STDs. I found one injecting drug user, Rassel who is married but very interested in outside sex. He mixes with family girls (those who don't treated as bad girls), hotel girls and sometimes brothel girls on a regular basis to fulfil his sexual urges with his friends. When he takes drugs he becomes crazy for sex, and then he forgets his wife because he thinks that he can enjoy himself with her anytime and she is '*dal-vat*' (familiar) to him, and so he wants to 'taste the flavour of other dishes'. He told me another important reason:

"*My wife is not able to take my pressure for long intercourse. She becomes fed up, besides, other than sex, I need to do many things on the girl's body like biting and punching heavily, which behaviour would not be tolerated or allowed by my wife. From the outside sex, I have some scabies and itching problem in my penis because most of the times I don't use a condom.*"

I found an unmarried heroin and injecting drug user, Didar who has a sex addiction. He tells me that some of his friends inspired him to enjoy sex after taking drugs. From then onwards he became keen on girls as a recreation along with the drug addiction. He has visited almost every hotel in Khulna and all the nearest brothels. Besides, he 'uses' *family girls* for his sex addiction. Regarding condom use, some girls insist on condom use but he knows of hotel girls who will allow him to have sex without in which case he sometimes pays extra. Like Didar, many drug users' condom use with sex partners depends on the type of relationship. Recently he has been facing serious physical problems in the genital area but feels unable to consult a doctor.

4.3 Sorrows and Anger of HIV Positives

The impact of HIV/AIDS influences every aspects of the life of HIV positives (Ellis and Muschkin, 1996). Most people who suffer from AIDS may have been infected with the virus for a long time (often several years) before showing signs of its development (Haynes et al, 1996). Moreover, not everyone who is infected with HIV reacts in the same way (Scott, 1987). While some HIV-positive individuals succumb to AIDS within a few years, others may remain healthy for a decade or more (Thompson, 1996). Adaptation to chronic illness that encompasses the short- and long-term stresses and strains are presented by living with a chronic condition (Revenson, 2001). Living with HIV/AIDS on a daily basis is a particularly complex and difficult task (Wilton, 1996). It is hardly surprising that a wide range of adverse emotional reactions (Cawley, 1988) like suicide risk (Campbell, 1995) are regularly reported in HIV-positive people. Individual reactions to HIV positives are likely to be the more painful and severe because it is usually suspected that the disease is spread by sexual encounters. HIV has been linked to a wide range of neuropsychiatric syndromes including depression and anxiety. Perhaps the most pervasive feelings voiced by AIDS patients are anxieties and anger over the uncertainty surrounding their illness and treatment. Their questions about treatment and lifestyle modifications following acute illness are generally met with incomplete and unsatisfactory answers. As in other developing countries, HIV positives in Bangladesh have to face many unexpected matters which make them very frustrated and hopeless in their daily life. This section will look at these issues of how HIV positives express their sorrows in their everyday life and how they try to cope.

Insulting language: In Bangladesh, many HIV positives feel upset at the insults that come their way, when they themselves do not feel to blame, especially women who have been infected by their husbands. Recently some NGOs have been presenting HIV positives in different forums as speakers to create a mass awareness about the HIV issue among ordinary people. Yet in discussion meetings on awareness, HIV positives often face unbearable insults. In Khulna I met with some HIV positives who are working as NGO staff and appearing in different seminars despite their fear of the reaction. The main objective of these seminars is to share their suffering and raising awareness. But, instead of offering sympathy, the audiences tend to be very negative. One female HIV positive, Diba who has been to many forums told me that it is not uncommon for people

to say that all positives should be killed so that they cannot spread the virus. There are also sneers about the obvious inadequacy of their prayers; or how long they will have to wait for death, and how are they passing the time? Moreover, some would prefer to die because of the misery and money crises they face. One HIV positive, Keya, told me that she is alone in the world and cannot express her sorrows to anyone. She believes that she is the most hopeless girl in the world. She has travelled to many places for a livelihood, like a floating object, but she cannot stay anywhere for long and never finds any peace of mind.

The dilemma of marriage: The growing and continuing challenge of defeating AIDS has become more concentrated among women in the developing world, particularly countries in south Asia, where increasing rates of infection have shown women innocently succumbing to infections. HIV infection puts extraordinary stresses on people's lives. Most of these stresses are unusual and people are unsure how to handle them. During my field work at Khulna, I found a few husbandless HIV positive women (mainly abandoned) who want to get married. Some confessed that they had had offers of marriage but they do not have the courage to proceed because if they get married to a 'negative' man, the NGOs would stop their medical and nutritional support, and then would the husband be able to support them and provide for their needs? There are examples of marriages between 'positives' and 'negatives' where the 'negative' husband had not been infected. So many of them have the wish but they also have fears, sadness and a serious dilemma.

Feelings about hopelessness: Many HIV positives are living their lives not only with physical suffering but also with psychological stress. Among the HIV positives in Khulna, I met a woman who had married a Bangladeshi man when he was in Malaysia as a migrant worker. Although her family were cautious about her love affair with a 'foreigner' because of the long distance from Malaysia to Bangladesh, she was very serious about the relationship. Now she thinks that she made a mistake to take him as a lover because he did not mention anything about his HIV status before marriage, although he knew it. She only learned about it when she was brought to Khulna medical college hospital by her husband and felt an intolerable shock. Despite that, she considered it to be her fate until she realised that her husband was involved with other women, and then she felt hopeless and considered his behaviour to be a betrayal.

Physical suffering: In Bangladesh HIV positives commonly and continuously face diarrhoea problems, mouth ulcers, fever, colds, sneezing, coughs, tuberculosis (TB), herpes and skin diseases as 'opportunistic infections'. One HIV positive named Afsar recalled how he had suddenly noticed that his whole body, excluding only his eyes, was covered with a chicken pox type skin problem. There was a bad smell because of the pus and his body swelled up. He went to hospital and stayed there for three weeks. After blood tests they discovered that he had HIV. After a few weeks he got back his normal skin. An HIV positive widow, Shanti, who was an agricultural labourer, worked at cutting the crops and found that if she had any injury, it wouldn't recover. She also lost her taste because of the many ulcers in her mouth. She became black and very thin, with many abscesses, diarrhoea, stomach pain, headaches and frequent fever. She visited Khulna Medical College Hospital twice but they could not trace her problem. Some doctors diagnosed ulcers, and others mentioned cancer. Finally, after blood tests doctors identified her as HIV positive.

Expected longevity: In Bangladesh, many newly identified HIV positives don't know how long they have been suffering from the disease. Some have died within two years but others are still living who were diagnosed in 1997. The longevity of HIV positives depends on many issues. Experts and NGO professionals believe that this longevity depends on medical and nutritional support. Those who can afford good food and nutritional support, along with medicine, have extended lives, mainly where there is opportunistic infection along with ARV (Anti retroviral therapy). Many of the HIV positives themselves think that their life will not be sustained for long and I found very few HIV positives who wish to survive as long as a normal person.

Devotion to god: Despite anger and depression, almost all HIV positives, irrespective of gender and different religions are very devoted to their own god. The vast majority of the HIV positive participants described religious faith as a major source of support in coping with their sorrows and anger. Most of them believe that religious devotion to god can provide relief from the physical pain and suffering from HIV and different opportunistic infections. They also believe that devotion to god also keeps them away from mental suffering due to having HIV status. They think that religion will purify their mind and help them to be devoted to the god. I found many HIV positives who

believe that their life is for god and they have no pleasure without calling on god. Out of many, one of the female Hindu participants, Shanti, a former housewife, believes that her HIV disease was, in a sense, given by god. Although she has not done anything wrong, her husband did and she believes that when she got married she became part of his sin and virtue. As her husband was sinful, so she got a share (HIV) from god. Despite religious practice, she feels sad for her physical suffering due to her innocence. Some HIV positives believe that god has given them the disease and that god will remove it. So, some of them are not scared. One HIV positive, Jhorna, a former sex worker, told me that she believes that Allah has given her the disease so that he will rectify her life from bad to good. On the other hand, a few believers are angry with god for visiting disease on innocents.

Scaring HIV identification: Most people feel shocked and disorientated when they discover they have AIDS or are infected with the virus which causes it. They may refuse to accept the diagnosis and become angry. Alternatively, they may react by blaming themselves and feel depressed. Almost everyone feels anxious and scared. Anxiety is something we all experience at different times in our lives. In this context, however, the anxiety felt is likely to be far more severe and longer-lasting. In Bangladeshi society, the lack of knowledge about HIV is such that many positives, when they are first diagnosed, are not aware of the implications. They need counselling, but unfortunately often their first experience is to find themselves the object of curiosity. There seems to be no guarantee of patient confidentiality, whether in government or private medicine and the news leaks out quickly. One man, Dulal, told me about taking his son, who had diarrhoea and anaemia, to a clinic. The boy needed a transfusion but there was no O+ blood available, so he volunteered to donate his own blood. He was tested and was shocked to be identified as HIV positive. He then brought his wife and all of his sons to the medical centre and, tragically, all tested positive. This information was divulged by the lab attendants and hospital officials and soon the whole town knew. They became objects of morbid interest. According to him, more than 2000 people including journalists gathered in the clinic and were looking at him strangely like an animal from the *sunderbans* (mangrove forest of Bangladesh). Then he felt frightened and was crying because everybody was saying that he will be killed or likely to be burned. He became the 'talk of the town' in Khulna as well as in other parts of the country.

HIV positive people's reactions differ widely, but nearly everyone shares to some extent feelings of anger, depression, fear and guilt. One reason for anger is the unfairness of the situation. Depression is one of the most painful feelings a person can have. For almost all HIV positives, depression is both a common and an understandable reaction. Most people become depressed when they find out that they have AIDS. AIDS makes them feel that they no longer have any control over their lives which may contribute to a feeling of loss of identity. This makes HIV positives feel helpless. Many people with AIDS, especially in the latter stages of the disease, are weak and become increasingly dependent on others to look after them, which is another source of discomfort. They feel empty and uninterested in things that were previously central to their lives. In terms of physical limitations, people with AIDS, particularly women, may become isolated socially. Some feel guilty for having become infected. In Bangladesh, like in other developing country settings, after diagnosis, patients often fear that they are about to die and worry that no-one will come forward to bury them. They also think about their children's future and consider their dream to be broken. Those surrounding them may also be fearful and perhaps suggest that the diagnosis should be kept quiet. The patient and their relatives all need proper counselling and advice for changing their lifestyle.

4.4 Vulnerability of Differing Dreams and 'Vicious Cycle'

Vulnerability refers to the actual feeling of susceptibility to illness or misfortune (Nichter, 2003). It is a state of weakness, fear and worry for 'different categories of people' (Walklate, 2007). Killeas (1990) provides a useful taxonomy of vulnerability which explores physical, social and situational factors and clearly demonstrates that vulnerability is both internal and external to the individual. A sense of vulnerability is shaped by the conditions of existence, whether they are biographical, environmental or cultural (Green, 2007). Vulnerability is often used to express the level of risk posed to certain groups or individuals. The more vulnerable a person is the more they are at risk of victimization. Across the world, many vulnerable girls are choosing prostitution because they are poor. Here, the social conditions under which women turn to selling sex is an important area for investigation. It has sometimes been argued that the economic rewards of prostitution tend to be greater than those of most of the other occupations open to unskilled and uneducated girls in south Asian countries (Heyzer, 1986). Ford and Koetsawang (1991) argue that some sex workers see greater dignity in

their work than earning a pittance, for example as a housemaid. In the Bangladeshi context, Khan (1988) explains that in general, prostitutes have poor living conditions, no savings for the future and most lead a fatalist life. Many girls want to leave the highly stigmatized profession if alternative opportunities for coming back in the main social stream are provided. The most popular expectation among them is to be reinstated in social status terms through marriage. The following section focuses on brothel and non-brothel sex working girls' different dreams and the exploitation that makes them vulnerable physically, socially and economically.

4.4.1 Bonded girls' 'subordination to freedom'

It is widely perceived that many punters often seek young girls or virgins and sometimes offer substantial amounts of money for this, which is one of the factors in the trafficking of '*chemri*' or bonded girls or sex workers. Murthy and Sankaran (2003) found that once sex workers enter brothels, they cannot leave until they pay off the debt to the brothel owner or the concerned agent. There is a chain in the trade of bonded sex workers and they have the least freedom (Hammond, 2008) because a bonded sex worker has no control over her income and cannot be free from bond by her own will (JJS Report, 2001). They are required to entertain clients even when they are ill, putting at risk both themselves and their clients (Tahmina and Moral, 2004). Taposh (2006) explains that in general, the brothel '*sardarni*' (manager or mistress or house owner) pays money to brokers or pimps to 'buy' a girl or woman, to lawyers for an affidavit, a 'fee' to the local police, and maybe to remove any other barriers. The usual practice of entering the profession is the requirement of an adult woman to swear an affidavit before a first class magistrate or notary public to the effect that she wants to follow the profession of prostitution out of her free will. Such an affidavit is commonly considered as a 'licence'. The majority of prostitutes do not have such a 'licence', particularly those who are engaged in the street, hotel or residence. These 'licensed' young sex workers need to earn a lot of money in order to pay off debts to their brokers or owners or *sardarnis*. They have to hand over their earnings because the leaders create a captive situation in the brothel. In Khulna and Jessore, I observed that some minors under 18 years old are involved in sex work but they say that they have a 'licence' where it is

written that they are 18 (Fig 4.10). According to the Bangladesh constitution, anyone over 18 has the right to choose their own profession. But this system of affidavits is loose and brokers exploit it. When a new girl comes into the brothel, someone will buy her and she becomes a *chemri* under her *sardarni*. Basically *chemris* have to earn for their *sardarni* who do not need to work. When *chemris* cannot earn according to their desire, then they beat the girls and mistreat them. The system is that all the earnings of a *chemri* will go to her *sardarni* and if she (the *chemri*) is given any '*baksis*' or extra tips, sometimes the *sardarni* will take that as well. So they always live a sorrowful life. Regarding their subordinate girls' freedom, the *sardarnis* have a saying that "*we bought the cow from the market, so she must produce milk.*" This bondage lasts from a few months to a few years. It depends on the *sardarni's* behaviour and mentality.

Figure 4.10: Appearance of few Bonded Girls at Brothel

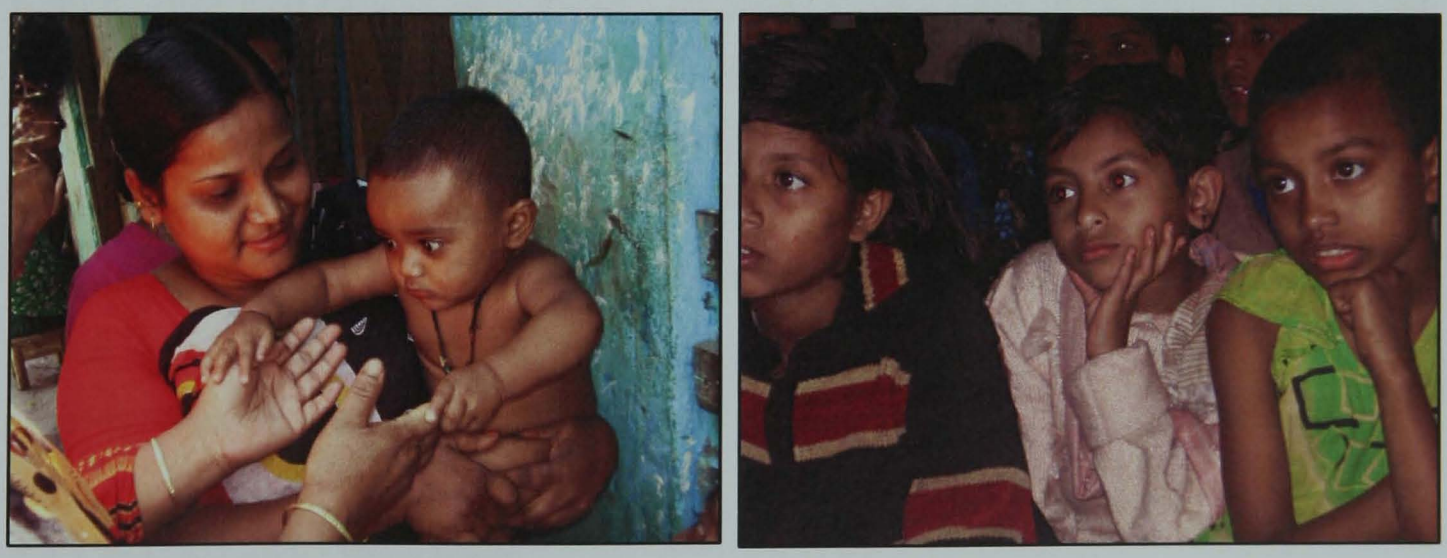
4.4.2 Brothel girls' common dream

In Bangladeshi society, most women typically want a life with hope in which there is a home, husband and children. Although sex workers have their own dream of leaving the brothel, they are not always clear how this may be achieved, and their dreams are often clouded by fear (Fig 4.11). The brothel-based NGO officials that I spoke to confirmed that almost all girls have a dream to leave but cannot because their lives are always in crisis. For example, many times girls take loans with high interest from their house mates, colleagues or *sardarnis* in order to contribute to their parents' welfare or some other family purpose. In this way they become tied to their leaders or *sardarnis* in financial bondage. They cannot save money from their daily income as the amount is

not enough. This cycle of crisis leads to frustration. They are often confused about their real destination due to their uncertain life. When I asked a question about dreams for the future, many workers said that they had none. After some time, they relaxed and tried to think about their future life target. One girl, Parul told me "*what I will do in future? I have no dreams. Everything has gone from my life!* [Then after some thought] ...*Will I do this work my whole life? No, I will go to my village and look after my baby, bring her up and spend money on her education.*" (Fig 4.12).

Figure 4.11: Sex Worker's Colourful Dream

Figure 4.12: Brothel Girl's Dream for Children



Many sex workers have a common dream to marry a 'good' man or be rescued from the brothel by a good man. According to their idea a good man would not give them any trouble, would not beat them and use vulgar words, and would not have an exploiting mentality. Many girls try to save money for a dowry and leave it with a trusted person, but theft is common under such circumstances. As the girls usually cannot get their desired 'good man' in life or be cheated, so some have recently been trying to get

involved in self employment training provided by different NGOs, for example candle making, or handicrafts. During the course of my field work, one day I found some Fultola brothel sex workers at an NGO office being trained in candle making. They told me that they earned lots of money in their life but right now they needed training as they know that they cannot do this work for ever. I asked them about their future destinies and they responded:

(Shefali) *"I have a desire to make a family, have a husband and children; I will buy some agricultural land with my savings."*

(Nipa) *"I have a dream that when I will leave the brothel, I will give my savings to a good young man to develop a business and will marry him and enjoy family life in peace and happiness."*

(Kobita) *"I will develop a co-operative for handcrafts with some other girls for self employment. The whole day we will work hard and in the evening we will sell our products and eat and sleep. We need happiness."*

Most of the sex workers strongly believed that they are cursed into the life of a prostitute. Many of them think that it is a way of life and a way to make money. People who hate them for their profession do not understand the hardships they are forced to endure. They also believe that, as they are poor, so they have to adjust to this life and they have to live with laughter, tears and sorrows. They also believe that if anybody is not fated to have happiness she cannot get it even by paying money. However, in the brothel, sex workers are isolated and cannot use government facilities. No-one seems to be taking responsibility for their rights like hygiene and security. The politicians blame police inaction and the police cite the problem of the house owners or *sardarnis*. The problem does not seem to be a priority for anyone.

4.4.3 Brothel girls' 'love trap'

Brothel girls consider themselves to be 'fond of love' (Fig 4.13). Almost all of them are being exploited in the brothel by their so-called lover or '*dada babu*' or '*babu*' which seems to be a 'love trap' for them. In a study on Tangail brothel, Bangladesh, it was found that 62 percent of the women had *babu* or steady lovers and they do not use condoms in these private relationships (Jenkins, C. 1999). These are former customers

with whom the girls share their dreams. But the dream of rescue and marriage, without exception, never comes true in reality because most of the *dada babus* are unemployed and they stay in the brothel to solve their own problems. I was told that it is common for the *dada babu* to run off with money and other belongings, but he may soon be replaced by another.

During a FGD with Jessore brothel girls, they told me that they all want to love someone but that 'brothel love is fake'. If they leave to live with a *babu* then most return to the brothel after a while after their money runs out. Here are two stories of a brothel sex worker's relationships with a *babu* or *dada babu*. The first tells of the girl's hope; the other about exploitation.

Future Hope- Sapla is a sex worker at Baniashanta brothel:

"*I have a dada babu who has no relation with any other girl. I love him because he looks very nice. Sometimes my dada babu stays with me during the night. Recently he has not been allowing me to take any customers. I have many dreams about him. I don't believe that my dada babu will act like the others. He will not steal my money and belongings. You cannot compare my dada babu with others because mine is exceptional. His mother and the whole family know about me, that I am staying here to make a business. He spends money on me because he considers me as his wife. If my dada babu notices that I am talking and smiling with other men he becomes very angry; then I know that he likes me. I think that life is a combination of good and bad. I believe that I will go to my husband's house very shortly.*"

Exploited Victim- Santa a sex worker at Baniashanta brothel, had a *dada babu.*

"*One of my regular customers forced me to take him as my dada babu when I arrived in this brothel. If I hadn't agreed he would have arranged an 'accident'. He was a mastaan in the area, not a good type of man. He was involved in burglary in the forest area of the sundarbans. He stayed with me and lived on my income. There was a lot of trouble and he abused and swore at me. When I left him, I lost all my savings and ornaments. Now I don't trust anybody.*"

Babus are very influential men in the brothel. Although some are abusive and exploitative, most of the women value their relationships with these men. Most of the *babus* have wives and children outside the brothel and some are *babus* to women in other brothels as well. It is highly likely that these women are at risk from the multiple sex partnerships of their *babus*.

Figure 4.13: Brothel Girl's Lover

4.4.4 Non-brothel girls' 'temporary love' and mental depression

Women sex workers have been blamed for the spread of HIV but, as frequently pointed out, sex work exists only because of the demand from men. The casual sex workers I spoke to told me of their techniques of sustaining a livelihood. When a girl finds a friend-cum-customer, they maintain the relation for few visits and tell their 'miseries' and take the opportunity to borrow money from the man. Such relationships turn into sex after some time. Usually a girl will be loyal to her friend and not look for other customers. But after some time, ranging from a few weeks to few months, this kind of temporary love or friendship stops due to the man's lack of commitment. He may realise that she is a call girl or lose the taste for sex, and may break the relationship by mistreatment or making an accusation. The girl will then look for another potential man who will give her money in exchange of 'temporary love'. I found several call girls in Jessore and Khulna who described the above situation.

Many hotel girls are mentally depressed due to their financial position. In some hotels, girls stay for a few days and perform sex acts on a contract basis. They cannot protest about any inflated bills for fear of facing physical and mental abuse. They put up with it because they have debts in the village which need to be paid. I found one hotel and residence-based sex worker, Lima who had physical problems for a long time due to her own negligence of her body but she did not feel able to see a doctor. Others become pregnant by customers who refuse to use a condom and then insist on an abortion. I spoke to Sathi who had recently been through this process. She now feels very

frustrated. Others turn to alcohol or cutting themselves to release their anger. One brothel girl, Ripa told me that:

"*When the girls feel sad, they drink alcohol. They want to forget their sadness. We are deprived from many things, such as family, relatives, and a husband. When I want to cross the road, people comment on my identity. We cannot go to our parents or talk to relatives.*"

There are also many frustrating situations prevailing in the sex worker's life. They openly complain about exploitation and cheating by various powerful groups such as the police. It is commonly reported that most of their earnings go to exploitative groups, such as pimps, madams, muscle men or corrupt officials. Some sex-workers have also experienced difficulties including abuse from relatives or previous lovers resulting in a certain level of depression and other problems. Recently, however, there have been some improvements for sex workers through NGOs' provision of training on rights. These capacity-building lessons are based on avoiding harassment, rights to proper health services, and the empowerment of the girls.

4.5 Addict's Life-Cycle with Recovery and Relapse

Substance abusers exhibit complex problems. In the past 20 years multiple substance use has become common, and a lifelong disorder- a 'chronic relapsing disease' (Lex, 2000). Kellehear and Cvetkovski (2004) characterize the drug user as respectively, morally bereft, ill, or a social victim. In the past, addiction has been viewed as a generic phenomenon (Baker, 1988). The 'disease theory', for example, highlights similarities between addiction and infectious disease (e.g. Vaillant, 1983; Frawley, 1988). It attempts to explain why some people develop problems with drugs. They generally assert that drug dependence is a symptom of a physical or mental disease. Following Lee (2004), there are many varied conceptualizations that are primarily psychological and/or personality based (e.g. Murphy and Khantzian, 1995). However, recent theories of addiction draw implicit or explicit parallels between addiction and a wide range of other behavioural phenomena. Behavioural theories are largely restricted to the explanation of observable and measurable behaviour. Loewenstein (1999) views addiction as a wide range of behaviours that are influenced or controlled by 'visceral factors' which include drive states such as hunger, thirst, and sexual desire, moods and

emotions, physical pain and most importantly for addiction, craving for a drug. Here, behaviour is seen to be a consequence of learning or conditioning (e.g. Siegel, 1979). Cognitive-behavioural theories hypothesize that both behaviours and cognitions (thoughts and beliefs) are learned and can therefore be 'unlearned', but they differ significantly in their focus on the behavioural or cognitive factors in change (e.g. Beck et al, 1993; Jones et al, 2001).

As substance abuse is a relapsing disease, there is no cure but there are several paths to recovery (O'Brien and McLellan, 1996). Addicts develop different attitudes during addiction, such as the belief that drugs are good for every ailment, and the rejection of moral taboos, and this predisposes the former addict to revert to the use of drugs (O'Donnell and Ball, 1966). In other words, the disease of drug addiction affects the whole person of the drug user - physically, mentally, emotionally and spiritually (Drahozal, 2004). Addicts usually should not expect steady improvement or rapid return to pre-drug use levels of functioning, and immediate establishment of life without substance abuse. However, the high rate of relapse is attributed largely to the continued association of the patient with addicts after detoxification. The 'cured' addict returns to the same addict sub-culture and quickly reverts to their former pattern of drug use. Most of them who detox relapse after treatment due to not having a job, skill or training. They must be engaged in productive activities in society, so that they can become employed. They also need support to uplift their image and their self-esteem. My research found that addicts are more likely to relapse unintentionally, by 'playing around' with drugs again, than to resume their addiction deliberately. The next section will look these vulnerability issues and how the addicts follow a life-cycle of relapse and recovery. In addition, I will look at how the 'surrounding environment' of the addict plays a role in 'polluting' the addicts.

4.5.1 Addiction: reason and nature of vulnerability

An addiction is primarily a human-made illness that has its roots in socio-environmental conditions (Suchman, 1972). Most users learn about heroin for sometime before they actually have a chance to try it. Most of them had also seen someone inject or snort heroin. The first opportunity comes about in a simple, casual way. Many of the boys

were offered a 'shot' or a 'snort' by a youthful friend, and, in about another third of cases, the opportunity developed in a group setting and at the initiative of the group. In most cases, the heroin was obtained easily and without cost for their initial doses. Bangladeshi addicts take some simple drugs like cannabis as their 'starter'; eventually many enter the world of injectable drugs and finally graduate to deadly drugs such as heroin. Sometimes heroin addicts switch over to needle use but they come back again to inhaling heroin. Most of the drug addicts, particularly the heroin users that I spoke to in Jessore and Khulna, got involved with addiction mainly from curiosity about something new or by keeping bad company. One of the respondents in Jessore named Kamrul told me:

"*Drug addiction including heroin and injecting drugs comes from curiosity, family quarrels, bad company, the failure of love affairs, mental stress, unemployment, sadness, all are responsible. When you can't see a way out, it's like medicine.*"

There is a common saying about heroin addiction that 'you may want to leave me (heroin), but I will not leave you'. Drug addiction, particularly heroin addiction, is like 'vampire behaviour'. In the movie we see that when a vampire bites anyone who is resisting, the victim becomes in turn a vampire themselves. So it is with heroin addiction. Dealers will deliberately encourage potential addicts in order to create easy business. After a time, the addict will become a dealer and so on, in a chain. Many times during my field work I heard of innocent people who had been lost to drug addiction. An example is the young protester who tried to rid his area of addicts. Then all of the local peddlers tried to involve him in addiction by providing free cigarettes which contained a small quantity of heroin. When he asked for more, he was introduced to a dealer to buy it and learned how to take it. When he managed to come to a treatment centre, then again he became determined to evict these people from his area. Although they have different reasons for their addictions, all of them suffer from the same physical problems (Fig 4.14). Addicts told me that although when they take drugs they feel 'the best', actually they become 'the beast'.

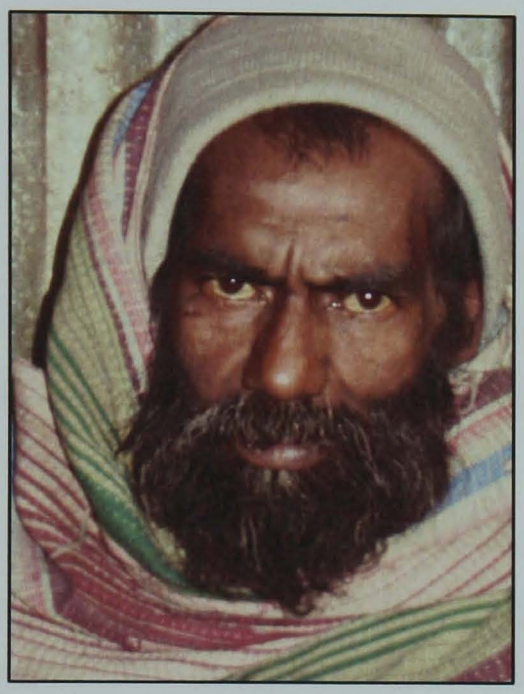
Figure 4.14: Everyday Addiction and Vulnerability

4.5.2 Helpless addicts' relapse and fail to 're-life'

Relapse refers to a process entailing a series of lapses (Brownell et al, 1986). Usually it is best to assume that the relapse is a temporary slip rather than a permanent slide back into drug use (Irwin, 1973). Many times, the addict thinks that their life may be so destroyed that it can never become as good as it was before getting 'hooked' (Elster, 2000). The causes of relapse can be divided into individual or intrapsychic versus interpersonal and socio-environmental cues. The first type could include physical sensations as well as psychological states such as cognitions and emotions. The second type could include cues such as other individuals using drugs, the smell of drugs, or the sight of drugs, as well as the physical surroundings associated with drug use. In Bangladesh, most of the drug patients in the treatment centre feel that they will eventually recover. Their mental strength seems remarkable, but when they come out from the treatment centre they return to the context of addiction in which they can save themselves for a few weeks to a few months at best. Heroin addicts are attracted by the smell of the smoke and it is easy to fall into the same trap of relapse. There are many factors causing relapse, like mixing with addict friends again, or over-confidence about staying clean (Fig 4.15). I met one drug addict, Kabir who has been taking drugs for a long time. He asked me a vital question about the value of drug treatment:

"People can get treatment from NGOs, but they return again to drugs because this environment is polluting. If I don't change the place it will not be possible to change my addiction. If I take the treatment in the centre, and stay for 15 days, the government will spend 15,000 taka on me, but this money is a waste if I start taking drugs again. So what is the value of the money?"

Figure 4.15: Addict's Cycle of Recovery and Relapse



When drug addicts take treatment, they may reflect on their life of addiction. I talked with one addict in a rehabilitation centre who was addicted to injecting drugs and now felt that he had made his family suffer. He also thinks that he had no sense to judge what was right and wrong. Many drug addicts want to go back to mainstream life but they cannot tackle the suffering, and control their own minds. Many addicts' families also try to help them return to normal life. I interviewed one addict, Shapon who wants to help himself:

"Many times I think that I will surrender my life under a truck, commit suicide, because I have no income. If I am able to manage one meal, the next one may be two days away, so why I will keep this life? Sometimes I feel I want to get back to normal. I can remember my school life."

I found a boy named Islam in a drug rehabilitation centre in Jessore during a participant observation session. Islam does not know what will happen in his life after finishing the treatment course in the centre. He actually cannot confirm that he will be able to leave the addiction or not, or when he will leave the rehab centre. However, I met with some drug patients in the same treatment centre who thought that if they lost the opportunity,

they would go mad and destroy themselves. Drug addicts believe that they can leave the drugs if the environment helps them. At the same time, family support is also important for leaving the addiction. Recovery addicts have a high social pressure to prove themselves to be drug free. The ready availability of drugs is an important issue in compromising the recovery of addicts.

Many addicts eventually try to stop using heroin on their own or at least to cut back on their dosage as a part of self-control. Some realize that they have become alarmingly thin and unhealthy looking, that they are an economic burden for their family, that they could no longer participate in communal activities of the neighbourhood or village, or that their social reputation has declined. However, most of the time, particularly after taking the drug, they come to believe that they are harming themselves by their addictive behaviour. Then they decide that they would be better off were if they were not addicted. But the addict cannot keep to these wishes for long, because in the meantime, withdrawal symptoms appear. As relapse is fairly common in recovery from substance addiction, it should be incorporated into treatment planning.

4.6 Everyday Life and HIV Vulnerability

Individual vulnerability and health risk are part of everyday life among the marginalized people which have been illustrated in this chapter through their 'lifeworlds'. Such biographies provide clear evidence of individuals' social and physical risks which constitute a key role for their potential ill-health, particularly from HIV. Here, poverty, lack of education and employment, poor self-esteem, poor health and nutrition, low social status, and exploitation play a role in increasing vulnerability. However, psychological problems also interrupt the individual's daily life. The narratives of commercial sex working women contain examples of their marginalization and the risks that they face every day. The economic, emotional and physical vulnerability of brothel and non-brothel sex workers means that they are easy targets for all manner of abusers and all manner of abuse. They suffer from chronic health problems, which are a result of sexual assault, untreated health problems, and overwhelming mental stress. In addition, sex workers' low status in society and uncertainty of income are common issues for them and can push them into risk of HIV infection.

The everyday social context of drug users' lifestyles promotes poor health because drug use is not only a serious public health threat, but also a social threat. The physical consequences of the individual's lifestyle mean that they are at risk of a host of diseases, such as hepatitis and HIV. Besides, depression and hopelessness can also affect their individual vulnerability. Rejection by society and segregation with others after the recovery stage of addiction may lead to the development of subgroup values and customs, which again further reinforce the addictive pattern and the development of deviant, antisocial behaviour. However, with respect to HIV transmission, there is a fear that addicts who are still inhalers might change their mode of addiction to injection when heroin is unavailable. The narratives of HIV-positive people contain strong traces of the marginalized life that they face everyday, including sorrows and anger due to the state policy actions. The 'lifeworlds' of HIV positives is a combination of distressing emotions of anxiety, depression, and helplessness. Finally, it can be said that poor economic conditions and marginalized social status leaves their health vulnerable because of their high identity crisis, stigma and prejudice. As they are less likely to seek appropriate and timely health services, serious health problems like HIV may affect them. HIV is not only a health problem but also a social, economic and cultural issue. In other words, marginalized people's lives are not only a combination of economic and physical vulnerability, but also an effect of social issues like stigma and identity. Their identity and stigmatized status may encourage discrimination and so create a difficult situation. These issues will be discussed in the next chapter.

Chapter Five

Stigmatized People and Societal Prejudice

Chapter Five

Stigmatized People and Societal Prejudice

Stigma is not only an isolated sociological concept but is also more closely wrapped up with many other aspects of the human condition, leading to discrimination and marginalization. The term 'stigma' refers to an attribute that serves to 'discredit a person or persons in the eyes of others' (Franzoi, 1996; p.403) or 'devalues the person' (Hopper, 1981); it can be seen as a 'principled refusal' (Fischhoff, 2001) or in terms of 'socially disqualifying' attributes (Katz, 1981). Kasperson et al (2005) define stigma 'as a mark placed on a person, place, technology, or product, associated with a particular attribute that identifies it as different and deviant, flawed or undesirable' (p.171). Parker and Aggleton (2003) argued that stigma is a social process that produces and reproduces inequalities and in this case, stereotyping may be one mechanism through which the process takes place. Stigma in Erving Goffman's (1963) terms is an undesirable differentness from what the non-stigmatized have anticipated. According to Goffman, there are three different types of stigma. First, physical disfigurement, deformities and disease; Second, aberrations of character and personality; and third, social categorizations such as race, nationality and religion. A stigmatized act is unacceptable whatever the associated benefits. An important aspect of stigma is that stigmatized people often themselves accept the concept of stigma that is current in their own culture. In other words, stigma is very often also 'self-stigma', an attribution which the despised minority internalizes (Goffman, 1963). In Goffman's conception of stigma, there is the implication that the attributions spoil the person's identity permanently. The experience of stigma has a profound effect both in its emotional impact for the individual concerned and in its social repercussions for the marginalized group as a whole. At an individual level the impact of stigma and social exclusion can be devastating, leading to low or diminished self-esteem (Hogg, 1985), poor social relationships, isolation, depression, self-harm (Mason et al, 2001), and feelings of loss of control,

embarrassment and deficiency (Benjamin, 2001).There is a close interplay of psychosocial factors contributing to the changing dynamic of stigmatized groups and individuals in society (Franzoi, 1996). Stigmatized groups are, by definition, devalued in and by society (Hogg and Vaughan, 2002), they have relatively low status and little power, and they find it difficult to avoid society's consensual negative image of them. In other words, victims are frequently marginalized, sometimes completely ignored and further victimized as a result of the responses to their victimization (Williams, B. 1999). In general, although some stigmatized individuals are vulnerable to low self-esteem, diminished life satisfaction and in some cases depression, most members of stigmatized groups are able to weather the assaults and maintain a positive self-image (Crocker et al, 1993 & 1998).

Various socioeconomic and cultural aspects create an environment of vulnerability to HIV/AIDS (Ghosh et al, 2009). In order to study the objective of marginalised people's stigmatised lives, factors such as stigma, identity, rights and suffering caused by discrimination have been explored. In this research, these marginalized people are struggling every day for their economic, social and physical survival and lead a very stigmatized life, without access to health care services, little knowledge about their rights, and a feeling of hopelessness. I have explored identity, stigma and discrimination issues affecting certain groups- commercial sex workers; drug users, mainly heroin users; and HIV positives- towards the community, including family and friends.

5.1 Identity 'Crises' and Consequences

'Identity' is a commonly used term in a number of different ways (Butler and Scott, 1992) which can shake the foundations of our lives in everyday discourse (Jenkins, R. 1999). It is a relational construction and relative to situations and contexts which have both temporal and spatial dimensions (Holzner and Robertson, 1980). Identity only becomes an issue when it is in crisis, when something assumed to be fixed, coherent and stable is displaced by the experience of doubt and uncertainty (Mercer, 1998). An individual's identity is formed and maintained in the course of interaction with others, because we all need the 'positive regard' of others and strive to obtain from others confirmation of our view of ourselves (Blacking, 1983). Erikson observed that every person's 'psycho-social identity' contains both positive and negative elements (1968).

These negative elements or 'identity crises' caused or reinforced by stereotypes held by members of other groups, can lead to self-hate. In an 'identity crisis', a person (e.g. sex worker or drug user) is denied easy access to her/his relatives or neighbours due to involvement in 'unsocial' work or with unsavoury elements of society (Butler, 2004). This can lead to a deep sense of displacement, a sense of not knowing or not belonging to the 'social world' (Lawler, 2008). In this research, the identity of the sex workers is illustrated, particularly how the sex workers are treated by their families and villagers and how their spoiled identity is affecting their lives.

5.1.1 Sex workers' 'bad' identity

The term 'sex worker identity' is commonly used to refer to the imagined or portrayed personage in the women's stories. Many of them consider their own profession as 'bad', demeaning or shameful (Chant and McIlwaine, 1995). Phoenix (2000) constructed a few contingent elements of the 'prostitute identity' for example, prostitutes as 'workers', 'commodified bodies', 'loving- partners' and 'victims'. Women working as prostitutes are perceived as bad girls, suffering stigma and increasingly criminalized by the state (O'Neill, 1997). They may also choose to describe themselves in a variety of ways: as escorts, masseuses, working women, or simply as prostitutes (Wilton, 1994). Women who continue to live in regular households but who sell sex without the knowledge of their families and neighbours maintain a close secrecy about their working lives (Asthana, 1996). A prostitute's subsequent life is spent almost entirely with her fellow workers and clients, for her parents dare not keep in touch because of fear of social ostracism (Blanchet, 1996). Here the identity of sex workers is analysed in terms of the ways in which they are publicly discussed, socially treated and officially depicted.

Commercial sex workers in Bangladesh generally try to hide their profession from their family, neighbours and village community. They face an identity crisis and introduce themselves as a factory or garment worker, nurse, family planning worker or NGO worker to protect their status and maintain a good image (Fig 5.1 shown as symbolic). Almost all sex workers have a tendency to change their names when they enter the profession in order to conceal their 'real' identity. But some sex workers believe that their mother may have guessed their profession. One of the hotel sex workers I interviewed in Jessore, Nipa said that "*my mother may know because she can read her*

child's mind." But a casual girl, Lota, thinks that although her mother may assume she is a sex worker from her earnings, she has never asked about it due to the possible disgrace, but she sometimes asks 'why I didn't come to home last night'. On the other hand, one of the Baniashanta sex workers, Salma told me that her mother knows her profession. As she is the only earner in their family, her mother is compelled to accept this. Her mother sometimes comes to the village adjacent to the brothel and collects money from her daughter. Salma also visits their house in Khulna city and stays with her mother for a few days. Her mother emotionally asks her not to return to the brothel again. She consoles her mother because she needs to earn money, otherwise neighbours or relatives will spread 'stories'. She believes that money can remove the disgrace: "*When people see money then they will not say anything, even if I do some bad things in our house nobody will ask anything.*" Sex workers, particularly brothel girls, may introduce their lover or *babu* as their husband to their relatives and neighbours in order to overcome the marital status problem, which is an issue for women in Bangladesh. Alternatively, some sex workers like Lota are less concerned about their stigmatized identity. When neighbours make any odd comments, she just ignores them. Although she feels that she cannot answer back, she does not care about their remarks.

Figure 5.1: Sex Workers' Identity 'Crises'

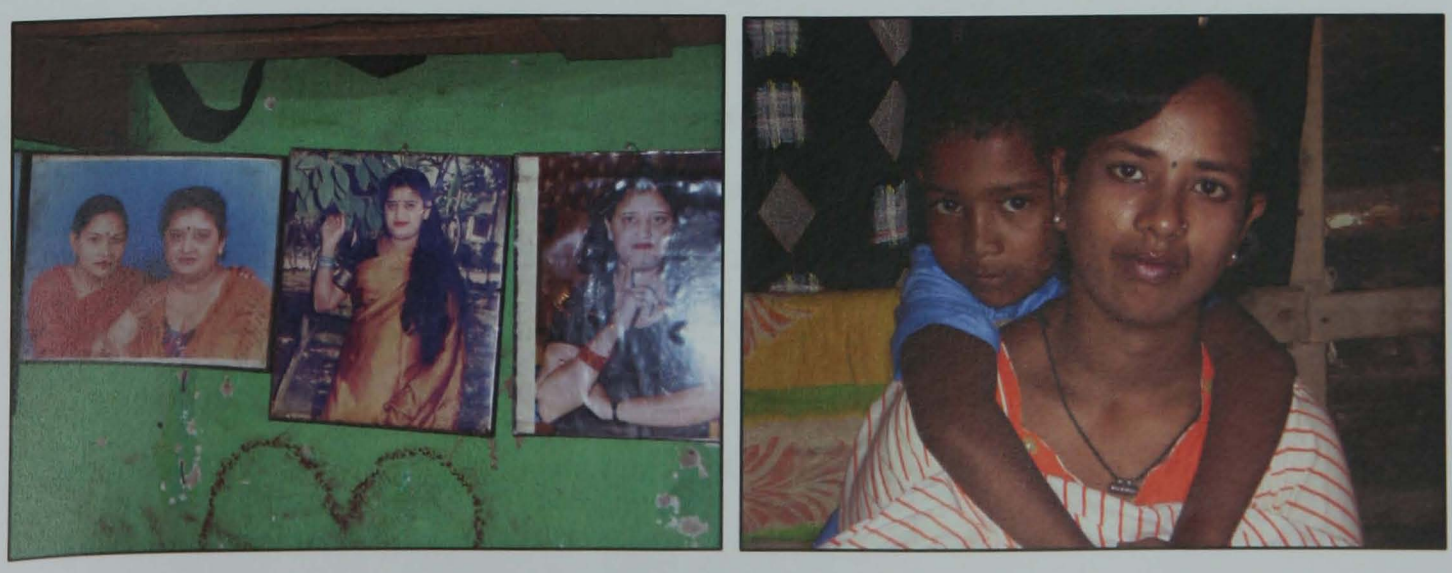
Sex workers, particularly brothel girls, believe that society has a double standard towards them. On the one hand, male relatives who know about their profession, particularly brothers or uncles, threaten them with violence or death if they stay at the brothel. On the other hand, these relatives take money, although they refuse acknowledgement for fear of losing status. Many family members of sex workers receive gifts from them, but villagers or neighbours do not know the source. Also,

according to the girls, the biggest hypocrisy is that the kind of men who commonly criticise them are also their customers. I met with a girl named Bristi who is working in the Jalaipotti brothel of Jessore. She told me of her family problems:

"*In our village, no relatives recognize me. They have forbidden me to go home because I am living in the brothel. Recently one of my family members died but none of my family informed me and I got the information two weeks later. When I asked why, I was told that if I had attended the villagers would not have buried your relative because of your profession. I felt very sad but I realised that my presence would create embarrassment for my parents. Already the villagers do not mix with them properly because of me. But if I leave the brothel forever for the sake of family status, I would lose on both sides. My family would not accept me and it would be difficult to return here again.*"

Sometimes casual sex workers like Parvin, Fatema and Johura entertain customers in their own houses by introducing them as relatives or colleagues but they face many problems with neighbours, particularly women, who make comments. They need to give many explanations to maintain their reputation as a 'good girl' (Fig 5.2 shown as symbolic). All the time sex workers need to be conscious about concealing their 'bad' identity. Sometimes, local *mastaans* threaten the girls, telling them to leave, or they demand money. However, casual sex workers who have (ir)regular husbands, always need to hide their profession. One of the hotel-based girls, Keya told me that her husband knows that she is employed by an NGO that works with hotel girls. So she has no fear of going to the hotel. But when she has sex with her husband she practises some techniques 'so that he won't guess about her outside sex'. Another sex worker told me that her husband is sometimes suspicious about her character. Then a 'soft reminder' is given by the wife, as her husband depends on her income.

Figure 5.2: Sex Workers' Identity and Sorrows



Adjacent villagers' perceptions or attitudes towards Baniashanta brothel girls are mixed. Some consider them to be '*kharap meye*' (lost girls) but many like the brothel girls. Moushumi told me that they mix freely with the village people. In the past, school teachers were rude to their children and villagers obstructed them from collecting water but now everything has been changed because of NGO pressure and advocacy meetings with different groups. Also, one of the old members of this brothel, Nargis thinks that villagers are benefiting economically from the brothel girls because they can sell their vegetables and fish and the older women can work in the sex workers' houses as a maids or cooks. Villagers can sell water, and if any villagers face hardship, the brothel girls help them. Efforts to reduce the stigma attached to sex work might eventually allow sex workers to maintain ties with their families and hope for a better future.

5.1.2 Self estimation about 'sex work'

Although society's tolerance or acceptance of prostitution has varied at different times and places, there is no place and no time that has it has been entirely without stigma or repression. A woman who has engaged in sexual activity outside the protective family framework is in a very vulnerable position and she may be rejected by her family (Goddard, 1993). In Bangladesh, women and girls are being driven to this profession through trafficking (Khan, 1988). To date there is no legislation that recognizes commercial sex as a profession and sex workers are considered to be fallen women who do not deserve social dignity or recognition (Ara, 2005). They are subjected to exploitation and violence, and their activities beyond the law limit their access to the very health and other services which might serve their health and safety needs and the health of their clients. As a result, many negative feelings have developed among sex workers. Most have low self esteem and feel that they cannot go out freely and mix with other people on the outside because of stigma. As a result, inferiority complexes develop in their minds and ultimately they start to think that they are alone in the world. So, they want the recognition of sex work as 'work'. Their logic is that they did not come to the brothel willingly and that this work was forced on them. One of the sex workers in the Jessore Maruari Mandir brothel, Bobita told me that in this respect "*the state should give us the official status of workers.*"

With regard to self esteem, brothel girls have a variety of views (Fig 5.3 shown as symbolic). Some in a FGD at Baniashanta said that they are doing bad work and that they feel they are 'lost girls'. They consider 'good work' to be employment in a garment workshop, a beauty parlour, embroidery, or handicrafts. But one countered this: "*is there anything written down on our bodies to say that we are bad women? If we go to another place, how will people know us as bad?*" Moushumi was even more positive: "*some people want to say that sex work is a bad thing, but I don't consider it as such because you will not give me 10 taka if I do not give you pleasure. We do not steal money from anyone; we earn through labour.*"

Figure 5.3: Sex Worker's Own Judgment about their Work

Regarding the brothel, many girls consider it as a 'hell' or 'prison' but they have to stay there in order to buy food to live. Baby told me that "*I feel always sad, have many sorrows, I don't talk with others. Here the girls joke with each other but I cannot take part. Basically I don't like this environment but what could I do on the outside? I would still need to do sex work, so it would be the same*!" On the other hand, some girls consider the brothel to be a good place to work independently, without disturbance, with freedom. One girl, Kazol told me at the Jessore brothel that "*I consider this place as a peaceful place, for food, for clothes, recreation. I have a TV, a CD, everything and importantly we are safer here than outside.*" However, many girls also explained that they have no interest in working in a garment factory because, firstly, it is an under-waged and labour-intensive job; and secondly, many girls are forced into sex with their immediate boss without pay or respect.

In terms of sex workers' incomes, there are some beliefs among the girls about honest and dishonest income. Many believe that they are earning the money in a dishonest way, so their money will somehow dwindle away within a short time. On the other hand, if they could earn money in an honest way, for example doing a 'respectable' job, then the money would bring blessings or abundance to them. Many sex workers consider their work as a 'sin' and their logic is that it is forbidden in the holy book. They are confused whether Allah will forgive them for this kind of '*kharap kaz*' (bad work). One home based sex worker, Dibba told me that "*I am trying to overcome this sin as it's a dishonest income. I cannot say to anybody about my earnings. Allah has forbidden this type of work and income, so I am saying it is dishonest money.*" I found one casual sex worker, Priyanka, who believes that, due to her sin, her baby daughter has been suffering from sickness and there is no improvement, but now the money she earns is going fast. "*I always think that I am doing sinful work, I am feeding my baby with sinful money, I feel very bad with myself; she is always sick.*"

Sex-workers continue to suffer stigma and abuse particularly at the hands of those who should help, such as police officers. The constitution of the People's Republic of Bangladesh says that 'the state shall adopt effective measures to prevent prostitution and gambling' (Article 18:2). However, there is also provision for an adult woman to take up prostitution by making an affidavit in a first class magistrate's court with a notary public. This provision is proof enough that the state does not prohibit the sale of sex (see also, Hossain, R. 2005). To some extent, these women sense entrapment, as they feel 'forced' to choose a profession that is highly stigmatized and not regarded positively by society due to poverty and lack of educational background. This can result in high levels of stress.

5.1.3 Rights and empowerment

Today, some or all aspects of prostitution are illegal in all countries (O'Neill, 1997) and most societies define the prostitute as a 'criminal' and many people care little about either the violence that is committed against prostitutes or treating them as ordinary human beings (Alexander, 1996). As a marginalized group with no legal recognition and inadequate protection, the rights of commercial sex workers in Bangladesh are often violated (Ara, 2005). Every person involved in the profession has become a victim of

social exclusion and marginalization. Even death fails to end the sex workers' misery. Regardless of whether a sex worker is Hindu, Muslim or Christian, she is still denied basic funeral rites. However, due to social taboos and widespread prejudice, prostitution has not yet been identified as an economic problem of a serious nature (Khan, 1988). In Bangladesh, most of the women who are bound to sex work have little or no rights. Sex workers think that their entrance in this 'profession' itself is the result of continuous violation of human rights in the country. They are being harassed and tortured by law-enforcing agencies due to a lack of transparency legally about their profession. The social status of sex workers in Bangladesh is considered so low that in the past they were not allowed to wear shoes/sandals when leaving the brothel, nor even the typical dress (*shalwar-kameez*). Preventing sex workers from wearing sandals and *shalwar-kameez* enables society easily to identify and ostracize them.

To counter the historic stigmatization, some NGOs in Bangladesh have been implementing various programmes for sex workers (Fig 5.4). NGO officials believe that in the last 10 years much of the stigma associated with prostitution has been broken down by the increasingly positive attitude of government and the public. In addition, in some brothels, sex workers are organizing themselves into self–help groups for mutual welfare and to protect themselves from harassment. Recently, some NGOs like Care Bangladesh, have started organizing and encouraging sex workers to develop self-help groups like *Durjoy Nari Shangha* (United Brave Women), *Alokito nari unnayon sangho* (empowered women's development organization) and *Nari Mukti Shangha* (United Women's Freedom), which are working as alliances with other similar organizations. Despite such positive initiatives, most sex workers still find it difficult to access public services, such as education and healthcare. Some brothel girls told me that in the past they did not understand anything about their rights. Now their eyes have been opened and they are more united. They also feel that now they can answer back when government hospital doctors refuse to provide treatment in a timely manner, or when school teachers want to know about the father's identity for their children at school admission. They now understand that they have the right to enrol their children and that the mother's identity is enough. Rotna told me:

"I didn't come in the brothel from my mother's womb. Someone forced me to join. Actually previous girls were foolish and scared about their identity and rights, but now if anybody challenges us, we can argue because we have been trained by the NGOs, and now we understand that we have the right to go to a bank and open an account, the right to buy land and build a house, the right to go to a big function, or to go to a 'milad mahfil' (religious meeting) because Allah also created us."

Figure 5.4: Sex Worker's Self Employment Training and Works

Due to different rights based approaches and empowerment efforts by different NGOs, sex workers are now able to raise voices on different issues. Although there are still *mastaan* and police problems, many girls believe that 'the law is equal for all'. Regarding burial rights, I heard that in the past when someone died at Baniashanta brothel, they were not able to organize a religious ceremony, and there was no system for burying or '*janaza*' or prayers. Recently they have been given a piece of land by the government for a graveyard due to pressure by NGOs. Moushumi told me "*when infants died at birth in Baniashanta brothel we could not arrange any religious ceremony for the dead bodies, we had to bury them on a 'char' or barren island or float them on the river current. When we went to any 'hujur' for religious involvement, they refused, but that baby was innocent. We may guilty for bringing the baby into this world, but they never heard our requests, and always blamed us in the name of religion.*" In this connection, in Khulna I asked an Islamic cleric, Shajahan (not his real name) that in islam, there is a '*fotowa*' or Islamic law that when a girl is involved with commercial sex openly then she looses the '*iman*' or faithfulness. As a result, they are not allowed burial according to Islamic law. But he thinks that as a human being they can get burial rights.

5.2 Stigmatized Drug Addiction

Goffman (1963) suggests that stigmatization is a complex process of social interaction between stigmatized and non-stigmatized persons with certain culturally salient characteristics which leads to social consequences of reduced opportunities, discrimination and even outright rejection (see also, Hopper, 1981; Mason et al, 2001). "When we come across terms such as 'drugs' or 'addiction', we all bring to it a limited 'common-sense' view of these concepts that are shaped by our culture, the media, our own prejudice and other factors" (McDermott, 1992; p.195). The social meaning of drug use differs across time and geographical space. The relationship between drug abuse and social deprivation holds in developed as well as developing countries (Currie, 1993). Drug users' lifestyles may additionally be harmful because of the associations that are bound to be made to obtain an illegal drug such as heroin (Robertson, 1987). It is clear that the drug user is living in a violent or potentially violent world. The life is one of risk and confrontation with peers, criminals, police and society and therefore violent acts are commonplace. Most cultures have adopted a largely punitive approach to heroin use. Illicit drug use is highly stigmatized and virtually all habitual drug users in Bangladesh are marginalized and discriminated against (Knight, 2006b). In Bangladesh, the term 'drug user' is used to refer to those who ingest illegal psychoactive substances. But it is also a stigmatized term for those who are unable to sustain their habit financially, fulfil commitments to others and to society at large, and retain control over life circumstances. However, the stigma of drug use is compounded for users who inject drugs and have risky behaviours. In describing drug users' stigmatized worlds, my research stresses their living place, their inadequate home life, their continued use of drugs as part of ordinary social relationships and their generally hopeless and futile future. In the following section, addicts' stigmatized lives, their identity and related prejudice that surrounds them will be described through a number of case studies.

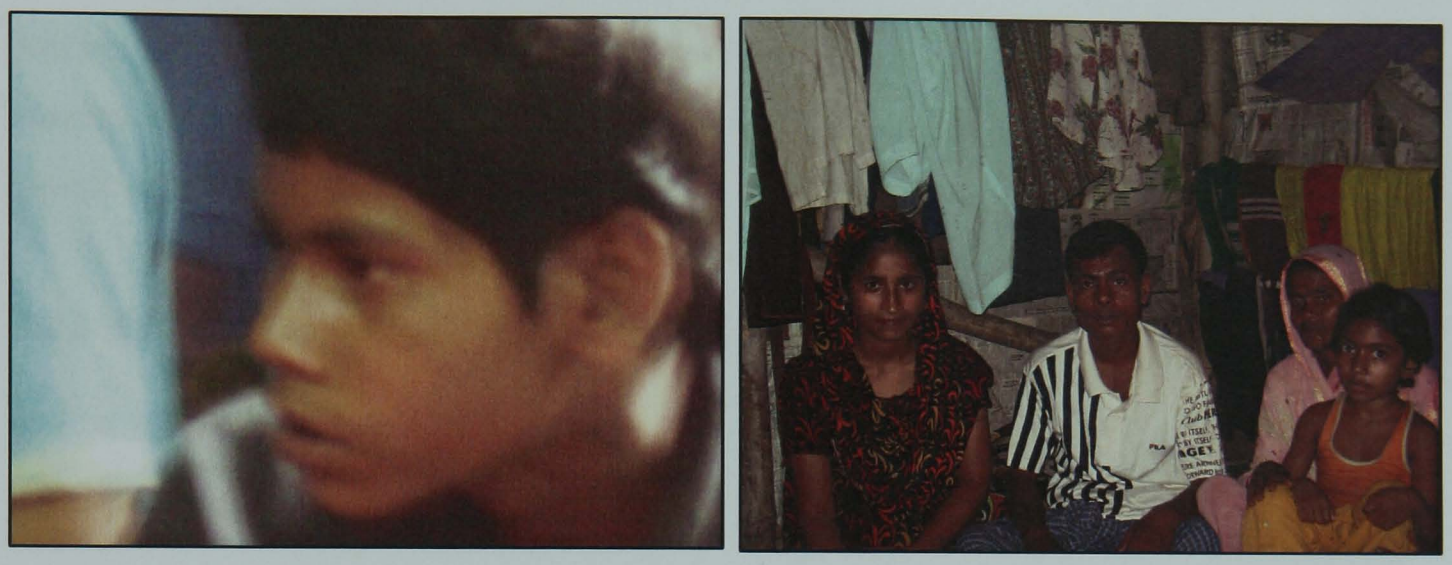
5.2.1 Addicts' blamed lives

The social and economic marginalisation of drug user populations which combines to produce a shared sense of social suffering may in turn reinforce close social bonds within networks which 'act as the conveyor belts of drug injection technical knowledge and encouragement' (Singer, 2001; p.205; see also, Bourgois, 1998). The general poor health, and social and material conditions of many drug users complicate the relationship between substance use and ill-health. Consequences of substance abuse occur throughout the life cycle and include compromised health, family malfunctioning, and poor child welfare, as well as increased crime and incarceration rates (Lex, 2000). The negative effects of the substance may involve impairment of physiological, psychological, social or occupational functioning (Lewis et al, 2002). A stigmatised person's social values may decrease to levels below what one would expect taking into account the risks associated with it. In Bangladesh, there are views about good and bad drugs. People no longer mind about cannabis, although it was considered a 'bad addiction' a few years ago. Recently young people have started taking a stimulating syrup of Indian origin, *phensidyl*, containing codeine phosphate and ephedrine, which was originally used as a medicine for coughs and colds but due its misuse it was banned a few years ago. In fact, nearly 80 percent of the drugs used by IDUs are easily available at chemist shops in Bangladesh and in the South Asian region at large.

Many drug users have lost touch with their own families and with mainstream society due to their involvement in different crimes including burglary and blackmail (Fig 5.5 shown as symbolic). When their *bera* or withdrawal symptoms appear, they become desperate and some addicts steal goods from their own house or make demands or threats to their parents and other family members to get drug money and for this reason many are abandoned by their relations. When they start using heroin they become a disruptive element in the family and are introduced to the neighbours as dishonoured. The addiction locks them into a cycle of transgression which makes it difficult to get proper guidance and to break out of a lifestyle which makes them vulnerable. I talked with wives of recovered drug addicts who suffered much from their husbands during their addiction. One of them, Sabina, said that:

"My husband never tried to understand me. He always looked for my savings and he even sold our son's wrist watch for heroin money. When his addiction took hold he had no sense of what is right and wrong. Many times he borrowed money in my name and I had to pay these debts. Sometimes the lenders would beat him for their money and I had to rescue him. He even sold our mosquito net. He hit me when I tried to stop him taking heroin. He never thought of spending money on us, and only thought of heroin."

Figure 5.5: Drug Users' Stigmatized Life



Drug addicts are stigmatised their whole lives. Sometimes they spend time in restaurants or in other places to experience the drug's effects as they have no shelter or a good place to take a proper sleep. They are asked to leave when they are recognized and they are not able to protest. They always face blame and many drug addicts want to commit suicide. In Bangladeshi society addicts have to face insults and physical abuse from people in general and they lack close friends because nobody trusts them. If anything negative happens in an area, people always blame addicts. Addicts are victims of discrimination. I found one in Jessore railway station, named Shapon. He tearfully told me about his addicted life:

"I don't like this life, because nobody likes us. People insult us wherever we go. For example, if any dog comes to you, you will feed to the dog, but if I come along, you will not give me any food, and you may even beat me. So a dog is better off than a heroin addict. You see, my clothes are dirty, I cannot sleep and take food properly, but sometimes I want to practise 'namaz' (prayers) for purifying myself, but if I go to the mosque, people will consider me a thief due to my identity as heroin addict."

Drug addicts lose respect in society. The stigma may affect other members of the family. For instance, an addicted parent may find that no family will come forward for his of her daughter to marry. I found one female addict in Jessore, Jomila who has two sons. But when she became addicted, local people forced her two sons to leave their

mother. The concern was that they would also become addicts. Drugs make the addict hopeless in the eyes of society and their independent voice disappears. The hatred of heroin addicts is so universal that even small children blame them. During my interviewing of drug users at Jessore rail station, local people warned me that they would steal from me. When I was talking with one addict, a woman came close to us and thought that I was from a government department and would punish the heroin smokers. She shouted that they should be jailed or killed because they are a liability to society and the country. They steal state property like steel plates from the railway line to sell to raise the money for heroin.

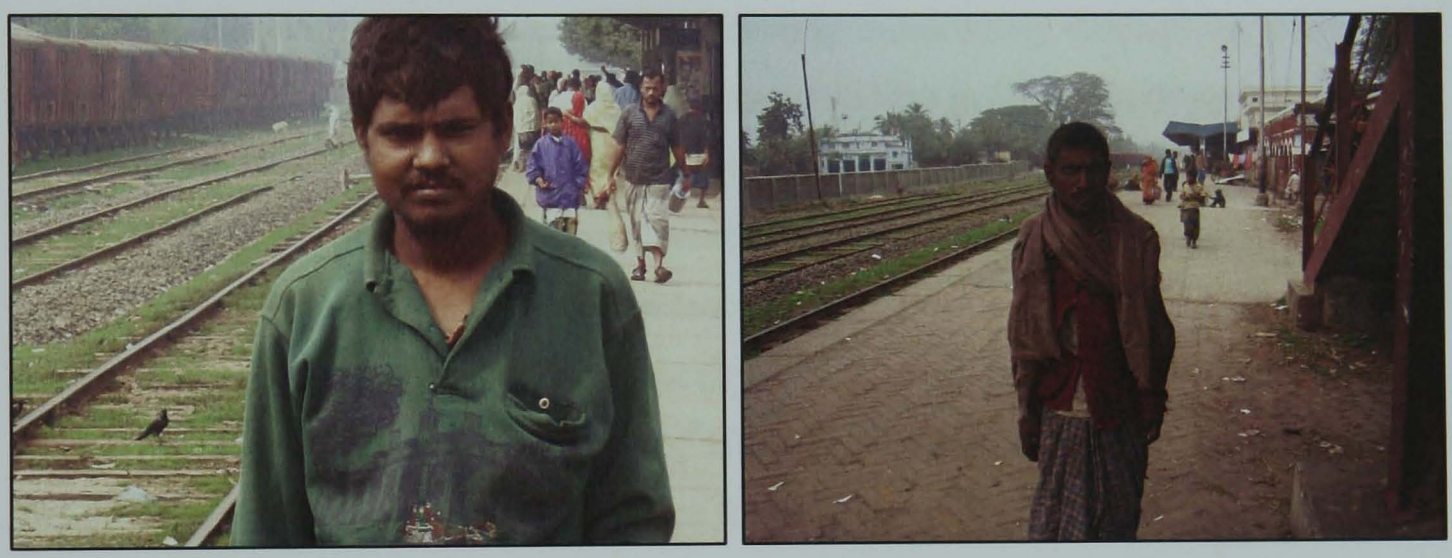
5.2.2 Addicts' negative identity and impact

Life as a drug addict is a breeding ground for other assaults such as violence, poverty, homelessness, poor familial relations or abandonment (Zierler, 1997). Problem drug use can seriously affect families, leaving those involved floundering in a sea of anger, frustration, fear and isolation (Barnard, 2007). In terms of the link between specific illicit substances and criminality, the association with the longest historical pedigree is the link between opiates and crime (Carnwath and Smith, 2002). The development of drug problems in a close family member was often an insidious process marked by small, but significant, changes in manner, behaviour and appearance (Usher et al, 2005). Once the family became aware that there was a problem with drugs, the most likely reaction was utter panic, arising from a lack of knowledge and experience.

Drug addicts have such a negative identity that most have no access to, or acceptance by, their parents and other family members (Fig 5.6 shown as symbolic). I found one female addict at Jessore, Rabeya, who has been facing denial by her brothers. As she takes drugs, she cannot afford to wear good clothes, and roams around the town collecting rubbish to manage the drug money, so her brothers do not recognize her as their sister. She is not allowed take even a glass of water from their house. In most cases, even close family members do not trust them. In one participant observation in a NGO-run drug treatment centre in Jessore, I found one drug patient, Asadul who told me a story of mistrust by his own younger brother and friends:

"My younger brother asked me to buy some academic books for him. I went to one of my friends and requested his help to purchase these books. But my friend said that you are involved in heroin addiction, so I don't believe you. Bring your younger brother with you. When I mentioned this to my younger brother, he felt embarrassed and puzzled, because he was thinking 'if I go with a heroin addict, what will people think of me?' I felt ashamed and thought how bad a man I am. My brother asked me to go ahead and that he would follow rather than going along with me. Then my friend asked me in front of my brother how many books he needed and he gave a letter to one of his book shop friends so that he could place the order. I went to the book store with the letter and they asked many questions when they saw my face, an addicted face! When they were about to hand over the book someone asked, 'will you now take the book and sell it in another bookshop?' I asked why they said this and one of them told me that I look alike an addict. Then I thought what a strange situation. Nobody believes me, even my younger brother. This is just one of the many insults that I have faced as an addict."

Figure 5.6: Addicts' Negative Identity in the Society



Family discovery of a member's addiction gives rise to a family crisis. Family and relatives try to argue why s/he should leave addiction or make threats but typically no positive results come out. Separation or divorce may take place and then it is ordinarily not a long step toward allowing neighbours to know. Family members, relatives and neighbours gradually stop trusting the addicted person with money due to his/her image and social role. Addicts are progressively left out of important decisions regarding the family or village; their opinions carry less and less weight. They receive less emotional support from others, despite their increased need for it as their finances and health deteriorate. Although loss of identity and self-esteem is not frequently given as a reason for seeking treatment, it is often an important conscious element in the addict's maintaining abstinence after treatment.

5.2.3 Prejudice towards addicts

Heroin has been referred to as the 'devil drug', synonymous with addiction and crime (Miller, 1994). The major consequence of this criminalization/stigmatization is causing addicts to conceal the fact that they use drugs (McDermott, 1992). The idea that heroin use leads to crime is put forward today almost as a matter of common sense. The popular argument is that people turn to property crime (and may employ violence) in order to support their heroin habits (Dorn and South, 1987). In qualitative work on drug users, Ware et al (2005) found that stigmatization and stereotyping may contribute to unequal treatment for drug users and other populations who are living with HIV. Therefore, we have a large number of people, engaging in a very dangerous form of behaviour, and with a high potential for inflicting unnecessary damage on themselves and others. Knight (2006b) mentioned that many addicts in Bangladesh are targeted for extortion and beatings by the police or street gangs. Most of my interviewees raised one common issue: state discrimination towards them. In Bangladesh, many of the local police still see drug users as engaged in 'social evils'. Basically the police force them to leave public areas and abuse them physically, which often drives drug users away from life-saving care, and fuels the spread of HIV. The addicts think that the government should leave them alone and instead target the drug smugglers and dealers. They believe that if the state can control the peddlers, then the number of '*khor*' (fully addicted) will decrease. Kabir said that "*you find many drug users with broken fingers or legs due to police beatings, but those who are the sellers, making money and destroying us, they are out of reach.*" During a FGD with addicts at Jessore I was given another example of the social status of addicts:

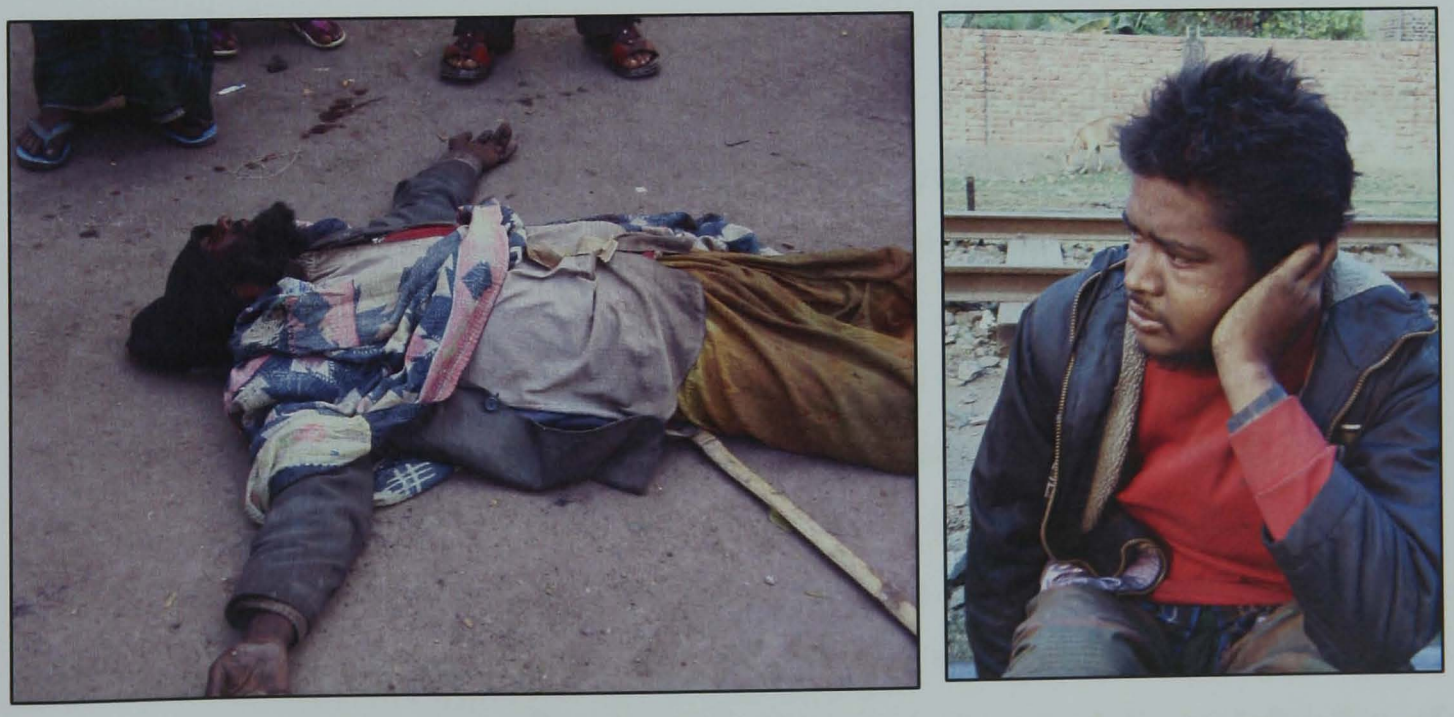
> "*If any normal person falls or dies on the street, people will come and collect the sick person or dead body but in the case of addict, particularly a heroin 'khor', nobody will come forward to give him service even if he dies. Basically people hate us, but we can't leave this addiction.*"

Some addicts said if they want to get a job nobody will show any interest in employing them because of their negative reputation. Biswajit said in this regard that "*many shop owners do not want to take me as staff due to my previous habit and mixing with bad friends. In my area many people know me, so I am trying to get a job elsewhere.*" When drug users become *khor*, they stop contributing to the family because they need to spend

their whole income on drugs. As a result, they lose their status. However, many doctors view treating addicts as unattractive. Treating addicts is sometimes seen as a low-status occupation within psychiatry. Even physicians then practise a form of discrimination against addicts. Basically when an addict goes to a government hospital after a beating, the doctors insist on a guardian being present before they will start treatment. The doctors' fear is that addicts are likely to have a heart problem, so they need to be cautious. But nobody wants to be the guardian of an addict.

The adverse consequences of the relationship between drug users and society are various. As society shows discrimination, so the number of marginalized addicts will increase (Fig 5.7). Addicts' ties to the social fabric decrease and are replaced by a sense of alienation and a desperation to continue to fund their drug habit. As a result, their treatment and health education options are further threatened. As a whole, society should acknowledge drug use as a social problem. The criminalization of drug users makes it very difficult to eradicate the problem from society.

Figure 5.7: Discrimination towards Drug Users and their Sorrows



5.3 Discrimination towards HIV Positives

Discrimination is the behavioural expression of prejudice (Hogg and Vaughan, 2002). A person's experience of discrimination is most acutely felt at the individual level in their day-to-day interactions with others (Bennett, A. 2005). HIV/AIDS is an illness associated with perceptions of stigmatized sexual acts and illicit drug use. Sontag

(1989) has pointed out that the stigma of AIDS elicits fear and avoidance rather than sympathy. In many societies AIDS is seen as a disease of shame and a number of HIV/AIDS infected people have faced discrimination in terms of medical care, and have been rejected by family and friends or forced to leave their occupation (Muyinda et al, 1997). HIV infection and AIDS draw a particularly negative societal response, which can result in individual suffering, and group marginalization (Clarke, 2001). As yet there is no cure for AIDS, and this uncertainty remains a strong influence on the way in which HIV and AIDS impact psychologically on those people who are infected and affected (Carlisle, 2001). The lack of a cure also affects the way in which the virus is viewed by society (ibid). Despite the biological vulnerabilities, the AIDS epidemic also exposes hidden social vulnerabilities in the human condition, such as stigma and discrimination. Stigmatization of people suffering physical or mental illness has commonly occurred throughout history, for diseases such as leprosy and tuberculosis when sufferers have been subjected to discrimination or loss of human rights (Kiemle, 1994). Such discrimination has always existed and is often associated with the fear of death. Discrimination is one such reaction which faces people affected by HIV, and stigmatizing societal responses are the product of complex beliefs, many of which are rooted in views around sexuality and sexually shared infections (Bennett, A. 2005). Social prejudice may play an analogous role in the development of psychological symptoms in the AIDS patient. Prejudice distorts judgment with negativism and sensitivity; victims of discrimination are seen as fundamentally different from other persons, less deserving of basic human rights, such as the treatment they receive. Although fears of social abandonment are common in those facing a life-threatening illness, patients are immediately confronted with this reality. In Bangladesh, like many other developing countries in the world, social stigma in respect of HIV and AIDS is extreme and extensive, particularly for HIV positives. Any person detected as HIV positive, if their confidentiality is not kept, will face widespread and extreme social stigma. Patients soon find that neighbours consider it to be a 'bad disease'. For fear of being discriminated against at every step and also being subjected to inhuman harassment and suffering, the main concern of that person becomes to keep his disease secret as long as possible, otherwise that person may be forced to leave the village. Sometimes a patient's name and address is exposed in the media and can make headlines in the newspapers. As a result, patients become isolated from their home and family and marginalised in society. Their children cannot go to school or play with

others. Under the circumstances, the person is not only denied treatment facilities to increase longevity and maintain normal health but is also forced to pose a potential health hazard for others around him, with the potential for infecting unsuspecting healthy people.

5.3.1 HIV-positives' identity and societal neglect

The AIDS epidemic exposes hidden vulnerabilities in the human condition, not only the individual's physical health but also a series of psychological pressures at several levels (Anderson and Bury, 1988). For most HIV-positive people, these pressures lead to what has been called 'biographical disruption' (Bury, 1982). That is to say, their sense of themselves is radically changed by the reality of their illness and also by the way they believe others would view them. People with HIV/AIDS face many problems as AIDS is a severely stigmatizing illness (Richardson, 1989; Bamford et al, 1988). Goffman writes that a person with a stigma is 'reduced in our minds from a whole and usual person to a tainted, discounted one' (Goffman, 1963, p.3) and that there is a distancing from the stigmatized person from the non-stigmatized 'normal' people; along these lines, it is important to make sure that sex-workers are not repeatedly shunned by society. The stigma associated with HIV and AIDS can have the effect of polarizing individuals within families into those who accept the positive person and those who reject them (Powell-Cope and Brown, 1992; Featherstone, 1992). Most alarming has been the frequent discrimination against families with an HIV-infected member. Schools have revisited the admission of children with AIDS and some communities have ostracized and, on occasion, expelled such families in an effort to ensure their isolation (Bennett, A. 2005). Stigma and social exclusion related to HIV and AIDS have numerous effects, most notably in relation to the effect of concealment on the potential for emotional support throughout the disease trajectory (Carlisle, 2001). Almost all HIV-positive men in Bangladesh try to hide their status from friends and community (Foreman, 1999). Both educated urban men and rural men are often secretive, as they are afraid of discrimination and of 'losing face' and status if they admit that they have the virus.

In south Asian cultures, where unorthodox sex is considered a sin, stigmatization of the patient occurs due to the mode of transmission, notably from family and close relatives

as a punishment for the so-called misconduct. During my field work I heard a lot about what could be called the 'silent torture' of HIV positives, particularly in rural areas. Most cases are due to the fear, confusion and hesitation of the villagers, who have many misconceptions about HIV and they have no hesitation in making trouble for the HIV-infected person. I met with an HIV positive in Khulna named Shanti who has been facing this kind of social neglect by her neighbours and other villagers for a long time:

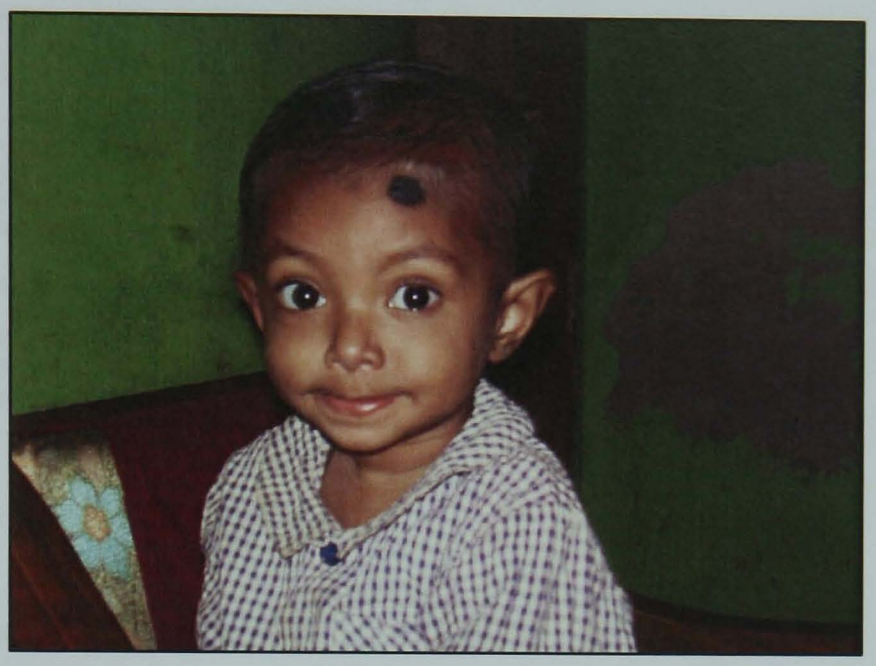
"*As soon as local people somehow got to know about my problem, they put pressure on my brother and blamed me for the disease. They asked him to leave the village, and threatened to evict us all. Our village is actually very conservative. I couldn't go out anywhere, and even my daughter was prevented from playing with her friends. When my brother denied the matter, some people became angry and our house was declared off limits. Nobody visits us and even poor people do not want to take food with us. If we offer anything to the local beggars they sometimes refuse. Our neighbouring families don't mix with us because they believe that if I talk to them or visit their house, they will catch the problem. They don't permit me to go to the pond and if I go to tube-well they bar me from touching it. They have the idea that if I touch the water, all of it will be contaminated with HIV. They use vulgar language against me. My mother has to bring water from the tube-well or pond for my bath, which I take in our house yard*" (she was crying).

The distress associated with having a fatal, stigmatized illness can destroy the individual's sense of self or identity (Fig 5.8 shown as symbolic). People with AIDS can face considerable blame for their illness and are often deemed a group unworthy of support. These are clearly negative events that would be expected to impact on one's life to various degrees. The psychological impact of the disease varies from person to person. Although Shanti's brother could probably have stayed in the village, he would have faced many problems, social and economic, on a daily basis. Shanti herself was deeply remorseful about her stigmatized identity and faced many distressing situations. Lack of scientific knowledge about how HIV is transmitted can lead for instance the idea that the virus can be contracted from burial grounds. In the north-eastern Indian state of Mizoram corpses are buried in polythene bags for this reason.

Another reason why someone with AIDS may not mix socially is because they feel too upset or embarrassed about their physical appearance. Apart from weight loss, a person with AIDS may have disfiguring lesions on their face and other parts of the body, which are socially stigmatizing. Women are particularly accused and abused, and occasionally

expelled from their marital homes. They are dispossessed of their inheritance and property rights by their families because of their infection.

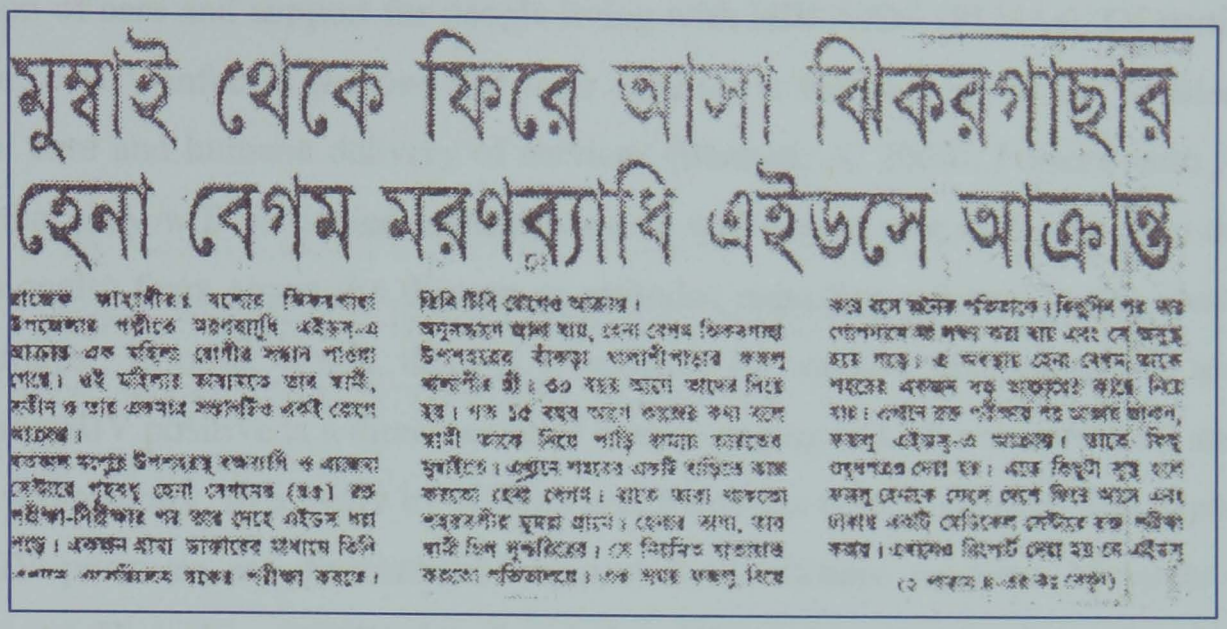
Figure 5.8: An HIV Positive Baby



The stigmatization and exclusion of HIV/AIDS patients from the community prevents them from seeking testing, counselling and treatment. There are a good number of at-risk people who do not want even to be tested for fear of social isolation. Many sufferers say disclosure of their status mainly through the media has caused their isolation (Fig 5.9). Media coverage of AIDS is sometimes highly sensational, making moral judgments between the 'innocent' and 'guilty'. Some patients criticize the role of the 'irresponsible' local media that disclosed their names or even NGOs whose activities may inadvertently identify positives to their neighbours. I had the opportunity to talk with some family members of an HIV positive, Badol, brother of Shanti, in Khulna. His sister was identified in just such an insensitive way:

"*The NGO people gathered at our house and took photographs and a video of my sister, and this affected us greatly. The local villagers became suspicious and asked us why these NGO people were visiting our house so frequently and where they came from. Some curious people went to the NGO office and saw their signboard and realized that my sister must be infected with HIV.*"

Figure 5.9: HIV Positive's Identity Disclose by Media



মুম্বাই থেকে ফিরে আসা ঝিকরগাছার
হেনা বেগম মরণব্যাধি এইডসে আক্রান্ত

Source: Sherso Barta (2004) Khulna

Due to frequent campaigns about HIV transmission and NGO influence, some people are now more favourable in their attitude but many HIV positives reported to me that villagers still have fears and confusion. As an example, Shanti, who previously had not been allowed to participate in religious devotions, recently found that this changed. Her HIV-positive daughter now plays with other children, but she still observes that people are cautious when mixing with her and her family members. In one sense, villagers have developed some sympathy for her but they still hesitate to treat her normally. Like Shanti, many HIV positives remain afraid that their neighbours might find out about their HIV status because they would face serious problems, for instance in arranging their relatives' marriages. There have been well-funded campaigns on HIV awareness but the response for testing is still very poor. Social stigma and economic constraints remain as major barriers to the treatment of AIDS patients. It seems essential from a humanitarian, and also from a social, point of view that the infected person should be diagnosed and given guidance and medication. In addition, a de-stigmatization campaign about HIV positives would help.

5.3.2 Doctors' discrimination

HIV/AIDS may be illustrative of a more general phenomenon in which individual and population vulnerability to disease, disability and premature death is linked to the status of respect for human rights and dignity (Mann et al, 1999). Stigma and discrimination

associated with HIV/AIDS hinder the prevention of further infections, as well as the provision of care and support for people living with HIV/AIDS (PLHAs). Of particular concern to HIV-infected persons and their families is the issue of access to adequate medical care and humane delivery of services (Bennett, A. 2005). Persons with AIDS worry that they will be denied medical care or will not receive sufficient care due to professionals' fears about the disease or attitudes regarding persons in the identified 'risk groups'. In other words, there is a tendency for medical practitioners to assume that being HIV positive is a direct result of their engaging in high risk activities, such as sexual promiscuity. In a study by Alonzo and Reynolds (1995) concern was expressed that HIV positives are discriminated against by healthcare workers. Muyinda et al (1997) and Upayokin (1995) also found that HIV/AIDS-related stigma has had an adverse effect on the treatment seeking behaviours of HIV positives and the coping strategies of their families. Discrimination is an overt act of unequal treatment or evaluation based on group or identity status, and may also include actions that result in unequal consequences due to identity status (Baker, 2001). Discrimination based solely on disease status has not yet received sufficient attention as a human rights violation (Annas, 1999). In developing countries, HIV/AIDS is like a death sentence for those who do not receive treatment. The national HIV/AIDS policy in Bangladesh states that AIDS patients will be treated within the existing health care system (Panos, 2006). No health care institution or health care worker has the right to refuse to provide treatment to AIDS patients or to those with HIV infection. But almost none of the hospitals will agree to admit them if their status is known in advance. In the following, I will describe an example of attitude of doctors and nurses towards an HIV positive and her non-positive family member.

Diba, an HIV positive I met in Khulna, described a difficult situation when she went to the Divisional Medical College Hospital in Khulna along with her ill brother:

"*Once my elder brother got sick and I took him to the Medical College Hospital for treatment. Some of the doctors knew me to be positive, so rumours spread that my brother was also suffering from HIV. I felt very sad and insulted when I saw the Specialists, who regarded me as an object of mockery. They visited the other patients but not to my brother. When the doctors claimed my brother was HIV positive, I had his blood tested and he was found to be negative. Despite this, still no doctor saw him and I heard the nurses also whispering about the issue. I asked them why they thought he was positive. Was it because of his fever? Were there no other symptoms of HIV? I tried to*

challenge their prejudice but failed, and then I took my brother to a private clinic. Next day there was news in a local newspaper that an HIV positive had been found and that he had left the hospital due to fear. Even when I was in the government infectious disease centre with my husband in Dhaka, the nurses didn't give me the medicine themselves. They wrapped the medicine in paper and left it outside the room. "

This is a common reality that most HIV positives face outright discrimination by medical service providers, including doctors, both in government hospitals and private clinics in Bangladesh. Many NGO programme officers in the field reported how nurses have misconceptions about the cause and spread of HIV. Some believe that HIV can spread on the breath, or through the saliva when spitting. This is due to poor training. One hospital authority even refused to provide medical support for an HIV-positive woman in delivering her child (see Aziz, 2004). Finally, she was taken to a rural dispensary where no proper medical support was available at the time of delivery.

Although the number of people living with HIV/AIDS is increasing, the only treatment option is the Infectious Diseases Hospital (IDH) in Dhaka and a few private specialized hospitals. The state-run IDH has provided treatment guidelines for HIV/AIDS patients since 1989 (Fig 5.10). But they do not get proper treatment as the IDH is yet to provide antiretroviral (ARV) therapy for these patients since it is very expensive (Panos, 2006) and the government-owned Essential Drugs Company does not produce ARV (Zannat, 2008). Although antiretroviral drugs (ARVs) have been registered for manufacture in Bangladesh, they are not available through the public health care system (Panos, 2006). According to Zannat, the IDH does not have any special funds for HIV/AIDS patients, and it is not possible for the hospital with its limited funds to spend the huge amount of money needed for them. The IDH can provide only around 50 percent of drugs required for AIDS. It just provides treatment for opportunistic infections that occur due to the collapse of the patients' immune systems. Ideally they also need psychological and nutritional support.

The IDH has no modern facilities and even here there is staff prejudice. There are stories of nurses and other medical service providers refusing to change bedpans, feed, wash or even talk to someone in their care who has AIDS. There was a newspaper report (Aziz, 2004) that a nurse refused to attach an oxygen mask to a dying patient and instead sent a cleaner. Nurses also refuse to put up a saline drip because this requires

inserting a needle into a vein. Outside contractors are brought in for such duties. In short, patients are not receiving proper treatment. Sometimes, in other hospitals, medical service providers force the patient silently to leave the hospital bed when they come to know about their disease (personal communication with many NGO officials in field). In an interview, one HIV expert, KP/Expert-1 told that during a visit to a hospital, he found the doctors and nurses on duty were not giving intravenous saline to an HIV positive patient, though there was express advice for that. When he asked why, the doctors indifferently replied, 'what is the benefit in giving him saline? He will die anyway' (Aziz, 2004). He also said doctors at Dhaka Medical College Hospital morgue even refused to carry out autopsies on dead bodies of HIV positive people. These are the expressions of serious violations of human rights towards HIV positives (ibid). Most unfortunately, in many cases, HIV positives' relatives also face discrimination because there are doctors who know the family's circumstances and who then refuse treatment to them all (personal communication with many NGO officials in field) like Diva and her brother. Known HIV positives are turned away from government hospitals and they are forced to fall back on private clinics, but even here they cannot stay long. Due to a lack of acceptance of this disease among the doctors and nurses, AIDS patients present with false ailments. When the clinic doctors come to know of the patient's status from their previous prescription, it is common for this information to spread to the whole clinic and, as a result, the patient has to change clinic because of security concerns. Confidentiality of a person's HIV antibody status is particularly important because of the potential personal, social and economic harm that may result from disclosure of this information.

Figure 5.10: Infectious Disease Hospital in Dhaka

Source: The Daily Star, December 1, 2006

In Bangladesh, HIV positives also fear journalists because local papers have no compunction about publishing their medical details, causing distress and trouble for their friends and family. Although Diba eventually found treatment for her brother, she considered herself to have been discriminated against and victimized. She also felt insulted and sad about the negligence of the doctors in the medical college hospital. One retired justice of South Africa, Edwin Cameron, questioned in a UN forum "when any identified HIV positive comes to know that he/she will not get treatment, do we have the right to ostracize him/her after that?" (see also Khan, 2007; Moral, 2007).

People living with HIV and AIDS are stigmatised, isolated and deprived of care, despite the fact that the UN Commission on Human Rights has confirmed that discrimination against people living with HIV/AIDS, or those thought to be infected, is a clear violation of their human rights. This declaration has been signed and ratified by all member countries including Bangladesh. There is some hope because, although in the early years of the epidemic people affected by HIV were discriminated against by neighbours, friends and sometimes family members, over the years attitudes have been changing gradually.

5.4 Identity, Stigma and HIV Danger

The social situations of many marginalized people like sex workers, drug users and HIV positives, have exposed them to violence and stigma due to their negative identities in society. This has crushed their self-esteem. Violence is a significant threat to marginalized people's physical and psychological wellbeing, especially for poor, marginalized people who are not well-linked to health and social services. Stigma has resulted in widespread discrimination against those marginalized people. For example, Bangladeshi society discriminates against sex workers as immoral women. Although violence is not a major problem at different brothels in Bangladesh, sex workers are heavily stigmatized by their family, relatives and neighbouring community. Second, uncontrolled use of narcotic drugs is apt to evoke social condemnation rather than sympathy, and more likely to result in legal punishment than medical care. All drug users are stigmatized but heroin addicts are often regarded with particular abhorrence. Third, people living with HIV and AIDS have to face cruelty and social boycotts

because of superstitions, myths and misconceptions about HIV infection. Sex workers, drug users and HIV positives often refrain from seeking medical treatment because of the risk that they will be identified as sex workers, or drug users or HIV positives within their community and ostracised. In my fieldwork I found that stigma blocks the way for marginalised people to access appropriate medical health care and leads to discrimination by families or communities. Many of them are denied property and inheritance rights. Because of the increasing spread of HIV/AIDS in vulnerable communities, identity and stigma are interconnected, which feeds prejudices and fuels victimization.

A rights-based, participatory approach, comparatively new in the field of public health, is required not just for tackling the HIV epidemic but for promoting health and better quality of life among CSWs, DUs, and HIV positives because their life and occupation is deeply entrenched in gender discrimination, exploitation and marginalization. Returning to the central thesis of this chapter, there is the tendency to regard HIV/AIDS as a problem to be dealt with at the biomedical/behavioural level or as an individual human rights issue rather than seeing it as a broad social and developmental issue. In the next chapter, risk behaviours, consciousness and risk coping issues of the marginalized and vulnerable people will be discussed.

Chapter Six

HIV Risk Behaviour, Consciousness and 'Risk Coping'

Chapter Six

HIV Risk Behaviour, Consciousness and 'Risk Coping'

Public health 'problems' involve not only concern for the exposure of populations to biomedical risks, but also concern for managing social risks such as fear, apathy and misinformation (Lawrence et al, 2008). Contemporary constructions of HIV risk in epidemiological research associate unprotected sex and needle sharing as 'risk behaviour' among the 'most at risk' groups (Rhodes, 1995). Without having a gateway to health knowledge and self-protection, sex workers and drug users are very much susceptible to health risks, particularly HIV infection. Bangladesh is currently a low HIV prevalence country with its own at-risk populations (Jenkins and Rahman, 2002), but the threat of an HIV epidemic is looming over the country, as STIs and other indications of risky behaviour have been found to be high (Gibney et al, 1999b). Among the factors which make Bangladesh at risk of the spread of HIV, are an emerging intravenous drug use problem with inappropriate injection and sterilization practices and a low awareness of their health risks. In order to control the spread of HIV infection, primary prevention, such as through awareness and changing behaviours, is the highest priority in HIV control programmes around the world. But awareness about HIV/AIDS among the general population of Bangladesh is poor (Gibney et al, 1999a; Islam et al, 2002). Like many developing countries, the use of unsterile therapeutic injections in formal and non-formal health-care settings (Gibney et al, 1999b), and the prevalence of untreated or ineffectively treated STDs, which may act as co-factors for HIV transmission, are the potential biomedical risk factors for HIV. Following Rhodes (1995), this qualitative research points to the importance of researching how the everyday routines or behaviour influence how risk, and HIV risk, is perceived. In this chapter, I will investigate the risk behaviours of vulnerable people and their level of knowledge about health risks. In addition, different risk-minimizing techniques adopted by these vulnerable people will also be addressed.

6.1 Risk Behaviours of Vulnerable People

The idea of risk has recently emerged as an important concept in the field of health and illness (Nettleton, 1995), for instance to identify lifestyle factors or to know the consequences of people's reactions to, and tolerance of, health dangers (Pollak et al, 1992). This might include indicators that can be measured and related to the risk of criminal victimization (Walklate, 2007). Here, individual perceptions of risk susceptibility are influenced by everyday understandings of 'risk acceptability' (Rhodes and Quirk, 1996). Perceptions of risk acceptability and priority tend to be a function of the norms and routines of lifestyle rather than of individual decision-making alone (Douglas, 1986). Risk perceptions are socially constructed, and individual behaviours are driven by perceptions or beliefs about risks (Frewer, 1999). The concept of 'risk groups' in HIV discourses leads to the idea that individuals within these groups are inherently more at risk from AIDS and are more likely to infect the general population and so should be treated differently. Consequently, boundaries between those 'at risk' and the 'general population' are created (Nettleton, 1995).

In Bangladesh, the level of commercial sex is higher than elsewhere in Asia and condom use during commercial sex is still low (NASP, 2003). Apart from sexual activity, drug use is a complex problem. Situated very close to the golden triangle and having common borders with India and Myanmar, illicit drugs are easily obtained (Mahbubur Rahman et al, 2000) and are a prime cause of the growing numbers of drug users in Bangladesh. As a significant part of vulnerable community, truckers' risk of acquiring sexually transmitted infections is increased by having sexual relations with CSWs (Gibney et al, 2002), as shown in the literature on Bangladeshi sex workers' STDs (Choudhury et al, 1989; Azim et al, 2000). The following sections consider issues of vulnerable people's risk behaviours individually.

6.1.1 Health risk behaviour of sex workers

Sex workers were incorporated into the western AIDS discourse initially as a 'risk group' category (Murray and Robinson, 1996). Generally, women seem to be susceptible to the HIV virus as they are vulnerable in terms of early marriage, forced

sex and unhygienic conditions. Research indicates that both ulcerative STDs (syphilis, herpes, chancroid) and non-ulcerative inflammatory infections (gonorrhoea, chlamydia, trichmoniasis, bacterial vaginosis) can be co-factors for HIV infection (Laga et al, 1991; Wasserheit, 1992; Cohen et al, 1995; Khaw et al, 2000). Female sex workers play an important role in heterosexual transmission of HIV (Gangopadhyay et al, 2005) because they are considered both a core group for the acquisition and transmission of STIs and HIV, and as a bridging group to the general population. There is a concern that HIV or STD infections will increase among sex workers and their clients who will then form a 'bridge' to clients' wives and girlfriends in the general population. As prostitutes are prone to sexually transmitted diseases, evidence from several studies in Bangladesh show higher rates of STIs in different sub-groups of commercial sex workers. Thus among brothel based sex workers Sarkar et al (1998) and Nessa et al (2005) found a high prevalence of STDs such as syphilis, chlamydia and/or gonorrhoea, which indicate that if HIV is introduced, it will rapidly increase among brothel girls first and then among the general population. Nessa and her colleagues (2004) found that the prevalence of STIs among hotel girls in Dhaka was high. They found that hotel-based sex workers have a higher client turnover than their peers on the streets and in brothels. In a study of street based sex workers in Dhaka, Motiur Rahman et al (2000) found that the prevalence of STIs among street girls was also high. Azim et al (2000) show that infection rate of STDs, particularly syphilis, among floating sex workers is higher than brothel-based sex workers.

In terms of condom use, many girls tried to skirt around the issue when I asked. From my experience I can say that none of them told me willingly about sex without a condom. When I asked a primary question for condom use, they would just say 'no condom, no sex' but deeper enquiry revealed that sex without a condom was possible for 'very close friends'. After spending more time with me, some girls found me trustworthy, and confessed that they need to do sex without a '*packet*' (condom) because of the money. Particularly when I asked some questions about contraceptives and pregnancy, I usually got some hints about their sexual habits and preferences. During my field work, I found substantial differences in condom use between the different types of sex workers. Many are willing to work without condoms for extra cash and these girls also have unprotected sex with their lovers or husbands (Fig 6.1). Although many of them understand the risk, they cannot acknowledge it to their friends

or husbands for reasons of stigma. Many non-brothel sex workers have 'good friends' who do not like to use a condom either and, if asked, would be suspicious about her character. One told me that "*I always carry a condom with me in my bag. But I don't offer it to my good friend because he might wonder why I am carrying condom and perhaps think that I am having sex with others. Then I will have a problem*" (laughs).

Figure 6.1: Keeping Condom in a Brothel House and Using Dustbin

Among street girls, condom use depends on whether customers are known or unknown. One street girl, Subarna said "*I know many people who have been coming to me for 7-8 years. As I know them I can do 'work' without condom, but with those I don't know, I insist on a condom.*" I found some older street girls who usually do not ask for condom use as a deliberate strategy because customers will otherwise go to younger girls. However, I observed that there are some customers who are considered as regulars in the brothel who want to stay for a long time with their sex partners. Most brothel girls do not insist on condom use by their lover or *babu*. I found one girl in the Jessore brothel who confirmed this: "*He (babu) is my own man, why should he use a condom? It's not right! I want to say that I don't insist on a condom because I love him.*"

Bargaining for condom: Condoms are offered depending on the type of sexual partner. For new clients, CSWs are more persuasive about condom use than with repeat or regular clients. Closer interactions revealed that many sex workers allowed their clients, as well as those forced on them by their commercial sex partners, to have sex without a condom. Condom negotiation between girls and customers makes for many chaotic situations. Customers say that, as they are paying, they will decide whether to use a condom or not. Girls think that if they argue with a customer over this issue, he will not

be lost just for one day, but for ever. One consideration is that some customers suggest that if they do wear a condom it will take them longer to ejaculate. Crudely speaking, sex workers want their customers to perform quickly and leave, reducing the physical impact upon themselves and making way for a new customer. Many sex workers do not persuade or try to convince their clients to use a condom because they consider it as a waste of time. In this study women expressed serious concern that they would lose the opportunity to earn money if they ever raised the issue of condom use with their clients. Women are also afraid to insist upon condom usage because they fear violence from clients, especially from drunken and uneducated clients who do not believe that it is possible to enjoy sex with a condom. They are least bothered about protected sex and transmission of STIs and HIV. Professional immaturity of younger sex workers who may have joined the profession recently is another factor in incidences of unprotected sex with their clients, as is poverty and high levels of competition among sex workers.

STDs and risk behaviour: Health risks associated with sex practices are an ongoing hazard associated with sex work. Most sex workers simultaneously have a number of symptoms of STDs and RTIs, such as vaginal discharge, cervical discharge, swelling over the groin, burning sensation during urination, or painful recurring superficial ulcers on the vulva. Sex workers' vulnerability and risk of contracting STDs increases greatly for those unable to practise safer sex where money and timing play a role. The prevalence of STDs in Bangladesh indicates that high-risk sexual activity is occurring through extramarital and premarital sexual intercourse with sex workers. As a result, health risks, particularly of STDs, are transferred from the customer to sex worker and vice versa. In Khulna, I found one girl, Lima who told me about this risk-spreading cycle. Many times she has had sex in hotels without a condom. As she has some sexual diseases and a fear of an unwanted pregnancy, she is habituated to taking homeopathic and herbal medicines. Although she has a husband, she is not recognized by his family because he already has another wife. She said:

"Sometimes I feel that I am at risk because most of my work is without a condom case and I also feel that I may be transferring disease to others. For example, I am working with customers without a condom, then I am sleeping with my husband. Then he is having sex with his first wife. So all of us are at risk."

Similarly, I found a Benapole girl, Johura who works as a cook in the bachelor's quarters in the customs area and is involved in commercial sex work at night. The bachelors never use a condom because they say that they have no other sexual relations and so do not need to. But they do not realise that she is earning more income for her livelihood with the many transport workers at Benapole port. My conversation with her illustrated many risk dimensions of human psychology and of hypocrisy. Apart from the STD issue, many sex workers are reported to have sexual intercourse during their menstruation period. Sex practices during menstruation are also associated with a higher transmission of HIV (Sarkar et al, 2005). A significant portion of sex workers continue to engage in sexual intercourse during menstruation. However, the marked increase in the proportion of women agreeing to anal intercourse is striking. Anal sex is associated with a higher risk of HIV transmission than peno-vaginal sex (Sarkar et al, 2005). Jenkins and Rahman (2002) found that female sex workers in Bangladesh frequently state that they dislike anal penetration, but the threat of diminished income is likely to have pressured their acquiescence which is also found in my study.

Conservative society and sexuality: Although Bangladesh has a conservative society sexually, poverty puts women in a vulnerable position. Many women told me that girls become 'lost' due to their environment and economic situation. Recently in Bangladesh access to multiple partners has become a matter of 'masculinity' (Fig 6.2 shown as symbolic). An example is that hotel customers want a different girl on each visit. Some want new, young girls, though this depends on the customer's psychology. However, one NGO programme manager LCS/NGO-2 in Khulna told me that there are many casual sex workers who have a husband. These are 'unreachable' for NGO workers because they work during the day as maids, factory workers, construction assistants or cleaning girls and also have multiple sexual partners. The NGO survey found that they are forced to have sex with their contractors, or mill owners in order to get a job and keep it. These girls feel cheated that they are paid nothing for this, so they decide to work independently. During my field work, I also talked with some outreach workers who are raising awareness among sex workers about HIV and are also providing condoms and other materials. One of them, Mala told me that they cannot approach many of the casual girls who use hotels because of their irregular commuting behaviour. She assumes that some girls come from the village and some are local college students. Both groups do not stay in the hotel for long and so the NGO workers find it difficult to

get across the message about risky behaviour. However, many residence-based girls told me that in every residential area there are many madams' homes which have a 'good environment' or secure status. All of these 'unreachable' girls are potential sources of risk bridging. Moreover, brothel and non-brothel girls claim that diversified types of customers come to them like drivers, policemen, rickshaw pullers, officers, college and school students, civil servants, and others, both married and unmarried. Married men come when their wife becomes pregnant. Old customers encourage their friends to become new customers. This customer variety can be said to enhance the risk profile of the brothel and non-brothel settings. Almost all are playing a role in disseminating risk knowingly. The girls know that they have many customers who do not use condoms and the customers insist on a high turnover of girls and this must increase the probability of a transfer of the virus.

Figure 6.2: Many Customers are approaching at Baniashanta Brothel

6.1.2 Addicts' realization of risk 'transfer'

Substance abuse is a major vector of HIV transmission, especially through the use of contaminated injection paraphernalia (Tyler, 1986). Social networks influence pathways into drug injecting, as well as patterns of injecting risk behaviour. For example, one study associates continued low HIV prevalence among IVDUs in a neighbourhood characterised by the presence of many HIV positive IVDUs and by high levels of sexual risk behaviour, with peer and network norms protective against IVDU (Friedman and Aral, 2001). Other studies have shown that syringe sharing is influenced by the size and

density of IVDU networks (Latkin et al, 1996) and that HIV transmission may diffuse more readily once HIV has entered the 'core' of large IDU networks (Friedman et al, 1997). However, there are many health risks common to substance injections including vein damage and inflammation and infections at the injection site. In other words, impurities in the drug and poor injecting techniques can lead to abscesses, septicaemia and gangrene. Injecting drug users have traditionally been a group at high risk from early mortality and the AIDS epidemic has increased this risk. However, much research on drug users show that the majority are sexually active, that their rates of partner change are relatively high (Des Jarlais et al, 1992; Rhodes and Stimson, 1996) and that the majority of drug users never use condoms with their casual partners (Rhodes, 1994). In the context of Bangladesh, although syringes are cheap and easily available in the open market, needle sharing is extremely common, and nothing is done to sterilize the equipment between uses. As a consequence, injecting drug users present a tremendous potential for an HIV epidemic due to their needle-sharing habits, while non-injecting drug users are also prone to spread or receive HIV infection through their unsafe sexual behaviour. Most of the drug addicts, particularly heroin users, look for sexual 'pleasure', and such risk-takers provide a risk bridge for the transfer of sexual and other infectious diseases (Fig 6.3). I found one drug user, Shapon at Jessore, who is involved in many risks. He injects heroin and other drugs, sometimes shares needles, and is a professional blood donor to raise money for drugs. He then visits brothels or uses street girls, both without using a condom. He has some concerns about selling his blood and knows that there is no screening for whether it is pure or infected. He told me:

"I always feel that I am doing wrong about drug addiction, sex without a condom, and selling blood selling but I have no self-control. In particular I cannot tolerate withdrawal symptoms and need a fix. If I have no money, blood selling is my only option. After taking the drugs, if I feel the need for sex then I go to brothel or mix with the 'station girls'. I have some problems in my penis, and maybe these can be transferred to them."

He also mentioned that he used to go an NGO treatment centre but they refused to admit him because he has a blood shortage problem in his body. I found some addicts who confessed to sharing needles with their addict friends and in some cases with Indian drivers at Benapole. This was mainly when they ran out of needles from the hospital, dispensary or NGO office. Although some IVDUs share their needles due to lack of money, others regard it as a symbol of solidarity. Another vulnerability is that

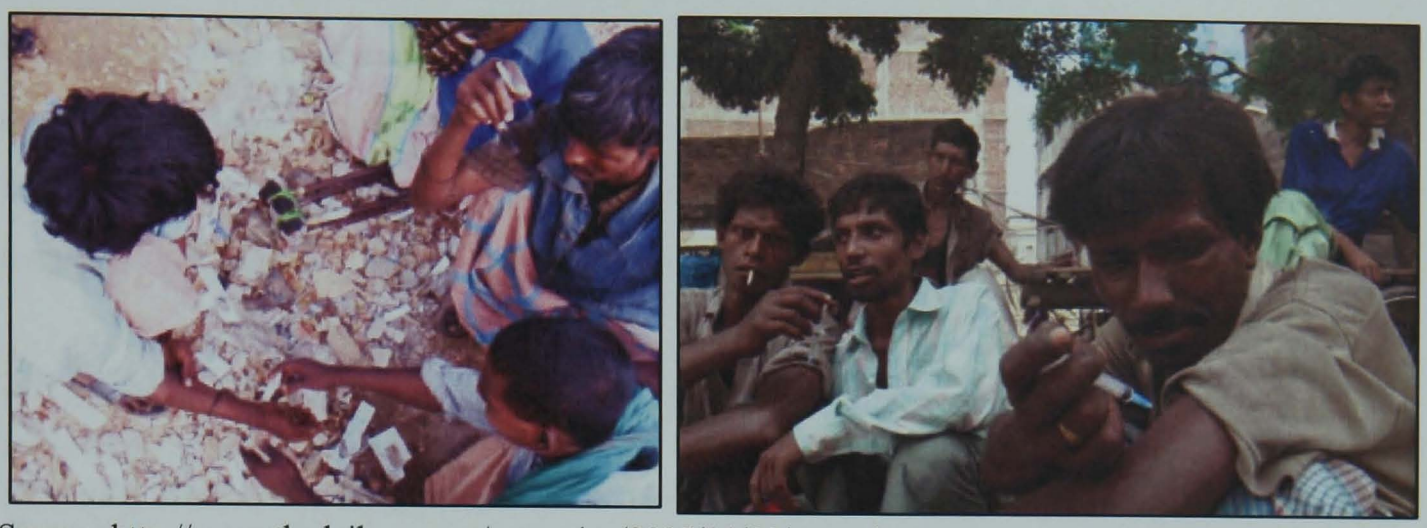
sometimes they use a '*cocktail*' of drugs instead of heroin. Following Mallick et al (2006) in order to make cocktailing drugs, injecting drug users frequently mix up Benzodiazepines (sedil, sedaxin) and anti-histamines (phenergan, avil) with the main drug (usually buprenorphine) to enhance and prolong the intoxicating effects, and alleviate the unpleasant side effects. Sometimes heroin smokers cannot get enough money together to buy heroin, which is expensive, and so they take a cocktail mixture of injectable liquid drugs which they believe to be more stimulating at a lower price.

Figure 6.3: Condom Packet found in a Drug User's Den

Due to a good number of awareness and syringe distribution programmes by NGOs, many addicts are now using individual needles rather than sharing. But the problem is that they are taking the *cocktail* of drugs from a big ampoule with different needles and they cannot help but mix their blood into the drug cocktail and then pass it into another's body (Fig 6.4). So, although they are using individual syringes, they are vulnerable due to the sharing of the *cocktail* by everyone. One participant told me that there are some syringes found in the market which have been used but subsequently repackaged. According to him, people collect used syringes from waste bins in hospitals or clinics and sell them on the black market. They go to Dhaka to be re-packed and are then widely distributed. On the other hand, when people cannot afford a '*pata*' (a small wrap) of heroin, they share their money and jointly take the drugs. Sharing the same pipe for taking the '*mal*' (drugs) can cause the spread of infectious diseases such as hepatitis B or C. In addition, adding to fears that current and future heroin users in Bangladesh will convert from inhalers to injectors is the fact that most IVDUs in the

neighbouring Indian state of Manipur and the neighbouring country Myanmar (Burma) were heroin addicts.

Figure 6.4: Intravenous Drug User's Needle Sharing



Source: http://www.thedailystar.net/magazine/2005/11/03/cover.htm

6.1.3 Transport workers' multi-sexual relationships

Most of the STD/HIV-related global literature on truckers, particularly long distance drivers (Carswell et al, 1989; Omari et al, 1991; Bwayo et al, 1994; Mbugua et al, 1995) clearly shows their attachment to high risk behaviour, particularly sexual activities which ultimately expose them to STDs and HIV (Singh et al, 1993; Singh and Malaviya, 1994; Podhisita et al, 1996; George et al, 1997; Lacerda et al, 1997). It is also mentionable in many studies that truckers are an important client group for commercial sex workers as they spend extensive periods away from their families, which may contribute to them getting involved in new and different types of sexual relationships. Gibney et al (2003) examined Bangladeshi truckers' (drivers and helpers) behaviour that could influence STD/HIV transmission and they found that their sexual behaviour placed them at high risk of STDs. They found that truckers with STIs affect the rate of STD transmission due to the long duration of infectiousness. There are also some Bangladeshi women who are not CSWs but are likely to be at higher risk than women in general due to their contacts with men at high risk for STDs, such as truckers and drug users. One study found that women living close to a truck stand in Dhaka city are likely to be at higher risk for STDs and genital tract infections (Sabin, 1998; Gibney et al, 2001 & 2002).

It was reported to me that many transport workers use a girl group-wise, so there is every chance of cross-infection from one body to another. As many girls have no scope to wash after sex, many of them suffer from skin infections, particularly in the genital area. These skin problems, and STDs generally, are then transmitted by the transport workers to their wives and other sex partners in their own village or home, where they also avoid using a condom. In other words, they provide a significant long-distance bridge for the spread of diseases such as HIV/AIDS. In Benapole, I found a few transport workers willing to discuss this. Jamal is one of them:

"*I had sex with a street girl for the first time 3 years ago. Now we find many girls on the street and I have sex almost every night. I don't like condoms because they don't give the same pleasure. The girl doesn't insist on a condom because she needs the money. It doesn't matter to her how I am having sex with her! Although I have been facing some itching and other problems, when I see the girls I cannot control myself. We don't need to go to them, they come to us and ask about our needs. Many times we friends do sex with one girl. I've heard about the AIDS disease, that it can come to my body from the girls as I don't use condom. When I go to home after a while, I also have sex with local girls, such as my neighbour's bhabi [sister in law] who lives beside our house. We have had sex many times without condom in her house. She likes me and wants sex from me.*"

Regarding protection, some transport workers claim that cannot buy condoms at night, and if they are offered one by the street girl, they feel embarrassed and insulted. Because they are paying, it seems to them that the girl should have no role in establishing 'the rules'. Moreover, most transport workers are non-literate and seem to have little idea about the proper utility of a condom and are concerned about personal satisfaction during intercourse. Mahbub at Benapole told me that "*it's a matter of pleasure; the 'taste' is different with and without a condom. I don't like condoms; actually I cannot get a sense of what I am doing if I use a condom. Sometimes the girl asks me but I don't care. I want to the body touch but a condom acts like a veil.*"

Although many transport workers, particularly drivers, are involved in commercial sex, their wives do not know about their husbands' attitude. Some guess and forbid mixing with other women. But none of the drivers confess and the wives remain unaware of the risk they are running in having unprotected sex. In this regard, a truck driver, Idris at Khulna never says anything about his sexual exploits, in order to maintain marital stability and peace. He is confident that his wife is unaware of his extramarital relationships and before he returns home his sexual 'deficit' is filled.

6.2 HIV Knowledge and Consciousness

In the case of HIV infection prevention, many 'risk theories' have been developed by researchers to examine how people adopt behavioural change. In the public health discourse of HIV/AIDS, risk is usually considered as a certain type of lifestyle, such as unprotected sex as a risky behaviour (Bloor et al, 1992; Campbell, 1997). Knowledge of the ways in which HIV is transmitted is critical to adopting behaviours that prevent infection (UN, 2002). From the late 1980s to the present, social science research has focused on surveys of risk-related sexual behaviour or the knowledge, attitudes, beliefs and practices (KABP) about sexuality which might be associated with the risk of HIV infection through quantifiable data (Turner et al, 1989; Cleland and Ferry, 1995). Different models have been formulated in this respect, such as KABP on condom use. But some authors (e.g. Holland et al, 1991; Denscombe, 1993) criticized these perspectives 'for treating individuals as free agents in terms of their response to risk and ignoring socio-cultural factors that constrain choice' (Teye, 2005; p.66). Their argument is that individual risk perception is a social construct and depends not only on knowledge but also on controls that people feel they have on their own and with their partners. In the developing world, particularly in sub-Saharan Africa, gender and religious involvement play an important role in HIV/AIDS-related knowledge, attitudes and preventive behaviour (Lagarde et al, 2000; Frasca, 2003; Turmen, 2003; Takyi, 2003). The rapid sexual spread of the HIV virus worldwide has increased awareness of the importance of more effective control programmes for other STDs. But in Bangladesh there are many misconceptions about the transmission of STDs or HIV such as kissing, using contaminated clothes, sharing food, and sharing toilets, or even being in a room with an HIV-infected person (Fig 6.5). Most had heard about syphilis and gonorrhoea, but they did have some misconceptions. Interestingly, when I asked sex workers anything about HIV, they responded quickly that 'it's a matter of needle-sharing'. On the other hand, when I asked drug users, they replied that prostitution is responsible. So, both of these vulnerable groups do not perceive themselves as 'risky' people for HIV dissemination. They prefer to blame others. This section will describe vulnerable people's knowledge and consciousness about STDs and HIV and also related reasons for their beliefs.

Figure 6.5: Posters showing HIV/AIDS Transmission Ways and Misconception

Source: NASP Leaflet

6.2.1 Sex workers' HIV 'knowledge'

Although the infection rate of HIV/AIDS among the total population in Bangladesh is still very low, commercial sex workers' risk of being infected is considered to be significant (Ara, 2005). Hosain and Chatterjee (2005) found a high risk of HIV/AIDS transmission due to inadequate knowledge of the basic concepts of HIV/AIDS, low frequency of condom use and lack of treatment for STDs among sex workers. In a study on India, Asthana and Oostvogels (1996) showed that low levels of knowledge about AIDS are compounded by even lower rates of condom usage. In the field, when I put HIV-related questions to my respondents, some became worried. Sex workers particularly replied very promptly that they have no HIV in their body. Possibly they thought that, if they showed any curiosity about the disease, I would think that they were infected. Some replied in the same way about STDs thinking that I might identify them to the NGOs as 'bad' or 'sick' women. They also thought that, if they told me about their physical problems, word might get back to their customers through other girls. As a result, they always tried to keep the matter silent or ignore it. Some wanted to show themselves as 'fine' but demonised others due to local stigma.

When I asked the sex workers in different FGDs or in individual interviews about the ways in which HIV can be transmitted, many girls told me that they know everything about HIV transmission and means of prevention. Many were aware of the HIV epidemic in India. At Benapole, sex workers admit that AIDS is coming from neighbouring India and claim themselves to be disease free although their regular partners are Indian truckers. One girl's (Popy) told me "*I have heard that about AIDS disease, but I've not met anybody who is infected. People say that AIDS has come from India. If I sleep with any of them it will happen. It can happen if I take shower in the same bathroom, or sleep together, or take food from the same plate.*" Some believe that HIV is a disease sent by Allah to punish 'sinful work' and that there are no effective medicines.

Although many girls have a fear of HIV, all are agreed that men do not appear to be concerned. When sex workers asked customers to use protection measures during intercourse, most defended themselves as either 'fresh' or 'virus free'. One hotel girl, Lima told me that "*when I ask them to use a condom use, some customers tell me that they have had a blood test and that they are 'virus free.*" On the other hand, if a girl tells the customer that she is sleeping with many men, and that she might be carrying the 'virus', many customers are prepared to take the risk and say, "*if I'm willing to catch your virus, what is your problem*?" As a result, some girls are recently feeling fearful about getting AIDS as their customers do not use proper protection. One of the Benapole girls, Sajeda told me in this regard that "*after I came to know about AIDS I am thinking that it may happen in my body because I never use a condom. I don't know whether it has appeared in my body or not.*" Some sex workers are so aware of the HIV issue that they refuse sex without a condom. I found one residence-based sex worker, Keya at Khulna who was very determined about HIV prevention:

"*I love my son and I want to live for him. Maybe my life has no value to my customer. If I work with a customer without a condom, he will give me 100 taka at best, but he might give me the virus for my whole life. How many 100 taka I would need to spend for my treatment then? So I don't want to be sick for not using a condom.*"

Recently there was a condom shortage in the market and girls faced an inadequate supply. They still needed to work with customers because of food costs and house rent.

If condoms are unavailable or highly priced in the local market, then the health risk will increase. One girl in a FGD at Jessore told me that:

"*If a condom is unavailable, then I have to either refuse the customer or have sex without condom because I have to survive. I will not give you a guarantee that I will not work if condoms are unavailable. We will be forced to do that even if the disease appears, I would not care.*"

Many outreach workers told me that condom use awareness among the girls has been increasing, but the lack of knowledge among new girls is causing them repeated STD problems. One peer educator, Khairun told me that many street girls do not assimilate HIV awareness programmes properly due to their illiteracy, or sometimes girls are irritated by hearing the message repeated. However, there are still misconceptions about condom use. Most commercial sex workers, though many have knowledge about HIV, cannot follow or practise the concept of 'safe sex'. Some girls think that out of five clients, if two are without a condom they will not contract the infection, or it will not be very strong. In practice, girls can persuade their older clients but the young ones refuse protection or offer extra money. Particularly among brothel-based and street-based sex workers, the level of knowledge is quite low due to lack of education, compared to the hotel- or residence-based sex workers. I noticed that, although awareness campaigns have been started on safe-sex practices in Bangladesh, there is still confusion about the effectiveness of that awareness among sex workers. It is very difficult to get the real picture from the girls about their condom use. Usually it depends on who is dominant, the sex worker or the customer. Here men's involvement should be incorporated more precisely in 'safer sex' practice.

6.2.2 Drug users' consciousness of HIV

There are many different beliefs among drug users about the ways in which HIV is transmitted. This was obvious in one FGD with drug users in Jessore. Though some participants mentioned sexual contact without a condom, and needle-sharing as risk factors, others emphasized different ideas:

"*HIV can spread from urine, such as when people urinate in a same part of an open field. If others urinate there, they will be affected by HIV. AIDS is like chicken pox;*

spots will cover the whole body from head to toe. It's like a skin disease or leprosy. Some insects come out from the black spots."

My field observation is that most drug users believe that HIV is caught only from sex workers. Their mindset is that HIV is a sex-related disease and that the reservoir of the virus is in the woman's body. They do not think primarily that needle sharing or blood selling can spread HIV. Two serious drug users, Badiul and Kabir, told me that "*AIDS comes from the 'magi' (prostitute). If I have sex with one, it will come, so I need to use a condom.*" Regarding needle-sharing, many addicts confessed that they have shared needles in the past but now there are increasing levels of consciousness, and understanding of the dangers after NGO attempts to spread the word about HIV issues. However, as many drug addicts have unprotected sex, sexual diseases are common. I interviewed a drug addict, Rafiq in Khulna, who believes that he is suffering from AIDS because he has many STDs:

"*I believe I am an AIDS patient as I have many sexual problems. I don't know how it comes through, maybe by girls or injection, but I am not taking treatment because I want to die to get relief from my sufferings.*"

Lack of awareness of HIV/AIDS is considered an important risk factor. Levels of knowledge and awareness are very low among drug users, making them a vulnerable group for potential HIV infection. Many respondents have heard of the HIV virus but their knowledge of the symptoms and means of prevention are often inaccurate. It could be argued, therefore, that more effective mass media public health awareness campaigns about STDs and HIV/AIDS are needed.

6.2.3 Transport workers' HIV awareness

Transport workers often ignore the danger of AIDS since they go to sex workers for pleasure or recreation. They appear to hold this aspect of their behaviour in a separate box from their understanding of risk. Here education or awareness-raising meets resistance because of a particular mentality and taste for excitement. Because AIDS patients are rare and mostly invisible in Bangladesh, many of those exhibiting risky behaviour do not feel any need to change. Truckers have their own beliefs about the origin and spread of HIV. One is that HIV is transmitted through mosquitoes and dogs

and that people who have sex with their pets and then with a partner are spreading the virus. Another issue relates to physical appearance as demonstrated in the following extract:

"*People say that those who have AIDS become slim, so I avoid slim girls. We can see who is suitable for us by their walking style. We suspect those who are very slim, so we take fat girls, not very fat but medium size. Otherwise we don't feel good.*"

Many truckers told me that HIV/AIDS can come through sex with 'bad women'. Many transport workers think that brothels and street prostitutes have HIV, and that they are solely responsible for the spread of HIV in Bangladesh. One transport helper, Jasim, told me that as he does not use a condom, many germs including HIV, have access to his body:

"*Prostitutes have the AIDS disease germs because they mix with many people, so they carry the germs. The girls are mainly responsible as they are mixing with many people. Brothel and street girls have many customers, so they are at greatest risk.*"

During a FGD with rickshaw pullers in Khulna, I was told that few use a condom and many do not believe in HIV (Fig 6.6). They think that all the messages are fake because their ancestors never used condoms. The girls use contraceptive pills, so they do not need to use a condom. Condoms might be important for brothel girls, because they mix with many customers and they might have sexual diseases, but not with other girls. When I asked a group of drivers at Benapole about their knowledge of sexually transmitted diseases, many participants said that itching, spots on the front side of the penis, a burning sensation during urination and gonorrhoea are considered as 'sex diseases'. According to them, condoms prevent the 'poison' going from the woman's body to the man's body. Some truckers also believe that if they use a condom with their sex partners, the girls will benefit, not the men. Some were embarrassed about discussing sexual problems or even to know about the HIV issue. They think that if they discuss it, they might be thought to be suffering from it themselves, with the inevitable loss of prestige. Some truckers said that they were not interested in hearing about HIV because they themselves had not faced this kind of disease. One of the drivers summed up his reserve: "*I will not speak about my secret things to a doctor, because he might think that I am a very bad person.*"

Figure 6.6: A Transport Worker showing a Condom

In this aspect, I talked with an outreach worker, Jabed who works with truckers in order to pass on HIV knowledge. He told me that many transport workers have physical symptoms of STIs but they have a tendency to hide the problem. Usually they say that one of their friends is suffering this type of problem and pretend to listen on his behalf. Although genital infections are common, they will only go to a doctor when they feel severe pain or experience serious problems. In a FGD with rickshaw pullers, mostly non-literate people, I found that they have little knowledge of condoms and AIDS. Like the truckers, many rickshaw pullers will not disclose their sexual problems to a qualified doctor; rather they visit back street healers or hawkers to solve their sexual diseases. I found one transport worker at Benapole, Mahbub who told me that risk-related feelings do not come into his mind before work. His mind is full of anticipation about sex and girls, but afterwards he repents because of not using a condom. He said that "*I cannot think that 'sex without condom is wrong', though I believe the NGOs message, but before sex it doesn't come to my mind. I cannot remember that message because my brain doesn't work properly. Different feelings appear in my mind such as 'how can I get the girl, will I get pleasure?' I forget about the future, but after sex I regret taking risks.*"

After contracting STDs, some truckers have come to see commercial sex as a 'sin' and have been thinking about making a commitment to refrain from it in future. Sukkur said that "*after contracting a penis disease, my mentality has become bad; I am always feeling gloomy and now I feel weak physically. I consider my disease as a punishment from God. So I am begging pardon from him.*"

The present study's findings illustrate that the sexual behaviours, beliefs and stigma of a large proportion of the transport workers place them at high risk of STDs and HIV/AIDS. Communication strategies can increase clients' knowledge of AIDS and STD transmission and prevention is a critical first step. Initial efforts might employ communication materials including posters and brochures and outreach educational workers at commercial sex sites, as this strategy has proven useful elsewhere.

6.3 Health 'Risk Coping' Practices

Over the last 25 years, a variety of studies by social scientists have addressed questions about how people manage illness in their everyday lives. Following Bury (1988), the main research and ideas are on the 'strategic management' of illness (Wiener, 1975), on 'narrative reconstruction' (Williams, 1984), on 'trajectories' and adaptation (Strauss, 1975), and on the management of uncertainty (Davis, 1963). Revenson (2001) covers the broad topic of adaptation to chronic illness, including the coping process. Literally, coping strategies are adopted by people to maintain their 'maximum' relative normality in the face of incapacitation or stigmatization (Gerhardt, 1989). Corbin and Strauss (1991) have called it a process of 'comeback' and draw attention to the physical and biographical processes in achieving a satisfactory life in the face of illness and disability. These two central aspects of 'comeback' may be seen to underpin dimensions of adaptations that bridge self, identity and social action or a shift from an image of 'the disabled self' to one of 'the capable self'. The 'coping' model emphasizes the role of drugs in moderating the stress and insecurity of life in unstable, disorganized and deprived communities (Currie, 1993). While public awareness of AIDS is a necessary condition for behavioural change, actual change depends to a great extent on: the perceived severity of the disease; the accuracy of knowledge about contracting and preventing AIDS; and each individual's perceptions of the risk of becoming infected with the disease (UN, 2002). In this section, vulnerable people's varied health risk coping techniques will be described.

6.3.1 Sex workers' physical risk minimization

Coping is a psychological mechanism for managing stress, involving thoughts, feelings or behaviours (David and Lee, 2001). For instance, many sex workers in Madras believe that washing their genitals after intercourse in urine, soda water or lime juice will prevent STDs. Another idea is that, whilst intercourse by a roadside or railway track encourages the spread of disease, sex in a confined room does not (Asthana and Oostvogels, 1996). In Bangladesh, as many sex workers do not have the opportunity to use a condom, some of them are involved with techniques to minimize their risk. Some use 'traditional' techniques in order to be risk free; some try to negotiate condom-use according to their ability; some take homeopathic and herbal medicines; some take female contraceptives to prevent pregnancy; some have had an abortion; and there are a few who wear an '*tabiz*' (amulet) to relieve menstrual pains. Although many STD patients get treatment, their partners do not have that opportunity and, as a result, they are infected. Some patients do not attach much importance to STDs and take only half a course of treatment. So their cycle of STI infection continues.

'Traditional' coping strategies: To reduce the risk of pregnancy, most use female contraceptives and think that washing after sex is a means of reducing the risk of disease. In brothels girls usually use water with soap and savlon to clean themselves after sex. In the case of floating girls, they carry soap in a small bag and wash the vagina in the toilet. Sometimes they prefer to wash with warm water and apply savlon after returning home to reduce the risk. Hotel sex workers follow 'traditional' techniques to be risk free. They try to urinate instantly after intercourse so that the semen comes out along with the urine. They think that if they sleep or lie on the bed after sex, pregnancy will develop. After urinating, they wash simply with water in most cases. Some girls use shampoo and soap after sex in an attempt to be risk free. In an FGD with hotel girls at Khulna, they said:

"*When I feel I need to take this work without a condom, before sex I drink a lot of water, so that afterwards I can urinate. If the semen is left in the vagina, you have to urinate as soon as possible. Then all of the semen will come out.*"

Many girls need to take customers without using a condom, so they are accustomed to using herbal or homeopathic medicines or '*kabiraji*' to protect themselves from sexual

disease and unwanted pregnancy. Interestingly many are fearful about modern medical instruments for checking STDs. They are fearful of using contraceptive pills, which are said to affect their uterus. One hotel girl, Lime, told me at Khulna that she took homeopath medicine to 'clear' a possible pregnancy; she became 'clean' and she started her menstruation again after one week. However, some sex workers wear the *tabiz* to get relief from physical suffering. They have a strong superstitious belief that if they wear the *tabiz* their physical problems will disappear. I found one girl, Sapla at Baniashanta brothel, who was using a *tabiz* to relieve an abdomenal pain. She bought it from a local *huzur* or religious man. Other girls in that brothel influenced her to collect it because many of them also using that kind of amulet. After using this *tabiz* the problem has persisted but she believes that its effect will come after a few days. Moreover, although many girls think that the condom is a symbol of women's security, they cannot force their customers to use it. Some girls try to check the customer's body and whether he has any scabies or any visible disease or not. Some sex workers check the penis of their clients for visible ulcers or discharge before engaging in sex, but in most cases the customers refuse. They also assume that their repeat or regular clients are free of AIDS and STDs, and believe that clients who look healthy and clean do not have any disease.

Female contraceptive: Regarding female contraceptive use, the girls' fears mainly focus on the possibility of unwanted pregnancy rather than on STDs or HIV problems. To them, pregnancy is more important than disease because, if they become pregnant, they will immediately be identified as a sex worker by the community. It has been seen that many brothel or non-brothel-based sex workers are adapting to contraceptive methods most of the time (Fig 6.7). Apart from natural family planning like the calendar method, they use temporary methods such as pills, injections and implants, as well as permanent methods like bilateral tubectomy.

Commercial sex working girls use contraceptives for different purposes along with condoms to keep themselves as 'safe' as possible. For the sake of their business, girls want to control their bleeding during menstruation periods by taking contraceptive pills and iron tablets, which control the hormone levels in the body, and also to avoid pregnancy. Some girls like pills, others prefer injections. One floating girl, Johura told me that "*I don't take the pill because it creates some side effects like vomiting. Instead I*

have injections which last for 3 months. They are safe, but with pills I cannot remember to take them properly." Many girls like the 'injection' method to escape blame and stigmatization. If they are seen to use the pill, people will say that 'you have no husband, so why you are on the pill?' But in the case of injections, nobody will know. A local healer in Benapole told me that he has many female STD patients who are using female contraceptives to prevent unwanted pregnancy. So, they have no pregnancy problems, but suffer from disease. When NGO doctors ask a girl about condom use, she will just reply 'yes' because girls do not usually trust the doctors; but they may subsequently confess to not using condoms consistently. They do not like to tell this fact to the doctor, so doctors need to behave in a friendly way to open a sex worker's window of recovery.

Figure 6.7: A Family Health Center for Female Contraceptives Opportunity

Abortion: Apart from the physical risk of complications, psychological responses to abortion are the most difficult to assess and evaluate (David and Lee, 2001). Legally, abortion is only permitted in Bangladesh to save the life of women, but menstrual regulation (MR) is legal, provided that pregnancy has not been confirmed (Streatfield, 2001). Due to social stigma and confidentiality issues, a large majority of induced abortions are by traditional methods and the result is often a long duration of continuous bleeding and a fever for more than five days (Bhuiya et al, 2001). The majority of sex workers usually prefer to prevent unwanted pregnancies through contraceptive use rather than through abortion. Normally, as soon as a sex worker realises that she is

pregnant, she discusses the matter with her close friend or *babu* or *sardarni*. Then in most cases she contacts a local healer for an abortion. It is widely believed that local healers or midwives have more information about MR than an NGO doctor. Frequent performance of MR is common among commercial sex workers. Some sex workers have MRs performed two or three times per year, which causes excessive bleeding and weakness and leaves them in ill health.

Many floating girls are reluctant about condom use and forget to take their contraceptive pills on time. As a result, many of them need to have abortions for unwanted pregnancies. Almost every sex worker has had the experience of an abortion. One street girl, Chompa told me:

"*Recently I was carrying a baby, I wanted to abort it, but who will give me the money to 'wash' it? I took some medicine to kill it but failed; right now I cannot 'work' properly because some customers know about my pregnancy. They make many bad comments. It's hampering my earnings.*"

Sex working women have resorted to abortion to end unwanted pregnancies and often at considerable risk to personal health. However, social stigma attached to induced abortion may be a reason for not seeking safe abortion services by poor girls, since it may not remain confidential. If the local healers or clinic operators fail to abort the fetus, girls need to go to a large hospital and spend more money. But unfortunately none of the healers or clinic operators will take responsibility for any negative consequence or side effects caused by their treatment, the abortions or the MRs they perform.

Condom negotiation: Condoms are associated with contraception rather than disease prevention and are presumed to negatively affect sexual pleasure. As a result, they are rarely used in encounters between CSWs and their clients. Some call girls have a gentle approach about condom negotiation. They ask clients about virus transmission and its long term impact. Recently a few hotel or residence girls have been practising a technique to wear the condom by keeping it in the mouth in the name of oral sex. On the other hand, recently some brothel girls have been trying to develop a system informally that is 'payment first, sex after' for general customers to ensure condom use. After getting payment, the girl asks about condom use. If the customer does not agree then they push him out of the brothel. However, some sex workers have the experience with

female condoms but many do not like them because they are complicated to use, and many girls feel uneasy because semen remains and so the next customer can be infected with a previous one's STD.

6.3.2 Drug users' risk minimizing techniques and 'coping'

Chronic substance abuse has adverse and potentially life threatening health consequences (Alling, 1992) and detoxification is the first stage of treatment to protect the user from the withdrawal symptoms (Roehrich and Goldman, 1993). Persons detoxified from opioids, such as heroin, may be given a slower acting opioid, such as methadone, or clonidine, a nonopiate drug that decreases activity of the central nervous system (Lex, 2000). Some mixed agonist-antagonists, such as buprenorphine, are now used to relieve pain. It is understandable that people dependent on tranquillizers should feel that the best thing to do is to stop taking them immediately. Some people have looked to alternative medicine, herbal remedies, homeopathy, acupuncture and hypnotherapy, and other therapies as alternatives to tranquillizers to help them withdraw (Hamlin and Hammersley, 1993). Other than treatment, addicts are required for the physical and psychological rehabilitation and care to attempt to change the environment to which the 'cured' addict returns (O'Donnell and Ball, 1966; Mendelson and Mello, 1994; Schuckit and Segal, 1994). In Bangladesh, many drug addicts think that they will die from their addiction. This fear basically comes from their physical weakness and marginalised status. As a result, many addicts, mostly those who are involved with NGOs, are trying to engage with risk-reducing strategies like sexual abstinence, detoxification, the use of traditional medicine and treatments, drug rehabilitation training, and even a preference for going to prison. This section will describe drug users' techniques for 'coping' with the health risk and their perceptions of obtaining relief from risk.

Treatment for drug addicts: The traditional approach to detox is clinic-based. Treatment is necessary for those abusers who have become most deeply involved with drugs. A drug user is considered as toxified for his or her physical and psychological dependence, which is exposed through withdrawal symptoms. In Bangladesh, low availability and limited success make the government-run detox clinics non viable for

most poor people (Knight, 2006b). Many are used to being admitted to private drug treatment centres by their relatives. But most of these drug addiction treatment centres are run as for-profit businesses. Usually they have a casual or locum doctor (some centres have no staff doctor) and a number of unqualified staff, who give injections and act like a nurse. They are responsible for treatment, although standards are well below those that are desirable. When people see their sons or relatives becoming difficult and disturbed, they seek out this kind of treatment centre, which may also be considered as a 'gentle prison' for middle class people. Some addicts come here by their own choice and also leave similarly. In that case, the centre's role is merely to provide a commercial service like any other. Most expect that a patient will come again to their centre when the addiction crosses a certain threshold of suffering. When addicts arrive for the first time, they can bargain for their living expenses or room rent. Perhaps surprisingly, the centre staffs give patients a chance to take heroin for the 'last time'. There is an accusation that some private treatment centres even sell it at a market rate and a cynic might label some as heroin desire extending centres rather than centres for protection from heroin.

There are also a few NGO drop-in-centre (DIC) and treatment facilities where drug addicts are allowed to get treatment (Fig 6.8). Those that have been providing service for drug addicts have two kinds of treatment facilities: short and long term. The main goal of short term treatment is to remove physical toxification and long term treatment removes the psychological dependence on drugs. NGOs often give Clonidine-type medicines to decrease withdrawal pains, along with some anti-histamine and sleeping tablets. During the follow-up period they use a medicine named Naltrazone to cut and block heroin toxicity. However, in the drug treatment centre, bath therapy is a commonly used technique for the drug patients in order to erase withdrawal symptoms. In a participant observation with drug patients in one NGO treatment centre, the centre manager told me that almost all drug patients have a mental demand for drugs for up to 72 hours, then it decreases gradually. I met with some treatment taking drug patients and one of them, Rahim/KL, said to me that they are learning some techniques to avoid the bad company which may 'pollute' them again.

Figure 6.8: NGO Drop-in-Center for Drug Users

Mind control lessons at rehab: Psychopharmacology often plays a key role by stabilizing patients so that gains can be made in psychosocial areas. A variety of therapies have been used in individual and group formats (Washton, 1992). Self help groups, such as Narcotics Anonymous (NA) are very inexpensive and highly effective community resources that verbalise beliefs and values that encourage and facilitate responsible, insightful behaviour without the use of drugs (Vaillant, 1983). In Jessore, I found a few drug addict rehabilitation centres. In the rehabilitation centre, many mind control lessons have been provided for the drug patients to keep their mind stable, as it is thought that there is a close relationship between the mind and drugs, so by controlling emotions, it is possible to control the addiction. In addition, prayers are performed for relief from the world of addiction in future (Fig 6.9). They seek god's help for controlling their minds. The morning and afternoon prayers are:

"*Almighty god, please bless addicts, please give us peace, so that we can change. Give us courage so that we can change whatever it is possible, and give us knowledge so that we can understand the difference*!"

In the afternoon there is a session in the rehab centre called 'face to face'. In this session addicts openly criticize each other for wrong behaviour in the previous week, with reminders about the punishments for misdeeds in the programme. After their confession, punishments are meted out to increase their tolerance level as much as possible. Finally, they share their real life stories and miseries from drug addiction to increase their self consciousness.

Figure 6.9: Taking Oaths and Listening Class Lectures at Rehab Centre

Prison considered as an opportunity for a 'new life': Private detox treatment is expensive and prison is cheaper than detox (Knight, 2006b). Sometimes the family sends the drug user to prison or the users get themselves into prison just to get off drugs. When some drug users feel that their life is spiralling out of control, they welcome a period in prison as a chance to get a 'new life' to come back into the mainstream. They think that if they can go to prison for a long time, their mind will be controlled against addiction and the body will become stable. As a result, many addicts see it as a form of safe custody. I found a few addicts who wanted to start a 'new life' or wanted to get relief from their health risks. One drug user, Lavlu who wants to get a new life by going to prison, said "*I want to come back again to normal life. I asked my wife to manage some money which will be needed for a 'new life'. I will go to jail and will stay there for minimum of 6 months. If I face bera (withdrawal symptoms) then I will have to tolerate it.*"

In order to be admitted to prison, addicts first give money to the local police as a bribe to be brought into custody and falsely accused. Such addicts avoid the NGO treatment centre because it is only a short term measure but in one of my participant observations in a rehab centre at Jessore, most of the participants did not agree with that concept. Their main logic is that if the addict could not control his mind, he will be addicted again. They think that in prison the addict will refrain from drugs for few days or months, but when they comes out of jail they will go back to a heroin dealer.

Showing fear or gaining awareness? During my field work I was a participant observer in sessions in a drug rehabilitation centre in Jessore, where drug patients are being given treatment and training to know how to detach themselves from drugs when they leave the centre (Fig 6.10). I took the opportunity to organize some group discussions with participants. I asked which is more important for addicts to refrain from addiction: fear or gaining awareness? One man said that showing fear would work for him to leave addiction, but the rest disagreed with him. They thought that "*if you force someone leave addiction due to fear, he will be more crazy for that addiction. In all of our cases, family members tried several times to detain us and even beat us but we never left addiction. Instead the experience helped to fuel the addiction. If someone's consciousness is raised, it works promptly.*"

Figure 6.10: Common Works at Rehab Center among the Addict Patients

In Khulna, some drug patients told me that they needed counselling on psychological issues to do with mind control. As they believe that drug addiction is a mental problem, so they thought that they should be given support with psychological problems. However, they also thought that if they have some form of vocational training, they would be more independent and this would help them to establish themselves on the outside. In addition, some drug users felt that there should be tablets to minimize the health risk from drug addiction.

Sexual abstinence and treatment: Many recovering drug users have fallen back into the trap of drug taking. One claim by married addicts is that they are afraid that when they have recovered after treatment, they will not be able to 'perform' with their wife as previously. So their wife will be dissatisfied. In a participant observation in a private

treatment centre at Jessore, I asked one of the treatment-taking patients (Rabiul) how he will manage and he told me:

"*After getting treatment I will need to ask my wife, whom do you want? A man of sexual appetites or a drug-free man? If you wish a man with a sex drive, I will have to go to the pushers and take heroin again, then I will perform as before. If you want to a drug-free man, please give me six months to recover my sexual performance, which collapsed with my previous addiction. I believe my wife will wait for me.*"

Many STD patients buy medicines from back street 'doctors' including homeopaths and herbal practitioners who claim that they can treat HIV. Pharmacists also recommend medicines for patients with STDs who cannot afford to visit a conventional doctor. These various healers understand the patients' mentality and have a very friendly attitude and a common touch. Patients are wary of recognized doctors, who may be suspicious of their character and try to explore their identity. I found one addict, Didar who is suffering many sexual problems. One of his relatives advised him to use soap and mustard oil on the penis for his disease which he is now doing. Moreover, I found one injecting drug user, Rassel at Khulna who used a 'hot water touch' to get back feeling in body parts which had become senseless due to frequent needle use. In order to prevent relapse, other than these addicts' coping techniques, local communities' attitudes toward the former addict needs to be changed. As of now, the addict returning to the community is likely to find themselves treated as ex-criminals. Negative public attitudes may drive former addicts back all the more quickly into the addict subgroup, with an even more confirmed anti-social attitude.

6.3.3 Transport workers' herbal treatment

In the global South, evidence suggests that only a very small percentage of STD sufferers attend public facilities, the majority instead seeking clinical care from private doctors (Asthana, 1996), where both diagnosis and case management tend to be inadequate, or resort to self-medication. Ahmed et al (1997) report that traditional healers are poor at recognizing these diseases and readily refer clients to modern health services. Bhuiya and Ansary (1998) show that only 13 percent of poor women and men in Bangladesh sought treatment from licensed medical doctors. One worker, Zillur feels that his sex 'power' has been decreasing and now he cannot sustain intercourse for long.

Another, Sukkur told me that his problems remain despite taking many medicines from local healers and some homeopathic and *kabiraji* (herbal) medicine.

Unqualified medical practitioners like *kabiraj* (herbal practitioners) or homeopathic doctors usually start their businesses in a neighbourhood of transport terminals, brothels, slums and other areas where commercial sex workers congregate. As most of the vulnerable people like sex workers, drug users, or transport workers are uneducated, they rarely inquire about the qualification of the doctors. Generally, those who visit prostitutes and face symptoms such as loss of sexual drive, or physical changes in the penis, first consult an unregistered doctor for treatment and only seek the help of qualified practitioners in extreme cases. However, I did speak to transport workers and drug users who seek modern medical assistance from chemist shops and the 'doctors' (actually compounders or prescribing pharmacists) who work there. This use of medicine from local healers is common among participants in illicit sex and few go to medical practitioners due to the stigma. One local healer in Benapole told me that drivers and helpers are interested to take advice or medicine for short term relief and then they visit doctors in Dhaka, who will prescribe antibiotics for STDs. Many people in Bangladesh, especially poor people and migrants, prefer traditional local healers because they have time to listen and to communicate in an understandable and sympathetic way.

6.4 Knowledge, Risk Minimization and Sustaining of HIV Risk

There is a significant difference in AIDS-related knowledge and behaviours among the population groups related to HIV prevention. In Bangladesh, there are certain social and cultural barriers to discussing and addressing HIV/AIDS, with the result that there is a low level of knowledge among the general public, including vulnerable people. As sex work and drug use are 'taboo' subjects, so people are reluctant openly to address the issues and are much more likely to hide their concerns about HIV. High rates of STDs and other health problems amongst vulnerable people reflect very low levels of condom usage by sexually active individuals in Bangladesh. Many sex workers and their clients particularly transport workers, think that condom use is related to shyness and a symbol of sickness to some extent. Many male respondents feel stigmatized about condom access and usage or feel that there is no need to use a condom because their sexual

partners are not sick. This lack of acceptance of messages about safe sex among the male participants is due to their myths, beliefs and practices. I also found that many sex workers are not aware of the significance of STIs because some STDs are asymptomatic and, importantly, there is a fear and stigma attached to seeking care and treatment for a STD.

Drug users do not have access to formal health care to counter their risk behaviour. Due to not having the financial ability to seek treatment and also having a negative community attitude, drug users cannot change their risky behaviour easily. There would seem to be an opportunity for the mass media to implement awareness programmes on the risks of needle sharing and its association with HIV. However, the consistent use of condoms is perhaps the single most important determining factor in controlling STIs among these vulnerable people. The growing incidence of HIV risk behaviour means that greater emphasis needs to be placed on methods that achieve disease prevention through proper health education and awareness raising. In the next chapter, I will examine the role of 'place' in channelling potential risk and the importance of geographical location in determining the hidden disaster of HIV in Bangladesh.

Chapter Seven

Place, Mobility and Channelling of HIV Risk

Chapter Seven

Place, Mobility and Channelling of HIV Risk

The relationship between population mobility and the spread of infectious diseases in general has been examined in many different contexts around the world (Massey et al, 1993). For the acquisition of HIV, movement has been identified as an independent individual risk factor in a wide range of settings (Lagarde et al, 2003). HIV infection is itself a trigger for mobility in a variety of contexts (Berk et al, 2003). Smith (2005) adopts a migration streams framework which is shaped primarily by the social networks of individual migrants who play a role in shaping the geography of new HIV infections. It is generally reported that migrant workers in developing countries are more likely than non-migrants to take part in HIV risk-taking behaviours. In other words, rural-urban migrants are more likely to be disease carriers (Castle, 2004), and are frequently identified as 'bridging populations' for HIV transmission (Morris, 1997).

Bangladesh has been recognized as one of the countries in Asia where HIV/AIDS infections are increasing rapidly (Alam, 2007; Hossain, 2007). It has been discussed in the previous chapters that the AIDS pandemic could be set to explode in Bangladesh in the near future because of the marginalized 'lifeworlds' of vulnerable people and their stigmatized identity, along with their high risk behaviour and low awareness. In addition, the high mobility of vulnerable people particularly in border areas has a role in the potential channelling of health risk and it is another major threat in the context of HIV/AIDS in Bangladesh. In other words, the notions of 'place' and 'borders' play an important role in shaping responses to the challenges of HIV/AIDS. In this chapter, I will discuss how place is playing a role in health risk, particularly the HIV threat among vulnerable communities. Secondly, the risk channelling role of border towns and land ports will be described in terms of their implications for women. Finally, this chapter

will examine the hidden HIV cases in Bangladesh and will draw on relevant case studies.

7.1 Place as a 'Risky' and 'Safe'

By tradition, geographers have been interested in the character of places. The importance of place, more recently, has been reasserted through the development of the sense of place concept, which describes the consciousness people have of places holding a special significance for them (Tuan, 1991). Eyles (1985) has extended this idea, pointing to the relationship between an individual's place-in-the-world and experience of place. The concept of place and of the link between place and health are central developments in contemporary health philosophy and one such development is the emergence of a conceptual model firmly based on ideas of health rather than medicine (Kearns, 1993). This includes the socio-ecological model of health (argument of White, 1981) involving an interactive set of relationships between a population and their social, cultural and physical environment. As part of the global but uneven spread of the HIV/AIDS epidemic, notions of 'place' play an important role in shaping responses to the challenges of HIV/AIDS. This section will look at drug addicts' 'own place', sex workers' perceptions of safe or non-safe places, and transport workers' preferred sites, which are key to the HIV threat facing them.

7.1.1 The stigma of place of drug users

The kind of drug used by an addict will depend upon such factors as geographical location, socio-economic status, sex and personality, and the price and availability of the drug (O'Donnell and Ball, 1966). For example, after purchasing heroin or some other injectable substance in a local drug selling area, users are faced with three logistical problems (Inciardi, 1992): how to get off the street quickly to avoid arrest for possession of drugs; where to obtain a set of equipment with which to administer the drugs; and where to find a safe place or 'shooting gallery' to take the drugs. Drug transactions usually take place on the street, on a roof, in a cellar, in a private house or some other public abandoned establishment (Chein et al, 1964). Shooting galleries contain all of the risk factors to the individual which together make a 'risk environment'. An understanding of risk environments encourages a focus on the social

situations, structures and places in which risk is produced rather than a reliance on a concept of risk as endogenous to individuals' cognitive decision-making and immediacy of interpersonal relations (Singer, 1994; Barnett and Whiteside, 1999; Rhodes, 2002). Following Rhodes et al (2005), I define 'risk environment' as the places where a variety of factors combine to increase the possibility of HIV transmission.

The physical environments in which drug injecting occurs can determine access to clean injecting equipment as well as the capacity of IVDUs to maintain safer injecting routines without disruption (Singer et al, 2000; Carlson, 2000; Rhodes et al, 2003 & 2005). Epidemiological research identifies shooting galleries as physical environments in which injectors gather to inject drugs, and associates such places with an elevated risk of HIV transmission, particularly in galleries in which injecting equipment is rented or stored for re-use (Des Jarlais and Friedman, 1990; Chitwood et al, 1990; Page, 1990; Celentano et al, 1991; Carlson, 2000). In other words, injecting in public or semi-public places has in turn been associated with urban disadvantage, homelessness and a fear of police arrest resulting from high-profile policing practices (Celentano et al, 1991; Bourgois, 1998; Maher and Dixon, 1999). In Madras, India, for example, a qualitative study of public injecting environments illustrates HIV risks associated with the sharing of injecting equipment stored directly at the shooting place for re-use, noting that seclusion from police, privacy from family and friends, and lack of private housing combine to maintain a public injecting scene (Rhodes et al, 2005). Aside from increased HIV risks, the selection of public injecting places secluded from police surveillance or the public gaze has been associated with an increased risk of fatal overdose in some areas (Dovey et al, 2001).

In Bangladesh, drug addicts have their 'own place' where they can take drugs freely and without fear (Fig 7.1). On the other hand, there are bad places where they face harassment. In their own safe haven they not only take drugs but also exchange feelings. This variety of places forms one dimension of their 'map' of health hazards. When forced into the melée of bad places they are more likely to be at risk, for instance from needle sharing, or staying in unhygienic conditions; but, unfortunately, there are very few places that addicts can call their own. A concomitant fear of the carriage of used needles and syringes as constituting evidence of possession or providing a rationale for increased police interest also discourages injecting drug users from using local

pharmacies for the purchase of clean injecting equipment. If they sit in a public place they will soon attract threats, and because the police try to arrest addicts at the point of sale, most prefer to take their drugs in quieter places where they will not be disturbed. This may be a garden, slum area, grave yard or an abandoned building. One injecting drug user at Khulna, Salauddin, feels that addicts need to take drugs in a hidden place, as secret as possible. Sometimes they take drugs with friends in the market or in an open field in secret and they need to be careful not to be noticed.

Figure 7.1: Drug Users' Common Place for taking Drugs

Drug users' desperation and mobility: Borders and major trade routes are physical structural determinants of heightened HIV vulnerability given that they facilitate population movement and mixing. Rhodes et al (2005) identified critical factors such as border trade and transport links (Lacerda et al, 1997; Beyrer et al, 2000), population movement and mixing (Lyttleton and Amarapibal, 2002; Hammett et al, 2003), and urban or neighbourhood deprivation and disadvantage (Takahashi et al, 2001; Wood et al, 2002) in the social-structural production of HIV risk associated with drug injecting. High rates of injecting drug use in Bangladesh have been associated with its proximity to the 'Golden Triangle' of Burma, Laos and Thailand where 20% of the world's heroin is estimated to be grown and processed (Asthana, 1996). Being very close to the 'Golden Triangle' and having thousand of kilometres of common border with India, particularly the north-eastern state of Manipur where cheap and easily available good quality heroin is fuelling an HIV epidemic amongst intravenous drug users is also spreading the potentiality of HIV transmission in Bangladesh. In Manipur, India, the prevalence of HIV among IVDUs increased from 0% to 50% within six months due mainly to the lack of awareness regarding the risks of needle sharing (Sarkar et al,

1993). In Manipur, the distribution of IVDUs and HIV was associated with its main trading road from Myanmar with subsequent research in rural areas linking the prevalence of drug injecting with the presence of drug trafficking routes (Sarkar et al, 1997). In a community-based cross sectional study on drug users in the Darjeeling district of West Bengal, India, which has boundaries of three countries including Bangladesh, Sarkar et al (2005) found that the overall HIV sero-prevalence among IVDUs is rising and is expected to increase further due to several factors including risky sexual behaviours. Their recommendation is a combined effort of urgent interventions with all bordering countries at the local and national level.

Injection of any sort is an even more efficient way of spreading HIV than sexual intercourse. Since injecting drug users are often linked in tight networks and commonly share injecting equipment with other people, HIV can spread very rapidly in these populations. Regarding heroin or other drug selling points drug users told me that there are many such places in both Jessore and Khulna (Fig 7.2). Sometimes local people resist the dealers but after a few days they come back and sell again. In both towns, drugs are sold close to educational institutions, the railway station, market, bus terminal and in nearby villages. The availability of drugs in a society is an important and indirect, indication of the heroin use pattern in a country (Carnwath and Smith, 2002). If heroin becomes more widely available and cheap, it is clear that there will be many more users. The easy availability of drugs is a prime cause of the growing number of drug abusers in Bangladesh. During my participant observation, in a commercial drug treatment centre at Jessore, I met with one field level worker who collects patients for his centre and has been working with addicts for a long time. He thinks that drug addiction is becoming more of a problem than HIV because so many youths take drugs at one time or another and they are being 'polluted', which can lead to death. He said:

"*In the Jessore region you will see huge numbers of people are involved with drugs, particularly heroin. Most of our heroin is coming from India. You can easily buy it, from a tea stall even. I have found in many places even rural settlements are affected by drugs.*"

Regarding mobility and the need for drugs, many users admitted to me that the level of desperation is at times so great that addicts do not care about place or threat to life. When they face police harassment in Jessore then they collect their drugs from

Benapole, which means more business for the dealers there. In the south-western region of Bangladesh, Benapole is considered to be one of the most 'trustworthy' heroin collection points. Drugs users from different parts of Bangladesh know the reputation of Benapole for its 'reliability'. If necessary they also cross the rather porous border with India to buy the product. In Jessore, one FGD participant told me:

"*When we feel a crisis, we go to Benapole, because it is a 'base' station for heroin, we take the utmost risks to get the product on time. We don't care about the river, jungle or even the border security force. When the BDR or BSF notice us, they show sympathy to us as 'heroin khor'. They permit us to cross the border sometimes.*"

Figure 7.2: Drug Selling Points in Slum Area

Some aspects of street life such as extreme mobility, low knowledge of HIV and recreational sex, compound the vulnerability of street drug users. However, it can be said that drug addicts have to be geographically aware and tactical users of place due to the stigma attached to their activities and the identity crisis that this causes, and, as a result, they try to take drugs in controlled areas where they can manage everything themselves and nobody will disturb them. On the other hand, they do not hesitate to go to any place where they will have access to drugs. Basically, they collect their everyday drugs from local dealers but when there is a supply crisis, a price hike, or they need the assurance of a good quality product, then they have to move. The tactics of place-selection for drug collection can make the addicts vulnerable (Fig 7.3). Homelessness is associated with elevated levels of HIV and related risk behaviour among IVDUs, influenced by living conditions and lack of socio-economic resources. In addition, border and urban growth points can increase the health risk, particularly HIV

vulnerability, not only through high population movement, the sex and drug trade, and availability, but also due to fear of violence, exploitation or deportation.

Figure 7.3: Stigmatized Place and Drug User's Common Risk

7.1.2 Sex workers' 'risky' places

The notion of risk is profoundly gendered (Wilton, 1994). For some men, an element of risk apparently makes casual sex exciting, but for women the association of risk and sex is of ancient origin (Jeffreys, 1987; Richardson, 1990). The exercise of male power can act directly against women's sexual safety (Wilton, 1994; Sen, 1998). Rape, sexual abuse and pregnancy are risks. In other words, women's generally disadvantaged social position in the context of a capitalist society is central to their experience as prostitutes (Mcleod, 1982). In order to explore the narratives of women who have experienced violence whilst working as prostitutes, Hoigard and Finstad (1992) mentioned that some women experience very few physical assaults and attacks because they are good at 'gentling' the men, at 'negotiating' and 'counselling'. O'Neill (1996) found some prostitute women who were used to being hurt physically and emotionally but also they had 'cut off their feelings'. In Bland's (1992) work, marginalized prostitutes saw themselves as 'deserving victims' due to lack of state action about violence against women. For the street and floating sex workers, violence is such a frequently occurring matter that most of these women expect it to happen at some point and consider themselves 'lucky' if they had no fear or managed to avoid it (Mckeganey and Barnard, 1996). In recent years, there has been a rapid growth of prostitutes in the cities and towns of Bangladesh (Khan, 1988), particularly in hotels (Nessa et al, 2004). Here, the closure of many brothels and stigma-driven harassment of sex workers is also playing a

role (Jenkins and Rahman, 2002). Almost all prostitutes, including brothel and non-brothel workers, face a wide range of violence, including the extraction of money, free sex, harassment and arrests, across the full range of different locations.

Girls' views about 'safe' places: Violence is a common theme in the prostitute's life. Different girls have different conceptions about the relationship of risk and place. They disagree, for instance, about degrees of safety between a madam's residence and a hotel, but almost all of them consider customers' houses to be unsafe because of the unpredictable attitude of the punter. Some girls think that risk can come from unprotected casual sex with multiple partners, some also consider the place as unsafe. In Jessore and Khulna there are a few recognized brothels but many unrecognized and hidden brothels in both. For example, many hotels have a sex sideline for the sake of their sustainability. This is an open secret to all. Interestingly there is another type of brothel which is located in ordinary residential properties and stays hidden. Many sex workers prefer these so-called '*madam*' houses as the safest places for commercial sex. The *madam* looks after the safety issue and protects them from neighbours' suspicion. Each madam keeps only one or two girls, who are known to her neighbours as her 'daughters.' Sometimes additional girls visit the house after a phone call from the 'madam' when she has a request from a potential customer. The customer and the girl visit the house as her relatives. In order to stay in business, the madam will have to pay a bribe to the police and protection money to local *mastaans*. But if local people hear about it, they will need to move away, to a new place. I asked a girl, Ruma, who is mostly working at the residence under a madam's control, what are the safety issues in the residence. She told me that "*when police sources trace our madam's house, the madam gives them money and a girl, whoever they want; then they become quiet and they protect the madam and her girls.*" On the other hand, some girls told me that hotels are safe and residences are risky after only two to three months when it becomes known and the locals can identify the sex workers easily. Hotels are comparatively safe where there is a good connection between the hotel management and the local administration and so girls are less likely to be victimized. When I asked the girls about the advantages and disadvantages of hotels and residences, one girl, Keya, who works in both told me that "*actually the madam's house or residence is fine; I don't need to mix with many people. The disadvantage is that customer flow is low. On the other side, in*

hotels there is continuous work and we can earn easily but the problem is that we have to face police raids."

Risks in 'safe' places: Many hotel-based sex workers are obliged to have sex without a condom with known customers and the hotel manager. Sometimes hotel managers request them to have sex without a condom for a 'VIP customer' (an influential customer). In one FGD with hotel girls at Khulna, they said that "*we cannot force about two out of five customers to wear condoms, and some hotel owners request us to take some customers without a condom.*" Sometimes hotel-based sex workers are not fully paid and need to provide money to brokers. There are many opportunities to be cheated, for instance as a result of the shift systems operated by hotel managers because customers want 'fresh' and 'new' girls for each visit. If a girl does not get a customer in her allocated shift her income is uncertain and she becomes more dependent upon the customer's choice. She may be pressured into having 'free sex' in order to guarantee another shift in the future. I found one hotel- and residence-based sex worker, Keya, who told me that she has to have sex with hotel managers because "*I have to convince them and need to develop their trust on me. It's in my interest for continuous business.*"

Many residence-based sex workers, also considered 'call girls' due to their high status, are fearful of visiting new places. Some go with their '*bandhobi*' (friends) to a madam's house but, until they reach the house, they do not know where they are going. They are always fearful that they will meet someone who will recognize their family identity. However, when I enquired about the health risk situation in residence houses, one girl confessed that sometimes the madams will encourage them to take customers without a condom, suggesting that it is enough to use contraceptive pills and have a thorough wash. Some customers offer 1000 taka for 'one shot' without a condom, and since many sex workers are poor, they may be tempted by 30 minutes of work for such a sum.

'Contract' trip and preferences: Floating and street sex workers need to go to many uncertain places for their 'business' with the customer, which causes many dangers and physical risks for them. Many floating or casual sex workers travel around the region with customers well known to them and stay with them for few days in some cases. I found a few girls who have had this experience of travelling around the region with their customers, staying in hotels as husband and wife. I also found some girls willing to

travel long distances for 'contract work', visiting, say, Dhaka or Faridpur and staying there for up to a week. At Benapole, I found sex workers who go for these 'contracts' and visit many districts. These girls are known as '*saree*' (traditional clothes) sellers in the area. During the 'contract' trip, they have to face rough behaviour and suffering and customers also force upon them 'bad requests'. One girl, Tania, explained that some customers want anal or oral sex and it is dangerous to refuse. When she is on the customer's territory, it is difficult to manage his attitude, especially if he is drunk or refuses to use a condom. A group of floating sex workers in Khulna shared their experiences with me about these 'outside' risks:

"*If you go outside, you must to face many types of problem. First, you will need to work with many people rather than a few. Second, with people coming and going up to midnight, there is the fear of local people knowing. Then we face many dangers, particularly police harassment and threats of rape. Third, among the customers, if anyone has sex without condom and if he mentions it to others, then they will also want to do it without a condom, and we are without protection.*"

A sex worker may also find that she does not have enough condoms if she faces many people beyond her expectation. One NGO counsellor told me that girls working at night in a customer's house may be threatened with a knife so as not to have to use a condom, and sometimes they have to face group anal, oral or vaginal sex. Sometimes they take hard drinks with their clients and as a result are more susceptible to abuse, and sometimes they are not even able to collect money from their customers. Floating and street girls are so marginalized and economically insolvent that when a customer contacts them by mobile phone or on a street corner, they usually bargain about payment and its surety rather than checking the 'danger' of the place of assignation (Fig 7.4). They think that they will stay there for a few hours, not a whole day and night. One floating sex worker Lota told me that "*I ask the punter about the payment first, then assess the 'danger' of the place where he wants to bring me. If I feel the place would be 'safe' for me I decide to go.*"

Regarding the relationship between place and risk, many street sex workers in Benapole say that there is no fixed place for their work. They need to conduct their business in places like on the road, on the hillside, by the river, under a truck, in the bushes or wherever they can find somewhere, so they cannot negotiate about their health protection measures. When they get a customer, they aim to finish the work quickly and

do not think so much about the place. Silpi told me that "*we get little chance and we need to finish the work in a very short time, so how can we manage condom use*?" I found some street girls at Khulna railway station who use places such as empty train compartments, under the rolling stock and behind shops, meaning that they cannot properly negotiate about payment and condom use as well. Sometimes, when they are caught sight of by police or guards, they need to negotiate the matter very quickly, sometimes to give a bribe or give their body in order to protect themselves from prison or a mob of local people.

Figure 7.4: Floating and Street Girls' Customer Collection Point

"Brothel is less vulnerable than outside": It is generally considered that a brothel is a risky place for HIV infection or transmission but many brothel girls disagree with this. Their logic is that they are careful and aware about condom use and the brothel itself insists on condom issue. Outside the situation is different because there is no control of condom use. Moreover, many young age girls are having casual sex because of economic hardship. One peer educator, Bobita, who had worked in a brothel as a sex worker for a long time, told me:

"*On the streets casual girls can be killed or tortured for insisting on a condom but in the brothel there are so many people available here with views about condom use. In the brothel, girls not only use condoms, but also check the men's bodies.*"

In the view of many brothel girls, it is the customers who are responsible for the potential spread of the HIV virus. Their lack of care with condoms and their sexual behaviour puts the women in a most vulnerable position. It is well recognized that non-brothel sex workers in Bangladesh comprise a significant mobile population. The level

of risk of violence associated with sex work is amplified by the space where the work is taking place. For example, women who work solely on the street indicate much more vulnerability with regard to not being able to assert their power with clients. They experience high levels of physical abuse. On the other hand, those women who work mainly in hotels or in a madam's residence have the added advantage of having in-house security. Many reported that the security was effective and that they felt safe. If they had a problem with a client such as showing threat or unwilling to make full payment, then security was on-hand and was helpful in dealing with the problem. However, many hotel sex-workers complained that hotel management and security could get violent if sex-workers were unable to pay rents at the end of the month or week; and that they sometimes demanded sexual favours. Besides, hotel and street-based sex workers suffer violence and abuse from the police and from *mastaans* and the hotel girls are often arrested and harassed. Regarding the brothel as a place for sex workers, it is considered that many sex working women are too powerless in the face of a strong brothel power structure to be able to achieve high levels of condom use through negotiation on a person to person level with a client, though the law and order situation in brothels has been improving in Bangladesh due to an NGO presence in many. Despite this, brothels remain non-secure places for many due to competition among the girls to secure customers; the need for girls to obey *sardarnis* or house owners and facing the police and other influential people. However, due to the closure of city brothels such as Tanbazar, Nimtoli and Magura and an increased demand for sex workers in non-stigmatized locations, there has been a remarkable change in the nature of the non-brothel-based sex work in recent times. Moreover, in slum areas many women live in very difficult conditions in terms of income because they have no regular husband. Many slum girls are married by the age of 12-13 years and within a year they are giving birth to their first baby. Divorces are common and many have problems with their husbands, such as long absences or the husband having two or three wives. For many slum women, prostitution is a coping strategy and may be combined with being a construction worker or a maid servant.

7.1.3 Transport workers' preferred 'sites'

Truckers need to move across the country for goods transfers and they stay away from their families for long periods. As a result, many of them have been habituated into

commercial sex and alcohol as a part of their leisure and also consider it as stimulating for the driving profession. In a study on long distance truck drivers Marck (1999) has explored their sexual cultures by reviewing the African (i.e. Nigeria, Zimbabwe, Kenya) and Asian (i.e. India, Thailand) literature on truckers (Orubuloye et al, 1993; Singh and Malaviya, 1994; Morris et al, 1996; Jackson et al, 1997; Rao et al, 1999; Mukodzani et al, 1999). This ethnographical literature review shows that long distance truckers in the above mentioned countries have been found to participate in vigorous or diverse sexual cultures at roadside settlements and border points with poor young women including commercial sex workers. In Nigeria and in India, most drivers have multiple partners at short intervals (Marck, 1999). In Bangladesh, there are estimated to be over 300,000 truck drivers and their helpers (Foreman, 1999), who are at high risk of contracting HIV because of their frequent absences from home and their sexual contacts with prostitutes and, in some cases, with each other. Although premarital sex is not openly accepted in conservative Bangladeshi society (Caldwell et al, 1999), it is assessed in one study (Gibney et al, 2003) that 73% of married and 78.4% of unmarried truckers were involved in sex on their travels and the mean age at first sexual intercourse was 17.8 years.

Transport workers' 'refreshing' sites: There are some reasons frequently articulated for transport workers having relations with sex workers which are absence from their wives, a desire for fun, peer pressure and importantly, the glamour and sexual techniques of sex workers and their willingness to engage in acts that subjects did not want to perform with their wives. Most Bangladeshi truckers, who visit Dhaka, favour this city as a good place for encounters with sex workers in the street or in congested truck terminal areas. Many Benapole-based truckers prefer to have sex in the Goalondo ferry terminal on the way to Dhaka or the wholesale markets in Dhaka such as Armanitola and Babubazar, during the loading and unloading of goods. Many drivers also prefer either a hotel or a friend's house where they will not be disturbed.

Rather than hotel and brothel girls, many transport workers prefer 'site' girls (those who are based in local street and floating). They consider these to be 'safer' (from their point of view) than hotel and brothel girls in terms of the number of customers and cleanliness. When truckers drive during the night, in some remote and isolated areas they get 'signals' by someone spreading lentils on the ground, which means that

someone is available. If they want to proceed, then they park the truck beside the road and finish their 'business' in a dark place within a short time. One truck helper, Mahbub, told me about the reason for his preferences: "*I like 'site' girls but not brothel girls because many people go there and brothel girls have sex with many customers. But site girls do sex with only a few men. So they are satisfied with a few customers and we do not need to use condoms. So we do it in the open air and that's my preference.*" When I asked him about the risk of having sex with 'site' girls, he said "*why should I be afraid, we are men! If the girls can come out from their house at night, so why should I be scared? I am not afraid about that.*" Mahbub also admitted another reason behind choosing 'site' girls: "*There is no hurry with 'site' girls. If there's no-one after me, then I can enjoy whatever I like. It doesn't matter where I am biting or kissing her, if she is good girl she will allow me to bite or kiss her body.*"

Different views about 'safe' places: One helper, Zillur, was opposed to sex at 'sites'. His logic is of dangers on the streets, such as being caught 'in flagrante'. He prefers a '*para*' or brothel because he is more relaxed there. Another transport helper, Sukkur, does not want to be restricted to the *para* although he fears being captured by local people and being considered a 'bad guy'. Some drivers told me that they feel a need for sex but they exercise self-control because, if they go to the local *para*, it might be possible for them to be traced. If they go instead to a hotel, this is less likely. Faruk said that "*hotels are comfortable. Nobody will see you. If you ask the hotel manager he will supply a girl, so I don't need to go to any trouble. This opportunity is not available in the brothel, where girls misbehave with the customers for extra money. But in a hotel you just offer the girl your contract money only.*" However, some drivers with a muslim sensibility follow the religious dictum to avoid brothels but this does not stop them looking for street girls.

During an FGD with rickshaw pullers in Khulna, all were agreed that they prefer brothel girls because of their affordability (Fig 7.5). Many also pick up girls from the park, street or station area who sell sex for a low price. Here price was a priority over 'safety' concerns. When they saved sufficient money, they visited the local brothel named Fultola, which is located close to Khulna city. Some rickshaw pullers consider this brothel to be 'safe' because its environment is good. There is no noise and the brothel is surrounded by a brick wall.

Figure 7.5: A View of Baniashanta Brothel

7.2 Mobility and Role of Border Towns in Transmitting Health Risks

Analysis of the geographical distribution and migration of HIV is an established field of study (Gould, 1993; Smallman-Raynor et al, 1992; Hogg et al, 1995). Although the cause of the global spread of HIV is complex and multifaceted, increasing population mobility both within and across countries has been implicated as a major factor for spreading the virus and migrants are more vulnerable to HIV than non-migrants (UNAIDS & IOM, 2001). Mobile populations including sex workers, drug users and transport workers may themselves be considered as 'core' or as 'bridging populations' (Cates and Dallabetta, 1999) for transmitting HIV/STIs to lower-risk groups in countries/regions of origin as well as destination. In other words, migrants may act as a bridge population in the spread of HIV as infected migrants return home with the virus and unknowingly pass it onto their sexual partners (Hirsch et al, 2002; Anderson et al, 2003; Lurie et al, 2003). Numerous studies have cited migration as one of the important factors leading to the rapid diffusion of HIV in the context of developing countries (Caldwell et al, 1997; Parker, 1997; Campbell and Williams, 1999; Wolffers et al, 2002) and developed countries (Wallace et al, 1994; Gras et al, 1999; Lansky et al, 2000; Wood et al, 2000b; Wallman, 2001).

Economic marginalization, social isolation and lax social control all contribute to elevated HIV risk behaviours among migrants (Yang, 2006). Ming (2005) also puts HIV/AIDS in the context of cross border mobility. In Bangladesh, it is a great concern that surrounding nations India, Myanmar and Nepal have high rates of HIV and it is

commonly thought that HIV could be 'imported' (Chowdhury et al, 1995; Gibney et al, 2003), especially from India through cross-border smuggling activities, and the behaviour of Indian truckers and Bangladeshi sex workers. With a highly mobile population in aggregate, the border towns may be considered high-risk environments, or even 'core environments' with little differentiation in levels of risk between groups within them. People working here might be considered as 'bridging populations' when they return from the town to their home region. Here, the 'bridging' concept defines the transfer of health risks to what we might call 'innocent' parties. In this study I found much evidence of this kind of mobility pattern and 'risky' behaviours by local sex workers and Indian truckers at Benapole port near the border.

7.2.1 (In)visible role of border women

Involvement in the commercial sex industry is generally characterized by a high level of geographical and occupational mobility. Wijers and Lap-Chew (1997) think that confusion resulting from the equation of 'trafficking in women' and smuggling of aliens arises in the context of 'consent' (p.32). In the border area of Bangladesh smuggling is a regular business and regarded by many as a legitimate source of earning. I was told that many of the girls involved in smuggling are used as a means of negotiating with the Indian Border Security Force (BSF): sex traded for ease of transferring goods from India to Bangladesh. Basically Bangladeshi women bring fruit, eggs, banned drugs including heroin etc. from India and they cross the border with the help of '*ghat*' (illegal crossing points) people. Those who cross the *ghat* illegally have to wait for a signal from the middlemen on both borders, who are called 'the syndicate'. They control the border security forces through bribes and the trafficking of 'women' for sex. The middlemen give a 'token', a special small document which acts as a pass. A smuggler woman Monowara explained this:

"When I have money I make a payment to the syndicate people for allowing me to cross the 'ghat'. Otherwise I must have sex with them. I prefer this rather than giving money, for the sake of my livelihood. Sometimes the syndicate people take wine/ alcohol before sex and this can take a long time. Sometimes I need to do sex with Indian businessmen and often also with the Indian BSF when I come back to Bangladesh. They usually do it in the evening in a dark place. After sex I then go to somebody's house in the name of using the toilet, and wash my vagina, otherwise the HIV disease will come, and I will die, so I try to wash."

In the literature population movement is thus structurally connected with both economic disadvantage and social inequity (Gillies et al, 2000; Soskolne and Shtarkshall, 2002). For example, in many poor countries poverty is the primary force driving the migration of women from rural to urban areas, where they are often tempted or absorbed into the sex trade. This reminds us that a number of environmental issues combine to produce geographic effects in HIV association with migrant women. In the context of Bangladesh borders, migration is a central feature of life in the border towns. Large-scale trade between India and Bangladesh has brought a rapid influx of different people including sex workers to the borders. Some migrant women come in search of employment. It is locally known that there are eight *ghats* around Benapole port and its 2-3 mile hinterland. As a result, everyday mobility has been causing many health risks but these are mostly ignored by the girls due to their need for a livelihood. Although these girls have given their 'consent' for sex, most of the time they are forced into sex without taking any protection in the exchange for easy accessibility across the border. Many Bangladeshi truckers believe that brothel girls have the 'germ' but not Benapole's street or smuggling girls.

7.2.2 'Open secret' role of Indian truckers

Most studies consider migration to be a major vector of HIV transmission, which can be attributed to migrants' risky behaviour (Brockerhoff and Biddlecom, 1999). Truck drivers have been identified as having high risk lifestyles for STD transmission in India, Thailand, and sub-Saharan Africa (Singh et al, 1994; Mbugua et al, 1995; Podhisita et al, 1996). Transport workers who stay long hours on the road and often spend several days in one place for clearing customs or resolving mechanical problems of vehicles, seek entertainment through sexual activity mainly as they are away from their spouse or regular sexual partner. In other words, sexual freedom appears to be one of the attractions of the town or a compensation for separation from home to the transport workers. Indian drivers have reported a large number of non-regulars, usually commercial, partners where they may not get home for several months (Rao et al, 1999). In Benapole 300-700 Indian trucks and more than 500-700 Bangladeshi trucks arrive every day (Fig 7.6). Indian trucks stay at Benapole terminal from a few days to weeks due to loading and unloading. In the meantime the truckers introduce themselves

to brokers who have good contacts with the local girls. Although there is a gate to the terminal area, at night the girls can enter the area where the Indian truckers stay. Some of the regular Indian truckers have fixed or known girls. When they arrive at Benapole, they inform a broker and give an advance for the 'business' that is to come at night. Regarding the preferred customer, most girls at Benapole prefer Indian transport workers rather than Bangladeshis. They are said to behave better with the local girls and pay more. Although most Indian transport workers do not use condoms, the girls allow it because either they have a good intimacy or are earning a good amount. Monowara told me that "*foreigners talk sweetly and pay well, including tips, as they like Bangladeshi girls, so they spend their money on us, but the Bangladeshis try to exploit us. Bangladeshi drivers pay at most 50 taka, but foreigners give 100 taka. Some Indian drivers even give us loans, so we don't force them to use condoms.*"

During my field work, I discovered another preference for Indian truckers as customers by the local girls which might be a cause for changing risk. Among those sex workers involved with Indian customers, some expressed a preference for Muslim rather than Hindu drivers. They believe that sex with Hindus amounts to a greater 'sin'. Silpi told me about that "*many Indian drivers are hindu and many girls will have sex with them and do not differentiate between hindu and muslim. I am more careful. I only mix with muslims, because I am a muslim girl. Although many girls do not care abut it, I prefer muslims because we have to give an account to Allah. I want to know his name first and then I can judge whether he is muslim or hindu. I have good relations with many Indian muslim drivers. When they come they let me know and then they come to the house at night.*"

However, some Indian drivers take a 'wife' in Benapole. They choose a girl who has been economically abandoned and spend as little as possible in monthly costs on her. In exchange for marriage, the girl will get some assurance for getting monthly money, and if payments become irregular or stop then the girl will consider that her husband is not interested in continuing the relationship. One outreach worker, Jabed, told me the story of a girl named Jamila of Benapole who married an Indian driver but within three months she got married to another man. Other relationships are, however, more stable. For instance I met one woman, Popy who married an Indian driver and started a family.

Figure 7.6: Approaching Indian Trucks at Benapole Land Port

7.2.3 Indian truckers' sex, from Benapole to Bombay

In 2002, the U.S. National Intelligence Council (NIC) reported India to be one of five 'second wave countries', where infections with HIV are on the verge of a 'breakout' from 'high-risk' populations into the general population (Sarkar et al, 2005). In a study of non brothel based female sex workers in India, Dandona et al (2005) found that street based workers are a significantly higher HIV infection risk compared to brothel girls due to them being 3.5 times less likely to use condoms with clients. Gangopadhyay et al (2005) found that in West Bengal, the Indian state bordering Benapole, many sex workers agree to unprotected sex if forced or offered extra money. In a study to assess the west Bengal brothel girls' HIV status, Sarkar et al (2005) found that the prevalence of HIV infection was 9.6% including 0.6% HIV-2 infection, which probably indicates their sexual exposure to multinational clients, particularly seafarers. Some consider it a matter of pride to enjoy sex with a '*bangla meye*' (Bangladeshi girl). Some consider these girls to be disease-free. Some Bengali-speaking Indian truckers shared their experiences in a FGD about the women who are visible in the custom godowns area and truck terminal area of Benapole. They 'use' these girls at night, either in the parking area or in the adjacent houses of the slum. They (Indian truckers) explained their preference: "*Some of us feel very excited to have sex with Bangladeshi women. The rate is cheap here, basically our 100 rupees being the equivalent of 200 taka. Some girls are available for 50 taka or 25 rupees, whereas in India the minimum rate is 50 rupees, so this is a bargain.*" A few Indian truckers who reported having sexual relations in

Bangladeshi towns near the borders also had sex in boarding houses or with hotel sex workers. Sometimes some Indian truckers visit the Jessore brothels.

During my interviews in Benapole, I met with some Indian truckers in order to discuss their sexual experiences with Benapole girls. One of them, Abdul, related that:

"*Since 1991 I have been coming to Benapole and in the last 5 years I have been having sex with the local girls. In Benapole, when we are outside the parking area, the girls come at night and call to us. Some Indian drivers go to the nearest slum or to a girl's house. I prefer not to use a condom during intercourse because it is the girl who will benefit, not me. Though I have some itching problems on my penis, when I take medicine from the pharmacy, it gets better. Other than Benapole, I also enjoy hotels in Bombay and parts of Andhra Pradesh. Bombay is costly but Andhra is less expensive and just as good.*"

This case study shows how risk can be imported from one place to another. The girls stated that they have regular sexual and emotional relations with Indian transport workers, who are their main customers. This specific connection is likely to be substantially responsible for spreading the threat of HIV/AIDS and other STDs in this area. Because these drivers and helpers also travel to many different cities in India, including Bombay or Andhra Pradesh, they are an important channel for spreading the virus. From this primary 'imported' health risk, the infection has now moved in a secondary wave to the general population of Bangladesh.

7.3 Hidden HIV Cases in Bangladesh?

Essentially the pattern and pace of HIV transmission in particular geographical settings depends upon the interaction of two main factors; firstly, the nature of sexual and injecting drug using cultures, and secondly, the governmental and societal response to combating the threat of HIV/AIDS (Ford et al, 1997). In South Asia, the dramatic rise of HIV infection in India and Myanmar alarmed public health officials in Bangladesh (Chowdhury et al, 1995). This rise in cases, coupled with the rapid spread of HIV/AIDS in India, has raised fears for Bangladesh because of its illustration of how rapidly a minor rate of HIV infection can turn into an epidemic in a country with socio-cultural and economic similarities (Gibney et al, 1999a). Although the rate of infection of HIV is lower than expected, Rahman and his colleagues (1999) think that low HIV prevalence

as currently reported does not reflect the true situation. The first HIV case was detected in Bangladesh in 1989 (NASP, 2004) and the rate of HIV infection is predicted to increase in Bangladesh because all of the behavioural and bio-medical risk factors are prevailing in the country (Gibney et al, 1999b). In this section, I will look at the issue of women trafficking which is contributing to the spread of HIV infection in Bangladesh. However, the research also seeks the 'unrecognized source' of HIV infection which is playing an unseen role in this conservative society.

7.3.1 'Contribution' from trafficking

Trafficking in women includes all of those acts involved in the recruitment and/or transportation of a woman within and across national borders for work or services by means of violence or threats of violence, abuse of authority or dominant position, debt bondage, deception, or other forms of coercion (Wijers and Lap-Chew, 1997). It has become a global business that affects almost all countries and reaps enormous profits for traffickers and their intermediaries. United Nations' reports estimate that 4 million women have been trafficked from one country to another and within countries (Raymond et al, 2003). United States reports calculate that 700,000 to two million women and children are trafficked internationally each year into the sex industry and for labour (ibid). Within South Asia, trafficking of women for the sex trade is common in Nepal, Bangladesh, Pakistan and India (Fernando, 1997).

Several thousand women and girls are trafficked annually from Bangladesh for the purpose of sexual exploitation, primarily to India, Pakistan and the Middle East. Apart from trafficking for sexual purposes, women in the region are also traded as marriage partners, domestic workers, child-carers, construction workers, beggars, casual industrial workers and nurses, particularly to Middle Eastern countries (Murthy and Sankaran, 2003). Although reports and studies identified these border routes, traffickers use different routes at different times in order to avoid police and other law enforcement agencies. To enter India through Kolkata, the two most common routes are the Benapole border in Jessore, across which almost 50% of the trafficking takes place and Satkhira (ICDDR, B Report, 2001). It is worth noting that a good number of CSWs from Bangladesh have crossed the border into India and engaged in prostitution in Kolkata (Islam et al, 1999). There are as many as 18 transit points along the India-

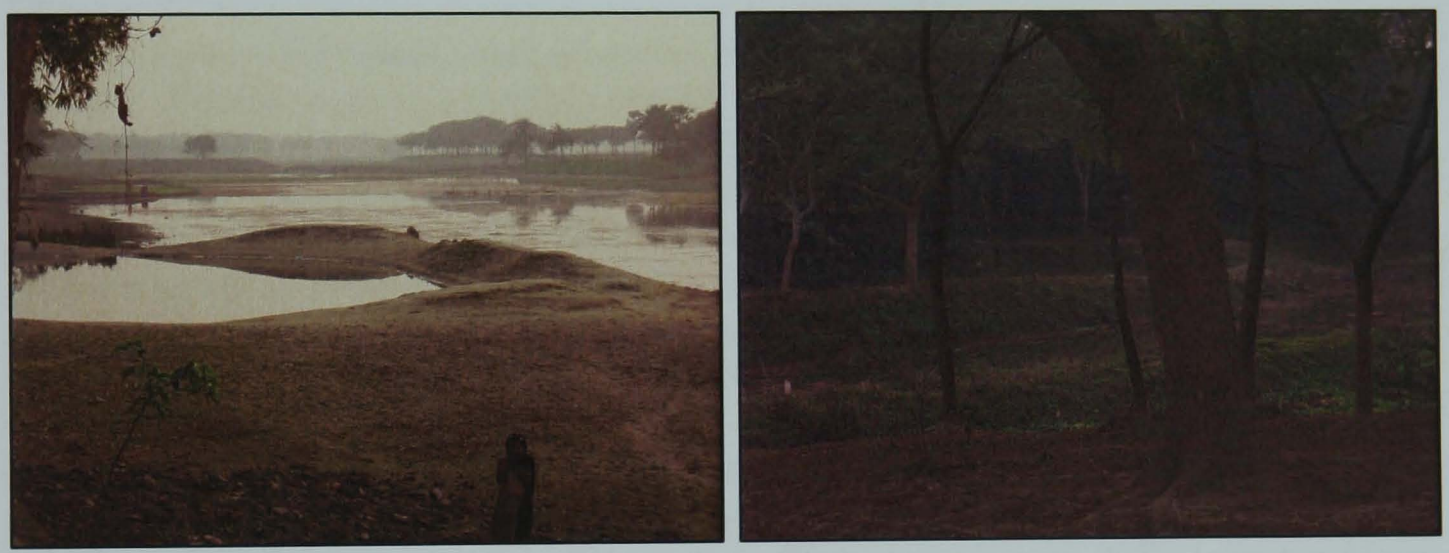
Bangladesh border through which children and women are smuggled out of the country (ICDDR, B Report, 2001). According to an Independent Bangladesh report an estimated 90 percent of trafficked women were forced to engage in prostitution (Ahmed, 2006a).

Some trafficked girls are taken to Bombay as West Bengalis. Some start their work there as maid servants but after a time they turn to prostitution. Many are young women from remote villages and poor border communities who are lured from their villages by local recruiters, relatives or neighbours promising jobs or marriage. According to a Human Rights Watch Report (1995) most of the trafficked women are sold for very small amounts to brokers who deliver them to brothel owners in India for anywhere from Rs 15,000 to Rs 40,000. This purchase price becomes the 'debt' that the women must work to pay off - a process that can stretch on indefinitely. One Bangladeshi transport worker who has visited many parts of India told me that Bangladeshi women are working in many cities of India including Bombay and Kolkata either as dancers or part time sex workers. Many of the women working in the brothels of Jessore and Khulna regularly cross the Indian border and spend time for shopping and also working in the brothels in Kolkata, before returning to their previous work (Bhuiya et al, 1995). Bangladeshi young women are in demand in India: they look conservative, reserved, over dressed and '*neerog*' (disease-free), and, in the imaginations of the customers, possibly virginal. Many of the border villages are said to be '*bombay para*' (village named Bombay) because many of the local girls have been trafficked at one time or another to Bombay and some of them have returned with a good amount of money. This encourages other girls' families to fall into the trap of traffickers. During my field work in Benapole, I found one girl, Sajeda, who had recently come from Bombay after a long time and was now doing commercial sex work in the Jessore region:

"*As we were poor, I went to Bombay from Benapole at the age of 12-13 with a broker, to help my mother and younger sisters. He said he would find me a good job there. This turned out to be a job in a bar. I had sex with the customers without a condom and took many risks. I worked there as a prostitute for three years and earned lots of money. I faced many types of customers who came from different places. I also had group sex experiences with 4-5 people. I came back to Benapole in 2005 because the Indian government forced us to leave their country before the elections. Now I am working here as a sex worker in the Jessore area but sometimes I go to Dhaka with customers. Here customers also do not want to use condoms. I don't know what kind of problems may arise from having sex without condom. I've heard about AIDS, but I am not sure whether it is in my body or not.*"

Trafficked girls who become prostitutes have no family trace to report to on the girl's welfare. The trafficked girls forced into the brothels do not want to return to their homes once they are into it for more than one year. Such girls believe they would be victim of social stigma and face discrimination from society and that their families would also suffer. One boundary is the *Isamoti* river but in some places this has no existence in summer and winter and people can go to India by jumping over the channel (Fig 7.7). The BDR and BSF are unable to trace the traffickers because the people who live along the border on both sides are tightly knit.

Figure 7.7: Showing Bangladesh-India Natural Border



Trafficked women are particularly vulnerable to violence and sexual exploitation by officials such as police, immigration authorities and border guards because they are undocumented, have little knowledge of the language of the country to which they are trafficked, and no legal knowledge of their rights (Williams, B. 1999). Many are raped and often receive little or no medical attention. It has been stated by various Indian NGOs that girls are often locked up, starved, beaten and burnt with cigarettes for not complying with the brothel owner or the customer's needs (Prasai, 2008).

In West Bengal, Kolkata is considered a hub for the trafficking of women and girls where large numbers are smuggled in from Nepal, Bangladesh or Burma (BBC News, 2007). From Kolkata, they are sold on to brothels in Mumbai and Delhi. In the south western part of Bangladesh, particularly in the Khulna region, a good number of women who have been trafficked back and forward across the border have been identified as

HIV positives and the 'victims' of women's marginalization. One girl in Khulna named Shahana is a good example:

"*I lost my jute mill worker father at the age of 6 months along with my brother and two sisters, and my mother spent all of our deposited money on his treatment. Then my mother went to my father's village, but they refused to help, and she came back to Khulna again. Then some people advised my mother to go to India for work. When I was 3 years old, we went to India. My mother arranged my marriage at the age of 12 in Kolkata, and I became a mother at 14. My husband was a labour-cum-contractor but he didn't contribute to the family expenditure. So I took work, as an assistant to a carpenter but I left due to sexual harassment. I couldn't manage to give a proper diet to my small daughter, then I started a little vegetable business but some mastaans disturbed me and threatened rape. I tried for many jobs, including maid servant. In the meantime I gave birth to my second baby and my husband died accidentally in Delhi. Then one of my relatives advised me to go to Bombay as I was workless. I left my babies with my mother but I didn't talk about my expected profession. I promised to send her money. I decided to go to a Bombay brothel for the sake of my children's future. At the beginning I was busy but within one month I become pregnant and had to come back to Kolkata for an abortion. My mother understood when she saw my symptom - vomiting and weakness - and she told me to beg rather than do sex work. But I was determined to go there again in order to give an education to my babies. I saved a large amount of money, but after some time, I had some physical problems, like frequent fevers. Most customers didn't want to use a condom and we were not allowed to refuse a customer. I visited doctors often and was cured. After two and a half years I gave my savings to my brothers to buy a land in Bangladesh. Then I met a Bangladeshi man who wanted to marry me. One day I went to a medical centre in Bombay for a blood test and they asked me to collect the report in the evening. When I went there in the evening I was surprised to see that everyone was looking at me. I didn't understand what was going on until they told me that HIV had entered my body.*"

It has also been reported that many women choose of their own accord, within the options available to them, to migrate from one country to another or from rural to urban areas.; if one equates 'trafficking' with (illegal) migration, one may say that 'a woman is trafficked with her consent' (Wijers and Lap-Chew, 1997). In this case study, Shahana also accepted her profession knowingly and gave her 'consent' to start it. However, I found another woman in Khulna whose whole family had migrated to India to a village in the state of Karnataka. Her family arranged her marriage with a local villager who was a lorry driver. After her husband's death, one of her babies also died due to a lack of proper diagnosis and treatment. Then she, along with her daughter and other family members, returned to Bangladesh and a few years later she and her daughter were identified as HIV positive. She believes that her present disease came from her husband because there were no other possible sources of infection.

7.3.2 Unidentified 'sources'

Thousands of Bangladeshis travel frequently to countries known to have high HIV prevalence, such as India or Thailand, for business, tourism, medical treatment, recreation or education (Rahman et al, 1999). In addition, about two million people from Bangladesh currently work in foreign countries, including Saudi Arabia, Malaysia and Singapore (ibid). Rahman and his colleagues (1999) suggested that there is insufficient AIDS awareness among overseas workers, with 74 percent of overseas job seekers completely lacking any knowledge of AIDS. In this section of the chapter, I will focus on some participants who are already infected. Some are infected as a result of their risky behaviour but some are 'innocent victims' who do not know the source of their infection.

Case-1: In Khulna I found one HIV positive named Shahana who was infected in a Bombay brothel, who told me that in many Indian brothels they have no opportunity to choose their customers and they have to work with everyone without protection. According to brothel rules, if they refuse a customer they face physical abuse. Most trafficked girls and women are sexually abused; often they also experience other forms of physical and psychological violence. They are in the highest category of risk of becoming infected with STDs, including HIV/AIDS. Shahana said that she met many Bangladeshi men in Bombay. They visited the brothel and then returned to Bangladesh and slept with their wives. For example, recently, an HIV positive has died in Noakhali general hospital who worked in India for a long time as a labourer (The Daily Ittefaq, 2006). Shahana believes that many hidden HIV positive cases like her are living in Bangladesh.

Case-2: There are many Bangladeshi girls who work in the garment industry, fish companies or in construction work for their survival. In Khulna I found one HIV positive named Keya who was involved in her life with all three and was infected with HIV. She started her life as garment worker in Chittagong and then joined a fish farm in Khulna as a helper. She was also involved in '*jogali*' (construction) work during off season at the fish farm. As her husband did not like her fish farm work, she switched to *jogali* work in the Khulna region. After leaving her husband, she went to India for few

months as a dancer and bar worker. One of her 'close friends' sold her to the Baniashanta brothel and she started her life as sex worker. In the Baniashanta brothel, a brothel located beside the sea port of Mongla, many girls have experienced sex with foreign ships' crews, mainly from China, Korea, Burma, Thailand and Greece. Although they paid well, they never used condoms. After a while Keya developed pains in her wrist and ankle, and she sometimes had a fever. She took medication but was not cured. Finally, she left the brothel and returned to *jogali* work. Here the female workers are forced to have unprotected sex with the '*mistri*' (contractors), otherwise they are not given work. Meanwhile, her physical sufferings continued. The doctors thought she had rheumatism but then she developed gangrene problem in her leg and was admitted to hospital where her blood was tested and she was found to be HIV positive. There is a strong possibility that Keya has already transmitted her virus to many people who are still unidentified. From this case study, it seems that there are some important considerations about Keya as an invisible pathway of transmission. Firstly, if she caught the virus from a *jogali* worker before she joined the brothel, she must have transmitted it to many others. Secondly, if she caught it in the brothel from foreign sailors, there would also have been many possibilities of transmitting it to many local customers in the brothel at that time and, in addition, to many other people when she left the brothel and worked again as a *jogali* worker until her diagnosis.

Case-3: For migrant men away from the conservative culture of home they feel less inhibited and, with money in their pocket, they are vulnerable. Afsar spent a few years in Malaysia as a migrant worker and shared with me his experiences about the risks of getting HIV in Malaysia. He thinks that nobody would consider Malaysia a Muslim country if they saw the availability of foreign girls, especially Chinese and Russians, who enter on tourist visas. These girls have a contract with a hotel through an 'agent'. Usually they rent some houses and their agents provide the customers, and it is a very profitable business. Among the foreign girls, Russians are most in demand among the migrant workers. Afsar talks about how he became infected:

"*When I went to Malaysia, I was only 18-19 years old. When people leave the country, and they have no guardian over them, there is scope to make mistakes. In my life I made some mistakes. I don't know where I got the virus. I think my behaviour was responsible for that because I had many sex relations.*"

Case-4: Migrants have no political rights and they are economically under-privileged and socially displaced in the receiving countries. In most receiving countries, migrants are subjected to mandatory health tests only to ensure that they will not infect local people with disease. Their health is screened without prior explanation of what they are tested for and how they will be tested. Without pre-and post-test counselling, even if migrant workers are found to be HIV positive, they would not know their sero-status and thus would be denied the opportunity to seek treatment at an early stage. Citing national health security reasons, receiving countries usually deport HIV positive migrant workers. Uninformed HIV positive migrant workers are sent home ignorant of the risk of spreading the disease back home.

In Bangladesh, it is believed that migrants carry the virus from abroad, particularly when they return from periods of work in the Middle East. An irony of HIV in Bangladesh is that wives of these migrants are the most numerous group of the infected. I found one HIV positive woman in Khulna who told me that, despite her honesty and dedication to a 'pure' unmarried life, she got HIV as soon as she got married. She had grown up in a conservative family, so she had no sexual experience. But her husband was a migrant worker in Saudi Arabia with experience of commercial sex. She does not know whether the HIV he passed on to her was from abroad or from a local brothel.

Case-5: Recently one of my interviewees named Salma who recently identified as HIV positive, told me that she would be reluctant about insisting upon condoms because if she asked a 'friend' to use a condom, he would be curious about her motives and she might be caught and even killed for transmitting the virus. This is despite the possibility that she might transmit the virus to a new group of partners. She stated:

"*I want to make family life again, but how? I am thinking that I will go with men but ask them to use a condom, though it's a difficult matter. But if anybody wants to sleep with me and I tell him to use a condom, a problem may arise. If I try to protect him, he might suspect that I have a problem. And if he doesn't want to use a condom, what can I do? I will not tell him about my HIV status.*"

Sex may be an emotive subject for antibody positives or those who have AIDS. Salma has not had sex with anyone since she was diagnosed. She says that this is because she has not met anyone she wants to have sex with. But she also recognizes that having the

virus has made her stop and think a lot more about it. A woman who has AIDS may use help and support in telling her potential sexual partner although it would be a very difficult task.

Case-6: Like other parts of Bangladesh, in Khulna there are foreigners involved in construction projects such as highway bridges and communications projects. In the case of construction workers, many marry local girls on a contract basis. For example, during the Rupsha Bridge construction, foreign workers gave money to the bride's family for this kind of arrangement. I talked with a few girls who had sexual experiences with foreigners. One of the hotel-based sex workers of Khulna named Papri told me that she had experience with two foreigners.

Case-7: Other than sexual contact and needle sharing, blood transfusion is the next most serious risk factor for HIV transmission. Like many developing countries, in the Indian sub continent blood transfusion is still largely unscreened. I found one HIV positive in Khulna, Saiful, who had been diagnosed very recently along with his wife. Saiful got married at a very early age and had their first baby terminated because they were then still teenagers and poor. Two or three years ago when his wife had anaemia due to a miscarriage, he followed a doctor's prescription and bought a bag of blood from a private blood bank and gave it to her in a private hospital. They were shocked when HIV was identified in both their bodies.

All of the above examples show that HIV is spreading in Bangladesh silently and invisibly. Generally most cases of HIV in Bangladesh are being discovered by accident. The subjects are tested for another disease and are detected as positive. Bangladesh has high rates of internal and external migration. Some of the male internal migrants (from rural to urban areas) who live in the cities share the risk with their wives or other sexual partners when they return to their home villages. External migrants, other than illegal migrants to India, go to the Gulf States or South East Asian countries. Again, many are at risk of HIV/AIDS because of casual sexual relations with foreign commercial sex workers. If they are identified as HIV positive they may be forcibly returned home. People returning home with the virus may feel ashamed to be tested for fear of being socially isolated.

In Bangladesh, there is no arrangement for the migrant workers about voluntary counselling on HIV transmission, and this is urgently required. It is especially timely to call for public initiatives to provide AIDS information to migrants, particularly overseas job seekers before they leave Bangladesh.

7.4 Place, Mobility and HIV

This research shows how geographic place can be a contributing factor for health risks particularly HIV infection for vulnerable people in the context of Bangladesh. Among the 'most at risk' group, sex workers can be victimized due to their interaction with 'risky' places. Drug users also occupy risky environments in the form of 'shooting galleries'. In addition, transport workers' preferred 'safe' places also put them into vulnerability of infection. Apart from common 'most at risk' group in the country, widespread illegal migration and trafficking of women in the border areas as well as foreign transport workers play a large part in channeling the HIV risk from neighbouring countries especially India.

Risk behaviours, however, are not fixed in time and space. There has always been an important relationship between health risk and geographic space, particularly in border areas. Location is a factor in HIV infection through high risk sexual activity, as proven in much geographical research on HIV. But to date there has been no significant empirical research in Bangladesh on the importance of location or the role of place in examining exposure to potential health risk, particularly HIV. Having said that, Bangladesh policy planners have commented on the need to include geographically significant areas such as border towns, where a neighbouring country's citizens are present, in surveillance systems. But so far they have not included these places or vulnerable people in specific programmes. No official studies have been conducted to examine these issues, although academic researchers such as Laura Gibney, Bruce Caldwell and their collaborators have given prominence to the border towns. The theory that HIV could be imported into Bangladesh through risky cross border contacts, particularly through (in)visible relationships between sex workers and truck drivers, is borne out through the present empirical fieldwork. There is strong evidence that migrants act as bridging groups. As many Indian truckers need to stay for longer in the many land ports of Bangladesh, particularly at Benapole port for customs checks, so

there is a high possibility of transferring the health risk to the Bangladesh border women and to their sex partners back home. This situation is exacerbated by the inability or unwillingness of most of the border women to take any precautionary measures to protect themselves. Moreover, 'risky', and 'preferring' sites or places are also of critical importance in spreading the virus across the country.

The present research has found value in an environmental and geographical approach to sexual risk rather than attributing risk solely to individuals. In this case, the poverty of surrounding areas of border towns contrasted sharply with the potential income-earning and social advancement opportunities of the port, leading to an environment of high numbers and turnover of sexual partnerships. The next chapter will look at issues which have been introduced in previous chapters. It will discuss policy issues about the marginalization and stigmatization of sex workers, drug users and HIV positives, as well as the importance of risk behaviour and place in the spread of HIV in Bangladesh.

Chapter Eight

Policy to Practice:

Addressing HIV Issues from the National to the Local Scale

Chapter Eight

Policy to Practice: Addressing HIV Issues from the National to the Local Scale

Health policy can be broadly defined as a significant area of government action and interest in health. "Health policy" is used to encompass any policy which includes strategies and actions undertaken with the aim of maintaining or improving health and providing for the care, treatment, or cure of ill health (Curtis and Taket, 1996). Polices are usually surrounded by conflicts over who is in control and how policies should be implemented. Thus, the issue of health policy is concerned with the political and administrative dimensions involved in health and health care (Blakemore and Symonds, 1997). As HIV is one of the most concerning issues globally not only for health, but also social and economic policies, many countries have addressed these issues in different formats with a view to the prevention of HIV. Many authors highlight the importance of formulating local HIV prevention policies and strategies that acknowledge local models of risk behaviour. In the context of South Asia, Asthana (1996) evaluated Indian policy and legislation related to AIDS, and particularly emphasised 'community participation' (Asthana and Oostvogels, 1996). Khan and Hyder (2001) in a review of HIV/AIDS policy in Pakistan stressed the need for a proactive, organized and integrated policy and programmes that address 'high risk' behaviours and consider Pakistan's particular social and cultural framework. Effective HIV prevention requires strategies and policies that help reduce the vulnerability of so-called risk groups, like sex workers, to HIV infection by creating a social, legal and economic environment in which prevention is possible. In Bangladesh, the government adopted a comprehensive national policy for combating HIV/AIDS in 1997 (Panos, 2006). The second national AIDS strategic plan (NSP) was approved by the government in April 2005 for the period 2004-10. As Bangladesh is a low-prevalence country, its HIV/AIDS responses are prioritized towards prevention; to limit the spread and impact

of HIV in the country. In this chapter, I discuss issues related to HIV prevention including addressing marginalization and stigmatization issues that I found important in people in civil society at the grass roots level and among key personnel who plan policy.

8.1 Ambiguity of Recognition of Marginalized People in HIV Discourse

8.1.1 'Contradictory programmes' in HIV projects

Practical difficulties of gaining access to vulnerable groups in Bangladesh, such as commercial sex workers and drug users, have been compounded by a legislative context that reinforces their stigmatization and marginalization. In Bangladesh the sale and use of opiates is strictly prohibited but the state nevertheless provides free syringes through NGOs in the interests of preventing the spread of HIV, at the same time as it harasses addicts. There seems to be a problem in acknowledging the existence of drug users, mitigating their problems, and providing accommodation, particularly for the marginalized. There is no legal framework for promoting a 'safe mode' of drug use and the same is true of programmes for brothels, sex workers and condom issue. Human Rights Watch Report (2003) shows some contradictory provisions about prostituting girls between government law and the city police actions. According to Khan (1988) the suppression of Immoral Traffic Act, 1933, which states that engaging a woman for immoral purposes against her will is an offence, has some loopholes which not only allow the existence of prostitution but also indirectly help traffickers and pimps to operate the business. While in the constitution this type of work is seen as an 'immoral act', there is nevertheless a formal 'affidavit system' which in effect indirectly legalizes the brothel system because it recognises new girls who are entering a brothel. Also, sex workers have recently won a verdict from the High Court directing the government to rehabilitate sex workers evicted from brothels (BBC News, 2000). The government have worked for different HIV prevention projects like HAPP, of which three were focused on sex workers. Although the legal aspect of the profession is rather unclear, all of these above issues indirectly recognize its existence and establishment. KP/UN-1 (code name), told me that ambiguities in the system cause frustration for the HIV programme:

"If you look at the sex workers, are they legal or illegal? The distribution of needles and syringes, is it legal or illegal? We are all working in this limbo between the legal and the illegal! They keep themselves away from the society. That's the biggest frustration in any HIV programme. We need to look at the issue from a non medical perspective."

About the recognition issue, a few organizers disagree. For instance, NGO official KP/NGO-1 feels that:

"This is not the right time to tell the government to recognize them. It will happen in future but slowly. If we demand recognition now, it would be a strategic mistake because every matter has a maturation point and we are not yet at that point in this issue."

In this regard, a government official KP/GOB-1 acknowledges the ambiguity and told me that the government machinery is still not ready to deal with sex workers and drug users. As there are some contradictory laws about the sex workers and drug users issue, so the government operate their 'contradictory programmes' though NGOs. These NGOs have for some years been working with vulnerable people and have been providing condoms and needle syringes in order to reduce the risky nature of their behaviour, as a part of HIV prevention. Due to the stigma attached to working with high-risk groups, especially in the context of AIDS, many government officials are happy to pass the responsibility for HIV prevention activities to the non-governmental sector. The government steers clear because of political sensitivities and employs the NGOs 'at arm's length'.

Religious sentiment and brothel eviction: Prostitution is much more common than usually acknowledged in Bangladesh. Although the number of sex working women is unknown, many NGOs and experts estimate that 150,000-200,000 women are involved in both brothel and non-brothel settings. The majority of the CSWs are hotel-, home-, or street-based. The brothel business in Bangladesh as a whole appears to be on the decline (Jenkins, C. 1999), for instance due to forcible closure of several brothels (Jenkins and Rahman, 2002). Azim and her colleagues (2000) mention that the number of registered brothels in Bangladesh is 18 but Ara (2005) states that they have since declined to 14. Due to religious pressure, two years ago the Magura brothel, close to Jessore, like many other brothels, was forcibly closed and many sex workers were spread out across the Jessore and Khulna region as floating girls and workers in commercial hotels. The

effects of brothel evictions, violence against sex workers and the stigma-driven harassment are considered to be associated with AIDS and sex work (Fig 8.1). Regarding the negative impact of brothel evictions, LCS/UN-1, who is working in the field with brothel sex workers, told me that:

"*NGOs give support to the brothel girls, but that the situation is changing. Recently brothels have been closing due to commercial pressure upon the buildings they occupy. High profile physical evictions of the past are no longer happening, fear of human rights violations, but invisible evictions are going on. Within the last five years, two golis (lane) near to Jalaipotti have gone, and in the next five years I expect further change. One study shows that 5-6 members of a family are dependent on a brothel girl. If she is evicted then she will not leave the profession but, for her survival, she will either work from home or in the hotel or in the street. If that happens we will lose contact but in the brothel we can monitor her everyday.*"

Figure 8.1: A Sample of Brothel Shrinkage at Jessore

LCS/UN-1 also mentioned that some brothels might move from their present locations to government *khas* land (unoccupied land) because of overcrowding in the city centre, as happened with the Daulatdia brothel. But he cannot get the local authorities to discuss it because this is such a 'sensitive issue'. In Bangladesh, decision-making on 'sensitive' issues always has to take religious sentiment into account. For example, any mention of HIV or sexual matters on TV, maybe in an advertisement, is guaranteed to provoke the reaction that this is a breach of religious rules or values. As a result, politicians self-censor because they anticipate an electoral backlash if they stray 'off message' in this area. Some Islamic figures think that if the country can be reminded of its Islamic values, the HIV problem will fade away. They suggest that if men's morality can be improved, brothels will soon have to close.

Hindrance in recognition of prostitution: Prostitution brings fear, violence, criminalization, stigmatization and reduced civil liberties and rights of human dignity, as well as the risk of disease and, for some, death (O'Neill, 1997). There are three options in terms of the legal status of prostitution: legalization, the status quo, or decriminalization (Mckeganey and Barnard, 1996). The WHO called for changes to governmental laws and policies on sex work in Asia's rapidly growing sex industry because penalization of CSWs renders the implementation of HIV prevention programmes extremely difficult (Ahmad, 2001). Recently some advocates have spoken about decriminalization rather than legalizing prostitution, thus eliminating all state controls over the industry. Decriminalization is based on the proposition that prostitution is a legitimate occupation and a woman's choice in a gender-defined job market (Williams, B. 1999). In this view, trafficking as an offence disappears by redefining it as 'migration for sex work'.

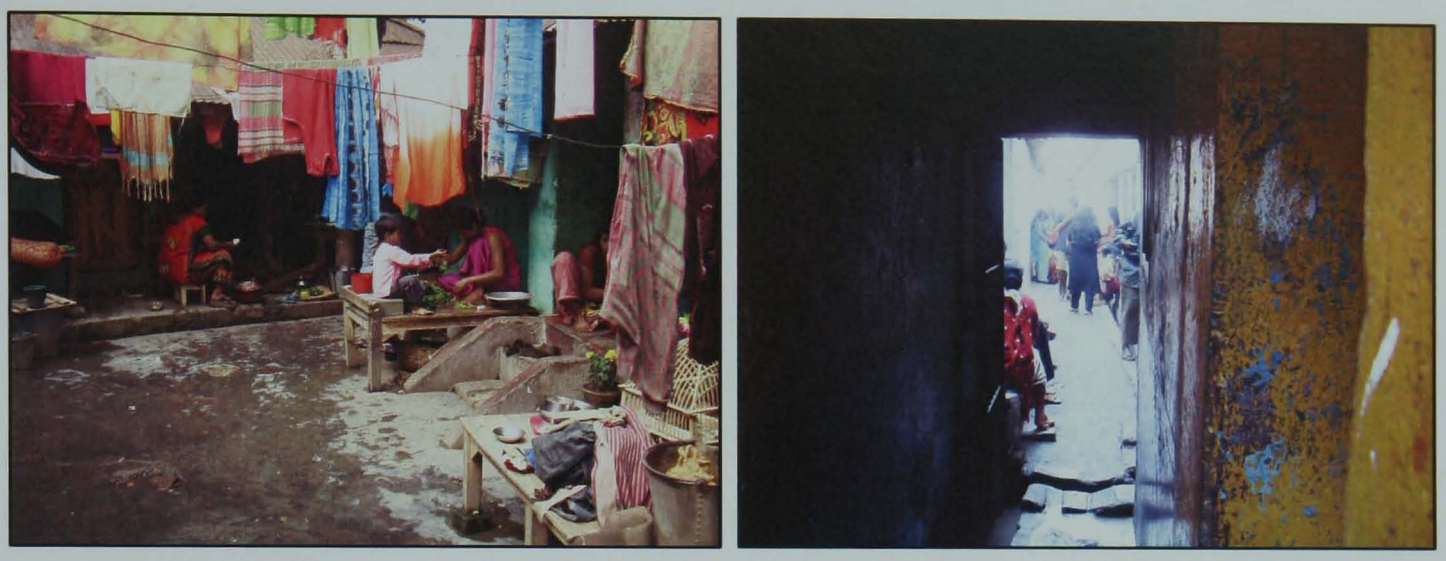
Sex workers' poor economic condition and marginalized social identity or status in Bangladesh is the cause of the violation of their rights (Ara, 2005). Their identity crisis as a group persists despite the recognition given to the sex work profession now being greater than in the past. It is surprising how many NGO people working for the welfare of this marginalized group are not themselves believers. I found one NGO manager at the field level who once helped religiously-minded politicians with the eviction of Daulatpur brothel, Khulna, even though he had been working for the NGO with the same sex workers. Dedication is in short supply in this sector of the NGO industry in Bangladesh. Although HIV/AIDS project workers are aware of the discrimination issue, there is still much prejudice. KP/NGO-1 makes a cautious analysis:

"*I am confused how long the more positive conception of sex workers can be sustained. As some government projects are going on, so they need to sit with those people, but if the project stops somehow, I don't know whether they will continue to sit with them!*"

Although there are some merits and demerits of legalizing prostitution, we should to take the initiative to improve the conditions of the brothel and non-brothel girls because in HIV prevention strategies sex workers are still powerless (Fig 8.2). But there is still a lack of coordination between different government agencies, like the police and the NGO bodies who work for the sex workers' welfare, in work on accessibility to health

rights and reducing harassment. To ensure their health rights, first guaranteeing their human rights is an absolute prerequisite. At a minimum, this requires the sex work profession to be legally recognized by the Government.

Figure 8.2: Jessore Brothel and its People



Sex workers' empowerment: The terms 'sex work' and 'sex worker' are used in line with recent academic literature (Payne, 1991). This terminology focuses attention on occupational aspects and activities and rejects assumptions about individuals based on stigma. Despite being stigmatized, prostitution in Bangladesh has been mushrooming as in other Asian countries. In Bangladesh, the prostitute stands outside mainstream society, which makes them morally susceptible and criminalized. Empowerment of brothel and non-brothel based sex workers is also very closely linked to the legal environment related to sex work in the country. Personal empowerment implies that a vulnerable individual has not only the knowledge and means, but the motivation and power to implement and sustain behavioural change. Dandona et al (2005) think that a sex worker empowerment model like that of Sonagachi, Kolkata can help in HIV prevention but it is difficult to organize the non-brothel based sex workers as a group. Bloem et al (1999) gave emphasis to a human rights approach, which leads to advocacy work and the initiation of self-help groups which, through empowerment, can assist with the improvement of their economic condition. Campbell and Mzaidume (2001) argued for a comprehensive and multilevel strategy with greater empowerment of CSWs, including blood-screening and education for them to protect their own health. In the Bangladeshi perspective, Hosain and Chatterjee (2005) suggest a rights-based participatory prevention approach which is not only for tackling the HIV epidemic but also for their own health promotion and quality of life. Ara (2005) argued for ensuring

sex workers' human rights and the legal recognition of their professional identity. In Bangladesh there are many NGOs working for the welfare of commercial sex workers. Their means of access, however, is mostly hierarchical. My observation is that it is the 'madam' or *sardarni* who benefits on all sides. These 'common faces' (the sex workers' leaders) sit with the NGO and Government officials; they help to make decisions on behalf of the sex workers without any consultation with them; and they take monetary benefits from the NGOs. As a result, it is uncertain what true level of empowerment is reaching the subordinates or bonded girls. During my field work I also observed that NGO people, when they do talk to the sex workers themselves, deal with the leaders or *sardarni* type women in the brothel. As a result, the less vocal ones are not getting proper empowerment training. In this regard, some local NGO officials and key personnel told me that they use the *sardarni* as their strategic way to have access to the others and to change their mind set. Hotel and brothel owners, *sardarni* and the pimps who earn their living from the sex workers' labour all need to be pressured into giving the women some economic freedom.

NGOs could work for improvements in the brothel environment alongside their HIV projects (Fig 8.3). For example, in the Maruary Mandir brothel, Jessore, more than 100 girls have only two toilets, which are also used by their customers, children and maid servants. As a result, both toilets are in an unhygienic condition. In order to minimize the brothel sex worker's 'structural vulnerability', recently some NGOs are trying to develop their standard of life by improving utilities like water, sewerage, drainage, gas, rubbish collection, and hygiene, so that girls can live with dignity. As their situation improves, so the girls' bargaining powers with customers about condoms will increase. In addition, recently some NGOs have introduced projects to safeguard the girls' money. Usually brothel girls face problems when they go to the bank and feel uneasy. The idea is to help them save money for the future and to provide loans. Another part of this is to educate the non-literate sex workers, so that they can protect themselves from exploitation by their so-called lovers. Promoting human rights and addressing social injustice also can contribute to a reduction in the different forms of stigma and discrimination towards women. Otherwise there is a possibility that the HIV/AIDS epidemic may be feminized.

Figure 8.3: Brothel Environment and Sanitation Facilities

Moreover, in contemporary society, prostitution for some women offers a good enough standard of income for short working hours and some degree of autonomy and independence (O'Neill, 1997). Regarding the sex workers' rehabilitation issue, during the field work I realized that the rehabilitation of sex workers, particularly brothel girls, is problematic because, although the NGOs are giving them training for self employment or other works, they tend to return to their old profession. One issue is the rate of pay in alternative work by comparison with that in sex work, and also the less labour-intensive nature of the job. Regarding hotel and residence sex workers, training in handicraft making would provide alternative income, along with the creation of savings groups through a micro-credit programme. Then they could be helped to form a cooperative and so establish networks of mutual support.

Drug users' prevention approach and social integration: In this century substance misuse has taken on a new importance (Bloor and Wood, 1998). Prevention refers to

activities that reduce or stabilize the incidence (occurrence of new cases) of substance abuse and thereby reduce or stabilize its prevalence (the total number of cases) (Lewis et al, 2002). The development, implementation and evaluation of substance abuse prevention programmes have not been an easy process (Miller and Nirenberg, 1984). Hamilton (2004) describes the drug prevention approaches in terms of supply, demand and harm reduction. Following Marlatt (1998), drug prevention efforts have involved supply reduction through strict legal enforcement, interdiction and taxation to reduce the availability of drugs in the environment. A second approach, demand reduction, focuses on users through education and treatment to change their behaviours and motivations. Both approaches aim for the same long-term goals: prevalence reduction and fewer users. Harm reduction approaches operate primarily in connection with the provision of methadone and clean needle exchange programmes to deal with the heroin epidemic. This is because of the commonly held view that drug problems may never be 'prevented' in any absolute manner. The goal is not to condone or encourage drug use but to contain or reduce the extent of health problems associated with it. The Bangladeshi national approach is to reduce the harm without necessarily changing the drug habit (see also, Panos, 2006). The government of Bangladesh has embarked upon both the supply intervention method and the demand reduction method (Khan, 2006). In India, by comparison, there are a number of different approaches and optional services such as needle exchange programmes, oral drug substitution, and treatment programmes. Detoxification is just an interim stage to stabilize the addict, help them to get back their self-confidence and remove their physical and mental dependence on drugs. It is not considered a sufficient intervention in its own right. The idea is that their lives can be changed if they get treatment but the problem is that relapse rates around the world are more than 80-90 per cent after treatment. Long-term treatment and rehab are also needed, along with detox. There are many people in civil society who think that NGOs should help recovering addicts by rehabilitating them. Society would benefit if NGOs spent some money on the treatment and rehabilitation of addicts alongside their awareness programmes. Drug use is not only a principal contributing factor to the rise in organized crime, petty thievery and street crime, but also creates social unrest and destabilizes society in Bangladesh through increasing drug trafficking, violence and

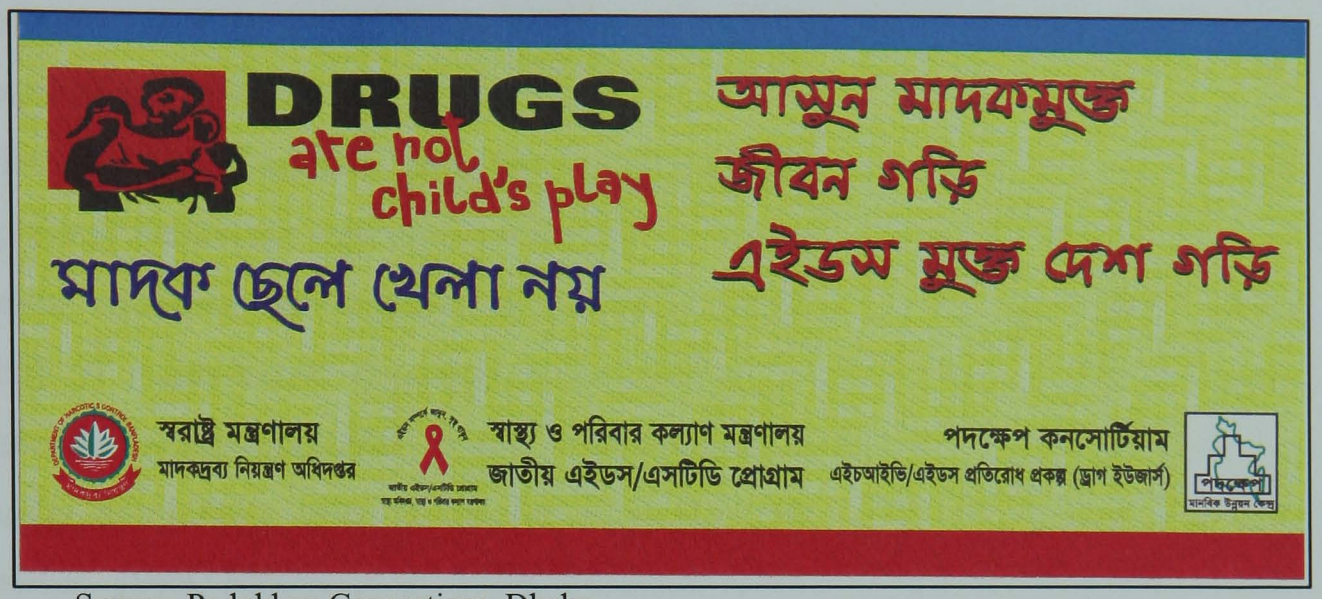
terrorism (Sharma et al, 2006). Presently, NGOs are providing them with knowledge but not with the means of applying it in practical terms. Vocational training would be an option because unemployment is a big issue for recovery addicts (RA). KP/NGO-2 sees this holistically:

"*Actually we have a good infrastructure at the field level: we know the addicts; we know their problems; we have a good contact and interaction with them; they are coming to our DIC and using the services. It's an achievement, and we can go further for more success along with them in a comprehensive approach.*"

He also thinks that to implement solutions, there is a need for more skills, and improved attitudes, capacity and knowledge. At the same time, funding is poor and it is not possible to address all of the issues in a comprehensive manner. For example, IDUs need social support along with treatment and they also need 'chain support' to come back into 'normal life'. In this case, NGOs need to start a social rehabilitation programme for drug users, along with their families, to prevent relapses. Recovery from drug addiction is a personal journey that cannot be made alone. Social support is critical. The family is one of the most important social structures that can support recovery and rehabilitation process (see also, Ahmed, 2004; Knight, 2006b). It is now recognized that drug addiction is a chronic psychiatric disease and a psycho-social problem. There are relapses and recoveries, as for diseases such as eczema, and addicts are rarely completely cured. There may also be deviations from the addict's own normal social values, maybe including criminal behaviour such as theft to raise money for the next fix. In such cases a counsellor, a doctor, or family members can play a positive role (Fig 8.4). However, one rehabilitation centre official told me we should be encouraging addicts to improve their mind control rather than giving them medicine in the name of detoxification. LCS/PO-1 said that

"*In the treatment centre, they only provide injections and lots of medicine. What is the gain? Have the addicts received any education? Actually they become robots, having no emotions, no feelings, and no sense. On the other side, in rehab, they receive education about how to manage withdrawal symptoms and cope with society after treatment. We train addicts to increase their mental tolerance level. Actually the process of mind ventilation is very important to prevent an addict's fall into relapse.*"

Figure 8.4: A Leaflet on Drug Addiction and its Bad Impact



Source: Padokkep Consortium, Dhaka

It is necessary to adopt a progressive policy towards drug users- a policy that is assimilative, rather than coercive, that seeks to integrate drug users into society rather than marginalize them (McDermott, 1992). According to Wall (1999) there appear to be three main positions in the drug policy debate: prohibition, partial or full decriminalization, and legalization. Regarding the preventive efforts for marginalized homeless drug users, 'floating support' (Dixon, 2003) efforts need to be implemented as comprehensive health promotion strategies along with continuous treatment service, risk behaviour change interventions and public housing improvement programmes (Corneil et al, 2006). For Bangladesh, considerable progress can be made if primary-care providers become more knowledgeable about substance abuse, screen their patients for physical symptoms and social problems, and make referrals to appropriate treatment programmes. As knowledge about aetiology and access to treatment increases, stigma and denial are likely to decrease. It is an urgent challenge to change the public and political notions about the issues of marginalized communities like drug users in the HIV field. Bangladesh needs to reform its health and narcotic laws, so that it can intensify prevention efforts and improve treatment and care. Under current laws, drug users are arrested and there is no chance to give them access to provide needle syringe or treatment. In summary, more knowledge about substance abuse can contribute to winning the numerous small battles that occur during the recovery process.

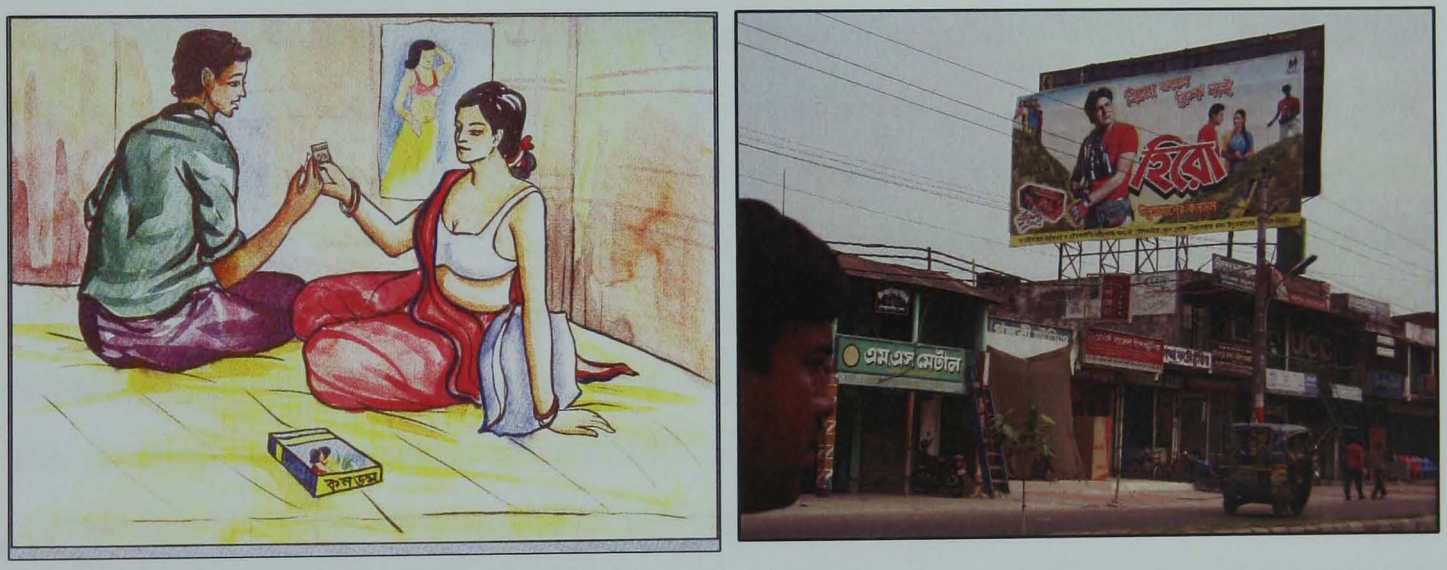
8.2 'Behaviour Change' in HIV Prevention and Limitations

Prevention is a dominant theme in medical and public health discourses. There is a debate about whether education or individual 'behaviour change' campaigns alone are sufficient. Some authors call for interdisciplinary approaches that move beyond traditional behaviour interventions towards social and structural change, which is also termed 'structural HIV prevention' (Parker et al, 2000; Zierler et al, 2000; Hefferman, 2002). A rights-based approach to HIV/AIDS is argued to be essential to anchor interventions that strengthen people's human and sexual and reproductive health rights, thereby supporting them to reduce risky behaviour and vulnerability to infection (Farmer, 1999; Bloem et al, 1999; UNAIDS, 2002b; Gruber and Caffrey, 2005). In developing countries, 'behavioural change' interventions continue to offer the best opportunity of preventing further spread of HIV/AIDS (Mann et al, 1992; Stover et al, 2002) but little is known about which interventions are most effective (Oakley et al, 1995; Clift, 1998) partly because of its (behavioural interventions) inadequate definition and the barriers to implementation that are rarely explored (Janz et al, 1996; Stephenson, 1999). In public health campaigns, 'community education initiatives' and 'participatory approaches' with many stakeholders need to be considered in the process of identifying health risks and raising awareness of HIV risk and in the design and implementation of community-based interventions for the management of social, attitudinal and behaviour change (Gruber and Caffrey, 2005; and Fajans et al, 1995; Sweat et al, 1995 for Thai experience; Dole et al, 1998 for risk behaviour in rural environments).

Preventive efforts need to focus on both behavioural and biomedical risk factors. As an important prevention part of 'behaviour change', condom promotion is still much stigmatised in Bangladesh. Many people there believe that condom promotion encourages illegal or unethical sex and they ignore arguments about the promotion of safer sex. Due to religious and cultural taboos people, especially in schools, social meetings and public gatherings, are shy of talking about the risks of unprotected sex (Haq, 2004). Leaders in Bangladesh are wary about speaking directly on HIV/AIDS and other sexually transmitted diseases. Much research around the world shows that condom education, condom skills and condom accessibility help to make for safer sex. But in Bangladesh condoms have become stigmatized because of the HIV awareness campaign

(Fig 8.5). According to KP/Org-Int-1, this is because "*now the use of condoms means 'going to prostitutes' and they have negative connotations.*" The simplest and most effective prevention measures, like condom promotion, were not adopted on a large scale. For most Bangladeshis, condoms are known as a means of contraception but are not widely used. Bangladesh government policy emphasises female-based family planning methods rather than male responsibility through condoms, and all of the health and family planning centres are female-focused. So the female contraception use rate is high but the condom use rate is low. Although all surveillance reports show that HIV awareness is rising among the risk groups, young people and general population, in practice that awareness is not being utilized. In this regard, KP/UN-2 told me that male involvement is actually more important than the empowerment of women. This is because the society is male-dominated, so until there is full male awareness about HIV, the part played by women will be less effective.

Figure 8.5: Awareness Making for Condom Use



Regarding the limitations in condom distribution, some NGOs distribute condoms among vulnerable people, particularly sex workers (Fig 8.6). The idea is that people need to get accustomed to them and then later they may buy them for safe sex. Condoms remain the main method of prevention, though as yet there is no systematic programming strategy for their use (Panos, 2006). I spoke to NGO officials who claimed that people at risk of contracting HIV, like sex workers, are nowadays more aware about the condom issue than previously due to awareness campaigns and condom distribution programmes. Yet there remains a gap about condom use. One hindrance is that many sex workers do not use condoms in order to please their customers because they know that, if they try to enforce safe sex, there are many poor and abandoned

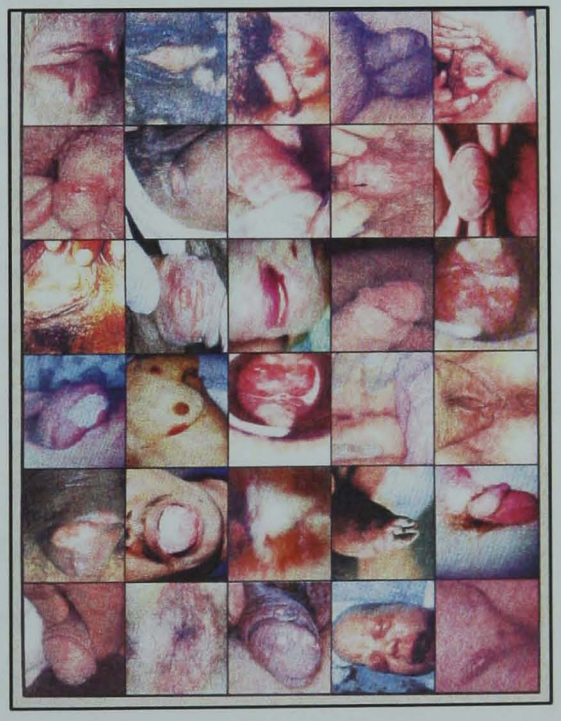
women willing to take their place. At the moment we do not know how many condoms are used in brothels and how many go into the dustbin. One NGO worker told me secretly that many girls throw out the condoms they are given. There is also some confusion between the NGOs that give them away free and those that sell them at a subsidized price. Better planned and integrated distribution would help.

Figure 8.6: NGO's Condom Distribution

Regarding the condom use dilemma and the increasing number of STD patients, some key personnel, including KP/Expert-1, think that increased condom distribution does not mean increased condom use. The test would be if the incidence of STIs had reduced but this is not the case. Sarkar et al (2005) found a big gap between the reported and evaluated condom use by sex workers. Due to the sex workers' existing socio-economic conditions, it is difficult to ensure consistent condom use unless clients are motivated. The research suggests that a suitable HIV intervention strategy needs to be developed, considering the socio-economic and cultural aspects, with a provision for continuous monitoring and evaluation. Some key personnel want to follow the 'Thai model' (Jenkins, C. 1999) where the aim is 100 per cent condom use but it is the 'Sonagachi model' (Gangopadhyay et al, 2005; Dandona et al, 2005) where social reform movement is preferred, that still predominates. Other than in the relatively ordered environment of brothels, condoms are simply not a priority for the girls working in hotels, residences and in the street, because they cannot earn sufficient to eat properly and are regularly subjected to violence by their customers and harassment by the police. Poverty and chaotic lifestyles make these women at the same time highly vulnerable and hard to reach with health messages.

In response to high STDs among the workers, many researchers in Bangladesh (for example, Sarkar et al, 1998; Nessa et al, 2005) emphasized the implementation of prevention programmes involving effective treatment of STDs, condom and sexual health promotion for CSWs as an emergency basis to check the HIV epidemic in future (Fig 8.7). Following Nessa et al (2005), data on the epidemiology of STIs among high-risk behaviour groups is limited in Bangladesh. Availability of diagnostic facilities, poor recognition of STIs as a major public health problem, lack of coordination between service providers and the research community, and poor attendance of STI patients at public clinics and academic institutes, are some of the main reasons for lack of STI data. An important further point is that there is a shortage of female doctors in government hospitals and health centres. Female STD patients prefer not to talk about their problems with male doctors due to the stigma of sexual disease. There is a similar problem with the STD-based NGO offices and health centres, which are stigmatised in the eyes of the public. NGO-based STD treatment would be a good tool if it could manage the referral system with the government health centres.

Figure 8.7: Different Kinds of STD



Source: World Vision Bangladesh (Khulna) Flip Chart, 2005

Regarding drug users' risk mitigation as a part of harm reduction approach, Rahman and Zaman (2005) emphasized safe sex education along with safer injection practices in HIV prevention programmes for injecting drug users. But the various NGO needle syringe exchange programmes have been accused of breaking the law and NGO employees of promoting drugs. Despite such opposition, surveillance reports indicate

safer drug use and a decrease in needle sharing. Nevertheless, some of my key informants told me that awareness campaigns alone cannot change risky behaviour, and that, in their opinion, target-wise intervention is essential. In other words, an addict's continuous interaction with peer educators and sourcing of new syringes and condoms can drip feed knowledge about levels of risk. This is risk personalization. In addition, they argued that more advocacy programmes are needed for different stakeholders, including a redirection of police time away from the harassment of addicts towards the disruption of drug smuggling rings. However, Gibney et al (2002) advocate public health campaigns targeting men in the trucking industry in order to increase use in contexts of casual and, in particular, commercial sexual encounters.

8.3 HIV Prevalence, Testing and Awareness

8.3.1 Low HIV prevalence 'mystery'

There is a 'mystery' about the low HIV prevalence in Bangladesh, as all of the behavioural and bio-medical risks are prevailing there. Some researchers have suggested potential reasons for this low prevalence. Sarkar et al (1998) emphasise the late introduction of the virus in Bangladesh. Nessa and her colleagues (2005) think that, despite high levels of STIs among females with high-risk behaviour, low HIV prevalence might be the result of circumcision. There is debate about the role of male circumcision in the low HIV rate across the world. Although two recent trials in Kisumu, Kenya and Rakai, Uganda, proved that circumcision can reduce the risk of contacting HIV by about 50 percent (Bailey et al, 2007; Gray et al, 2007), some scientists do not agree about its role in HIV prevention and speculate instead about the related risks from circumcision. In Bangladesh, it is sometimes said that this Muslim custom may be a factor, although KP/Expert-1, who has been working on HIV for a long time, is dismissive of this explanation:

"If you ask, why our HIV prevalence is so low despite of the many risk factors, nobody knows. There are so many factors behind it that we need to do more scientific research. I have done research on brothel girls but didn't find any significant rate of infection. I have come to that the conclusion that there has to be something in the Bengali population which is playing a role in the low HIV prevalence. Male circumcision is only practised among the Muslim population, but if you look at Hindu West Bengal the number of HIV positives is also low there in comparison with the rest of India. Maybe

there are some anthropological and racial matters that are contributing to the low HIV prevalence."

Apart from circumcision and stricter religious and social control issues, Gibney et al (1999b) say that Bangladesh remains relatively a more insular society than a country like India which has large numbers of tourists and external migrants. Rahman et al (1999) think that health policy decision-makers should not be too complacent about the current figures of HIV prevalence, but ought to set out to be fully prepared to tackle an imminent HIV epidemic.

In the last ten years many programmes have been started for HIV/AIDS prevention in Bangladesh. Many NGO officials like KP/NGO-2 think that despite the many HIV risk factors, Bangladesh's HIV prevalence rate is increasing only slowly and some consider this as a success. His logic is that in many countries of the world, the HIV infection rate has been slow at first, but then there has been a sudden sharp increase. But in the case of Bangladesh, the prevalence rate has not changed significantly. They also consider that Bangladesh has adequate prevention programmes. There are many organizations right now working under the HAPP (HIV/AIDS Prevention Project), the BAP (Bangladesh AIDS Programme), and the GFATM (Global Fund for AIDS, Tuberculosis and Malaria) projects, which all have the aim of preventing HIV. Although some doubt the quality of work being undertaken, most remain content about the low infection rate of HIV.

An alternative view is that the facilities in Bangladesh are so poor that much disease goes undetected. The HIV testing monitoring system is not well coordinated among GOs, NGOs and private medical centres. At the same time, Bangladeshi society is more closed (conservative in a sense) than its neighbour for message sharing. Indian society is more 'open' and has many HIV detection centres. During my interview with key personnel in Dhaka, I found a further potential explanation. Due to cultural values, people do not like to talk about sex and HIV, which are considered a matter of disgrace. They think that if they discuss it with others, even doctors, they will be blamed, and face social and economic discrimination. One NGO chief executive KP/NGO-3 who works with HIV positives, identified three causes of under reporting of HIV in Bangladesh:

"Firstly, there is the stigma and discrimination problem. When their status comes out, HIV positives face discrimination from their family first and then others. Secondly, if anyone is diagnosed, he or she will not be able to access proper medical services from anywhere. Third, due to lack of awareness, many potential cases don't know about their own status. Most of the HIV positives in Bangladesh were identified accidentally, when they go to a medical service delivery place for another problem."

It can be said that the stigma of HIV is playing an important role in under-reporting among the community at risk of HIV, and among the public generally. Most HIV cases are asymptomatic for a long period of time until the onset of AIDS when they recognize their infection for the first time and undergo HIV testing.

Stigmatized HIV testing at field level: HIV testing or Voluntary Counselling and Testing (VCT) activities were started in Bangladesh in 2006. Like a few organizations, Family Heath International (FHI) follows the rapid test kid system according to WHO guidelines. As HIV tests have become available mainly in urban-based NGO settings, many of these testing programmes fail to ensure confidentiality and cannot provide access to prevention information or treatment. In addition, the government is failing to address the widespread stigma faced by those testing positive. At the field level fear, stigma and discrimination are restricting HIV testing. In order to find out about attitudes, I talked with one VCT centre manager, LCS/NGO-1 in Khulna, who deals with the clients of local prostitutes. He explained the field level problem about HIV testing:

"Actually people feel fear the loss of confidentiality. When we manage awareness-raising meetings, many people show an interest in testing and tell us about their problems and risk behaviours but only a few of them come later to the centre for testing. Most seem to think that if they are tested, they will be identified as an HIV positive, and they will be an even worse situation in their family and society. Counselling about confidentiality can play a positive role. We need to provide more awareness about avoiding social discrimination. Sensitization meetings on the issue in the family and in society have a role in increasing people's mental tolerance levels."

Although some NGOs have developed testing centres in Dhaka and other big cities, their numbers are insufficient. The lack of trained counsellors is also proving to be a

handicap and more training programmes are needed if the number is to be increased. As many people fear testing, the 'de-stigmatization' of other medical service points can play a positive role in this regard. The government could launch an anti-stigma programme concerning at health care centres. Unless there are treatment support facilities near counselling and testing centres, HIV/AIDS patients will continue to be left in a vulnerable position. KP/Expert-1 told me that VCT programmes would be more acceptable to the public if the country's medical service centres and providers could be de-stigmatized:

"*If you find a positive, then what will you do? Where will you send the patient for treatment? That patient will be discriminated against wherever he or she goes, so you should to de-stigmatize the neighbouring clinics or hospitals of VCT centres because that patient would then not have to travel far away for treatment. Up to now this has not happened for the present VCT centres.*"

However, regarding the, some NGO officials doubt the notion of confidentiality in VCT centres. They said that 'if you keep a matter very confidential, it may cause harm', whereas an 'open secret' can have good results. Regarding sensitization to reduce fear and stigma, some NGO officials suggest advocacy workshops for religious people. They think that if the religious leaders can be properly sensitized, this would help to create a congenial atmosphere and ultimately reduce stigma and discrimination. In HIV prevention and control efforts, the government needs to gain the support of the country's mosque-based local religious leaders or imams (Panos, 2006). For example, a unique outreach programme based on the teachings of Buddhism is playing a significant role in preaching HIV prevention education by incorporating HIV messages used in the countries of the Mekong region, including Cambodia and Laos (IRIN News, 2007). Being an Islamic country, Bangladesh could take advantage of engaging '*imams*' (religious personalities) and Islamic leaders in active prevention programmes.

'Standard awareness campaign': HIV/AIDS is sometimes regarded as a problem confined to foreigners and highly marginal groups. Awareness is a big issue for

encouraging people to be tested and the gauge a more accurate level of HIV in Bangladesh. But general awareness raising programmes on HIV/AIDS still focus mostly on how HIV is spread, and there is very limited discussion of human rights, discrimination or stigma (see also, Panos, 2006; Rahman, 2007). Some NGO employees that I spoke to are of the opinion that HIV awareness campaigns as they are presently constituted actually increase stigma about HIV and appear to convince people that a positive diagnosis is a 'death sentence' (Fig 8.8). Different NGOs are campaigning differently according to their client group and there is no integration. KP/NGO-4 suggested that a 'national standard campaign' for reducing misconceptions would increase social acceptance:

"*We need a campaign to lessen misconceptions about HIV and increase the social acceptance of positives. Here we are campaigning for the sake of our target group, others are targeting sex workers, and still others for drug users. The campaigning techniques are different, some emphasizing STDs, while others focus on the high mortality of HIV/AIDS. There is no integration among the different groups, and there is a danger of confrontation between us and those who are saying that AIDS means death. They are trying to persuade people to refrain from the risky behaviour, but in reality they are responsible for increasing stigma and reducing the likelihood that at-risk people will go for testing. We need to coordinate our means of campaign implementation.*"

There is no doubt that the intention behind these campaigns is awareness-raising. But due to common understanding of the general people it has virtually turned into a 'death sentence' for HIV positives. This stigmatized campaign or myths about HIV have been creating a new sect of untouchables. As a result, HIV positives in many cases victimize themselves, thinking that their lives have no worth, whereas in reality the symptoms can be controlled. A few NGOs disseminate messages that becoming HIV positive does not mean the end of the world (Ahmed, 2006b). Here, the media has the potential to create mass awareness of HIV/AIDS, to promote positive attitudes towards people living with HIV/AIDS, and to influence people to change the high risk behaviour that makes them vulnerable to the infection.

Figure 8.8: Stigmatized HIV Awareness Campaign

Source: Save the Children (USA) and SMC (Surakka Project)

8.4 Discrimination, Support and Treatment for HIV Positives

8.4.1 Discrimination and hypocrisy

Negative attitudes from health care professionals and responsible institutions have further worsened a situation which is in violation of the WHO's policy that 'the right to health is the most basic of all human rights' (WHO, 1992; p.V). Although casual contact by carers has not been shown to transmit AIDS, many healthcare professionals continue to display prejudice against AIDS patients (Bennett, A. 2005). This prejudice may interfere with confidentiality and consideration of the patients' emotional well-being. In Bangladesh, HIV positives face much discrimination, such as the refusal to offer medical support or forcing them to leave hospital. This behaviour comes from all levels of health providers, from doctors and nurses to laboratory technicians. Many practitioners change their attitude as soon as they know the patient's status. In my interviews, this situation prompted NGO officials to ask how long such human rights violations will continue towards HIV positives. Since the first cases detected more than 15 years ago, hospital staff have received no training in the risks of treating HIV positives. As a result, fear and misunderstanding are universal. The problem appears to be one of attitude and unwillingness to deal with positives. At the field level, an international NGO manager at local level, LCS/NGO-2 told me of his experience in this respect:

"*Many doctors are not interested to listen to the messages in our advocacy workshops. Actually they have an arrogant mentality that they know everything. Although doctors know the real cause of HIV and its means of transmission, their attitude is still unhelpful for positives. Maybe deep down they don't trust their own knowledge and don't want to take any risks.*"

HIV/AIDS still perceived and experienced by private medical providers as a stigmatized and technically challenging 'disease' (Kielmann et al, 2005 for Indian examples). Bennett, A. (2005) thinks that health-care practitioners are often deeply concerned with the risk at which they put themselves, and potentially their families, in their delivery of health care. For example, nurses, physicians and oral surgeons may put themselves at risk of HIV infection by administering procedures (such as surgical procedures) that can lead to a direct infusion of infected blood into their systems (Mason et al, 2001). In this

regard, KP/UN-2 replied that most of the health sector is not geared to deal with HIV positives. Consequently, he thinks that although the patient has rights to receive treatment, at the same time doctors and other service providers also have rights to protect themselves. I was told that an NGO request for a separate room for HIV positives in a local hospital is blocked by physicians who ask 'where is the government policy for a separate room?' A leading NGO official responsible for HIV positives, KP/NGO-4 was scathing about the negative attitude of physicians:

"*Doctors' training in theory and in practice is quite different. We ask the government body to send doctors to our centre to deal with positives, but what is happening now? Some doctors go abroad to get training in the clinical management of HIV, so their visiting card changes but not their behaviour towards the positives. Some don't allow any referred positive patients into their consulting rooms and outside they breach the patient's confidentiality and identify them as HIV positive. It's hypocrisy and discrimination against HIV positives.*"

The interrelation of HIV/AIDS and human rights is mainly based on the logic that HIV infected and affected people should also enjoy fundamental and other rights such as the right to health, right to education, right to property and the same right to legal treatment as other people. According to UNAIDS, ensuring human rights of HIV-infected people is an effective weapon in the fight against HIV/AIDS (Ghimire, 2007). To eliminate the various forms of discrimination against HIV infected and affected people and to ensure their fundamental human rights, then, there is a great need for the restructuring of existing social and legal settings. There is a further need to assure society that HIV people can also live a dignified and meaningful life if they are respected by society. In the Bangladeshi constitution everyone has the right to access government health facilities. So, legally speaking, there is no need to adopt any new policy for HIV positives alone. Moreover, there should be effective laws to address the violation of human rights of HIV infected people.

Breast milk issue and dilemma: The risk of transmitting HIV through breast-feeding is hard to measure. Most children with HIV infection probably became infected before they were born, or while they were being born. The best studies on the risk of breast-feeding were done with women in Africa who became infected after their children were born and who were breast-feeding (Bartlett and Finkbeiner, 1993). Breast feeding by HIV positive mothers is a sensitive issue for stakeholders and policy planners.

Worldwide it is generally recommended that breast feeding is avoided because of possible infection. But in Bangladesh there is generally a presumption in favour of breastfeeding because the babies of poor mothers would probably otherwise be malnourished. Formula milk is too expensive for them to buy and at present NGOs are not providing this or other alternatives such as cow's or goat's milk. KP/Expert-1 is very critical of donors' role in this respect:

"The donors' logic is that we will not able to bear the cost of ready food but how many HIV positive mothers do we have? Can we not provide the money from our programmes to mothers for baby food? There is money for condoms, so why not also for baby food?"

I found a new born boy of a HIV positive couple who was given formula milk up to the age of two years to check mother-to-child transmission of the HIV from breast milk and he has been eating normal food for the last six months. Before the birth of the boy, the mother was given anti-retroviral (ARV) therapy and nutritional food by one NGO for a year.

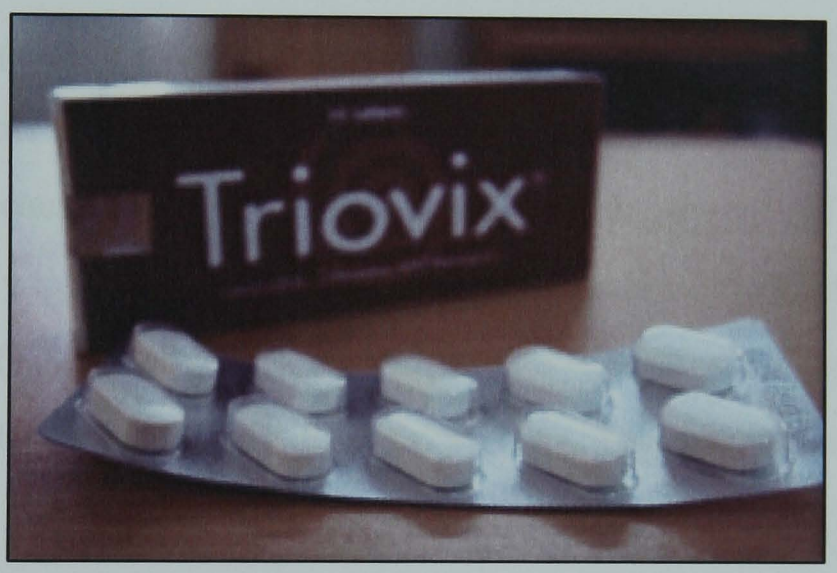
8.4.2 Care and medical support

AIDS is a disease whose treatment involves mental health issues, not only because of the neurological complications of the virus and opportunistic infections, but also because of the stress placed on AIDS patients by their families, friends and society (Galea et al, 1988). Diagnosis is an especially stressful event for AIDS patients and has been identified as a critical but often neglected intervention (Christ et al, 1988). Keeping a positive attitude towards HIV patients can change the way they think of themselves or can also change the way people feel about the future (Bartlett and Finkbeiner, 1993). Patients are often demoralized by the deaths of other AIDS patients that they have known. In Bangladesh, policy initiatives such as care and treatment for people already affected by HIV/AIDS are being implemented on a very limited scale (Panos, 2006). In terms of medical support, the government is not currently providing any ARV but there is a provision in the budget of their HNPSP (Health Nutrition Population Sector Programme) operational plan and also GFATM project in the 6th round. This involves plans to procure ARV for 1500 people up to 2012. They estimate that by 2012 there will be 15,000 HIV positives and that 10 per cent of them will need

ARV (Fig 8.9). Two pharmaceutical companies are producing ARV in Bangladesh, but neither has a pre qualification certificate from the WHO. Locally produced drugs are cheaper than Glaxo products and are said to be working well apart from the cases of a few people with problems of resistance. The government has a rule that if a drug is produced by local industry, it must not be imported. In this regard, one NASP executive (KP/GOB-1) told me about future plans:

"*If the WHO allows us, we can procure from the local market. Otherwise we will follow the guidelines of GFATM. Recently the World Bank suggested that we take help from the Clinton foundation to buy ARV at a cheaper rate from the world market and that they will ensure the quality. So we are thinking of different alternatives and options.*"

Figure 8.9: A Sample of Anti Retroviral Drugs



Source: The Daily Star, December 1, 2006, Dhaka

Regarding cost sharing matters of ARV, most of the other NGO chiefs think that the state should have responsibility for distributing ARV free of charge. In India, ARV is provided free to positives and at the same time they are available in the market. Their policy is that those who can afford it but do not want to disclose their identity, can buy from the local market. In Bangladesh, the government may in future distribute ARV to positives through NGOs, but there are some questions. First, will they be available in the market? The government will need to give thought to selling the medicine in the open market for those who do not want to disclose their identity. The second question is the debate about whether the idea of free medicine should be extended to other patients, such as those with cancer. One NGO chief KP/NGO-3 commented:

"Firstly, ARV is very costly and there are many other issues involved with an HIV case. For example, there is stigma attached to this disease which is absent for other diseases. Secondly, if you have a disease, you will need to take the drugs for a certain time to finish the course, as is also the case with tuberculosis, but in case of HIV you need to take the drug for your whole life, until death."

Most of the debate concerning the availability and access to antiretroviral therapy (ART), now revolves around the core issues of economics, equity and ethics. A mix of payment-free, subsidized and self-paying systems are applied by governments, and criteria for access to ART differ widely. In this respect, some officials think that the government can arrange for ARV to be free only for a certain period of time.

Worldwide there are 20 types of ARV for treatment of HIV/AIDS patients. But Bangladesh can provide only four types and with interrupted supply (Zannat, 2008). HIV/AIDS patients who temporarily stop taking their anti-retroviral drugs to reduce side effects or because of supply disruption, are doubling the risk of getting full blown AIDS or are likely to cause resistance to treatment. Second line drugs are the only hope for sustainable life, yet these drugs are much more expensive. At present, some NGOs provide first line treatment for HIV free of cost, but not the second line.

The national communication strategy provides a road map for addressing HIV/AIDS through a systematic and comprehensive set of strategic communication interventions designed to improve the health care delivery system, reduce stigma and harmful gender practices, ensure political commitment, and change risky behaviours (NASP, 2006a). The National Strategic Plan has set a goal of ensuring that anyone infected with HIV /AIDS has access to comprehensive systems of care, support and treatment by the year 2010. In this connection, Bangladesh can follow the Brazilian model which has proven that it is possible to contain HIV/AIDS in a resource-poor environment with a relatively weak health infrastructure. This model ensures the right to free access to treatment for HIV-positive people and others who have opportunistic infections; a strong relationship between the government and civil society groups, including religious people to reduce stigma and discrimination.

8.5 NGO 'Politics' and Donor Policy in HIV Prevention Discourse

8.5.1 Quality questions in HIV projects

A significant proportion of HIV/AIDS prevention activities in Bangladesh are implemented by NGOs (Panos, 2006). Currently, there are 385 separate NGOs involved in HIV/AIDS intervention programmes (FHI, 2003). Many NGOs are working well with HIV projects in Bangladesh to supplement government activities but there are also a few anomalies. For instance, during my field work, I visited a local NGO in Khulna, where no qualified doctor is available to see STD patients but every week they compile a list of people who have visited their drop-in treatment centre. I heard that although only two patients had been seen by a paramedic, twenty cases were reported. Such exaggeration is presumably to show the donors that they are active with STD patients. In the case of condom distribution, there is also evidence that they are also overstating the figures and taking the opportunity to misappropriate funds by selling condoms in the open market. I also observed several NGOs with staff of too low a quality to implement their projects, and I heard that some employees do not get their proper salary due to 'salary surrender' (a significant proportion of salary have to capitulate) to some high officials. Some of the drug users themselves complain about outreach workers and NGO doctors that they lack responsibility and efficiency. Despite all of these limitations, limited resources, and the many risk factors, there are well-intentioned NGOs that are developing their capacity. KP/NGO-2 thinks that:

"Some NGOs don't know the techniques for making scientific size estimations of the problem. Though they have government projects, their knowledge of how to handle that group is limited. As a result there is a question about the quality of these programmes."

Regarding the issue of transparency, KP/UN-1 told me that there is a need to monitor projects more intensively to expose cases of misappropriation of funds. Several key personnel consider that we need to monitor the government's role, the donor's role, and NGOs' role in every development project because accountability has two sides: one concerns the service providers and other the project participants. Accountability is not possible unless the target group understand the project and services which they can expect from the providers. The people have to be empowered first so that they can seek

services in an assertive way. If the people are aware then sustainability is possible. On the other side, donors should be more vigilant and they also need coordination among themselves to reduce the duplication of services. According to KP/NGO-1:

"*In India policy planners bargain with the donors but how much can we bargain with the donors? Are we handling matters skilfully? There is presently a lack of patriotism and there are mind-set problems.*"

Thus although, there have been some positive achievements from HIV projects in the last ten years including awareness and addition to the school curriculum, many organizations working in this field are not maintaining quality. Although NGO workers have more experience than government workers in the field of HIV prevention, there are still some doubtful practices.

Invisible 'conflicts' among NGOs: Newly 'discovered' HIV positives are subject to a kind of 'competition' among NGOs to visit them (see, Sherso Barta, 2004). They may go with government officials and local representatives and this creates curiosity among neighbours and other local villagers. This creates a negative impact on their status in their family, in the locality and, more importantly, in the patient's own mind. Visits therefore lack confidentiality and some positives flee the scene; a few commit suicide out of shame and desperation. Despite recent attempts to reduce stigma and discrimination, there is much work to do to change this mentality. Many HIV positives and civil society people accused some NGOs that they look at this sensitive matter from a professional perspective rather than on humanitarian grounds. They 'recruit' as many new positives as possible because then they will attract additional funds and receive credit for their work in the HIV field. Some HIV positives angrily told me that some, although not all, NGOs are running 'profitable businesses'. In other words, they inflate the number of HIV positives in their programmes in order to get more funds. KP/NGO-4 elaborated on this:

"*In Bangladesh, HIV positives are used now as a 'token' by some NGOs. Those NGOs are giving help, showing hope of foreign tours, dreams of leadership. Positives are thinking that this is for their benefit but they do not understand that the benefit is going to the NGO and that in truth the future impact will be bad. This is the way many HIV positives are being victimized. The NGO which has no expertise in care and support for HIV is trying to say that they have skilled staff and are able to handle care and treatment projects and they are looking for funds.*"

This 'unhealthy' competition among NGOs in the provision of HIV services is happening because there are not enough funds in this area. The government response is poor and there is misuse of foreign funds through the distribution of money among non-compliant organizations through the tendering process. Evidence suggests that a number of Bangladeshi NGOs are motivated by self-promotion rather than altruism. Many organizations would appear to be more interested in attracting international funds and attending international conferences than working in the communities they claim to serve. There seem to be some NGOs which lack appropriate expertise and experience. Sometimes they develop a consortium with existing NGOs in the field and so are able to access projects. In this regard, one NGO chief, KP/NGO-5, told me:

"*Fund distribution is not equal because some funds are not going to the 'right person'. Some NGOs have bid for projects who previously worked in micro-credit. They joined with other NGOs, made a good project proposal and finally got the project. They also maintained a 'good channel' with high officials.*"

I observed that there is an invisible conflict and lack of co-operation between the NGOs working at the field level, and this has negative impacts on the stakeholders. For example, they will not comment on the medication regimes of their clients in the name of secrecy. There is overlap in service provision but no integration or co-ordination of effort. At the moment the 'confidentiality' of their HIV positive stakeholders is one reason given by NGOs for not talking to each other.

HIV positives' desire and 'complaints': HIV positives seek many kinds of psycho-social, economic and treatment support from the NGOs. The latter try to provide medical support, usually irregular, such as ARV, nutritional support, hospital admission, referral, training and advocacy. But KP/NGO-3 comments on how expectations cannot always be met:

"*Their demands depend upon their status. Some positives cannot afford basic food at all and others need support to balance their nutrition. Some need money for medicines because their immunity to disease is low. Some need support to maintain their confidentiality. Others worry about who will take care of their children when they die, or just need help with their babies. Some unmarried HIV positives want to get married and have a baby.*"

Some NGOs make little impact. In Khulna a nationally renowned NGO started a nutrition support project among HIV positives. After six months this stopped without explanation as described by one HIV positive:

"(That NGO) *gave us some support, monetary help, but they stopped the project and in the meantime we had become dependent on this help. Now many of us are suffering. We need vitamins and nutritious food. We utilized the money, but now they have stopped it, so how can we continue the nutritious food?*"

One local NGO chief, LCS/NGO-3 identified the waste in many HIV projects. He commented how some Dhaka-based NGOs hold workshops or awareness raising sessions in the field for a few days and then return to Dhaka.

8.5.2 Donors' policy limitations

Donors play a vital role in HIV prevention. All of the HIV projects in Bangladesh are fund-based and designed according to the donor's wish. Currently the bulk of funding for the NASP comes via the government from the World Bank, DFID and the GFATM. In addition, other agencies such as World Vision and The Salvation Army provide funding directly to NGOs. It has been reported that each of these funding agencies disburses funds according to its own mandate and specific objectives, rather than the needs of the population (Panos, 2006). The coordination of donor activities is weak; leads to frequent overlapping of services but more comprehensive packages are needed (ibid). In HIV projects in Bangladesh, there are many issues which are obligated by different donors and their conditionality. This seems to me to be a limitation in HIV prevention in Bangladesh. Firstly, there is a place for outreach programmes that combine needle exchanges with treatment. But due to USA policy obligations, NGOs who are taking USAID funds cannot use a harm reduction approach towards drug addicts. They give treatment, rehabilitation and detoxification for addicts but needle exchange is not possible. The US government feels that needle exchange promotes greater addiction, although there is another view that needle exchange programmes are working well in some countries. For the same reason, US-funded NGOs are also prevented from using oral drug substitution and condom promotion. Even the terminology is restricted: advocating sex worker's rights is not possible because US policy does not acknowledge prostitution as a legitimate form of 'work'.

Second, although, there is a proverb that beggars cannot be choosers, Bangladeshi NGOs resent the 'conditionality' put upon donor funds and any 'interference', as they see it, with their on-going projects. But as they depend upon the donors for their sustainability, NGOs need to accept the strings attached, even though they may consider them inconvenient and even unethical. KP/Expert-1 explained further:

"*There is an institution called the World Bank which is very tricky. They give funds but with many instructions and restrictions. There are two sides to their control. Sometimes it is to prevent misuse but sometimes it is 'unscientific'. For instance, they do not have a budget for a cd4 counting machine in the lab. We wanted to take it as loan but they told me that they have no 'mandate' for that. Why would they have that kind of control? It is not grant money. If it was a grant, then they could give some suggestions. But it's our credit money and we will pay back the loan in time. So why do they need controls here*?"

However, I observed that some international agencies take funds from international donors and then give funds to local NGOs. But, at the same time, the international donor is also distributing money to the same NGOs. So local NGOs have 'multiple relations' with donors and there are sometimes 'cross donations' due to a lack of coordination. For example, in one small area, I found five NGOs providing almost the same services with the help of different donors' funds.

Third, due to contractual mechanisms, inefficiency and donor level bureaucracy concerning the release of money, NGOs frequently find that they are in between projects with no funds to manage the transition. Meanwhile HIV transmission continues. There are politics here at the donor levels that are partly the result of the culture of large organizations. Such donors are powerful and impose their policy on NGOs, with the result that decision-making at the local level is not possible. Some donors lack flexibility. One NGO programme manager KP/NGO-6 told me that during the HAPP programme, they could not make any long term plans due to the uncertainty of the project and its extension, and this hampered the project's achievements. He thinks that if they could know the total duration earlier, they would be able to make plans for the long term. Due to donor dependence, NGOs cannot work consistently or continuously. But with projects lasting only a year or two, they cannot prevent HIV, and so sustainability is a problem. NGO projects that have been initiated with outside

assistance may not prove sustainable once that assistance has been withdrawn. In order to overcome the uncertainty, some NGOs try to establish 'core funds' for their future. KP/Org-Int-2 said "*We need to develop a contingency plan and need to make a widow fund so that we can continue the project during the crisis time or bridging period.*"

Recently, a global policy in HIV prevention has come to a critical point. In HIV prevention projects, the ABC model (Abstinence, Be faithful to your partner, use a Condom) has been successfully used in many places in the world. Medical research has repeatedly and clearly shown that it is better access to condoms and greater use of these lifesavers in safer sex, which has the greatest impact on reducing the risks of dying from AIDS. In the 16th International AIDS conference in Toronto, Canada, Microsoft founder Bill Gates, as a keynote speaker said that the ABC approach had saved many lives but with some limitations (See, Tatoud, 2006). He stated 'Abstinence is often not an option for poor women and girls, who have no choice but to marry at an early age. Being faithful will not protect a woman whose partner is not faithful. And using condoms is not a decision that a woman can make by herself; it depends on a man'. He emphasized the social changes necessary to stop the spread of HIV/AIDS, for example the empowering of women (ibid). However, these are very broad social changes needed that will eventually end stigma and sexual prejudice and giving women the laws, social rights and medical care to protect themselves.

8.6 HIV Surveillance and Strategic Planning

8.6.1 Limitations of HIV surveillance

Surveillance systems are used to estimate HIV/AIDS prevalence and incidence, and these have provided some of the most important data available for gauging the course of the epidemic and for identifying subgroups of the population at high risk (Matsuyama et al, 1999). In order to provide improved surveillance, ethical concerns regarding confidentiality, stigmatization and the potential for the misuse of information must be dealt with sensitively and in partnership with the communities at risk (Khawaja et al, 1997; Khaw et al, 2000). In Bangladesh, AIDS control mechanisms are not well integrated with the basic public health care infrastructure facilities. Following the UNAIDS/WHO guidelines for a revised 'second generation surveillance' in a low

prevalence situation, in 1998 the government of Bangladesh set up a national HIV surveillance system (NASP, 2004). National serological surveillance has been undertaken consistently since 1998 and so far six rounds of sero-surveillance and five rounds of behavioural surveillance have been completed (Panos, 2006). But HIV/AIDS surveillance has always been accorded low priority in national planning and resource allocation causing discrepancies in surveillance mechanisms. This has resulted in inappropriate epidemiological data, causing confusion in policy planning and policy failure. For behavioural surveillance there is limited coverage but sero-surveillance is more widespread. Programmes of sero-surveillance involve approaching organizations for help in managing sentinel sites and sampling sites. In a sentinel site, syphilis, HIV and hepatitis C (for IDUs) is tested but the participants receive only the syphilis results immediately to ensure their STI treatment in an NGO centre. Surveillance staffs are currently considering changing the sampling strategy to make it more integrated and representative. This surveillance system has been acknowledged for its authenticity in the South Asian region. Recently respondent dependent sampling (RDS) has been piloted. In this system those interviewed are automatically given a blood test. This should reduce error. Regarding the limitations of serological surveillance, KP/Org-Int-3 explained that

"*In serological surveillance, NGOs use their Drop-in-Centres (DIC). They invite their participants in to check for syphilis. Maybe they don't tell them that they are also screening for HIV. I have heard some complaints that NGOs have invited those sex workers or drug users for the checks who are healthy and living well. They are intentionally avoiding the weak or sick participants, or those known participants who are not involved in risky behaviour. Maybe they want to show that their participants have a low incidence of STI in order to boost their positive reputation. This matter of 'reputation' is significant and leads to bias in the system of serological checks. If we want to avoid these NGO DICs, then we will need to develop satellite clinics, which would be costly. In this case, a neutral venue may reduce the error.*"

ICDDR, B has been conducting surveillance for HIV in the country on behalf of the Bangladesh government in collaboration with other partners. Surveillance data have been used to monitor the progress of the HIV epidemic and changes in risk behaviour over time. These data have also been used effectively in mobilizing and directing resources appropriately. However, more interaction between NGOs is needed to make the data more representative and therefore reliable for strategic planning purposes. These discussions should involve people at the grass roots for site and group selection.

Moreover, a major constraint identified in formulating evidence-based policies is the limited availability of local data on HIV/AIDS. In addition, many of the existing documents containing useful information on STDs or other determinants for HIV/AIDS are difficult to access, mainly because they are not organized (Bhuiya et al, 2004). Many key officials raise another issue about the 'clearance' order of surveillance reports or inconsistencies in the reporting from different government ministries and AIDS related committees. In this regard KP/Org-Int-4 commented on how reporting delays and documentation by the government are the main hindrances in translating research findings into action.

Bangladesh has a surveillance advisory committee of the technical national AIDS committee (TcNAC). Members of this committee select potentially vulnerable groups for sampling on the basis of available information and resource constraints. The objective of surveillance is covering the known target population and there is a parallel programme to uncover those who are presently unknown. Cost and time are factors in staying with the same group for sampling and places are selected on the basis of risk. Resource limitations are the main obstacle to sampling more sites and people. The border regions are seen by some to be on the front line of risk behaviour and vulnerability for HIV transmission but historically HIV surveillance on the border with India, particularly port areas, were not included intensively. In other words, the importance of geographic place has been largely overlooked in terms of surveillance. Following my analysis in the previous chapters and naturalistic observation, many HIV risk elements are concentrated in those areas and there is a need for place awareness to be included in surveillance strategies as a matter of priority. KP/Expert-1 commented:

"*A sudden HIV epidemic will start in our border areas which may gradually develop. Nobody will know the real situation unless we include the border areas in the surveillance properly.*"

Urban areas are the main foci of risk, much more so than rural areas, and the slums are the most vulnerable places of all. Creative thinking about interventions might include trying to reach those who live abroad with messages about minimizing their risk behaviour. Highly mobile workers, such as construction and transport workers, who have little AIDS prevention knowledge and are away from their families, are more likely to engage in high risk behaviours. However, Bloem et al (1999) found that policy

makers and HIV intervention implementers need to be convinced about the need for such initiatives. The government must implement a surveillance system that gives an accurate picture of HIV prevalence in both the vulnerable groups and in the general population (Panos, 2006).

8.6.2 Strategic planning

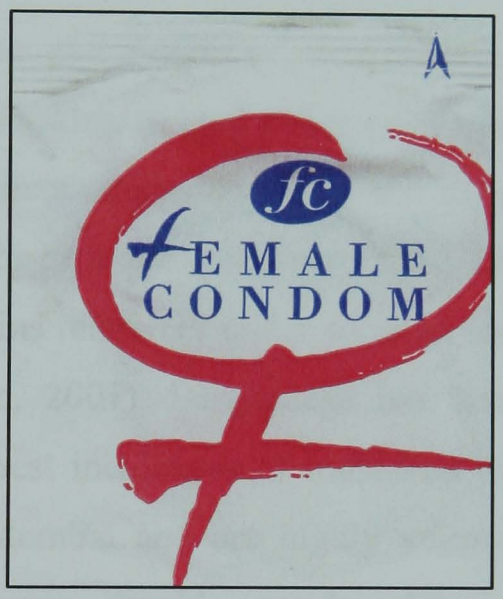
There is a need for HIV-related research projects relevant to be centrally collated and analyzed for their implications for understanding the epidemic and for improving the effectiveness of the response (NASP, 2005c). One local NGO official, LCS/NGO-3, remarked on how the theory of programme organization is very different to practice. He wants a review of HIV prevention strategies in order to manage resource utilization properly. KP/UN-3 thinks that Bangladesh needs to give priority to surveillance, capacity building and blood safety rather than to HIV mainstreaming (including HIV components in every development issue). And KP/Org-Int-2 considers that making strategic plans based upon surveillance reports is all very well but in many cases these become 'wish lists' of ambitious planning. He prefers working 'to the point' of what can really be achieved. However, there are some issues which need to be considered in the future planning for the sake of greater interest in HIV prevention and these are discussed below.

Condom supplies: Although demand for condom use is gradually increasing among vulnerable populations, supplies of condoms remain irregular (Panos, 2006). The lack of condom availability from time to time is a visible marker of the inefficiency of the system. There seem to be problems with estimation procedures and the implementation of planning. The building of a buffer stock is an obvious starting point and then a better set of procurement procedures. Otherwise stock outs undermine the success of programmes, leading to unintended pregnancies and the spread of infection. As the SMC (Social Marketing Company), the government and UNFPA are importing condoms, so they need more coordination to prevent shortages.

Female condoms: My key informants had varying views about female condoms (Fig 8.10). Some believe them to be an important tool to protect girls who cannot protect themselves and have no negotiation skills. Until these women are able to insist upon

condom use by their sex partners, the female condom is an effective alternative for safer sex, especially in the case of alcohol and drug users. On the other hand, some think that the female condom is not well accepted for a number of reasons. It is not practical, either for the sex worker or for the client. Clients who do not like the male condom also tend to reject the female condom because they can feel it during intercourse. Only if they are drunk or semi-conscious will they not be aware of it. Also it is costly, so there are commercial considerations, and there are associated risks because, if the girls do not wash it properly, there is a heightened chance of STD cross-infection from one client to another.

Figure 8.10: A Sample of Female Condom



Reproductive health: In many developing countries, health information is not equally accessible to the less educated, economically disadvantaged and socially marginalized people. Concerns about the adverse consequences of sexually transmitted diseases have led to renewed interest in the contraceptive and sexual behaviour of adolescents (Blanc and Way, 1998). Young people are the most vulnerable age group to sexually transmitted infections (STIs) and HIV: approximately half of STIs worldwide occur among young people aged 15–24 years (Rivers and Aggleton, 1999). Younger people in Bangladesh have many misconceptions and stigmas about sharing information regarding sex and sexuality (NASP, 2006b). These lead them to risky sexual behaviour and reduce their sense of vulnerability. Adolescents in Bangladesh receive inadequate information about HIV and reproductive health since discussions about sex, drugs and HIV are taboo and the flow of information is obstructed by religious beliefs and cultural

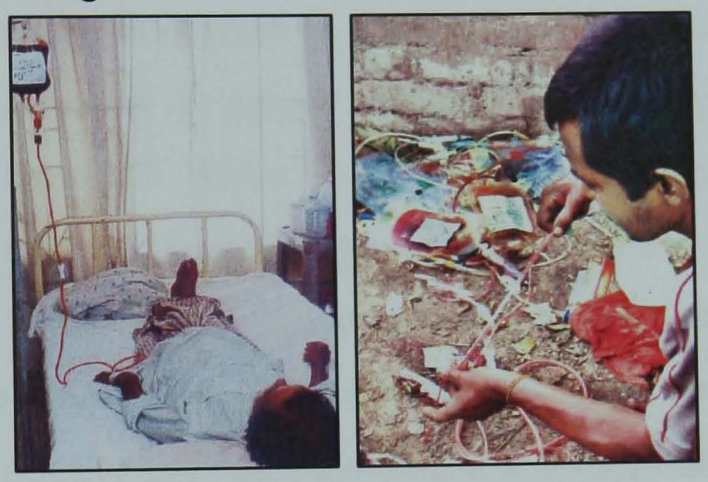
traditions. Khan (2002) found that female adolescents in Bangladesh are not sufficiently aware of AIDS and he recommended strong efforts to improve awareness and to clarify misconceptions about AIDS through improving access to education, mass media and condom use promotion. Regarding the need for reproductive health education, one NGO programme manager, LCS/NGO-2, told me that in the long term it will be useful. The example he gave was that children never ask questions about rape when they read about it in the newspaper which indicates that they understand the issue. Although the government has recently taken the initiative to include a chapter on HIV in a text book, many NGO staff feel that this is inadequate, requiring more illustrative discussions and training for teachers to overcome issues of shyness about sexual and reproductive issues.

Women trafficking: The global sex industry promotes trafficking and prostitution (Williams, B. 1999). Trafficking in human beings, especially women and children, is a crime that violates all tenets of human rights and dignity. According to one report, every day 50 Bangladeshi girls are lured across the Indian border and sold (Ahmed, 2006a). This sector remains relatively under focused and there is no strong measure to curb trafficking (Hossain, 2007). Bangladesh has been reported as one of the top countries having the highest incidences of trafficked women. They usually end up in brothels in Kolkata or Mumbai and are highly vulnerable to HIV/AIDS. Therefore, Bangladeshi policy planners should consider this issue not only from a health perspective but also as a matter of development.

Blood transfusions: Blood transfusion is the most efficient and also the most easily preventable mode of HIV transmission (Asthana, 1996). Although screening has reduced the risk through transfusion in most parts of the world, HIV is still transmitted through transfusions, even under stable conditions (Khaw et al, 2000). In Bangladesh blood is not always screened for HIV, and much of the supply is from professional blood donors (Quader, 2004 and Fig 8.11). Most of the private blood banks have been operating under the name of a laboratory to bypass certain rules (Hossain et al, 1996). Unfortunately, many donors have multiple sex partners and are positive for sexually transmitted diseases (STDs) and HIV. Most hospitals and blood banks in Bangladesh lack blood screening facilities. One study found 41 regularly functioning government blood transfusion centres in Bangladesh and another 33 centres that functioned

irregularly (Hossain et al, 1996). Apart from these government centres, there are many commercial blood banks. Almost no rules are followed by the private blood banks for collection, testing, processing, storage and distribution of blood. The government needs to implement initiatives to improve blood testing infrastructure and blood products with quality control, promote voluntary blood donation, develop and improve facilities for plasma fractionation, and improve the management, monitoring and evaluation of blood transfusion services. There is also a need for better control over the licensing and inspection of private blood banks.

Figure 8.11: Blood Transfusion in Bangladesh



Source: Prothom Alo and The Daily Star, 2006

8.7 Expected Role of Government in HIV Prevention

8.7.1 Political commitment and state role

The political, social and logistical challenges in increasing HIV prevention activity may seem overwhelming (NASP, 2001). Vulnerability to HIV/AIDS has a serious and in-depth impact on every aspect of life (Alam, 2007). Government is the most important stakeholder in fighting HIV/AIDS, but the various political parties and politicians could take up the HIV/AIDS agenda as an important priority. Stover et al (2002) stressed political commitment in HIV prevention for effective mobilization and efficient use of funds and programme implementation. The lack of political commitment to deal with HIV/AIDS remains a limiting factor. A stronger and sustainable political initiative and leadership to combat HIV/AIDS is needed to lead to a more meaningful national response and increased resources allocated to addressing the epidemic (Bhuiya et al,

2004; Haq, 2004). There have been calls for Bangladesh to mobilize political will to act rapidly and decisively to avert an HIV epidemic before it becomes too late (NASP, 2005b; Mahmood, 2007). Government and society generally must also acknowledge the scale of HIV/AIDS and take the initiative to reduce the associated stigma. At the moment this is almost absent in the political arena of Bangladesh where there is a reluctance to speak about the issue.

It has been proven that governance, either good or bad, has a direct effect on the HIV/AIDS epidemic. Instances of good governance marked by sincere political commitments to combat HIV/AIDS in Thailand, Uganda and Senegal have shown positive results in stemming its spread with the cooperation of the donor nations. In Bangladesh, more than 380 NGOs, AIDS service organizations and civil society organizations have been implementing programmes/ projects in different parts of the country (Hossain, 2007). These initiatives have focused on prevention of sexual transmission of the virus among high risk groups. There are some self-help groups working with HIV positive patients, providing counselling and financial help to them. But, despite funds from different global initiatives, the Bangladeshi government's response to the management of AIDS patients has been weak. Regarding their expectations of government, almost all HIV positives argue that politicians need to take greater responsibility for their care and treatment. They criticize government expenditure on seminars rather than on welfare. One HIV positive commented that:

"On world AIDS day the government always gives assurances. The health minister seeks to reassure us but in truth they depend upon the NGOs. In seminars they say too much, and make promises, but implement only a few works. They give responsibility to the NGOs and we are forced to survive with some help from these organizations. We have a health department and, given the political will, the government could provide us with treatment. We are not demanding centres in every district, but the government could establish a centre in Dhaka with every facility."

Patients also think that the government should emphasize HIV prevention in a more extensive way. In doing so, they should use HIV positive people to raise awareness. They believe that if government could utilize positive people in the struggle for HIV prevention, it may be more effective than any present work.

8.7.2 NASP role for coordination

Based within the ministry of health and family welfare, NASP is responsible in theory, at least, for facilitating overall coordination of the national response to HIV/AIDS (Panos, 2006). Its role is mainly coordination, monitoring, policy strategy formulation and guidance to all stakeholders in the HIV field. It has a stewardship role and a mandate to coordinate the activities of all organizations for HIV prevention. But presently NASP is not structured with sufficient capacity to promote overall programme planning, coordination, monitoring and evaluation, system wide information sharing and single programme steering (NASP, 2005c). My field work uncovered many criticisms of the NASP. One district deputy civil surgeon, LCS/GOB-1, for instance, openly stated that there are GO/NGO coordination problems: NGOs are not aware of government activities and vice versa. Many NGOs are implementing targeted and other interventions in different geographical areas in an uncoordinated and overlapping manner without system wide prioritization, coordination or information sharing (see, NASP, 2005c). One local elected municipal chairman, LCS/Rep-1, told me that "*the government has started a programme through the NGOs but they do not monitor it or follow it up. The government needs to play a more active role.*" A NASP executive, KP/GOB-1, told me that the NASP follows the UNAIDS' 'three point principles' that there should be a single policy framework, a single coordination mechanism and a single monitoring framework. He also commented on the success and limitations of the NASP:

"*We have a regular surveillance system, so that we know about the HIV situation within the high risk interventions and different geographical areas. With that information we are providing interventions. At least we can say we are trying to contain the epidemic with involvement from international organizations. With the support of these partners, we have many achievements. At the same time, we have many constraints, many resource limitations, and strong religious values, so many things remain to be done. It is true that we could not cover all of the most at-risk populations through the various packages because the funds were not sufficient and the initial size estimation was not properly done.*"

Internal collaboration and coordination is needed to avoid problems of duplication. This should be dealt with at the heads of programmes or donor level. Ideally resource allocation would be modified on the basis of real need. One suggestion is for one NGO to be responsible for STI treatment, another for peer education work, and so on. Regarding proper fund utilization, KP/NGO-5 suggested that the government develop

education materials for distribution amongst NGOs by generating a central department for communication materials development. At the same time, the government could provide training for NGOs on the basis of proper guidelines. These kinds of central activities for HIV projects would save money. However, sidelining this intrinsic care for HIV positives, NASP has been spending time, resources and energy in organizing conferences and seminars which are unreachable to the majority of HIV/AIDS patients. One local NGO chief, LCS/NGO-3, thinks that in Bangladesh, there is no GO-NGO coordination and actually the NGO people do not even like each other and do not want to see each other being successful. Finally, it can be said that in order to have optimum coordination in HIV projects, Bangladesh needs to develop an effective coordination mechanism in the NASP and NAC.

Limitations of NASP: The weak leadership of the NASP hinders the effective implementation of programmes at ground level (Panos, 2006). For example, many key personnel are critical about the NASP's unstable human resource policy. If an official stays for a few years, s/he would gain valuable experience by being trained, making foreign visits and being exposed to the HIV field. But frequent government transfers of personnel disrupt this capacity building. According to KP/UN-1:

"*Among our limitations, we have a shortage of resource persons and technical persons and we wish that we had more trained the people in the field who really understand the epidemic, are motivated to work, and would really like to see the epidemic come to an end. Often I have felt that it's a problem that people are very much motivated but they don't have the skills to use the millions of dollars coming into our country. I suppose quite obviously that's the case, but nonetheless we find it very difficult when we want to do something. Sometimes it takes 15 days to move a paper from one table to another, which is really sad. We are famous for bureaucracy, so we always start our all work 3-4 months behind.*"

In addition Bangladesh has no national body for monitoring and evaluation of its HIV projects. Monitoring and evaluation systems would seem to be essential for the purposes of learning, understanding, and improving programme performance and impact (NASP, 2005c). It is also necessary for accountability for financial and programme stewardship. In order to strengthen monitoring, a national independent body is needed which will monitor all HIV work on a regular basis. This would employ experts and work on behalf of government or under state control. Funds for this work could be top-sliced from the total HIV project allocations. KP/Org-Int-3 commented that:

"If you look at the programme critically, you can find many gaps. But some high officials may forbid you to be too critical because we are not interested to share our weaknesses."

There are management agencies for two large HIV projects in Bangladesh. They monitor NGO performance in the field beside their other activities. These management agencies play a role in building the development capacity of the implementing NGOs. There are some irregularities and a lack of transparency about NGO programmes, so some people have raised questions about the capacity and quality of these management agencies. KP/Expert-1, for instance, says:

"Why should our government's work be done by others? Why do UNICEF and Save the Children USA need to work as management agencies? We pay them and they select the implementing NGOs, but there is no proper monitoring or evaluation. We are not getting any data from these projects."

8.8 Concluding Remarks

Substantial sums have come to Bangladesh in the last 10-15 years for different HIV projects and this is a good time to ask questions about the optimum utilization of these funds. These should include the matter of poor coordination and why it has not been possible to develop referral systems between organizations. Networks are presently not working properly, and duplication of effort is partly due the lack of coordination and strategic thinking. It is partly also due to the idea that the broader the base of service provision the greater will be the power to attract funds. It is very difficult to overcome this mentality. Since the high officials in the projects are carrying out the donors' wishes, it is at the donor stage that the strategic thinking needs to take place. For instance, contingency plans need to be developed in order to sustain projects in between funding periods. So, instead of thinking of innovative methods, unfortunately it is necessary for the time being to think about the quality and coordination of existing works. HIV projects would be more fruitful if government could choose the right people, the right organization and the rights activists to do the work. Otherwise there will duplication, under-reporting or even over-reporting and the epidemic will not be checked. So, the government must handle programmes more carefully in terms of quality and coverage. The good NGOs who are working well should be identified, along with those that need a capacity build-up to do their work properly.

Chapter Nine

Summary and Recommendations

Chapter Nine

Summary and Recommendations

HIV/AIDS is no longer a problem just for individuals or nations: it has turned into a global issue. Every World AIDS day (1st December), people across the globe stand together as an opportunity of solidarity against HIV/AIDS because there is still no vaccine to prevent the disease and no medicine to cure those who are already infected by it. It has become one of the most harmful diseases humankind has ever faced. But in many countries policy makers initially perceived HIV to be just another public health problem rather than seeing it as a socio-economic threat or a national emergency. In Bangladesh, although the HIV/AIDS epidemic is not well researched, HIV is at least being detected among the 'most at risk' groups. There are many risk behaviours for HIV transmission, such as homosexuality, polygamy and illicit drug use, which are discouraged according to Muslim values but which still occur in practice. In the following sections, the research findings are discussed through a theoretical formulation of the reality under investigation before outlining a series of policy recommendations.

9.1 HIV/AIDS and Challenges for Bangladesh

In Bangladeshi society, several contextual features, including widespread poverty; the often subordinate status of women, including their role as marginalized sex workers; unequal access to health services; and low literacy and education are responsible for enhancing health risks. In addition, there is a lack of multi-sectoral integration, long term strategy, policy level response and commitment for empowerment of vulnerable groups to negotiate issues like stigma and discrimination. Moreover, operational research, which is essential for the effective implementation of any health programme, is limited. During fieldwork, I found different symbolic comparisons and concepts relating to the risks and vulnerabilities of HIV/AIDS. Some civil society participants

commented that "AIDS is spreading fast like electricity in Bangladesh" or "Bangladesh is on the HIV bomb which will burst at any time". These expressions serve to symbolise the concerns of civil society and to demonstrate the challenge of containing HIV/AIDS in a setting where conservative values inhibit people from discussing sex and related diseases, even with physicians. The stigmatized notion of 'sexualisation' of the HIV epidemic has prevented people, including health officials, from considering non-sexual routes of transmission. The stigma attached to HIV infection is related to under-reporting, and restricted testing and counselling facilities. Low levels of knowledge and heightened fears among medical service providers towards HIV positives is also exacerbating infection risk and brings about a lack of preparedness. Although there is an extensive awareness programme for reducing HIV risk behaviours, concerns remain that people are not employing preventative measures in practice.

From a geographical point of view, stigmatized places and high mobility are commonly cited as reasons for the rise of HIV/AIDS in Bangladesh. Frequent movement of the population into neighbouring countries where HIV rates are high may be an important source of entry of cases. Apart from women trafficking, injecting drug use is also more prevalent in border areas. Areas bordering India such as Manipur have particularly high rates of HIV infection among drug injectors. This research has uncovered how vulnerable groups, notably sex workers, drug users and transport workers are subject to heightened health risks due to the places they frequent. Rural-urban migration, border crossing for livelihoods, women trafficking, and the out-migration of unskilled people deserve further research in order to understand the 'channelling' of risk from one place to another.

9.2 Marginalization of Sex Workers

Sex workers in Bangladesh face exploitation and social ostracism. Prostitution is a largely invisible aspect of Bangladeshi society, but it is a readily available component of everyday life, particularly in urban areas. The growing level of cautiousness about HIV among clients and sex workers is affecting incomes while income uncertainty itself, in turn, brings raised health risks. Harassment increases the vulnerability of sex workers to sexually transmitted diseases and they are often victims of violence. Most aim to secure payment from clients before services are rendered and safe sexual behaviour is

prioritised where possible. But all groups of sex workers reported violence: rape, robbery, and beatings by both police and *mastaans*. Female sex workers in Bangladesh are commonly identified as a potential 'reservoir of infection' because of their limited choices. Men's refusal to use condoms or to stop relations with other partners denies women opportunities to protect themselves. In addition, most brothel and non-brothel sex workers find it difficult to maintain proper hygienic practices after attending a customer not only due to a lack of knowledge concerning its necessity but also because of the absence of hygienic facilities. This lack of knowledge and practice therefore serves to fuel potential health risks.

Importantly, the stigmatized identity of sex workers means exclusion from mainstream society. Many street-based, hotel or residence based sex workers suffer from depression and many attempt or consider suicide due to the high social stigma, economic vulnerability and physical violence. Stigma associated with identity and health risks may therefore negatively affect their 'lifeworlds'. Violence, low self-esteem and the dominant role of men impact on the vulnerability of these marginalized women to HIV infection. Table 9.1 summarises the different kinds of problems which commercial sex workers face.

Table 9.1: A Comparison of Different Sex Workers' Lives

Type	Living standard	Social status	Identity fear	Health risk
CSW-Street	Very Low	Worst	Medium	Worst
CSW-Floating	Low	Low	High	Worst
CSW-Residence	Medium	Suspicious	Very high	Medium
CSW-Hotel	Low	Suspicious	Very High	Worst
CSW-Brothel	Low	Very Low	High	Low

Given that NGOs provide condoms and run awareness programmes for brothel-based sex workers, this group may be categorized as having lower health risk but their social status as perceived by others, including their family and relatives, is very low. This low social status (stigmatized recognition) and poor living standards and condition cause frustrations among this group which may also indirectly impact on their health risk. In hotel- and residence-based sex workers fear for loosing 'good reputation' from neighbours, other family members etc. is very high as they always try to hide their

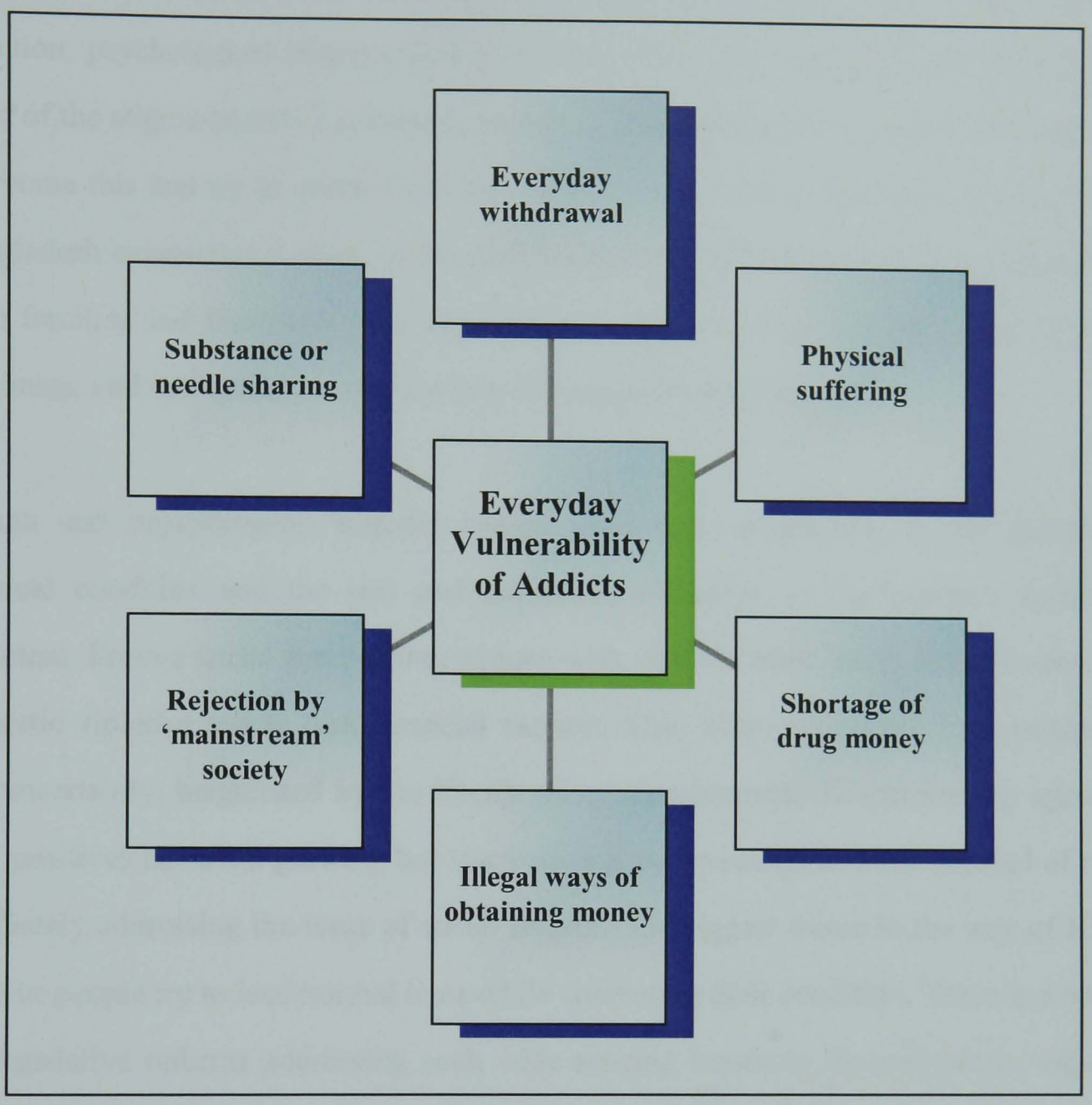
present profession. Hotel managers' or residence madams' exploitation ensures financially uncertainty that can exacerbate health risks for these groups. Street-based girls may be categorized as having very low living standards and diminished social status. Their health risks are also raised as their voices are unheard in issues such as requests for condom use by clients. Floating girls also have to face severe health risks as they are compelled to prioritise financial income over place of transaction or condom use.

9.3 Vulnerability of Drug Users

Narratives of drug users who took part in this research serve to highlight the physical vulnerability and risks they face everyday. Addictive behaviour poses different challenges to their lives. Different addict subgroups develop strong interpersonal bonds, similar images of appropriate and acceptable narcotic behaviour, a language and customs of their own, and feelings of being rejected by society. Addicts' 'lifeworlds' centre on drug taking with little time given over to hygiene-related practices such as taking a bath, washing clothes, brushing teeth, and social activities such as communicating with family members. Addictive behaviour is shaped by individual factors and by social problems such as financial crises or homelessness. Most drug users' poor health is related to these everyday uncertainties. Withdrawal symptoms and physical suffering, money earning for feeding the drug habit, stealing and needle sharing all are interlinked between drug use and its users. In addition, many addicts are considered as at-risk for HIV transmission because of their unprotected sexual behaviours, blood selling and low awareness of HIV/AIDS.

During my field work it became apparent how opiate drugs, particularly heroin, are products for which addicts have never-ending desires. My interviewees told me that when an addict earns 50 taka, s/he consumes heroin worth the whole amount and if s/he could earn 200 taka s/he would also consume the whole amount. Addicts consider heroin to be their main 'food' and they do not feel hungry for other foods such as rice before or after taking heroin. In Bangladeshi society, people are more like to despise the addict rather than the addiction while this marginalisation exacerbates the addict's need for drugs. Figure 9.1 illustrates this cycle of vulnerability in terms of economic marginalisation and social stigma.

Figure: 9.1: Vulnerability Cycle of Drug Users



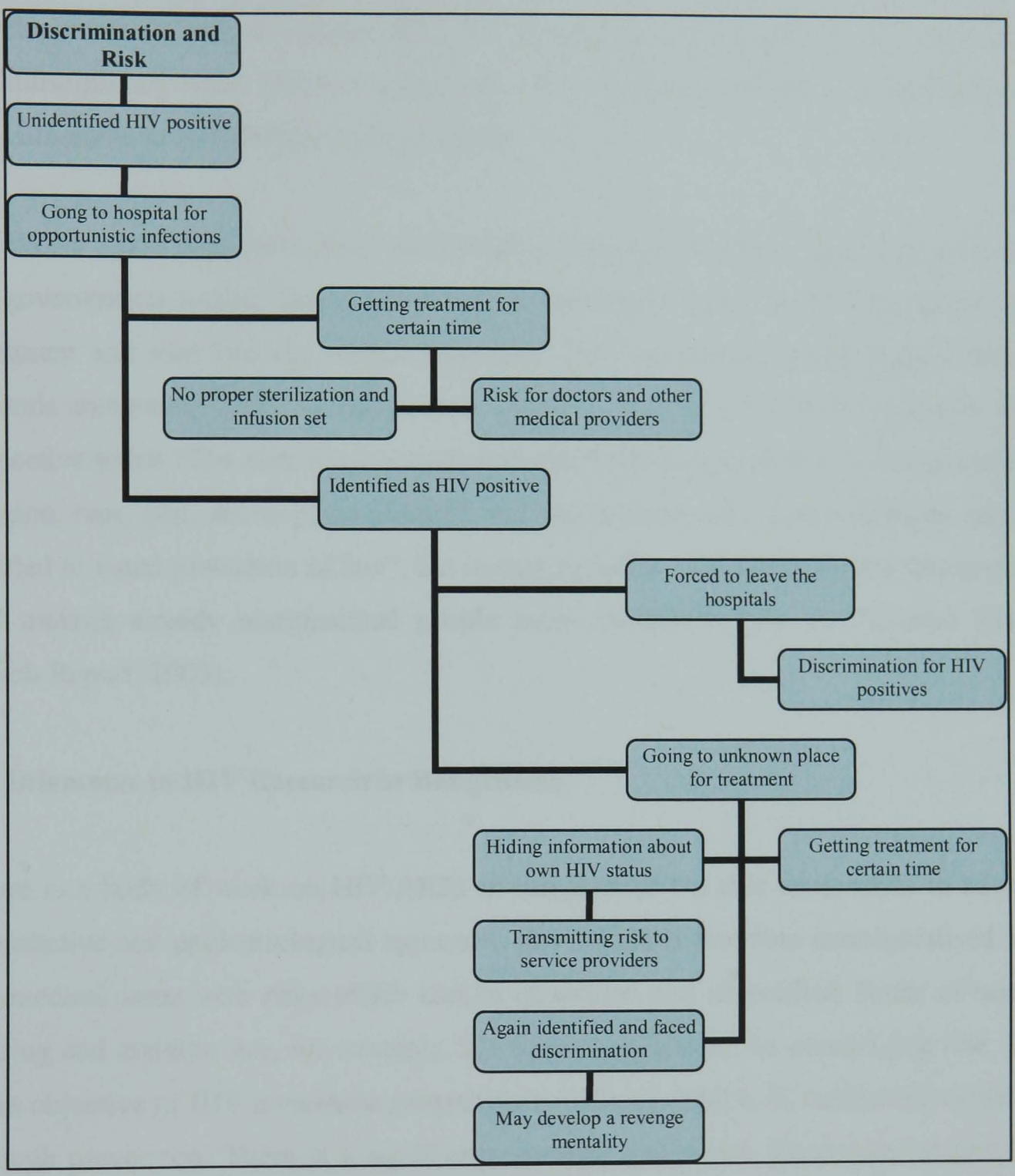
9.4 Dejected HIV Positives

Discrimination and prejudice are forms of social exclusion responsible for separating individuals from society. HIV has the most profound impact on HIV positives' lives, as most face discrimination which creates 'negative' dimensions of their identity. In Bangladesh, a lack of economic power reflects the marginalized status of most people with HIV/AIDS. Medical and social aspects of HIV/AIDS are inter-connected with the degree of stigma and psychological complications that are experienced by the HIV positive person. As stigma is the outcome of widespread fears and perceptions of risk,

HIV positives have to tolerate aspects of discrimination and neglect everyday. Three interrelated dimensions of the illness are important: physical impacts with opportunistic infection, psychological changes and social responses with negative public reactions. Most of the stigma-bearers experience a sense of shame and tend to employ strategies to overcome this and try to present themselves as 'normal'. Most HIV positive people in Bangladesh experience a range of social and emotional difficulties including separation from families and friends, loss of key roles, disruption of plans for the future, loss of self image and self-esteem, and uncertain and unpredictable futures.

Stigma and psychological impacts change over time, depending on the patient's physical condition and the real and perceived efficiency of the patient's medical treatment. From a social perspective, women with HIV are more likely to be victims of domestic violence and to lack financial support. They often experience fear, isolation and uncertainty, heightened by the likelihood of abandonment. Discrimination against HIV positives has been growing but successive governments have been accused of not adequately addressing the issue of social stigma - the biggest factor in the way of HIV positive people try to lead normal lives while combating their condition. There is a need for legislative reforms addressing such wide ranging issues as discrimination, ethics, access to treatment, privacy and confidentiality. Current legislation offers a very little support to HIV sufferers. In addition, the role of religious institutions in combating HIV in the south Asian region could be more pro-active. From the present research, it is clear that discrimination against HIV positive people is very common in Bangladesh. Discrimination and negative identities are inter-related and self-reinforcing, with raised health risks as a by-product. Figure 9.2 shows the links between discrimination and raised health risks including the impact of a stigmatized identity on treatment-seeking behaviour.

Figure 9.2: Relationship between Discrimination and Health Risk



9.5 Is HIV/AIDS Only a Health Concern?

The HIV/AIDS pandemic has shown a consistent pattern through which marginalisation, discrimination, stigmatisation and, more generally, a lack of respect for human rights and dignity of individuals and groups heighten people's vulnerability to becoming exposed to HIV. In the present research, individual biographies provide clear evidence of everyday life constituting a number of social, cultural and economic challenges for key marginalised groups in terms of HIV risk. In Bangladesh, HIV/AIDS is still, however, considered to be only a health problem or the concern of the

individual. Socio-economic and human rights perspectives are notably missing. In many lower-income countries, HIV/AIDS is now considered a threat for overall economic development and to be connected with aspects of globalization and therefore a multidisciplinary issue. But in south Asia, social reaction to marginalized people who are vulnerable to HIV further fuels the crisis.

On World AIDS day, 2007, the United Nations Secretary-General Ban Ki-moon called on governments around the world to allow universal access to HIV prevention and treatment and said that the stigma associated with the disease is the biggest barrier towards combating AIDS. In Bangladesh, article 27 and 28 (1) of the constitution state respectively that "The state shall not discriminate against any citizens on the grounds of religion, race, cast, sex or place of birth" and "All citizens are equal before law and are entitled to equal protection of law", but inequality before the law is clearly taking place and making already marginalized people more vulnerable (see also Human Rights Watch Report, 2003).

9.6 Dilemmas in HIV Research in Bangladesh

There is a body of work on HIV/AIDS in Bangladesh but this work tends to adopt a quantitative and epidemiological approach. HIV/AIDS is therefore conceptualised as a bio-medical issue with risks which can be quantified and objectified. Rates of needle sharing and condom use, for example, are used as indicators for quantifying risk. The main objective of HIV awareness programmes in Bangladesh is to control the epidemic through prevention. There is a significant research gap which the present project has sought to address by using qualitative methods to explore, for example, the rationale for low use of condoms or high rates of drug use including needle sharing. That is not to negate the value of the bio-medical approach to understanding the spread of HIV infection. Rather, in order to understand the individual, structural, medical, cultural and socio-geographical contexts of HIV transmission and prevention in a conservative society such as in Bangladesh, both qualitative and quantitative approaches are necessary.

Information from in-depth interviews, focus group discussions, participant observations and round table discussions has elicited important findings in terms of understanding

the 'lifeworlds' and health risks of HIV/AIDS in vulnerable people in two fieldwork sites. As a culturally sensitive issue, there is a large research gap present here. The Bangladeshi government is collecting some data through sero-surveillance for HIV but this is very limited in scope. As a result, policy planners face a scarcity of data about the health as well as social context of marginalized high risk groups and bridging populations. Without core data on these groups, planning for more effective measures for solutions is clearly limited. This research specifically addresses the themes of health and social management with the help of an interest in the geographical settings. One of the prime outputs of this research is a methodology of investigation for the study of the complex health and social environment in Bangladesh. The next section proposes a series of recommendations which may help to inform HIV/AIDS policy by emphasising the importance of socio-cultural contexts and dimensions of marginalisation, stigma and vulnerability.

9.7 Recommendations

1. The Bangladeshi government and non-government organisations should focus more concentrated efforts towards understanding the socio-cultural dimensions of HIV/AIDS. Associated social stigmas can begin to be addressed through consciousness-raising and addressing misconceptions and unfounded fears. Programmes of socio-cultural research and awareness raising are suggested to complement existing work which has traditionally adopted a bio-medical approach.

2. HIV is a challenge due to the marginalized status of those groups and individuals who are most vulnerable. Priority should be given to empowering commercial sex workers through self-help organizations and the provision of skills training. These interventions can ensure their different rights and negotiation of safer sex behaviour. For drug users, there is a need for social rehabilitation programmes along with treatment.

3. In order to address the criminalization and discrimination of marginalized people, there is a need for reform of discriminatory laws and establishment of a legal framework for improving community acceptance.

4. Along with HIV prevention programmes for the 'most at risk' groups, there is a need to implement care and support mechanisms for those already infected with HIV. Separate units for HIV case management in every divisional city would help in this need as would the creation of counsellor posts in district and sub-district level hospitals. In addition, affordable, confidential, supportive and user-friendly testing facilities should be made available in order to help reduce some of the shame and fear associated with the disease.

5. A number of HIV positive people in Bangladesh have lived abroad and there has been some questioning of the country's responsibility to treat them. There is also some debate about whether economic migrants should be educated before they leave or whether the recipient country has this duty, and whether the migrants themselves should pay for the services they use. There is a need for clearer economic policy and a legal framework around citizen rights in this respect.

6. There is a need for more open dialogue about HIV/AIDS which, in Bangladesh, is generally considered as only a sexually transmitted disease. In this regard, local civil society and religious institutions should be encouraged to play a stronger and more dedicated role in its understanding and prevention.

7. Published estimates of the number of HIV-infected people are available but their reliability is likely to be low given inconsistencies in reporting and the lack of a robust disease surveillance system. The continued focus on high-risk groups has created a false sense of security and complacency in the general population, including policy makers themselves. Continuous surveillance is the only medium through which accurate quantitative data may be provided on the scale of HIV infection in Bangladesh.

8. Policy level commitment has to be translated into action at grassroots level on a short-, mid- and long-term basis. Emphasis should be placed upon high-risk

behaviours rather than high-risk groups. Regional cooperation, for example, is needed to address the issue of trafficking.

9. Involvement of national government ministries, NGOs, the private sector and local communities is required for an integrated approach towards planning, implementation, coordination, monitoring and evaluation of HIV-related projects. A well-established GO-NGO network which will support the national response would help to initiate this need.

9.8 Concluding Remarks

Bangladesh has dealt with the causalities of many natural disasters, particularly devastating cyclones, for a long time. HIV/AIDS, a silent disaster, is still considered by many to be a low-level threat but the potential is there for losses from HIV/AIDS to impact on the nation's demographic, social and economic progress in future. AIDS is thought to be a disease of African or Indian people, whose sexual mores are different. But, despite being a Muslim country, Bangladesh has a long list of risk issues, including extra-marital sex which could fuel the spread of HIV/AIDS. Bangladesh is said to have a low prevalence of HIV, but reported statistics are unlikely to be wholly reliable. The NASP has produced an HIV strategic plan that is comprehensive but the problem is with implementation due to resource constraints. Many NGO key officials believe that the government has received enough from the GFATM project in the prevention of HIV but the problem is the channelling of funds. If the government can allocate resources to the right organizations at the right time, then there are opportunities to delay the epidemic. If the government's development partners and local civil society can make an intensive effort to work more closely, including involvement of marginalized communities themselves, positive results could be achieved.

References

References

Aase, A. and Agyei-Mensah, S. (2005) HIV/AIDS in sub-Saharan Africa: geographical perspectives, *Norwegian Journal of Geography*, 59 (1), 1-5

Adler, P. A. and Adler, P. (1994) Observational techniques, In N. K. Denzin and Y. S. Lincoln (eds) *Handbook of qualitative research*, Sage, London

Agar, M. (1980) *The professional stranger: an informal introduction to ethnography*, Academic press, New York

Agar, M. (1997) Ethnography: an overview, *Substance Use and Misuse*, 32, 1155-1173

Aggleton, P. (1990) *Health*, Routledge, London

Ahmad, K. (2001) Call for decriminalization of prostitution in Asia, *Lancet*, 338, 643

Ahmed, H. S. (2006a) Facing an uncertain future, Star weekend magazine, *The Daily Star*, Vol. 5, issue 121, November 24, Dhaka

Ahmed, H. S. (2006b) Life after HIV, Cover story, Star weekend magazine, *The Daily Star*, Vol. 5, issue 122, December 1, Dhaka

Ahmed, M. U., Ahmed, S., Khanum, P. A. and Khan, M. H. (1997) *Management of sexually transmitted diseases by rural practitioners*, ASCON VI Conference, Dhaka, Bangladesh: International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B) March, Special Publication No. 57, Dhaka

Ahmed, S. K. (2004) Drug use and HIV vulnerability: quest for a holistic national response, *The Daily Star*, November 30, Dhaka

Ahsan, R. M., Ahmad, N., Eusuf, A. Z. and Roy, J. (1999) Prostitutes and their environment in Narayanganj, Bangladesh, *Asia Pacific Viewpoint*, 40 (1), 33-44

Alam, A. (2007) Counting on gender development to contain spread of AIDS, *The Daily New Nation*, December 2, Dhaka

Alexander, P. (1996) Foreword, In *Sex work on the streets: prostitutes and their clients*, By N. Mckeganey and M. Barnard, Open University Press, London

Alling, F. A. (1992) Detoxification and treatment of acute sequelae, In J. H. Lowinson; P. Ruiz; R. B. Millman and J. G. Langrd (eds) *Substance abuse: a comprehensive textbook*, Williams and Wilkins, Baltimore, pp. 402-418

Alonzo, A. A. and Reynolds, N. R. (1995) Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory, *Social Science and Medicine*, 41 (3), 303-315

Anderson, A., Qingsi, Z., Hua, X. and Jianfeng, B. (2003) China's floating population and the potential for HIV transmission: a social-behavioural perspective, *AIDS Care*, 15, 177-185

Anderson, R. and Bury, M. (1988) (eds) *Living with chronic illness: the experience of patients and their families*, Hyman Unwin, London

Andrews, G. J. and Evans, J. (2008) Understanding the reproduction of health care: towards geographies in health care work, *Progress in Human Geography*, 32 (6), 759-780

Andrews, G. J., Cutchin, M., McCracken, K., Phillips, D. R. and Wiles, J. (2007) Geographical gerontology: the constitution of a discipline, *Social Science and Medicine*, 65 (1), 151-168

Anglin, M. D., McGlothlin, W. H. and Speckart, G. (1981) The effect of parole on methadone patient behaviour, *American Journal of Drug and Alcohol abuse*, 8, 153-170

Annas, G. J. (1999) The impact of health policies on human rights: AIDS and TB control, In J. M. Mann; S. Gruskin; M. A. Grodin and G. J. Annas (eds) *Health and human rights*, Routledge, New York

Annells, M. (1996) Grounded theory method: philosophical perspectives, paradigm of inquiry and post modernism, *Qualitative Health Research*, 6 (3), 379-93

Ara, Z. (2005) Violation & denial of access to health-rights for women involved in commercial sex work in Bangladesh, *Women's Health and Urban life*, 4 (1), 6-26

Arber, S. (2001) Designing samples, In N. Gilbert (ed) *Researching social life*, Second edition, Sage, London

Asthana, S. (1996) AIDS-related policies, legislation and programme implementation in India, *Health Policy and Planning*, 11 (2), 184-197

Asthana, S. (1998) The relevance of place in HIV transmission and prevention: the commercial sex industry in Madras, In R. A. Kearns and W. M. Gesler (eds)

Putting health into place: landscape, identity, and wellbeing, Syracuse University press, Syracuse, pp. 168-190

Asthana, S. and Oostvogels, R. (1996) Community participation in HIV prevention: problems and prospects for community-based strategies among female sex workers in Madras, *Social Science and Medicine*, 43 (2), 133-148

Atherton, J. (2003) *Marginalization*, SCM press, London

Aviles, N. R., Barnard, M., Rhodes, T. et al (2000) Qualitative research on the health risks associated with drug injecting: needle and syringe sharing, In EMCDDA (ed) *Understanding and responding to drug use: the role of Qualitative Research*, Scientific monograph series, No. 4, Luxembourg

Azim, T., Alam, M. S., Rahman, M., Sarker, M. S., Ahmed, G., Khan, M. R., et al. (2004) Impending concentrated HIV epidemic among injecting drug users in central Bangladesh (letter), *International Journal of STD & AIDS*, 15, 280-282

Azim, T., Bogaerts, J., Yirrell, D. L., Banerjea, A. C., Sarker, M. S., Ahmed, G., Amin, M. M., Rahman, A. S. and Hussain, A. M. (2002) Injecting drug users in Bangladesh: prevalence of syphilis, hepatitis, HIV and HIV subtypes, *AIDS*, 16 (1), 121-123

Azim, T., Islam, M. N., Bogaerts, J., Mian, M. K., Sarker, M. S., Fattah, K. R., Simmons, P., Jenkins, C., Choudhury, M. R. and Mathan, V. I. (2000) Prevalence of HIV and Syphilis among high-risk groups in Bangladesh, *AIDS*, 14 (2), 210-211

Azim, T., Rahman, M., Alam, M. S. et al (2008) Bangladesh moves from being a low-prevalence nation for HIV to one with a concentrated epidemic in injecting drug users, *International Journal of STD & AIDS*, 19 (5), 327-331

Aziz, A. (2004) Branded untouchables, Special feature, Weekend magazine, *The Daily Star*, Vol 1, No 153, May 7, Dhaka

Aziz, K. M. A. et al (1985) *Life stages, gender and fertility in Bangladesh*, Dhaka

Baden, S., Green, C., Goetz, Anne-Marie and Guhathakurta, M. (1994) *Background report on gender issues in Bangladesh*, Prepared for the British high commission, Dhaka, BRIDGE report no. 26, Institute of Development Studies, University of Sussex, UK

Bailey, R. C., Moses, S. et al (2007) Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial, *Lancet*, 369, 643-656

Baker, N. L. (2001) Prejudice, In J. Worell (ed) *Encyclopedia of women and gender*, Vol. 2, Academic press, New York

Baker, T. B. (1988) Models of addiction: introduction to the special issue, *Journal of Abnormal Psychology*, 97, 115-17

Bamford, M., Gaitley, R. and Miller, R. (1988) *HIV-AIDS a social work perspective*, BASW publications, Birmingham

Barnard, M. (1992) Working in the dark: researching female prostitution, In H. Roberts (ed) *Women's health matters*, Routledge, London

Barnard, M. (2007) *Drug addiction and families*, Jessica Kingsley publishers, London

Barnes, D. M. (1996) An analysis of the grounded theory method and the concept of culture, *Qualitative Health Research*, 6 (3), 429-441

Barnett, T. and Whiteside, A. (1999) HIV/AIDS and development: case studies and a conceptual framework, *European Journal of Development research*, 11 (2), 200-235

Barrett, F. A. (1980) Medical geography as foster child, In M. S. Meade (ed) *Conceptual and methodological issues in medical geography*, Chapel Hill, N.C., University of North Carolina, Department of Geography, 1-15

Bartlett, J. G. and Finkbeiner, A. K. (1993) *The guide to living with HIV infection*, The Johns Hopkins University press, Baltimore

Barton, M. (1999) *Scripture as empowerment for liberation and justice: the experience of Christian and Muslim women in Bangladesh*, CCSRG Monograph series 1, Department of Theology and Religious studies, University of Bristol

Bateson, N. (1984) *Data construction in social surveys*, Allen & Unwin, London

Baxter, J. and Eyles, J. (1997) Evaluating qualitative research in social geography: establishing 'rigour' in interview analysis, *Transactions of the Institute of British Geographers*, 22 (4), 505-525

BBC News (2000) *Bangladesh says prostitution legal*, British Broadcasting Corporation (BBC) News, March 14

BBC News (2007) *HIV fears over Nepal sex workers*, British Broadcasting Corporation (BBC) News, August 1

BBS (2003) *Bangladesh population census*, Bangladesh Bureau of Statistics (BBS), Government of Bangladesh, Dhaka

Bean, P. (2002) *Drugs and crime*, Willan publishing, Portland

Beck, A. T., Wright, F. D., Newman, C. F. and Liese, B. S. (1993) *Cognitive therapy of substance abuse*, Guildford press, New York

Becker, H. S. (1986) *Doing things together*, North Western University press, Evanston

Begum, A. (1991) Drug dependence problem in Dhaka, Bangladesh, *Bangladesh Medical Journal*, 20 (1), 33-39

Begum, H. A. (1976) *Sexual attitudes of Dhaka university students*, Dhaka University, Dhaka

Benjamin, C. (2001) Aspects of stigma associated with genetic conditions, In T. Mason., C. Carlisle., C. Watkins and E. Whitehead (eds) *Stigma and social exclusion in healthcare*, Routledge, London

Bennett, A. (2005) *Culture and everyday life*, Sage, London

Bennett, D. (2005) Replacing positivism in medical geography, *Social Science and Medicine*, 60 (12), 2685-2695

Benoliel, J. Q. (1996) Grounded theory and nursing knowledge, *Qualitative Health Research*, 6 (3), 406-428

Berer, M. and Ray, S. (1993) *Women and HIV/AIDS: an international resource book*, Pandora, London

Berger, A. A. (1997) *Narratives in popular culture, media, and everyday life,* Sage, Thousand Oaks

Berk, M. L., Schur, C. L., Dunbar, J. L. et al (2003) Migration among persons living with HIV, *Social Science and Medicine*, 57 (6), 1091-1097

Beyrer, C., Razak, M. H., Lisam, K., Chen, J., Lui, W. and Yu, X. F. (2000) Overland heroin trafficking routes and HIV-1 spread in south and south-east Asia, *AIDS*, 14, 75-84

Bhuiya, A. and Ansary, S. (1998) *Status of health and health equity in Bangladesh*, Report prepared for the global health equity initiative meeting, December 11-17, Dhaka

Bhuiya, A., Aziz, A. and Chowdhury, M. (2001) Ordeal of women for induced abortion in a rural area of Bangladesh, *Journal of Health, Population and Nutrition*, 19 (4), 281-290

Bhuiya, A., Hanifi, S. M. A., Hossain, M. and Aziz, A. (2000) Effects of an AIDS awareness campaign on knowledge about AIDS in a remote rural area of Bangladesh, *International Quarterly of Communication Health Education,* 19, 51-63

Bhuiya, I., Hossain, S. M. I. and Streatfield, K. (1995) *Situation of blood testing/ screening in relation to HIV/AIDS in Dhaka city*, Regional working papers, South and East Asia, No. 1, The Population Council, Dhaka

Bhuiya, I., Rob, U., Yusuf, N. and Chowdhury, A. H. (2004) *Bangladesh database on HIV/AIDS: South Asia political advocacy project*, Population Council and UNAIDS

Biswas, N. (2007) HIV/AIDS: Bangladesh at high risk? *The Daily Star*, December 1, Dhaka

Blacking, J. (1983) The concept of identity and folk concepts of self: a venda case study, In A. Jacobson-Widding (ed) *Identity: personal and socio-cultural*, A symposium, Uppsala, Academiae Upsaliensis, Stockholm

Blaikie, N. (2000) *Designing social research: the logic of anticipation*, Polity press, Cambridge

Blakemore, K. and Symonds, A. (1997) Recent trends in health policy: consumerism and managerialism, In S. Taylor and D. Field (eds) *Sociology of health and health care*, Second edition, Blackwell Science, Tokyo

Blanc, A. K. and Way, A. A. (1998) Sexual behaviour and contraceptive knowledge and use among adolescents in developing countries, *Studies in Family Planning*, 29 (2), 106-116

Blanchet, T. (1996) *Lost innocence: stolen childhood*, Dhaka: University Press Limited (UPL), Dhaka

Blanchet, T. et al (2003) *Bangladesh girls sold as wives in north India*, Academy for Educational Development (AED), Dhaka

Bland, L. (1992) The case of the Yorkshire ripper: mad, bad, beast or male? In J. Radford and D. E. H. Russell (eds) *Femicide: the politics of woman killing*, Open University press, Milton Keynes

Bloem, M., Hoque, E., Khanam, L., Mahbub, T. S., Salehin, M. and Begum, S. (1999) HIV/AIDS and female street-based sex workers in Dhaka city: what about their clients? In J. C. Caldwell; Pat Caldwell; John Anarfi, et al (eds) *Resistance to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in third world countries*, Health Transition center, Australian National University, Canberra, pp. 197-210

Bloor, M. and Wood, F. (1998) *Addiction and problem drug use: issues in behaviour, policy and practice*, Jessica Kingsley publishers, London

Bloor, M., McKeganey, N., Finlay, A. and Barnard, M. (1992) The inappropriateness of psycho-social models of risk behaviour for understanding HIV-related risk practices among Glasgow male prostitutes, *AIDS Care*, 4, 131-137

Blumer, H. (1962) Society as symbolic interaction, In *Symbolic Interaction*, Prentice-hall, Englewood Cliffs

Bogaerts, J., Ahmed, J., Akhter, N. et al (2001) Sexually transmitted infections among married women in Dhaka, Bangladesh: unexpected high prevalence of herpes simplex type-2 infection, *Sexually Transmitted Infections*, 77, 114-119

Bogaerts, J., Ahmed, J., Akhter, N., Begum, N. (1997) *Prevalence of reproductive tract infections among women attending the BWHC clinic in Mirpur, Dhaka*, ASCON VI Conference, International Centre for Diarrhoeal Disease Research, Bangladesh, (ICDDR, B), March, Special Publication No. 57, Dhaka

Bourgois, P. (1998) The moral economies of homeless heroin addicts: confronting ethnography and HIV risk and everyday violence in San Francisco shooting encampments, *Substance Use and Misuse*, 33, 2323-2351

Bourgois, P., Lettiere, M. and Quesada, J. (2003) Social misery and the sanctions of substance abuse: confronting HIV risk among homeless heroin addicts in San Francisco, In J. D. Orcutt and D. R. Rudi (eds) *Drugs, alcohol and social problems*, Rowman & Littlefield publishers, New York, pp. 257-278

Bradburn, N. M. (1983) Response effects, in P. H. Rossi; J. D. Wright and A. B. Anderson (eds) *Handbook of survey research*, Academic press, New York

Brannen, J. (1988) The study of sensitive subjects, *Sociological Review*, 36, 552-63

Brewer, J. D. (1990) Sensitivity as a problem in a field research: a study of routine policing in Northern Ireland, *The American Behavioral Scientist*, 33 (5), 578-593

Brockerhoff, M. and Biddlecom, A. E. (1999) Migration, sexual behavior and the risk of HIV in Kenya, *International Migration Review*, 33 (4), 833-856

Brown, M. (1995) Ironies of distance: an ongoing critique of the geographies of AIDS, *Environment and Planning D: Society and Space*, 13 (2), 159-183

Brown, M. (1997) *Replacing citizenship: AIDS activism and radical democracy*, Guilford press, London

Brown, T. and Duncan, C. (2002) Placing geographies of public health, *Area*, 34 (4), 361-369

Browne, A. W. and Barrett, H. R. (2001) Moral boundaries: the geography of health education in the context of the HIV/AIDS pandemic in Southern Africa, *Geography*, 86 (1), 23-36

Brownell, K., Marlatt, G. A., Lichenstein, E. and Wilson, G. (1986) Understanding and preventing relapse, *American Psychologist*, 41 (7), 765-782

Bruyn, S. T. (1966) *The human perspective in sociology: the methodology of participant observation*, Prentice-Hall, Englewood Cliffs, New Jersey

Bryman, A. (1996) *Quantity and quality in social research*, Routledge, London

Bryman, A. (2004) *Social research methods*, Oxford University press, Oxford

Bulmer, M. (2001) The ethics of social research, In N. Gilbert (ed) *Researching social life*, Second edition, Sage, London

Bunne, M. (1999) Qualitative research methods in otorhinolaryngology, *International Journal of Pediatric Otorhinolaryngology*, 51, 1-10

Bury, M. (1982) Chronic illness as biographical disruption, *Sociology of Health and Illness*, 4 (2), 167-182

Bury, M. (1988) Meanings at risk: the experience of arthritis, In R. Anderson and M. Bury (eds) *Living with chronic illness: the experience of patients and their families*, Unwin Hyman, London, pp. 89-116

Butler, J. (2004) *Undoing gender*, Routledge, New York

Butler, J. and Scott, J. W. (1992) (eds) *Feminists theorize the political*, Routledge, London

Butler, R. E. (1994) Geography and vision-impaired and blind populations, *Transactions of the Institute of British geographers*, 19 (3), 366-368

Bwayo, J., Plummer, F., Omari, M., Mutere, A., Moses, S., Ndinya-Achola, J., Velentgas, P. and Kreiss, J. (1994) Human immunodeficiency virus infection in long distance truck drivers in East Africa, *Archives of Internal Medicine*, 154, 1391-1396

CAAP (1998) *Self monitoring report*, Confidential Approach to AIDS Prevention (CAAP), Dhaka

Caldwell, B. and Pieris, I. (1999) Continued high-risk behaviour among Bangladeshi males, In J. C. Caldwell; Pat Caldwell; John Anarfi et al (eds) *Resistance to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in third world countries*, Health Transition center, Australian National University, Canberra, 183-196

Caldwell, B., Pieris, I., Barkat-e-Khuda, Caldwell, J. and Caldwell, P. (1999) Sexual regimes and sexual networking: the risk of an HIV/AIDS epidemic in Bangladesh, *Social Science and Medicine*, 48 (8), 1103-1116

Caldwell, J. C., Anarfi, J. K. and Caldwell, P. (1997) Mobility, migration, sex, STDs, and AIDS: an essay on sub-Saharan Africa with other parallels, In G. Herdt (ed) *Sexual cultures and migration in the era of AIDS: anthropological and demographic perspectives*, Oxford University press, New York, pp. 41-54

Campbell, C. (1997) Migrancy, masculine identities and AIDS: The psychosocial context of HIV transmission on the South African gold mines, *Social Science and Medicine*, 45 (2), 273-281

Campbell, C. and Mzaidume, Z. (2001) Grassroots participation, peer education, and HIV prevention by sex workers in South Africa, *American Journal of Public Health*, 91 (12), 1978-1986

Campbell, C. and Williams, B. (1999) Beyond the biomedical and behavioural: towards an integrated approach to HIV prevention in the Southern African mining industry, *Social Science and Medicine*, 48 (11), 1625-1639

Campbell, J. (1995) HIV and suicide: is there a relationship? *AIDS care*, 7 (supplement 2), S107-S108

Carlisle, C. (2001) HIV and AIDS, In T. Mason; C. Carlisle; C. Watkins and E. Whitehead (eds) *Stigma and social exclusion in healthcare*, Routledge, London

Carlson, R. G. (2000) Shooting galleries, dope houses and injection doctors: examining the social ecology of HIV risk behaviours among drug injectors in Dayton, Ohio, *Human Organization*, 59 (3), 325-333

Carlson, R. G., Siegal, H. A. and Flack, R. S. (1995) Qualitative research methods in drug abuse and AIDS prevention research: an overview, In E. Y. Lambert; R. S. Ashery and R. H. Needle (eds) *Qualitative methods in drug abuse and HIV research*, NIDA research monograph, 157, Rockville

Carnwath, T. and Smith, I. (2002) *Heroin century*, Routledge, London

Carswell, J. W., Lloyd, G. and Howells, J. (1989) Prevalence of HIV-1 in East Africa lorry drivers, *AIDS*, 3, 759-761

Castle, S. (2004) Rural children's attitudes to people with HIV/AIDS in Mali: the causes of stigma, *Culture Health & Sexuality*, 6 (1), 1-18

Cates, W. and Dallabetta, G. (1999) The staying power of sexually transmitted diseases, *The Lancet*, 354 (S4), 2

Cawley, R. H. (1988) Introduction, In L. Paine (ed) *AIDS: psychiatric and psychosocial perspectives*, Croom Helm, London

Celentano, D. D., Vlahov, D., Cohn, S. et al (1991) Risk factors for shooting gallery use and cessation among intravenous drug users, *American Journal of Public Health*, 81 (10), 1291-1295

Chan, P. A. and Khan, O. A. (2007) Risk factors for HIV infection in males who have sex with males (MSM) in Bangladesh, *BMC Public Health*, 7, 153

Chaney, D. (2002) *Cultural change and everyday life*, Palgrave, New York

Chant, S. and McIlwaine, C. (1995) *Women of a lesser cost: female labour, foreign exchange, and Philippine development*, Pluto press, London

Charmaz, K. (1983) Loss of self: a fundamental form of suffering in the chronically ill, *Sociology of Health and Illness*, 5 (2), 168-195

Charmaz, K. (2000) Grounded theory, In N. K. Denzin and Y. S. Lincoln (eds) *The handbook of qualitative research*, Second edition, Sage, London

Chein, I., Gerard, D. L., Lee, R. S. and Rosenfeld, E. (1964) *Narcotics, delinquency and social policy: the road to H*, Tavistock publications, London

Chelala, C. and Beyrer, C. (1999) Drug use and HIV/AIDS in Burma, *The Lancet*, 354, September 18

Cheng, S. (2005) Popularising purity: gender, sexuality and nationalism in HIV/AIDS prevention for South Korean youths, *Asia Pacific Viewpoint*, 46 (1), 7-20

Chitwood, D. D., McCoy, C. B. et al (1990) HIV seropositivity of needles from shooting galleries in south Florida, *American Journal of Public Health*, 80 (2), 150-152

Choudhury, A.Y., Arjumand, L. and Piwoo, J. S. (1997) *A rapid assessment of health seeking behaviour in relation to sexually transmitted disease*, PIACT Bangladesh, Dhaka

Choudhury, M. R., Rahman, A. S. M. and Moniruzzaman, M. D. (1989) Serological investigations for a detection of HIV infection in Bangladesh, *Bangladesh Armed Forces Medical Journal*, 13 (1), 1-9

Chowdhury, A. Q. M. B., Choudhury, M. R. and Lazzari, S. (1995) *Responding to HIV/AIDS in Bangladesh, Dhaka, Bangladesh*: National AIDS Committee, September, Dhaka

Chowdhury, R. (2006) "Outsiders" and identity reconstruction in the sex workers' movement in Bangladesh, *Sociological Spectrum*, 26, 335-357

Christ, G. H., Wiener, L. S. and Moynihan, R. T. (1988) Psychosocial issues in AIDS, In R. P. Galea; B. F. Lewis and L. A. Baker (eds) *AIDS and IV drug abusers: current perspectives*, National Health publishing, USA

Clark, D. A. (2002) Development ethics: a research agenda, *International Journal of Social Economics*, 29 (11), 830-848

Clarke, A. (2001) *The Sociology of health care*, Pearson, Harlow

Cleland, J. and Ferry, B. (1995) (eds) *Sexual behavior and AIDS in the developing world*, Taylor & Francis, London

Cliff, A. D. and Haggett, P. (1988) *Atlas of disease distributions: analytic approaches to epidemiological data*, Blackwell, New York

Cliff, A. D. and Smallman-Raynor, M. R. (1992) The AIDS pandemic: global geographical patterns and local spatial processes, *Geographical Journal*, 158 (2), 182-198

Clift, E. (1998) IEC interventions for health: a 20 year retrospective on dichotomies and directions, *Journal of health communication*, 3, 367-375

Clift, S. and Wilkins, J. (1995) Travel, sexual behaviour and gay men, In P. Aggleton; P. Davies and G. Hart (eds) *AIDS: safety, sexuality and risk*, Taylor & Francis, London

Clumeck, N. and DeWit, S. (1988) AIDS in Africa, In M. A. Sande and P. Volberding (eds) *The medical management of AIDS*, Saunders, Philadelphia

Coffey, A. and Atkinson, P. (1996) *Making sense of qualitative data: complementary research strategies*, Thousand Oaks, CA

Cohen, C. R., Duerr, A., Pruithithada, N. et al (1995) Bacterial vaginosis and HIV seroprevalence among female commercial sex workers in Chiang Mai, Thailand, *AIDS*, 9, 1093-1097

Cohn, S. E., Klein, J. D., Mohr, J. E., van der Horst, C. M. and Weber, D. J. (1994) The geography of AIDS: patterns of urban and rural migration, *Southern Medical Journal*, 87, 599-606

Colum, L. (2008) AIDS drugs reaching more people in developing world, *Washingtonpost.com*, June 10

Compton, R. (2007) Dynamics of HIV/AIDS in China and India: assessing governmental response, In R. L. Ostergard, Jr. (ed) *HIV/AIDS and the threat to national and International security*, Macmillan press, England

Conradson, D. (2005) Focus groups, In R. Flowerdew and D. Martin (eds) *Methods in human geography: a guide for students doing a research project*, Second edition, Prentice-Hall, London

Corbin, J. and Strauss, A. (1991) Comeback: the process of overcoming disability, In G. L. Albrecht and J. A. Levy (eds) *Advances in medical sociology*, Vol. 2, JAI press, Greenwich

Corneil, T. A., Kuyper, L. M., Shoveller. J., Hogg, R. S., Li, K., Spittal, P. M., Schechter, M. T. and Wood, E. (2006) Unstable housing, associated risk behaviour, and increased risk for HIV infection among injection drug users, *Health & Place*, 12 (1), 79-85

Cosmos Magazine (2006) Battle lines drawn against AIDS pandemic, Cosmos Magazine news, Agence France- Presse, August 15

Craddock, S. (2000) Disease, social identity, and risk: rethinking the geography of AIDS, *Transaction of the Institute of British geographers*, 25 (2), 153-168

Crocker, D. A. (1991) Toward development ethics, *World Development*, 19 (5), 457-483

Crocker, J., Blaine, B. and Luhtanen, R. (1993) Prejudice, intergroup behaviour and self-esteem: enhancement and protection motives, In M. A. Hogg and D. Abrams (eds) *Group motivation: social psychological perspectives*, Harvester Wheatsheaf, London, pp. 52-67

Crocker, J., Major, B. and Steele, C. (1998) Social stigma, In D. T. Gilbert; S. T. Fiske and G. Lindzey (eds) *The handbook of social psychology*, Fourth edition, Vol. 2, McGraw-Hill, New York, pp. 504-553

Cronin, A. (2001) Focus groups, In N. Gilbert (ed) *Researching social life*, Second edition, Sage, London

Cummins, S., Curtis, S., Diez-Roux, A. V. and Macintyre, S. (2007) Understanding and representing 'place' in health research: a relational approach, *Social Science and Medicine*, 65 (9), 1825-1838

Currie, E. (1993) *Reckoning: drugs, the cities and the American future*, Hill and Wang, New York

Curtis, S. (2004) *Health and Inequality: geographical perspectives*, Sage, London

Curtis, S. and Taket, A. (1996) *Health and societies: changing perspectives*, Arnold, London

Curtis, S., Gesler, W., Smith, G. and Washburn, S. (2000) Approaches to sampling and case selection in qualitative research: examples in the geography of health, *Social Science and Medicine*, 50 (7-8), 1001-1014

Cutchin, M. P. (2007) The need for the ''new health geography'' in epidemiologic studies of environment and health, *Health & Place*, 13 (3), 725-742

Dandona, R., Dandona, L., Gutierrez, J. P., Kumar, A. G. et al (2005) High risk of HIV in non-brothel based female sex workers in India, *BMC Public Health,* 5: 87

David, H. P. and Lee, E. (2001) Abortion and its health effects, In J. Worell (ed) *Encyclopedia of women and gender*, Vol. 1, Academic press, New York

Davidson, J. O'Connell (2006) *Prostitution, power and freedom*, Polity press, Cambridge

Davies, G., Day, R. and Williamson, S. (2004) Editorial: the geography of health knowledge/s, *Health & Place*, 10 (4), 293-297

Davies, P. M. (1986) *Some problems in defining and sampling non-heterosexual males*, University College Cardiff, Social research unit, Working paper No. 21

Davis, F. (1963) *Passage through crisis: polio victims and their families*, Bobbs-Merrill, Indianapolis

de Cock, K. M. (1984) AIDS: an old disease from Africa, *British Medical Journal*, 289 (6440), 306-308

Dear, M., Wilton, R., Gaber, S. L. and Takahashi, L. (1997) Seeing people differently: changing constructs of disability and difference, *Environment and Planning D: Society and Space.* 15, 455-480

Del Casino, V. J. Jr. (2001) Healthier geographies: mediating the gaps between the needs of people living with HIV/AIDS and health care in Chiang Mai, Thailand, *The Professional Geographer*, 53 (3), 407-421

Del Casino, V. J. Jr. (2004) (Re)placing health and health care: mapping the competing discourses and practices of 'traditional' and 'modern' Thai medicine, *Health & Place*, 10 (1), 59-73

Denscombe, M. (1993) Personal health and the social psychology of risk taking, *Health Education Research*, 8, 505-517

Denzin, N. K. (1978) *The research act: a theoretical introduction to sociological methods*, McGraw-Hill, New York

Denzin, N. K. and Lincoln, Y. S. (1994) (eds) *Handbook of qualitative research*, Sage, London

Denzin, N. K. and Lincoln, Y. S. (2000) *The handbook of qualitative research*, Second edition, Sage, London

Des Jarlais, D. C. and Friedman, S. R. (1990) Shooting galleries and AIDS: infection probabilities and 'tough' policies, *American Journal of Public Health*, 80 (2), 142-144

Des Jarlais, D. C., Friedman, S. R., Choopanya, K. et al (1992) International epidemiology of HIV and AIDS among injecting drug users, *AIDS*, 6, 1053-1068

Dey, I. (1993) *Qualitative data analysis: a user-friendly guide for social scientists*, Routledge, London

Dixon, C. and Leach, B. (1977) *Sampling methods for geographical research*, *CATMOG* (Concepts and Techniques in Modern Geography) series no. 17, University of East Anglia, Norwich

Dixon, L. (2003) *Housing services for drug users in the East Midlands*, Final Report, Nacro Consultancy and Training, UK

Dole, L. R., Elkins, D. B., Boonjear, K., Phiensrithom, S. and Maticka-Tyndale, E. (1998) Cattle markets and local festivals: development of HIV/AIDS prevention interventions for specific risk situations in rural northeast Thailand, *Health & Place*, 4 (3), 265-272

Dorn, M. and Laws, G. (1994) Social theory, body politics, and medical geography: extending Kearns's invitation, *The Professional Geographer*, 46 (l), 106-110

Dorn, N. and South, N. (1987) (eds) *A land fit for heroin?: drug policies, prevention and practice*, Macmillan education, London

Douglas, M. (1986) *Risk acceptability according to the social sciences*, Routledge and Kegan Paul, London

Dovey, K., Fitzgerald, J. and Choi, Y. (2001) Safety becomes danger: dilemmas of drug use in public space, *Health & Place*, 7 (4), 319-331

Downing, M. J. Jr. (2008) The role of home in HIV/AIDS: a visual approach to understanding human-environment interactions in the context of long-term illness, *Health & Place*, 14 (2), 313-322

Doyal, L. (1995) *What makes women sick: gender and the political economy of health*, MacMillan, London

Drahozal, B. R. (2004) *Drug addiction treatment, rehabilitation and after care*, In the publication of Department of Narcotics Control, on the International day against drug abuse and illicit trafficking, Government of Bangladesh, Dhaka

Dunn, C. E. (2007) Participatory GIS- a people's GIS? *Progress in Human Geography*, 31 (5), 616-637

Dunn, J. R. and Cummins, S. (2007) Placing health in context, In Editorial, *Social Science and Medicine*, 65 (9), 1821-1824

Dutt, A. K., Monroe, C. B., Dutta, H. M. and Prince, B. (1987) Geographical patterns of AIDS in the United States, *Geographical Review*, 77 (4), 456-471

Dwyer, C. and Limb, M. (2001) Introduction: doing qualitative research in geography, In M. Limb and C. Dwyer (eds) *Qualitative methodologies for geographers: issues and debates*, Oxford University press, New York

Dyck, I. and Dossa, P. (2007) Place, health and home: gender and migration in the constitution of healthy space, *Health & Place*, 13 (3), 691-701

Elliott, S. J. and Gillie, J. (1998) Moving experiences: a qualitative analysis of health and migration, *Health & Place*, 4 (4), 327-339

Ellis, M. and Muschkin, C. (1996) Migration of persons with AIDS- a search for support from elderly parents? *Social Science and Medicine*, 43 (7), 1109-1118

Elster, J. (2000) *Strong feelings: emotion, addiction and human behaviour*, The MIT press, Cambridge

Elster, J. and Skog, O. (1999) (eds) *Getting hooked: rationality and addiction*, Cambridge University press, Cambridge

Ely, M. et al (1991) *Doing qualitative research: circles within circles*, The Falmer press, London

Erikson, E. H. (1968) *Identity: youth and crisis*, Norton, New York

Eyles, J. (1985) *Senses of Place*, Silverbrook press, Warrington

Eyles, J. (1989) The geography of everyday life, In D. Gregory and R. Walford (eds) *Horizons in human geography*, MacMillan, London

Eyles, J. (1993) From disease ecology and spatial analysis to? The challenges of medical geography in Canada, *Health and Canadian Society,* 1, 113-146

Eyles, J. and Woods, K. J. (1983) *The social geography of medicine and health*, Croom Helm, London

Fajans, P., Ford, K. and Wirawan, D. N. (1995) AIDS knowledge and risk behaviours among domestic clients of female sex workers in Bali, Indonesia, *Social Science and Medicine*, 41 (3), 409-417

Farah, M. A. (1989) *A study of drug addicts admitted to four treatment and addiction rehabilitation centers in Dhaka*, Dhaka

Farberow, N. L. (1963) (ed) *Taboo topics*, Atherton Press, New York

Farley, M. (2001) Prostitution: the business of sexual exploitation, In J. Worell (ed) *Encyclopedia of women and gender*, Vol. 2, Academic press, New York

Farmer, P. (1999) *Infections and inequalities: the modern plagues*, University of California press, Berkeley

Featherstone, M. (1992) The heroic life and everyday life, *Theory Culture and Society*, 9 (1), 159-82

Featherstone, M. (1995) *Undoing culture: globalization, postmodernism and identity*, Sage, London

Ferguson, A. G. and Morris, C. N. (2007) Mapping transactional sex on the northern corridor highway in Kenya, *Health & Place*, 13 (2), 504-519

Fernando, N. (1997) *Trafficking in Asia- an overview*, Asian human rights commission, Bangkok

FHI (2003) *Mapping HIV/AIDS prevention and care activities in Bangladesh: GIS database*, Family Health International (FHI), Dhaka

FHI (2006) *Summary of an assessment of sexual behaviour of men in Bangladesh: a methodological experiment*, Family Health International (FHI), Dhaka

Field, D. (1997) Social definitions of health and illness, In S. Taylor and D. Field (eds) *Sociology of health and health care*, Second edition, Blackwell Science, Tokyo

Fielding, N. (1993) Ethnography, In N. Gilbert (ed) *Researching social life*, Sage, London

Fielding, N. and Thomas, H. (2001) Qualitative interviewing, In N. Gilbert (ed) *Researching social life*, Second edition, Sage, London

Filstead, W. J. (1979) Qualitative methods: a needed perspective in evaluation research, In T. D. Cook and C. S. Reichardt (eds) *Qualitative and quantitative methods in evaluation research*, Sage, Beverly Hills

Fischhoff, B. (2001) Defining stigma, In J. Elynn; P. Slovic and H. Kunreuther (eds) *Risk, media and stigma: understanding public challenges to modern science and technology*, Earthscan, London

Flick, U. (1998) *An introduction to qualitative research: theory, method and applications*, Sage, London

Folmer, S. et al (1992) *Condom use in Bangladesh*, Dhaka

Fontana, A. and Frey, J. H. (1994) Interviewing: the art of science, In N. K. Denzin and Y. S. Lincoln (eds) *Handbook of qualitative research*, Sage, London

Fontana, A. and Frey, J. H. (2000) The interview: from structured questions to negotiated text, In N. K. Denzin and Y. S. Lincoln (eds) *The handbook of qualitative research*, Second edition, Sage, London

Ford, N. and Koetsawang, S. (1991) The socio-cultural context of the transmission of HIV in Thailand, *Social Science and Medicine*, 33 (4), 405-414

Ford, N., Siregar, K., Ngatimin, R. and Maidin, A. (1997) The hidden dimension: sexuality and responding to the threat of HIV/AIDS in South Sulawesi, Indonesia, *Health & Place,* 3 (4), 249-258

Foreman, M. (1999) *AIDS and men: taking risks or taking responsibilities*? The Panos Institute, Zed books, London

Foucault, M. (1972) *The archaeology of knowledge*, Tavistock, London

Foucault, M. (1980) *Power/Knowledge: selected interviews and their writings 1972-1977*, Harvester, Brighton

Franzoi, S. L. (1996) *Social psychology*, Brown & Benchmark, London

Frasca, T. (2003) Men and women- still far apart on HIV/AIDS, *Reproductive Health Matters*, 11 (22), 12-20

Frawley, P. J. (1988) Neoro-behavioural model of addiction: addiction as a primary disease, In S. Peele (ed) *Visions of addiction*, Lexington books, Lexington MA

Frewer, L. J. (1999) Public risk perceptions and risk communication, In P. Bennett and K. Calman (eds) *Risk communication and public health*, Oxford University press, New York

Friedman, S. R. and Aral, S. (2001) Social networks, risk-potential networks, health and disease, *Journal of Urban Health*, 78, 411-418

Friedman, S. R., Neaigus, A., Jose, B. et al (1997) Sociometric risk networks and risk for HIV infection, *American Journal of Public health*, 87 (8), 1289-1296

Galea, R. P., Lewis, B. F. and Baker, L. A. (1988) (eds) *AIDS and IV drug abusers: current perspectives*, National Health publishing, USA

Gallo, R. C. (1987) The AIDS virus, *Scientific American*, 256 (1), 39-48

Gangopadhyay, D. N., Chanda, M., Sarkar, K., Niyogi, S. K. et al (2005) Evaluation of sexually transmitted diseases/human immunodeficiency virus intervention programs for sex workers in Calcutta, India, *Sexually Transmitted Diseases,* 32 (11), 680-684

Gardiner, M. E. (2000) *Critiques of Everyday life: an introduction*, Routledge, London

Gatrell, A. C. (2002) *Geographies of health: an introduction*, Blackwell, Oxford

Gazi, R., Mercer, A. et al (2008) An assessment of vulnerability to HIV infection of boatmen in Teknaf, Bangladesh, *Conflict and Health*, 2 (5), 1-11

Gee, J. P., Michaels, S. and O'Connor, M. C. (1992) Discourse analysis, In M. D. LeCompte, W. L. Millroy and J. Preissle (eds) *The handbook of qualitative research in education*, Academic press, San Diego

George, S., Jacob, M., John, T. J., Jain, M. K., Nathan, N., Rao, P. S., Richard, J. and Antonisamy, B. (1997) A case-control analysis of risk factors in HIV transmission in South India, *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology*, 14, 290-293

Gergen, M. M. and Gergen, K. J. (2000) Qualitative inquiry: tensions and transformations, In N. K. Denzin and Y. S. Lincoln (eds) *The handbook of qualitative research*, Second edition, Sage, London

Gerhardt, U. (1989) *Ideas about illness: an intellectual and political history of medical sociology*, MacMillan, London

Gesler, W. M (1991) *The cultural geography of health care*, University of Pittsburgh press, Pittsburgh

Gesler, W. M. (1992) Therapeutic landscapes: medical issues in light of the new cultural geography, *Social Science and Medicine*, 34 (7), 735-746

Gesler, W. M. (1998) Bath's reputation as a healing place, In R. A. Kearns and W. M. Gesler (eds) *Putting health into place: landscape, identity, and well-being*, Syracuse University press, Syracuse, pp. 17-35

Gesler, W. M. (2005) Therapeutic landscapes: an evolving theme, *Health & Place*, 11 (4), 295-297

Gesler, W. M. (2006) Geography of health and healthcare, In B. Warf (ed.) *Encyclopedia of human geography*, Thousand Oaks, CA, pp. 205-206

Gesler, W. M. and Kearns, R. A. (2002) *Culture/Place/Health*, Routledge, London

Ghimire, R. (2007) HIV/AIDS and Human Rights, Editorial, *The Rising Nepal*, January 17

Ghosh, J., Wadhwa, V. and Kalipeni, E. (2009) Vulnerability to HIV/AIDS among women of reproductive age in the slums of Delhi and Hyderabad, India, *Social Science and Medicine*, 68 (4), 638-642

Gibney, L., Choudhury, P., Khawaja, Z., Sarker, M. and Vermund, S. H. (1999a) Behavioural risk factors for HIV/AIDS in a low-HIV prevalence Muslim nation, Bangladesh, *International Journal of STD & AIDS*, 10, 186-94

Gibney, L., Choudhury, P., Khawaja, Z., Sarker, M., Islam, N. and Vermund, S. H. (1999b) HIV/AIDS in Bangladesh: an assessment of biomedical risk factors for transmission, *International Journal of STD & AIDS,* 10, 338-346

Gibney, L., Macaluso, M., Kirk, K., Hassan, M. S., Schwebke, J., Vermund, S. H. and Choudhury, P. (2001) Prevalence of infectious diseases in Bangladeshi women living adjacent to a truck stand: HIV/STD/hepatitis/genital tract infections, *Sexually Transmitted Infections*, 77, 344-350

Gibney, L., Saquib, N. and Metzger, J. (2003) Behavioural risk factors for STD/HIV transmission in Bangladesh's trucking industry, *Social Science and Medicine*, 56 (7), 1411-24

Gibney, L., Saquib, N., Macaluso, M., Hasan, K. N., Aziz, M. M., Khan, A. Y. M. H. and Choudhury, P. (2002) STD in Bangladesh's trucking industry: prevalence and risk factors, *Sexually Transmitted Infections*, 78, 31-36

Gilbert, N. (2001) Research theory and method, In N. Gilbert (ed) *Researching social life*, Second edition, Sage, London

Gillies, P., Tolley, K. and Wollstenholme, J. (2000) Is AIDS a disease of poverty? In A. J. Lemelle; C. Harrington and A. J. LeBlanc (eds) *Readings in the sociology of AIDS*, Prentice-Hall, New Jersey

Glaser, B. G. and Strauss, A. L. (1967) *The discovery of Grounded theory: strategies for qualitative research*, Aldine, Chicago

GOB (1996) *National policy on HIV/AIDS and STD related issues*, Ministry of Health and Family Welfare, Government of Bangladesh (GOB), Dhaka

GOB (1997) *Strategic plan for the national AIDS program of Bangladesh 1997-2002*, *The discovery of Grounded theory*, Government of Bangladesh (GOB), Dhaka

GOB (2000) *Yearly health situation report 2000*, Ministry of Health and Family Welfare, Government of Bangladesh (GOB), Dhaka

GOB (2002) *National assessment of situation and responses to opiate use in Bangladesh*, Department of Narcotics control, Joint survey conducted by

government and non-government agencies, Government of Bangladesh (GOB), Dhaka

GOB (2004) *The counter trafficking framework report: Bangladesh perspective*, Ministry of Women and Children affairs, Government of Bangladesh (GOB), Dhaka

Goddard, V. (1993) Honour and shame: the control of women's sexuality and group identity in Neples, In Pat Caplan (ed) *The cultural construction of sexuality*, Routledge, London

Goffman, E. (1959) *The presentation of self in everyday life*, HarmondsWorth, New York

Goffman, E. (1961) *Encounters: two studies in the sociology of interaction*, Bobbs-Merrill, Indianapolis

Goffman, E. (1963) *Stigma: notes on the management of spoiled identity*, Prentice-Hall, New Jersey

Gotlieb, M. S. et al (1981) Pneumocystis carinii pneumonia and mucosal candidiasis in previously healthy homosexual men: evidence of a new acquired cellular immunodeficiency, *New England journal of Medicine*, 305, 1425-31

Gould, P. (1989) Geographic dimensions of the AIDS epidemic, *The Professional Geographer*, 41 (1), 71-78

Gould, P. (1993) *The slow plague: a geography of the AIDS pandemic*, Blackwell, Oxford

Gould, P. and Wallace, R. (1994) Spatial structures and scientific paradoxes in the AIDS pandemic, *Geografiska Annaler*, 76 (2), 105-116

Gras, M. J., Weide, J. F., Langendam, M. W., Coutinho, R. A. and van den Hoek, A. (1999) HIV-prevalence, sexual risk behaviour and sexual mixing patterns among migrants in Amsterdam, the Netherlands, *AIDS*, 13, 1953-1962

Gray, R. H., Kigozi, G. et al (2007) Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trail, *Lancet*, 369, 657-666

Grbich, C. (2007) *Qualitative data analysis: an introduction*, Sage, London

Green, J. and Thorogood, N. (2004) *Qualitative methods for health research*, Sage, London

Green, S. (2007) Crime, victimization and vulnerability, In S. Walklate (ed) *Handbook of victims and victimology*, Willan publishing, Portland

Gregory, D. (1985) People, places and practices: the future of human geography, In R. King (ed) *Geographical futures*, Geographical association, Sheffield

Gregory, D. and Urry, J. (1985) (eds) *Social relations and spatial structures*, Macmillan, London

Gruber, J. and Caffrey, M. (2005) HIV/AIDS and community conflict in Nigeria: implications and challenges, *Social Science and Medicine*, 60 (6), 1209-1218

Guba, E. G. (1990) The alternative paradigm dialog, In E. G. Guba (ed) *The paradigm dialog*, Sage, CA

Habermas, J. (1978) *Knowledge and human interests*, Second edition, Heinemann, London

Habermas, J. (1987) The theory of communicative action, Vol. 2, *Lifeworld and System: a critique of functionalist reason*, Beacon press, Boston

Haggett, P. (1965) *Locational analysis in human geography*, Edward Arnold, London

Haines-Young, R. H. and Petch, J. R. (1986) *Physical geography: its nature and methods*, Harper and Row, London

Hamilton, M. (2004) Preventing drug-related harm, In M. Hamilton; T. King and A. Ritter (eds) *Drug use in Australia: preventing harm*, Oxford University press, Australia, pp. 159-181

Hamlin, M. and Hammersley, D. (1993) Managing benzodiazepine withdrawal, In G. Bennett (ed) *Treating drug abusers*, Routledge, London, pp. 91-114

Hammett, T. M., Des Jarlais, D. C., Liu, W., Ngu, D., Tung, N. D., Hoang, T. V., Van, L. K. and Dongua, M. (2003) Development and implementation of a cross-border HIV prevention intervention for injection drug users in Ning Ming County (Guangxi Province), China and Lang Son Province, Vietnam, *International Journal of Drug Policy*, 14 (5-6), 389-398

Hammond, C. (2008) I'm just here for survival, *The Guardian*, 9th January, London

Haq, N. (2004) An epidemic waiting to happen, Cover story, Weekend magazine, *The Daily Star*, Vol. 4, Issue 5, July 23, Dhaka

Harris, P. (2007) *Empathy for the devil: how to help people overcome drugs and alcohol problems*, Russel house publishing, Dorset

Hartnoll, R. (2000) General conclusions, In EMCDDA (ed) *Understanding and responding to drug use: the role of qualitative research*, Scientific monograph series, No. 4, Luxembourg

Harvey, D. (1969) *Explanation in geography*, Edward Arnold, London

Hasan, M. (2007) Harassment pattern of sex workers in Bangladesh: A situational analysis of three brothels, narratives and perspective in sociology understanding the past, envisaging the future, *Proceedings of the 8th Annual Conference of Hong Kong Sociological Association*, Hong Kong Shue Yan University

Hassan, K. M. (2005) Encountering HIV/AIDS, *The Daily Star*, April 20, Dhaka

Hassan, M. M. (2003) *Arsenic toxicity in Bangladesh: Health and social hazards*, Unpublished PhD thesis, University of Durham, Durham

Hawkes, S. (1992) Travel and HIV/AIDS, *AIDS care*, 4 (4), 446-49

Hawkes, S. (2001) Human immunodeficiency virus and hepatitis in Bangladesh: widespread or targeted prevention strategies? Commentary, *International Journal of Epidemiology*, 30, 885-886

Hayes, M. V., Foster, L. T. and Foster, H. D. (1994) (eds) *The determinants of population health: a critical assessment*, University of Victoria, Victoria

Haynes, B. F., Pantaleo, G. and Fanci, A. S. (1996) Toward an understanding of the correlates of protective immunity to HIV infection, *Science*, 271, 24-28

Hefferman, C. (2002) HIV, sexually transmitted infections and social inequalities: when the transmission is more social than sexual, *International Journal of Sociology and Social Policy*, 22 (4), 159-176

Hemming, P. J. (2008) Mixing qualitative research methods in children's geographies, *Area*, 40 (2), 152-162

Hewitt, J. P. (1994) *Self and society: a symbolic interactionist social psychology*, Sixth edition, Allyn & Bacon, Boston

Heyzer, N. (1986) *Working women in south-east Asia: development, subordination and emancipation*, Open University press, England

Highmore, B. (2002) *Everyday life and cultural theory: an introduction*, Routledge, London

Hirsch, J. S., Higgins, J., Bentley, M. E. and Nathanson, C. A. (2002) The social constructions of sexuality: marital infidelity and sexually transmitted disease - HIV risk in a Mexican migrant community, *American Journal of Public Health*, 92 (8), 1227-1237

Hogg, M. A. (1985) Masculine and feminine speech in dyads and groups: a study of speech style and gender salience, *Journal of language and social psychology*, 4, 99-112

Hogg, M. A. and Vaughan, G. M. (2002) *Social psychology*, Third edition, Pearson Education, Essex

Hogg, R. S., Schechter, M. T., Schilder, A., Strathdee, S. A., Goldstone, I. L. and O'Shaughnessy, M. V. (1995) Access to health care and geographic mobility of HIV/AIDS patients, *AIDS Patient Care*, 9, 297-302

Hoggart, K., Lees, L. and Davies, A. (2001) *Researching human geography*, Arnold, New York

Hoigard, C. and Finstad, L. (1992) *Backstreets: prostitution, money and love*, Polity press, Cambridge

Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S. and Thompson, R. (1991) Risk, power and the possibility of pleasure, *AIDS Care*, 4, 273-283

Holloway, L. and Hubbard, P. (2001) *People and place: the extraordinary geographies of everyday life*, Pearson Education, London

Holzner, B. and Robertson, R. (1980) Identity and authority: a problem analysis of processes of identification and authorization, In R. Robertson and B. Holzner (eds) *Identity and authority: explorations in the theory of society*, Basil Blackwell, Oxford

Hopper, S. (1981) Diabetes as a stigmatizing condition, *Social Science and Medicine*, 15B, 11-19

Hosain, G. M. M. and Chatterjee, N. (2005) Beliefs, sexual behaviours and preventive practices with respect to HIV/AIDS among commercial sex workers in Daulatdia, Bangladesh, *Public Health*, 119, 371-381

Hossain, M. M. (2005) *Illicit trafficking in drugs: perspective Bangladesh*, In the publication of Department of Narcotics Control, on the International day against drug abuse and illicit trafficking, Government of Bangladesh, Dhaka

Hossain, M. R. (2007) AIDS: epidemic bell ringing, *The Daily Star*, October 28, Dhaka

Hossain, R. (2005) Is sex work, work? Star weekend magazine, *The Daily Star*, Vol. 4, Issues 77, December 30, Dhaka

Hossain, S. M. I., Bhuiya, I. and Streatfield, K. (1996) *Professional blood donors, blood banks and risk of STDs and HIV/AIDS: a study in selected areas in Bangladesh*, Regional working papers, South and East-Asia, No. 6, The Population Council, Dhaka

Howard, S. (1997) Methodological issues in overseas fieldwork: experiences from Nicaragua's northern Atlantic coast, In E. Robson and K. Willis (eds.)

Postgraduate fieldwork in developing areas: a rough guide, Second edition, Monograph no. 9, Developing Areas Research Group (DARG), Royal Geographical Society, Keele University press, pp. 19-37

Human Rights Watch Report (1995) *Rape for profit: trafficking of Nepali girls and women to Indian brothels*, June 15, USA

Human Rights Watch Report (2003) Ravaging the vulnerable: abuse against persons at high risk of HIV infection, August 19, USA

ICDDR, B Bulletin (2007) Non-marital sexual behaviour of men in Bangladesh: implications for HIV transmission, *ICDDR, B Health and Science Bulletin*, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B), 5 (2), Dhaka

ICDDR, B Report (2001) *Trafficking of women and children in Bangladesh*, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B), Dhaka

ICDDR, B Report (2004) HIV in Bangladesh: the present scenario, *The Daily Star*, December 19, Dhaka

Inciardi, J. A. (1992) *The war on drugs II: the continuing epic of heroin, cocaine, crack, crime, AIDS, and public policy*, Mayfield publishing company, London

Innes, M. (2001) Exemplar: Investigating the investigators- studying detective work, In N. Gilbert (ed) *Researching social life*, Second edition, Sage, London

IOM (2004) *Revisiting the human trafficking paradigm: The Bangladesh experience*, International Organization for Migration (IOM), The Bangladesh thematic group on Trafficking, Geneva

IRIN News (2007) Regional Buddhist HIV outreach programme making an impact, *Reuters*, January 30

Irwin, S. (1973) A rational approach to drug abuse prevention, *Contemporary Drug Problems*, 2, 3-46

Islam, A. K. M. S. (2006) *The integration of Islamic values into drug demand reduction strategies-prevention*, In the publication of Department of Narcotics Control, on the International day against drug abuse and illicit trafficking, Government of Bangladesh, Dhaka

Islam, M. T., Mostafa, G., Bhuiya, A. U., Hawkes, S. and Andres de Francisco (2002) Knowledge on, and attitude toward, HIV/AIDS among staff of an international

organization in Bangladesh, *Journal of Health, Population and Nutrition*, 20 (3), 271-278

Islam, M., Mitra, A. K., Mian, A. H. and Vermund, S. H. (1999) HIV/AIDS in Bangladesh: a national surveillance, *International Journal of STD & AIDS*, 10, 471-474

Islam, S. (1981) *Indigenous abortion practices in rural Bangladesh*, Women for Women Research and Study Group, Dhaka

Islam, S. K., Hossain, K. J., Kamal, M. and Ahsan, M. (2003) Prevalence of HIV infection in the drug addicts of Bangladesh: drug habit, sexual practice and lifestyle, *International Journal of STD & AIDS*, 14 (11), 762-764

Jackson, D. J., Rakwar, J. P., Richardson, B. A. et al (1997) Decreased incidence of sexually transmitted diseases among trucking company workers in Kenya: results of a behavioural risk-reduction programme, *AIDS*, 11 (7), 903-909

Jaffe, J. H. (1990) Tobacco smoking and nicotine dependence, In S. Wonnacott; M. A. H. Russell and I. P. Stolerman (eds) *Nicotine psychopharmacology: Molecular, cellular and behavioural aspects*, Oxford University press, Oxford, pp. 1-37

Janz, N., Zimmerman, M., Wren, P., Israel, B., Freudenberg, N. and Carter, R. (1996) Evaluation of 37 AIDS prevention projects: successful approaches and barriers to program effectiveness, *Health Education & Behavior*, 23 (1), 80-97

Jeffreys, S. (1987) The body politic- the campaign against pornography, In K. Davies; J. Dickey and T. Stratford (eds) *Out of focus: writings on women and the media*, The Women's press, London

Jenesick, V. J. (2000) The choreography of qualitative research design, In N. K. Denzin and Y. S. Lincoln (eds) *The handbook of qualitative research*, Second edition, Sage, London

Jenkins, C. (1999) Resistance to condom use in a Bangladesh brothel, In J. C. Caldwell; Pat Caldwell; John Anarfi et al (eds) *Resistance to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in third world countries*, Health Transition center, Australian National University, Canberra, pp. 211-222

Jenkins, C. and Rahman, H. (2002) Rapidly changing conditions in the brothels of Bangladesh: impact on HIV/STD, *AIDS Education and Prevention*, 14, Supplement A, 97-106

Jenkins, C., Rahman, H., Saidel, T., Jana, S. and Hussain, A. M. (2001) Measuring the impact of needle exchange programs among injecting drug users through the national behavioural surveillance in Bangladesh, *AIDS Education and Prevention*, 13 (5), 452-61

Jenkins, R. (1999) *Social identity*, Routledge, London

JJS Report (2001) *Bonded sex worker in sex trade- case study of Baniashanta and Bagerhat brothel in Bangladesh: situation analysis from humanitarian and human rights perspectives*, Jagrata Juba Shangha (JJS), Khulna

Johnston, R. J. (1986) *Philosophy and human geography: an introduction to contemporary approaches*, Arnold, London

Johnston, R. J. (1991) *A question of place: Exploring the practice of human geography,* Blackwell, Oxford

Johnston, R. J., Gregory, D. and Smith, D. M. (1994) (eds) *The dictionary of human geography*, Blackwell, Oxford

Jones, B. T., Corbin, W. and Fromme, K. (2001) A review of expectancy theory and alcohol consumption, *Addiction*, 96 (1), 57-72

Jones, K. and Moon, G. (1987) *Health disease and society: an introduction to medical geography*, Routledge, London

Jones, K. and Moon, G. (1993) Medical geography: taking space seriously, *Progress in Human geography*, 17 (4), 515-24

Joseph, A. E. and Phillips, D. R. (1984) *Accessibility and utilization: Geographical perspectives on health care delivery*, Harper and Row, New York

Kabir, M. A. (1989) *Comparative study of institutionalized prostitutes in Tanbazar and floating prostitutes in Dhaka City*, Programme and information workshop on development strategies for prevention and control of STDs in Bangladesh, Dhaka

Kalipeni, E., Craddock, S., Oppong, J. R. and Ghosh, J. (2004) (eds.) *HIV and AIDS in Africa: Beyond epidemiology*, Blackwell, Oxford

Karim, S. (2004) Exploring the household compositions of female sex-workers in brothels: Daulatdia, a case study, *BRAC University Journal*, Dhaka, 1 (2), 33-48

Karner, C. (2007) *Ethnicity and Everyday life*, Routledge, London

Kasperson, R., Golding, D. and Kasperson, J. X. (2005) Stigma and the social amplification of risk: towards a framework of analysis, In J. X. Kasperson and R. E. Kasperson (eds) *The social contours of risk*, Vol. 1, Earthscan, London

Katz, I. (1981) *Stigma: a social psychological analysis*, Lawrence, New Jersey

Kearns, R. A. (1993) Place and health: towards a reformed medical geography, *The Professional Geographer*, 45 (2), 139-147

Kearns, R. A. (1994) Putting health and health care into place: an invitation accepted and declined, *The Professional Geographer*, 46 (l), 111-115

Kearns, R. A. (1995) Medical geography: making space for difference, *Progress in Human geography*, 19 (2), 251-259

Kearns, R. A. (1996) AIDS and medical geography: embracing the other? *Progress in Human Geography*, 20 (1), 123-131

Kearns, R. A. (1997) Narrative and metaphor in health geographies, *Progress in Human Geography*, 21 (2), 269-277

Kearns, R. A. (1998) Going it alone: place, identity, and community resistance to health reforms in Hokianga, New Zealand, In R. A. Kearns and W. M. Gesler (eds) *Putting health into place: landscape, identity, and well-being*, Syracuse University press, Syracuse, pp. 226-247

Kearns, R. A. and Gesler, W. M. (1998) *Putting health into place: landscape, identity and well-being*, Syracuse University press, Syracuse

Kearns, R. A. and Moon, G. (2002) From medical to health geography: novelty, place and theory after a decade of change, *Progress in Human Geography*, 26 (5), 605-625

Kellehear, A. and Cvetkovski, S. (2004) Grand theories of drug use, In M. Hamilton; T. King and A. Ritter (eds) *Drug use in Australia: preventing harm*, Oxford University press, Australia, pp. 53-63

Kemmesies, U. (2000) How to reach the unknown: the snowball sampling technique, I EMCDDA (ed) *Understanding and responding to drug use: the role of qualitative research*, Scientific monograph series, No. 4, Luxembourg

Kempadoo, K. and Doezema, J. (1998) (eds) *Global sex workers: rights, resistance, and redefinition*, Routledge, New York

Kesby, M. (2000) Participatory diagramming: deploying qualitative methods through an action research epistemology, *Area*, 32 (4), 423-435

Khan, A. W. (2007) Experts worried at increasing HIV cases among IDUs, Conference on AIDS, *The Daily Star*, August 24, Dhaka

Khan, I. K. (2000) *Socio-economic profile of sex workers of Chittagong*, Paper 11, Center for Policy Dialogue (CPD), Dhaka

Khan, M. A. (2002) Knowledge on AIDS among female adolescents in Bangladesh: evidence from the Bangladesh demographic and health survey data, *Journal of Health, Population and Nutrition*, 20 (2), 130-137

Khan, M. A. (2005) AIDS crisis looming: a disaster waiting to happen? *The Daily Star*, April 10, Dhaka

Khan, M. A. and Khanum, P. A. (2000) Influence of son preference on contraceptive use in Bangladesh, *Asia Pacific Population Journal*, 15, 43-56

Khan, M. A., Rahman, M., Khanam, P. A., Barkat-e-Khuda, Kane, T. T. and Ashraf, A. (1997) Awareness of sexually transmitted disease among women and service providers in rural Bangladesh, *International Journal of STD & AIDS*, 8, 688-696

Khan, M. H. (1999) *Collection of behavioral and socio-economic data from selected population of university students through rapid Assessment for use in program on HIV/AIDS/STDs*, AIDS Awareness Foundation (AAF), Dhaka

Khan, M. M. K. (2006) *Demand reduction approach and social impediments to solution of drug problem: a review in the context of Bangladesh*, In the publication of Department of Narcotics Control, on the International day against drug abuse and illicit trafficking, Government of Bangladesh, Dhaka

Khan, O. A. and Hyder, A. A. (2001) Responses to an emerging threat: HIV/AIDS policy in Pakistan, *Health Policy and Planning*, 16 (2), 214-218

Khan, S. (1988) *The fifty percent: women in development and policy in Bangladesh*, University Press Limited (UPL), Dhaka

Khan, Z. R. and Arefeen, H. K. (1989) *Potita nari: A study of prostitution in Bangladesh*, Dhaka University, Dhaka

Khan, Z. R. and Arefeen, H. K. (1992) *Prostitution in Bangladesh*, Dhaka: Center for Social Studies, Mimeographed monograph, Dhaka

Khaw, A. J., Salama, P., Burkholder, B. and Dondero, T. J. (2000) HIV risk and prevention in emergency-affected populations: a review, *Disasters*, 24 (3), 181-197

Khawaja, Z. A., Gibney, L., Ahmed, A. J. and Vermund, S. H. (1997) HIV/AIDS and its risk factors in Pakistan, Editorial review, *AIDS*, 11, 843-848

Kielmann, K., Deshmukh, D., Deshpande, S., Datye, V., Porter, J. and Rangan, S. (2005) Managing uncertainty around HIV/AIDS in an urban setting: private medical providers and their patients in Pune, India, *Social Science and Medicine*, 61 (7), 1540-1550

Kiemle, G. (1994) What's so special about HIV and AIDS? Stresses and strains for clients and counselors, *British journal of Guidance and Counselling*, 22 (3), 343-351

Killeas, M. (1990) Vulnerability: towards a better understanding of a key variable in the genesis of fear of crime, *Violence and victims*, 5, 97-108

Kim, S. H. (1993) Identifying alternative linkages among philosophy, theory and method in nursing science, *Journal of Advanced Nursing*, 18 (5), 793-800

Kirk, J. and Miller, M. L. (1986) Reliability and validity in qualitative research, *Qualitative research methods*, Series 1, Sage, California

Kitchin, R. and Tate, N. J. (2000) *Conducting research in human geography: theory, methodology and practice*, Pearson, London

Knight, V. C. (2006a) *Transport workers at risk to HIV: documenting our experience 2000-2004*, HIV program, Care Bangladesh, Dhaka

Knight, V. C. (2006b) *Drug users at risk to HIV: documenting our experience 2000-2005*, HIV program, Care Bangladesh, Dhaka

Knopp, L. (1992) Sexuality and the spatial dynamics of capitalism, *Environment and Planning D: Society and Space*, 10, 651-669

Koester, S., Rahman, K. Z., Kelly, R. and O'Day, T. (2005) *Drug sharing and injecting networks in Bangladesh: implications for HIV transmission*, In the publication of Department of Narcotics Control, on the International day against drug abuse and illicit trafficking, Government of Bangladesh, Dhaka

Krueger, R. A. (1998) *Analyzing & reporting focus group results*, Focus Group Kit 6, Sage, London

Kuhn, T. S. (1962) *The structure of scientific revolutions*, University of Chicago press, Chicago

Kuhn, T. S. (1970) *The structure of scientific revolutions*, Second edition, University of Chicago press, Chicago

Kumar, N., Raju, S., Atkins, P. J. and Townsend, J. G. (1997) Where angels fear to tread? Mapping women and men in India, *Environment and Planning A*, 29 (12), 2207-2215

Kwan, M. P. (2004) Beyond difference: from canonical geography to hybrid geographies, *Annals of the Association of American Geographers*, 94 (4), 756-763

Kwan, M. P. and Aitken, S. (2007) GIS and qualitative research: geographical knowledge, participatory politics, and cartographies of affect, In D. DeLyser et al. (eds) *Handbook for qualitative methods in geography*, Sage, London

Kwan, M. P. and Knigge, L. (2006) Doing qualitative research using GIS: an oxymoronic endeavor? *Environment and Planning A*, 38 (11), pp. 1999-2002

Lacerda, R., Gravato, N., McFarland, W., Rutherford, G., Iskrant, K., Stall, R. and Hearst, N. (1997) Truck drivers in Brazil: prevalence of HIV and other sexually transmitted diseases, risk behavior and potential for spread of infection, *AIDS*, 11 (Suppl. 1), S15-19

Laga, M., Nzila, N. and Goeman, J. (1991) The interrelationship of sexually transmitted diseases and HIV infection: implications for the control of both epidemic in Africa, *AIDS*, 5 (Suppl 1), S55-63

Lagarde, E. M. et al (2000) Religion and protective behaviours towards AIDS in rural Senegal, *AIDS*, 14 (13), 2027-2033

Lagarde, E. M., Schim van der Loeff, C., Enel, B., Holmgren, R., Dray-Spira, G., Pison, J. P. et al (2003) Mobility and the spread of human immunodeficiency virus into rural areas of West Africa, *International Journal of Epidemiology*, 32 (5), 744-752

Lakatos, I. and Musgrave, A. (1970) (eds) *Criticism and the growth of knowledge*, Cambridge University press, Cambridge

Lambert, E. Y., Ashery, R. S. and Needle, R. H. (1995) (eds) *Qualitative methods in drug abuse and HIV research*, National Institute on Drug Abuse, Monograph 157, Rockville

Lansky, A., Nakashima, A. K., Diaz, T., Fann, S. A., Conti, L., Herr, M., Smith, D., Karon, J., Jones, J. L. and Ward, J. W. (2000) Human immunodeficiency virus infection in rural areas and small cities of the southeast: contributions of migration and behavior, *The Journal of Rural Health*, 16 (1), 20-30

Last, J. M. (1998) *Public health and human ecology*, Second edition, Appleton & Lange, Stamford

Latkin, C. A., Mandell, W., Vlahov, D. et al (1996) People and places: behavioural settings and personal network characteristics as correlates of needle sharing, *Journal of Acquired Immune Deficiency Syndromes*, 13, 273-280

Lawler, S. (2008) *Identity: sociological perspectives*, Polity press, Cambridge

Lawrence, J., Kearns, R. A., Park, J., Bryder, L. and Worth, H. (2008) Discourses of disease: representations of tuberculosis within New Zealand newspapers 2002-2004, *Social Science and Medicine*, 66 (3), 727-739

Learmonth, A. T. A. (1952) The medical geography of India: an approach to the problem, In K. Kuriyan (ed) *The Indian geographical society*, The silver jubilee volume, Indian Geographical Society, Madras, 201-202

Lee, N. (2004) Psychological theories of drug use and dependence, In M. Hamilton; T. King and A. Ritter (eds) *Drug use in Australia: preventing harm*, Oxford University press, Australia, pp. 75-88

Lee, R. M. (1993) *Doing research on sensitive topics*, Sage, London

Lewis, J. A., Dana, R. Q. and Blevins, G. A. (2002) *Substance abuse counseling*, Thomson learning, USA

Lex, B. W. (2000) Gender and cultural influences on substance abuse, In R. M. Eisler and M. Hersen (eds) *Handbook of gender, culture and health*, Lawrence publishers, New Jersey, pp. 255-297

Li, W. H., Tanimura, M. and Sharp, P. M. (1988) Rates and dates of divergence between AIDS virus nucleotide sequences, *Molecular Biology and Evolution*, 5 (4), 313-330

Lindberg, O. (2000) Grounded theory and computer-assisted analysis of qualitative data: some proposals for the practice of qualitative research, In EMCDDA (ed) *Understanding and responding to drug use: the role of qualitative research*, Scientific monograph series, No. 4, Luxembourg

Lindquist, J. (2005) Organizing AIDS in the borderless world: a case study from the Indonesia-Malaysia-Singapore growth triangle, *Asia Pacific Viewpoint*, 46 (1), 49-63

Litva, A. and Eyles, J. (1994) Health or healthy: why people are not sick in a southern Ontarian town, *Social Science and Medicine*, 39 (8), 1083-91

Litva, A. and Eyles, J. (1995) Coming out: exposing social theory in medical geography, *Health & Place*, 1 (1), 5-14

Loewenstein, G. (1999) A visceral account of addiction, In J. Elster and O. Skog (eds) *Getting hooked: rationality and addiction*, Cambridge University press, Cambridge, pp. 235-264

Lofland, J. and Lofland, L. H. (1995) *Analyzing social settings: a guide to qualitative observation and analysis*, Wadsworth, Belmont, CA

Lowenberg, J. (1993) Interpretive research methodology: broadening the dialogue, *Advance in Nursing Science*, 16 (2), 57-69

Lurie, M.,Williams, B., Suma, K., Mkaya-Mwamburi, D., Garnett, G., Sturm, A., Sweat, M., Gittelsohn, J. and Karim, S. (2003) The impact of migration on HIV-1 transmission in South Africa: a study of migrant and non-migrant men and their partners, *Sexually Transmitted Diseases*, 30, 149-156

Lyttleton, C. and Amarapibal, A. (2002) Sister cities and easy passage: HIV, mobility and economies of desire in a Thai/Loa border zone, *Social Science and Medicine*, 54 (4), 505-518

Maanen, J. V. (1983) (ed) *Qualitative methodology*, Sage, California

MacDonald, D. and Mansfield, D. (2001) Drugs and Afghanistan, *Drugs education: prevention and policy*, 8 (1), 1-16

Mac-Phail, C. and Campbell, C. (2001) 'I think condoms are good, but, aai, I hate those things': condom use among adolescents and young people in a South African township, *Social Science and Medicine*, 52 (11), 1613-1627

Madge, C. (1997) The ethics of research in the 'third world', In E. Robson and K. Willis (eds) *Postgraduate fieldwork in developing areas: a rough guide*, Second edition, Monograph no. 9, Developing Areas Research Group (DARG), Royal Geographical Society, Keele University press, pp. 113-124

Maher, L. and Dixon, D. (1999) Policing and public health: law enforcement and harm minimization in a street-level drug market, *British Journal of Criminology*, 39 (4), 488-511

Mahmood, S. A. I. (2007) Leadership is a must to combat this scourge, *The Daily Star*, December 1, Dhaka

Maisto, S. A., Galizio, M. and Connors, G. J. (1995) *Drug use and abuse*, The Harcourt press, Toronto

Mallick, P. S., Asad, N. M. A., Khan, M. B. and Rahman, K. Z. (2006) *Heroin and injecting drugs: some facts and myths*, In the publication of Department of Narcotics Control, on the International day against drug abuse and illicit trafficking, Government of Bangladesh, Dhaka

Maloney, C. et al (1981) *Beliefs and fertility in Bangladesh*, Dhaka

Mamtaz, A. (1999) HIV/AIDS: response to the pandemic in Bangladesh, *Journal of Preventive Social Medicine*, 18 (1), 74-83

Mann, J. M. (1987) The global AIDS situation, *World Health Statistics Quarterly*, 40, 185-192

Mann, J. M. et al (1992) (eds) *AIDS in the world: the global AIDS policy coalition*, Harvard University press, Boston, MA

Mann, J. M., Gruskin, S., Grodin, M. A. and Annas, G. J. (1999) (eds) *Health and human rights: a reader*, Routledge, New York

MAP Report (2004) *AIDS in Asia: face the facts, a comprehensive analysis of the AIDS epidemics in Asia*, Monitoring the AIDS Pandemic (MAP) Report

Marck, J. (1999) Long-distance truck drivers' sexual cultures and attempts to reduce HIV risk behaviour amongst them: a review of the African and Asian literature, In J. C Caldwell; Pat Caldwell, John Anarfi et al (eds) *Resistance to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in third world countries*, Health Transition center, Australian National University, Canberra, pp. 91-100

Marlatt, G. A. (1998) (ed) *Harm reduction: pragmatic strategies for managing high-risk behaviours*, Guilford, New York

Marten, L. (2005) Commercial sex workers: victims, vectors or fighters of the HIV epidemic in Cambodia? *Asia Pacific Viewpoint*, 46 (1), 21-34

Mason, J. (1997) *Qualitative researching*, Sage, London

Mason, J. (2002) *Qualitative researching*, Sage, London

Mason, M. (2007) *Applications of geographic information systems to community psychology research & practice*, Discussant paper presented at the annual meeting of the society for community research and action, Pasadena, CA

Mason, T., Carlisle, C., Watkins, C. and Whitehead, E. (2001) (eds) *Stigma and social exclusion in healthcare*, Routledge, London

Massey, D. (1991) A global sense of place, *Marxism Today*, June, 24-29

Massey, D. (1999) Spaces of politics, In D. Massey; J. Allen and P. Sarre (eds), *Human geography today*, Polity press, Cambridge, pp. 279-294

Massey, D. S., Arango, J. et al (1993) Theories of international migration: a review and appraisal, *Population and Development Review*, 19 (3), 431-466

Matsuyama, Y., Hashimoto, S. et al (1999) Trends in HIV and AIDS based on HIV/AIDS surveillance in Japan, *International Journal of Epidemiology*, 28, 1149-1155

May, J. (1996) Globalization and the politics of place: place and identity in an inner London neighbourhood, *Transactions of the Institute of British Geographers*, 21 (1), 194-215

May, J. M. (1950) Medical geography: its methods and objectives, *Geographical Review*, 40 (1), 9-41

May, J. M. (1954) Medical geography, In P. E. James and C. F. Jones (eds.) *American geography: inventory and prospect*, Syracuse, New York

May, J. M. (1958) *The ecology of human disease*, MD publication, New York

May, T. (1997) *Social research: issues, methods and process*, Second edition, Open University press, Buckingham

Mayer, J. D. (1982) Relations between two traditions of medical geography: health systems planning and geographical epidemiology, *Progress in Human Geography*, 6, 216-230

Mayer, J. D. (1992) Challenges to understanding spatial patterns of disease: philosophical alternatives to logical positivism. *Social Science and Medicine*, 35 (4), 579-587

Mayer, J. D. (2000) Health geography, In R. J. Johnston et al (eds) *The dictionary of human geography*, Blackwell, MA

Mayer, J. D. (2005) The geographical understanding of HIV/AIDS in sub-Saharan Africa, *Norwegian Journal of Geography*, 59, 6-13

Mayer, J. D. and Meade, M. S. (1994) A reformed medical geography reconsidered, *The Professional Geographer*, 46 (1), 103-106

Mbugua, G. G., Muthami, L. N., Mutura, C. W., Oogo, S. A., Waiyaki, P. G., Linden, C. P. and Hearst, N. (1995) Epidemiology of HIV infection among long distance truck drivers in Kenya, *East African Medical Journal*, 72 (8), 515-518

McCoy, A. W. (1972) *The politics of heroin in southeast Asia*, Harper and Row, New York

McCreanor, T., Penney, L., Jensen, V., Witten, K., Kearns, R. and Barnes, H. M. (2006) 'This is like my comfort zone': senses of place and belonging within Oruamo/Beachhaven, New Zealand, *New Zealand Geographer*, 62 (3), 196-207

McDermott, P. (1992) Representations of drug users facts, myths and their role in harm reduction strategy, In P. A. O'Hare; R. Newcombe; A. Matthews; E. C. Buning and E. Drucker (eds) *The reduction of drug-related harm*, Routledge, London, pp. 195-201

McGlashan, N. D. (1972) (ed) *Medical geography: techniques and field studies*, Methuen, London

Mckeganey, N. and Barnard, M. (1996) *Sex work on the streets: prostitutes and their clients*, Open University press, London

McKinlay, J. B. (1992) Health promotion through healthy public policy: the contribution of complementary research methods, *Canadian Journal of Public Health*, 83, S11-19

McLafferty, S. (2005) Geographic information and women's empowerment: a breast cancer example, In L. Nelson and J. Seager (eds) *A companion to feminist geography*, Blackwell, MA, pp. 486-495

Mcleod, E. (1982) Prostitutes' working conditions, In R. Matthews and M. O'Neill (2002) (eds) *Prostitution*, Dartmouth publishing company, England

Mead, G. H. (1962) *Mind, self and society: from the standpoint of a social behaviorist*, University of Chicago Press, Chicago

Meade, M. S. (1977) Medical geography as human ecology: The dimension of population movement, *Geographical Review*, 67 (4), 379-393

Meade, M. S. and Earickson, R. J. (2000) *Medical geography*, Second edition, The Guilford press, London

Meade, M. S., Florin, J. W. and Gesler, W. M. (1988) *Medical geography*, The Guilford press, New York

Mendelson, J. H. and Mello, N. K. (1994) Cocaine and other commonly abused drugs, In K. J. Isselbacher; E. Braunwald; J. D. Wilson; J. B. Martin; A. S. Fanci and D. L. Kasper (eds) *Harrison's principles of internal medicine*, McGraw-Hill, New York, pp. 2429-2433

Mercer, A., Khanam, R., Gurley, E. and Azim, T. (2007) Sexual risk behavior of married men and women in Bangladesh associated with husbands' work migration and living apart, *Sexually Transmitted Diseases*, 34 (5), 265-273

Mercer, K. (1998) Welcome to the jungle: identity and diversity in postmodern politics, In J. Rutherford (ed) *Identity: community, culture, difference*, Lawrence and Wishart, London

Miles, A. (1993) *Women, health and medicine*, Open University press, Philadelphia

Miles, M. B. and Huberman, A. M. (1994) *Qualitative data analysis: an expanded sourcebook*, Sage, London

Miller, P. M. and Nirenberg, T. D. (1984) (eds) *Prevention of alcohol abuse*, Plenum, New York

Miller, R. (1994) What drugs do to users, In R. Coomber (ed) *Drugs and drug use in society: a critical reader*, Greenwich University press, Kent, pp. 5-23

Milligan, C. (2000) Bearing the burden: towards a restructured geography of caring, *Area*, 32 (1), 49-58

Ming, K. D. (2005) Cross-border 'traffic': stories of dangerous victims, pure whores and HIV/AIDS in the experiences of mainland female sex workers in Hong Kong, *Asia Pacific Viewpoint*, 46 (1), 35-48

Mohan, J. (2000) Geography of health and health care, In R. J. Johnston; D. Gregory; G. Pratt and M. Watts (eds) *The dictionary of human geography*, Fourth edition, Blackwell, Oxford, pp. 330-332

Moral, S. (2007) Notes from AIDS conference, On the world AIDS day, *The Prothom Alo* (Bangla daily), December 1, Dhaka

Moran, D. (2005) The Geography of HIV/AIDS in Russia: risk and vulnerability in transition, *Eurasian Geography and Economics*, 46 (7), 525-551

Morgan, D. (2004) Everyday life and family practices, In E. B. Silva and T. Bennett (eds) *Contemporary culture and everyday life*, Sociology press, Durham

Morgan, D. L. (1998) *The focus group guidebook*, Thousand Oaks, CA

Morris, M. (1997) Sexual networks and HIV, *AIDS*, 11 (Supplement A), S209-216

Morris, M., Podhisita, C., Wawer, M. J. and Handcock, M. S. (1996) Bridge populations in the spread of HIV/AIDS in Thailand, *AIDS*, 10 (11), 1265-1271

Mukodzani, L., Mupemba, K. and Marck, J. (1999) All roads lead to Harare: the response of the Zimbabwe transport industry to HIV/AIDS, In I. O. Orubuloye; J. C. Caldwell and J. P. M. Ntozi (eds) *The continuing African HIV/AIDS epidemic*, Australian National University, Canberra, pp. 131-138

Muntasir, Z. A. (2005) *Reduce injecting drug use and prevent the spread of HIV in Dhaka city*, In the publication of Department of Narcotics Control, on the International day against drug abuse and illicit trafficking, Government of Bangladesh, Dhaka

Murphy, S. L. and Khantzian, E. J. (1995) Addiction as a 'self medication' disorder: application of ego psychology to the treatment of substance abuse, In A. M. Washton (ed) *Psychotherapy and substance abuse: a practitioner's handbook*, Guilford press, New York

Murray, A. and Robinson, T. (1996) Minding your peers and queers: female sex workers in the AIDS discourse in Australia and South-east Asia, *Gender, Place and culture*, 3 (1), 43-59

Murthy, R. K. and Sankaran, L. (2003) *Denial and distress: gender poverty and human rights in Asia*, Zed Books, London

Muyinda, H., Seeley, J., Pickering, H. and Barton, T. (1997) Social aspects of AIDS-related stigma in rural Uganda, *Health & Place*, 3 (3), 143-147

Mykhalovskiy, E., Armstrong, P., Armstrong, H., Bourgeault, I., Choiniere, J., Lexchin, J., Peters, S. and White, J. (2008) Qualitative research and the politics of knowledge in an age of evidence: developing a research-based practice of immanent critique, *Social Science and Medicine*, 67 (1), 195-203

NACB (1990) *KABP survey in relation to AIDS in Bangladesh*, Final report, National AIDS Committee of Bangladesh (NACB) and World Health Organization (WHO), May, Dhaka

NASP (2001) *HIV in Bangladesh: where is it going*? National AIDS/STD Programme (NASP), Ministry of Health and Family welfare, Government of Bangladesh, Dhaka

NASP (2003) *HIV in Bangladesh: is time running out*? National AIDS/STD Programme (NASP), Ministry of Health and Family welfare, Government of Bangladesh, Dhaka

NASP (2004) *Bangladesh country profile on HIV and AIDS*, National AIDS/STD Programme (NASP), Ministry of Health and Family welfare, Government of Bangladesh, Dhaka

NASP (2005a) *National HIV serological and behavioural surveillance 2003-2004 Bangladesh*, Fifth round technical report, National AIDS/STD Programme (NASP), Ministry of Health and Family welfare, Government of Bangladesh, Dhaka

NASP (2005b) *National HIV serological surveillance 2004-2005 Bangladesh*, Sixth round technical report, National AIDS/STD Programme (NASP), Ministry of Health and Family welfare, Government of Bangladesh, Dhaka

NASP (2005c) *National strategic plan for HIV/AIDS 2004-2010*, National AIDS/STD Programme (NASP), Ministry of Health and Family welfare, Government of Bangladesh, Dhaka

NASP (2006a) *National HIV and AIDS communication strategy 2005-2010*, National AIDS/STD Programme (NASP), Ministry of Health and Family welfare, Government of Bangladesh, Dhaka

NASP (2006b) *Baseline HIV/AIDS survey among youth in Bangladesh-2005*, National AIDS/STD Programme (NASP), Ministry of Health and Family welfare, Government of Bangladesh, Dhaka

NAT (2005) *Fact sheet 3, Global statistics on HIV/AIDS*, National AIDS Trust (NAT), London

NAT (2008) *Global Statistics on HIV/AIDS*, National AIDS Trust (NAT), August, London

Nessa, K., Waris, S. A., Alam, A., Huq, M., Nahar, S. et al (2005) Sexually transmitted infections among brothel-based sex workers in Bangladesh: high prevalence of asymptomatic infection, *Sexually Transmitted Diseases*, 32 (1), 13-19

Nessa, K., Waris, S. A., Sultan, Z., Monira, S. et al (2004) Epidemiology and etiology of sexually transmitted infection among hotel-based sex workers in Dhaka, Bangladesh, *Journal of Clinical Microbiology*, 42 (2), 618-621

Nettleton, S. (1995) *The sociology of health and illness*, Polity press, Cambridge

Neuman, W. L. (1994) *Social research methods: qualitative and quantitative approaches*, Allyn and Bacon, Needham Hights

New York Times (1972) *New York Times*, 17th august, pp. 16

Nichter, M. (2003) Harm reduction: a core concern for medical anthropology, In B. H. Harthorn and L. Oaks (eds) *Risk, culture and health inequality: shifting perceptions of danger and blame*, Praeger, London

Nurco, D. N., Kinlock, T. W., Hanlon, T. E. and Ball, J. C. (1988) Nonnarcotic drug use over an addiction career: a study of heroin addicts in Baltimore and New York City, *Comprehensive Psychiatry*, 29 (5), 450-459

O'Brien, C. P. and McLellan, A. T. (1996) Myths about the treatment of addiction, *Lancet*, 347, 237-240

O'Donnell, J. A. and Ball, J. C. (1966) (eds) *Narcotic addiction*, Harper & Row, New York

O'Neill, M. (1996) Researching prostitution and violence: towards a feminists praxis, In M. Hester; L. Kelly and J. Radford (eds) *Women, violence and male power: feminist activism, research and practice*, Open University press, Buckingham

O'Neill, M. (1997) Prostitute women now, In G. Scambler and A. Scambler (eds) *Rethinking prostitution: purchasing sex in the 1990s*, Routledge, London

Oakley, A., Fullerton, D. and Holland, J. (1995) Behavioural interventions for HIV/AIDS prevention, *AIDS*, 9, 479-486

Omari, M. A., Bwayo, J. J., Mutere, A. N., Kreiss, J. K., Moses, S. and Plummer, F. A. (1991) *Changes in behaviour and the incidence of HIV and other sexually transmitted diseases in truck drivers from East Africa*, International Conference on AIDS, Vol. 325, Abstract No. W.C. 3118

Oppong, J. R. (1998) A vulnerability interpretation of the geography of HIV/AIDS in Ghana, 1986-1995, *The Professional Geographer*, 50 (4), 437-448

Ortner, S. (1998) Identities: the hidden life of class, *Journal of Anthropological research*, 54 (1), 1-17

Orubuloye, I. O., Caldwell, P. and Caldwell, J. C. (1993) The role of high-risk occupations in the spread of AIDS: truck drivers and itinerant market women in Nigeria, *International Family Planning Perspectives*, 19 (2), 43-71

Osmani, L. N. K. (1997) The grameen bank experiment: empowerment of women through credit, In H. Afshar (ed) *Women and empowerment: illustrations from the third world*, Macmillan press, London

Ostergard, R. L. Jr. (2007) HIV/AIDS, state capacity and the threat to national and international security: a theoretical overview, In Robert L. Ostergard, Jr. (ed) *HIV/AIDS and the threat to national and international security*, Macmillan press, England

Page, J. B. (1990) Shooting scenarios and risk of HIV-1 infection, *The American Behavioral Scientist*, 33 (4), 478-490

Pandit, N. R. (1996) The creation of theory: a recent application of the grounded theory method, *The Qualitative Report*, 2 (4), [http://www.nova.edu/ssss/QR/QR2-4/pandit.html]

Panos (2006) *Keeping the promise? A study of progress made in implementing the UNGASS declaration of commitment on HIV/AIDS in Bangladesh*, The Panos global AIDS programme, Dhaka

Parker, R, (1997) Migration, sexual subcultures, and HIV/AIDS in Brazil, In G. Herdt (ed) *Sexual cultures and migration in the era of AIDS: anthropological and demographic perspectives*, Oxford University press, New York, pp. 55- 69

Parker, R. and Aggleton, P. (2003) HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action, *Social Science and Medicine*, 57 (1), 13-24

Parker, R. G., Easton, D. and Klein, C. H. (2000) Structural barriers and facilitators in HIV prevention: a review of international research, *AIDS*, 14 (Suppl. 1), S22-32

Parr, H. (1998) The politics of methodology in 'post-medical geography': mental health research and the interview, *Health & Place*, 4 (4), 341-353

Parr, H. (2002) Medical geography: diagnosing the body in medical and health geography, 1999-2000, *Progress in Human Geography*, 26 (2), 240-251

Parr, H. (2004) Medical geography: critical medical and health geography? *Progress in Human Geography*, 28 (2), 246-257

Parsons, T. (1951) *The social system*, The Free Press, New York

Patton, C. (1990) *Inventing AIDS*, Routledge, New York

Patton, C. (1994) *Last Served? Gendering the HIV pandemic*, Taylor & Francis, London

Patton, M. Q. (1990) *Qualitative evaluation and research methods*, Second edition, Sage, London

Paul, B. K. (1985) Approaches to medical geography: an historical perspective, *Social Science and Medicine*, 20 (4), 399-409

Paul, B. K. (1994a) Commentary on Kearns' "place and health: toward a reformed medical geography", *The Professional Geographer*, 46 (4), 504-505

Paul, B. K. (1994b) AIDS in Asia, *Geographical Review*, 84 (4), 367-79

Paul, B. K. and Hasnath, S. A. (2000) Trafficking in Bangladeshi women and girls, *Geographical Review*, 90 (2), 268-276

Payne, S. (1991) *Women, health and poverty: an introduction*, Harvester, London

Pearce, J. (2003) Editorial: emerging new research in the geography of health and impairment, *Health & Place*, 9 (2), 107-108

Peterson, S. (2007) Human security, national security and epidemic disease, In Robert L. Ostergard, Jr. (ed) *HIV/AIDS and the threat to national and international security*, Macmillan press, England

Philo, C. (1996) Staying in? Invited comments on "coming out: exposing social theory in medical geography", *Health & Place*, 2 (1), 35-40

Philo, C. (2000) The birth of the clinic: an unknown work in medical geography, *Area*, 32 (1), 11-19

Philo, C. (2007) A vitally human medical geography? Introducing Georges Canguilhem to geographers, *New Zealand Geographer*, 63 (2), 82-96

Phoenix, J. (2000) Prostitute identities: men, money and violence, *British Journal of Criminology*, 40 (1), 37-55

Pickles, J. (1985) *Phenomenology, science and geography: spatiality and the human sciences*, Cambridge University press, Cambridge

Pile, S. (1993) Human agency and human-geography revisited- a critique of new models of the self, *Transactions of the institute of British Geographers*, 18 (1), 122-139

Piot, P., Plummer F., Mhalu, F., Lamboray, Jen-Louis., Chin, J. and Mann, J. (1988) AIDS: an international perspective, *Science*, 239, 573-279

Piper, N. and Yeoh, B. S. A. (2005) Introduction: meeting the challenges of HIV/AIDS in Southeast and East Asia, *Asia Pacific Viewpoint*, 46 (1), 1-5

Podhisita, C., Wawer, J. M., Pramualratana, A., Kanungsukkasem, U. and McNamara, R. (1996) Multiple sexual partners and condom use among long-distance truck drivers in Thailand, *AIDS Education and Prevention*, 8 (6), 490-498

Pollak, M., Paicheler, G. and Pierret, J. (1992) AIDS: a problem for sociological research, International Sociological Association, Sage, London

Popper, K. (1968) *The logic of scientific discovery*, Second edition, Hutchinson, London

Popper, K. R. (1976) *Unended quest: an intellectual autobiography*, Fontana, London

Powell-Cope, G. M. and Brown, M. A. (1992) Going public as an AIDS family caregiver, *Social Science and Medicine*, 34 (5), 571-580

Power, R. (2000) Qualitative research and community-level responses to illicit drug use, In EMCDDA (ed) *Understanding and responding to drug use: the role of qualitative research*, Scientific monograph series, No. 4, Luxembourg

Prasai, S. B. (2008) Call for global action to halt Nepalese women and girls trafficking, *American Chronicle National media network*, February 11

Pullen, K. (2005) *Actresses and whores: on stage and in society*, Cambridge University press, United Kingdom

Punch, K. F. (1998) *Introduction to social research: quantitative and qualitative approaches*, Sage, London

Pyle, G. F. (1969) The diffusion of cholera in the United States in the nineteenth century, *Geographical Analysis*, 1, 59-75

Pyle, G. F. (1979) *Applied medical geography*, V.H. Winston & sons, Washington

Quader, G. M. (2004) HIV and AIDS: present situation and future challenges, *The Daily Star*, November 29, Dhaka

Rahim, M. A. (2004) Blood and HIV/AIDS, *The Daily Star*, January 19, Dhaka

Rahman, A. Z. M. (2005) HIV/AIDS: Bangladesh country situation, World AIDS Day Special, *The Daily Star*, December 1, Dhaka

Rahman, J. (2007) Severity of AIDS in Bangladesh, *The New Nation*, November 11 and 12, Dhaka

Rahman, M. and Zaman, M. S. (2005) Awareness of HIV/AIDS and risky sexual behaviour among male drug users of higher socioeconomic status in Dhaka, Bangladesh, *Journal of Health, Population and Nutrition*, 23 (3), 298-301

Rahman, M., Shimu, T. A., Fukui, T., Shimbo, T. and Yamamoto, W. (1999) Knowledge, attitudes, beliefs and practices about HIV/AIDS among the overseas job seekers in Bangladesh, *Public Health*, 113, 35-38

Rahman, M., Uz-Zaman, M. S., Sakamoto, J. and Fukui, T. (2004) How much do drug abusers pay for drugs in Bangladesh? Letter to the editor, *Journal of Health, Population and Nutrition*, 22 (1), 98-99

Rahman, Mahbubur, Zaman, M. S., Sekimoto, M. and Fukui, T. (2000) HIV-related risk behaviours among drug users in Bangladesh, letter to the editor, *International Journal of STD & AIDS*, 11, 827-828

Rahman, Motiur, Alam, A., Nessa, K., Hossain, A. et al (2000) Etiology of sexually transmitted infections among street-based female sex workers in Dhaka, Bangladesh, *Journal of Clinical Microbiology*, 38 (3), 1244-1246

Rao, K. S., Pilli, R. D., Rao, A. S. and Chalam, P. S. (1999) Sexual life style of long distance lorry drivers in India: questionnaire survey, *British Medical Journal*, 318 (7177), 162-163

Ratcliff, D. (1999) *Qualitative research resources: data analysis (Part V)*, Qualitative research file, [http://don.ratcliff.net/qual]

Raymond, J. G. et al (2003) *A comparative study of women trafficked in the migration process: patterns, profiles and health consequences of sexual exploitation in five countries*, Coalition Against Trafficking in Women (CATW), USA

Revenson, T. (2001) Chronic illness adjustment, In J. Worell (ed) *Encyclopedia of women and gender*, Vol. 1, Academic press, New York

Rhodes, T. (1994) *Risk intervention and change: HIV prevention and drug use*, Health Education authority, London

Rhodes, T. (1995) Theorizing and researching 'risk': notes on the social relations of risk in heroin users' lifestyles, In P. Aggleton; P. Davies and G. Hart (eds) *AIDS: safety, sexuality and risk*, Taylor & Francis, London

Rhodes, T. (2002) The 'risk environment': a framework for understanding and reducing drug-related harm, *International Journal of Drug Policy*, 13 (2), 85-94

Rhodes, T. and Quirk, A. (1996) Heroin, risk and sexual safety, In T. Rhodes and R. Hartnoll (eds) *AIDS, drugs and prevention: perspectives on individual and community action*, Routledge, London

Rhodes, T. and Stimson, G. V. (1996) Sex, drugs, intervention and research: from the individual to the social, *International Journal of the Addictions*, 31 (3), 375-407

Rhodes, T., Barnard, M., Fountain, J. et al (2001) *Injecting drug use, risk behaviour and qualitative research in the time of AIDS*, EMCDDA, July, Luxembourg

Rhodes, T., Mikhailova, L., Sarang, A. et al (2003) Situational factors associated with drug injecting, risk reduction and syringe exchange practices in Togliatti city, Russian Federation: a qualitative study of micro risk environment, *Social Science and Medicine*, 57 (1), 39-54

Rhodes, T., Singer, M., Bourgois, P., Friedman, S. R., Strathdee S. A. (2005) The social structural production of HIV risk among injecting drug users, *Social Science and Medicine,* 61 (5), 1026-1044

Rich, M. and Ginsburg, K. R. (1999) The reason and rhyme of qualitative research: why, when, and how to use qualitative methods in the study of adolescent health, *Journal of Adolescent Health*, 25 (6), 371-378

Richardson, D. (1989) *Women and the AIDS crisis*, Pandora press, London

Richardson, D. (1990) AIDS education and women: sexual and reproductive issues, In P. Aggleton; P. Davies and G. Hart (eds) *AIDS: individual, cultural and policy dimensions*, Falmer press, London

Richardson, L. (1990) *Writing strategies: reaching diverse audiences*, Sage, Newbury Park

Riessman, C. K. (1993) *Narrative analysis*, Sage, Newbury Park

Ritchie, J. and Lewis, J. (2003) (eds) *Qualitative research practice: a guide for social science students and researchers*, Sage, London

Rivers, K. and Aggleton, P. (1999) *Adolescent sexuality, gender and the HIV epidemic*, HIV and Development Programme, United Nations Development Program (UNDP)

Robertson, R. (1987) *Heroin, AIDS and society*, Hodder and Stoughton, London

Robson, E. (1997) From teacher to taxi driver: reflections on research roles in developing areas, In E. Robson and K. Willis (eds.) *Postgraduate fieldwork in developing areas: a rough guide*, Second edition, Monograph no. 9, Developing Areas Research Group (DARG), Royal Geographical Society, Keele University press, pp. 51-74

Rock, P. (1973) *Deviant behaviour*, Hutchinson, London

Roehrich, L. and Goldman, M. S. (1993) Experience-dependent neuropsychological recovery and the treatment of alcoholism, *Journal of Consulting and Clinical Psychology*, 61 (5), 812-821

Rosenberg, M. W. (1998) Medical or health geography? Populations, people and places, *International Journal of Population Geography*, 4, 211-226

Rugg, G. and Petre, M. (2007) *A gentle guide to research methods*, Open University press, New York

Russell, B. (1961) *History of western philosophy and its connection with political and social circumstances from the earliest times to the present day*, George Allen and Unwin, London

Ryan, G. W. and Bernard, H. R. (2000) Data management and analysis methods, In N. K. Denzin and Y. S. Lincoln (eds) *The handbook of qualitative research*, Second edition, Sage, London

Sabatier, R. (1990) *Blaming others: prejudice, race and worldwide AIDS*, The Panos Institute, London

Sabatier, R. (1996) Migrants and AIDS: themes of vulnerability and resistance, In M. Haour-Knipe and R. Rector (eds.) *Crossing borders: migration, ethnicity and AIDS*, Taylor & Francis, London

Sabin, K. M. (1998) *A study of sexually transmitted infections and associated factors in slum communities of Dhaka, Bangladesh*, PhD Dissertation, The school of Hygiene and Public Health, The Johns Hopkins University, Baltimore, Maryland

Sabin, K., Hawkes, S., Rahman, M. et al (1997) *Barriers to seeking treatment for sexually transmitted diseases among the Dhaka slum dwellers*, ASCON VI Conference, International Centre for Diarrhoeal Disease Research, Bangladesh, (ICDDR, B), March, Special Publication No. 57, Dhaka

Sandelowski, M. (1995) Qualitative analysis: what it is and how to begin, *Research in Nursing and Health*, 18 (4), 371-375

Sarkar, K., Bal, B., Mukherjee, R., Niyogi, S. K., Saha, M. K. and Bhattacharya, S. K. (2005) Epidemiology of HIV infection among brothel-based sex workers in Kolkata, India, *Journal of Health, Population and Nutrition*, 23 (3), 231-235

Sarkar, K., Panda, S., Das, N. and Sarkar, S. (1997) Relationship of national highway with injecting drug abuse and HIV in rural Manipur, India, *Indian Journal of Public Health*, 41 (2), 49-51

Sarkar, S., Das, N., Panda, S. et al (1993) Rapid spread of HIV among injecting drug users in north-eastern states of India, *Bulletin on Narcotics*, 45 (1), 91-105

Sarkar, S., Islam, N., Durandin, F. et al (1998) Low HIV and high STD among commercial sex workers in a brothel in Bangladesh: scope for prevention of larger epidemic, *International Journal of STD & AIDS*, 9, 45-47

Schuckit, M. A. and Segal, D. S. (1994) Opioid drug use, In K. J. Isselbacher; E. Braunwald; J. D. Wilson; J. B. Martin; A. S. Fanci and D. L. Kasper (eds) *Harrison's principles of internal medicine*, McGraw-Hill, New York, pp. 2425-2429

Scott, A. (1987) The virus behind the disease tests to detect infection attack on the immune system, *New scientist*, 26th March, 36-37

Seamon, D. (1979) *A Geography of the lifeworld: movement, rest and encounter*, CroomHelm, London

Seib, C., Fischer, J. and Najman, J. M. (2009) The health of female sex workers from three industry sectors in Queensland, Australia, *Social Science and Medicine*, 68 (3), 473-478

Sen, A. (1981) *Poverty and famines: an essay on entitlement and deprivation*, Clarendon press, Oxford

Sen, P. (1998) Violence in intimate relationships: a research project in India, In H. Afshar (ed) *Women and empowerment: illustrations from the third world*, Macmillan press, London

Shannon, G. and Dever, G. (1974) *Health care delivery: spatial perspectives*, McGraw-Hill, New York

Shannon, G. W. and Pyle, G. F. (1989) The origin and diffusion of AIDS: a view from medical geography, *Annals of the Association of American Geographers*, 79 (1), 1-24

Shannon, G. W., Pyle, G. F. and Bashshur, R. L. (1991) *The geography of AIDS: origins and course of an epidemic*, Guildford press, New York

Sharma, M., Rahman, K. Z., Kelly, R. and O'Day, T. (2006) *Reducing the demand for drugs and preventing HIV in Bangladesh: a partnership between law enforcement, the community and treatment agencies*, In the publication of Department of Narcotics Control, on the International day against drug abuse and illicit trafficking, Government of Bangladesh, Dhaka

Shaw, M., Dorling, D. and Mitchell, R. (2002) *Health, place and society*, Pearson, Essex

Sherso Barta (2004) *Hena has given her life for the rumor of AIDS- who is responsible*? (in Bengali), Second volume, Khulna

Shirin, T., Ahmed, T., Iqbal, A., Islam, M. and Islam, M. N. (2000) Prevalence and risk factors of hepatitis B virus, hepatitis C virus, and human immunodeficiency virus infections among drug addicts in Bangladesh, *Journal of Health, Population and Nutrition*, 18 (3), 145-150

Sieber, J. E. and Stanley, B. (1988) Ethical and professional dimensions of socially sensitive research, *American Psychologist*, 43 (1), 49-55

Siegel, S. (1979) The role of conditioning in drug tolerance and addiction, In J. D. Keehn (ed) *Psychopathology in animals: research and treatment implications*, Academic press, New York

Silverman, D. (1993) *Interpreting qualitative data: methods for analyzing talk, text and interaction*, Thousand oaks, California

Silverman, D. (2005) *Doing qualitative research: a practical handbook*, Second edition, Sage, London

Singer, M. (1994) AIDS and the health crisis of the US urban poor: the perspective of critical medical anthropology, *Social Science and Medicine*, 39 (7), 931-948

Singer, M. (2001) Toward a bio-cultural and political economic integration of alcohol, tobacco and drug studies in the coming century, *Social Science and Medicine*, 53 (2), 199-213

Singer, M., Stopka, T., Siano, C., Springer, K., Barton, G., Khoshnood, K., Gorry de Puga, A. and Heimer, R. (2000) The social geography of AIDS and hepatitis risk: approaches for assessing local differences in sterile-syringe access among injection drug users, *American Journal of Public Health*, 90 (7), 1049-1056

Singh, N. S. C., Sivek, C., Wagener, M., Hong Nguyen, M., and Yu, V. L. (1996) Determinants of compliance with antiretroviral therapy in patients with human

immunodeficiency virus: prospective assessment with implications for enhancing compliance, *AIDS Care*, 8 (3), 261-269

Singh, Y. N. and Malaviya, A. N. (1994) Long distance trucks drivers in India: HIV infection and their possible role in disseminating HIV into rural areas, *International Journal of STD & AIDS*, 5 (2), 137-138

Singh, Y. N., Singh, K., Joshi, R., Rustagi, D. K. and Malaviya, A. N. (1993) HIV infection among long distance trick drivers in Delhi, India, *Journal of Acquired Immune Deficiency Syndrome*, 6 (3), 323

Smallman-Raynor, M. R. and Cliff, A. D. (1990) Acquired Immune Deficiency Syndrome (AIDS): literature, geographical origins and global patterns, *Progress in Human Geography*, 14 (2), 157-213

Smallman-Raynor, M. R., Cliff, A. and Hagget, P. (1992) *London international atlas of AIDS*, Blackwell, Oxford

Smith, C. J. (2005) Social geography of sexually transmitted diseases in China: exploring the role of migration and urbanization, *Asia Pacific Viewpoint*, 46 (1), 65-80

Smyth, F. (2005) Medical geography: therapeutic places, spaces and networks, *Progress in Human Geography*, 29 (4), 488-495

Smyth, F. (2008) Medical geography: understanding health inequalities, *Progress in Human Geography*, 32 (1), 119-127

Sontag, S. (1989) A new book on stigma, In S. Rogers (ed) *Explaining health and illness: an exploration of diversity*, Harvester Wheatsheaf, New York

Soskolne, V. and Shtarkshall, R. A. (2002) Migration and HIV prevention programmes: linking structural factors, culture and individual behaviour- an Israeli experience, *Social Science and Medicine*, 55 (8), 1297-1307

South, N. (1999) (ed) *Drugs: cultures, controls and everyday life*, Sage, London

Stamp, L. D. (1964) *The geography of life and death*, Ithaca, Cornell University press, New York

Stephenson, J. M. (1999) Evaluation of behavioural interventions in HIV/STI prevention, *Sexually Transmitted Infections*, 75 (1), 69-71

Stern, P. N. (1980) Grounded theory methodology: its uses and processes, *Journal of Nursing Scholarship*, 12 (1), 20-23

Stover, J., Walker, N., Garnett, G. P., Salomon, J. A. et al (2002) Can we reverse the HIV/AIDS pandemic with an expanded response? *The Lancet*, 360, 73-77

Strange, K. C. and Zyzanski, S. J. (1989) Integrating qualitative and quantitative research methods, *Family Medicine*, 26, 449-451

Strauss, A. and Corbin, J. (1990) *Basics of qualitative research: grounded theory procedures and techniques*, Sage, London

Strauss, A. and Corbin, J. (1997) (eds) *Grounded theory in practice*, Sage, London

Strauss, A. and Corbin, J. (1998) *Basics of qualitative research: techniques and procedures for developing grounded theory*, Sage, London

Strauss, A. L. (1975) *Chronic illness and the quality of life*, Mosby, St. Louis

Streatfield, P. K. (2001) Role of abortion in fertility control, Editorial, *Journal of Health, Population and Nutrition*, 19 (4), 265-267

Suchman, E. A. (1972) The 'addictive' disorders as socio-environmental health problems, In H. E. Freeman; S. Levine and L. G. Reeder (eds) *Handbook of medical sociology*, Prentice-Hall, New Jersey, pp. 148-168

Sudman, S. and Kalton, G. (1986) New developments in the sampling of special populations, *Annual review of Sociology*, 12, 401-429

Sui, D. Z. (2007) Geographic information systems and medical geography: toward a new synergy, *Geography Compass*, 1 (3), 556-582

Sutherland, I. (2004) *Adolescent substance misuse: why one person may be more at risk than another, and what you can do to help*, Russell house publishing, Dorset

Sweat, M. D., Nopkesorn, T., Mastro, T. D., Sangkharomya, S., Macqueen, K., Pokapanichwong, W., Sawaengdee, Y. and Weniger, B. G. (1995) AIDS awareness among a cohort of young thai men: exposure to information, level of knowledge and perception of risk, *AIDS care*, 7 (5), 573-589

Tahmina, Q-A. and Moral, S. (2004) *Sex-workers in Bangladesh- livelihood: at what price*? The CAD System, Dhaka

Takahashi, L. M. (1997) Stigmatization, HIV/AIDS, and communities of color: exploring response to human service facilities, *Health & Place*, 3 (3), 187-199

Takahashi, L. M. and Dear, M. J. (1997) The changing dynamics of community opposition to human service facilities, *Journal of the American Planning Association*, 63 (1), 79-93

Takahashi, L. M. and Smutny, G. (2001) Explaining access to human services: the influence of descriptive and behavioural variables, *The Professional Geographer*, 53 (1), 12-31

Takahashi, L. M., Wiebe, D. and Rodriguez, R. (2001) Navigating the time-space context of HIV and AIDS: daily routines and access to care, *Social Science and Medicine*, 53 (7), 845-863

Takyi, B. K. (2003) Religion and women's health in Ghana: Insights into HIV/AIDS preventive and protective behavior, *Social Science and Medicine*, 56 (6), 1221-1235

Taposh, S. (2006) Continued exploitation deters rehabilitation of sex workers, *The Daily Star*, Issue 256, September 30, Dhaka

Tatoud, R. (2006) Gendering the fight against AIDS, O*penDemocracy limited*, August 21

Tatum, P. S. and Schoech, D. (1992) Migration of persons with HIV disease: the search for care, *AIDS Public Policy Journal*, 7, 56

Teye, J. K. (2005) Condom use as a means of HIV/AIDS prevention and fertility control among the Krobos of Ghana, *Norwegian Journal of Geography*, 59, 65-73

The Daily Ittefaq (2006) *An HIV positive has died in Noakhali*, The Daily Ittefaq (Bengali daily), July 11, Dhaka

The World Bank Report (2006) *AIDS in South Asia: understanding and responding to a heterogeneous epidemic*, Launched at the 16 th international AIDS conference in Toronto, Canada

Thomas, R. W. (1992) *Geo medical systems: intervention and control*, Routledge, London

Thomas, R. W. (2001) *Geography of AIDS*, International encyclopedia of the social and behavioural sciences, Elsevier, UK, pp. 350-355

Thompson, C. (1996) The genes that keep AIDS at Bay, *New scientist*, 16, 6th April

Townley, G., Kloos, B. and Wright, P. A. (2009) Understanding the experience of place: expanding methods to conceptualize and measure community integration of persons with serious mental illness, *Health & Place*, 15 (2), 520-531

Townsend, P. (1979) *Poverty in the united kingdom*, Penguin books, London

Trad, P. V. (1995) The pharmacologic aspects of psychoactive substances: implications for medical management, In T. P. Gullotta; G. R. Adams and R. Montemayor (eds) *Substance Misuse in Adolescence*, Sage, London, pp. 147-174

Tuan, Yi-Fu (1991) A view of geography, *Geographical Review*, 8 (1), 99-107

Turmen, T. (2003) Gender and HIV/AIDS, *International Journal of Gynecology and Obstetrics*, 82 (3), 411-418

Turner, C. F., Miller, H. G. and Moses, L. E. (1989) (eds) *AIDS: sexual behavior and intravenous drug use*, Acad. Press, Washington

Tyler, A. (1986) *Street drugs*, Coronet books, Kent

UBINIG (1995) *Trafficking in women & children: the cases of Bangladesh*, Unnayan Bikalper Nitinirdharoni Gobeshona (UBINIG), Dhaka

Ullah, A. K. M. A. (2003) Prostitution and AIDS in Bangladesh: is the ignorance endangering us? *Asian Center for Women's Studies*, 9 (2) 95-114

Ullah, A. K. M. A. (2005) Prostitution in Bangladesh: an empirical profile of sex workers, *Journal of International Women's Studies*, 7 (2), 111-122

UN (2002) *HIV/AIDS awareness and behaviour*, United Nations (UN), Department of Economic and Social affairs, Population division, United Nations, New York

UNAIDS (1997) *Impact of HIV and sexual health education on the sexual behaviour of young people: a review update*, Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva

UNAIDS (2002a) *Report on the global HIV/AIDS epidemic*, Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva

UNAIDS (2002b) *Gender and AIDS*, Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva

UNAIDS (2006) *UNAIDS Annual report: making the money work*, Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva

UNAIDS (2008) *Report on the global AIDS epidemic*, Executive summery, Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva

UNAIDS and IOM (2001) *Population mobility and AIDS*, Joint United Nations Programme on HIV/AIDS (UNAIDS) and International Organization for Migration (IOM)

Unwin, T. (1992) *The place of geography*, Longman, Harlow

Upayokin, P. (1995) *Treatment choice, disease outcome and stigma: an investigation of leprosy patients and illness behaviour in Thailand*, U-M-I Dissertation services, Michigan

Urquhart, C. (2000) Strategies for conversation and systems analysis in requirements gathering: a qualitative view of analyst-client communication, *The qualitative report*, 4 (1&2) [http://www.nova.edu/ssss/QR/QR4-1/urquhart.html]

Usher, K., Jackson, D. and O'Brien, L. (2005) Adolescent drug abuse: helping families survive, *International Journal of Mental health Nursing*, 14 (3), 209-214

Vaillant, G. (1983) *The natural history of alcoholism: course, patterns and paths to recovery*, Harvard University press, Cambridge

Valentine, G. (2005) Tell me about.....using interviews as a research methodology, In R. Flowerdew and D. Martin (eds) *Methods in human geography: a guide for students doing a research project*, Second edition, Pearson, London, pp. 17-118

VHSS (1993) *Survey of truck drivers*, Voluntary Health Service System (VHSS), Dhaka

Wainwright, D. (1997) Can sociological research be qualitative, critical and valid? *The Qualitative report*, 3 (2) [http://www.nova.edu/ssss/QR/QR3-2/wain.html]

Walklate, S. (2007) (ed) *Handbook of victims and victimology*, Willan publishing, Portland

Wall, H. (1999) To legalize or not to legalize: is that the question, In J. Elster and O. Skog (eds) *Getting hooked: rationality and addiction*, Cambridge University press, Cambridge, pp. 137-172

Wallace, B. J., Ahsan, R. M., Hussain, S. H. and Ahsan, E. (1987) *The invisible resource: women and work in rural Bangladesh*, Westview press, London

Wallace, R. (1991) Traveling waves of HIV infection on a low dimensional 'socio-geographic' network, *Social Science and Medicine*, 32 (7), 847-852

Wallace, R., Fullilove, M., Fullilove, R., Gould, P. and Wallace, D. (1994) Will AIDS be contained within US minority urban population? *Social Science and Medicine*, 39 (8), 1051-1062

Wallman, S. (2001) Global threats, local options, personal risk: dimensions of migrant sex work in Europe, *Health, Risk and Society*, 3 (1), 75-87

Ware, N. C., Wyatt, M. A. and Tugenberg, T. (2005) Adherence, stereotyping and unequal HIV treatment for active users of illegal drugs, *Social Science and Medicine*, 61 (3), 565-576

Washton, A. M. (1992) Structured outpatient group therapy with alcohol and substance abusers, In J. H. Lowinson; P. Ruiz; R. B. Millman and J. G. Langrd (eds) *Substance abuse: a comprehensive textbook*, Williams and Wilkins, Baltimore, pp. 508-519

Wasserheit, J. N. (1992) Epidemiologic synergy: interrelationships between human immunodeficiency virus infection and other sexually transmitted diseases, *Sexually Transmitted Disease*, 19, 61-77

Wasserheit, J. N., Harris, J. R., Chakraborty, J., Kay, B. A and Mason K. J. (1989) Reproductive tract infection in a family planning population in rural Bangladesh, *Studies of Family Planning*, 20 (2), 69-80

Watts, M. J. (1991) Mapping meaning, denoting difference, imagining identity: dialectic images and postmodern geographies, *Geografiska Annaler*, 73 (1), 7-16

Westermeyer, J. (1982) *Poppies, pipes and people: opium and its use in Laos*, University of California press, Berkeley

Whelan, G. (2004) The pharmacological dimension of psychoactive drugs, In M. Hamilton; T. King and A. Ritter (eds) *Drug use in Australia: preventing harm*, Oxford University press, Australia, pp. 17-32

White, N. F. (1981) Modem health concepts, In N. F. White (ed) *The health conundrum*, Toronto, pp. 5-18

Whiteside, A. (2008) *HIV/AIDS a very short introduction*, Oxford University Press, Oxford

WHO (1992) *Women's health: across age and frontier*, World Health Organization (WHO), Geneva

WHO (1997) *AIDS: some questions and answers*, World Health Organization (WHO), Regional Office for South-East Asia, New Delhi

Wiebel, W. (1996) Ethnographic contributions to AIDS prevention strategies, In T. Rhodes and R. Hartnoll (eds) *AIDS, drugs and prevention: perspectives on individual and community action*, Routledge, London

Wiener, C. (1975) The burden of rheumatoid arthritis: tolerating the uncertainty, *Social Science and Medicine*, 9, 97-104

Wiersma, E. C. (2008) The experiences of place: veterans with dementia making meaning of their environments, *Health & Place*, 14 (4), 779-794

Wijers, M. and Lap-Chew, L. (1997) *Trafficking in women, forced labour and slavery-like practices in marriage, domestic labour and prostitution*, Anraad, The Netherlands

Wiles, J. (2005) Conceptualising the importance of place in the care of older people: the role of geographical gerontology, *International Journal of Older People Nursing*, 14 (8b), 100-108

Wiles, J. L., Allen, R. E. S., Palmer, A. J., Hayman, K. J., Keeling, S. and Kerse, N. (2009) Older people and their social spaces: a study of well-being and

attachment to place in Aotearoa New Zealand, *Social Science and Medicine*, 68 (4), 664-671

Wiles, J. L., Rosenberg, M. W. and Kearns, R. A. (2005) Narrative analysis as a strategy for understanding interview talk in geographic research, *Area*, 37 (1), 89-99

Wilkie, L. A. (2001) Race, identity and Habermas's lifeworld, In C. E. Orser Jr. (ed) *Race and the archaeology of identity*, The University of Utah press, Salt lake city

Williams, A. (1999) Introduction, In A. Williams (ed) *Therapeutic landscapes: the dynamic between place and wellness*, University Press of America, Lanham, MD, pp. 1-11

Williams, A. (2002) Changing geographies of care: employing the concept of therapeutic landscapes as a framework in examining home space, *Social Science and Medicine*, 55 (1), 141-154

Williams, B. (1999) *Working with victims of crime: policies, politics and practice*, Jessica Kingsley publishers, London

Williams, G. (1984) The genesis of chronic illness: narrative reconstruction, In P. Brown (ed) *Perspectives in medical sociology*, Wadsworth, Belmont

Williams, M., Bowen, A., Ross, M., Freeman, R. C. and Elwood, W. (2000) Perceived compliance with AZT dosing among a sample of African-American drug users, *International Journal of STD & AIDS*, 11 (1), 57-63

Wilton, R. D. (1996) Diminished worlds? The geography of everyday life with HIV/AIDS, *Health & Place*, 2 (2), 69-83

Wilton, R. D. (1999) Qualitative health research: negotiating life with HIV/AIDS, *The Professional Geographer*, 51 (2), 254-264

Wilton, T. (1994) Feminism and the erotics of health promotion, In L. Doyal; J. Naidoo and T. Wilton (eds) *AIDS: setting a feminist agenda*, Taylor & Francis, London

Win, K. (2006) War on humanitarian concern: virus and violence, *Asian Tribune*, 27 th August

Wolcott, H. (1988) Ethnographic research in education, In R. M. Jaeger (ed) *Complementary methods for research in education*, American Educational Research association, Washington

Wolffers, I., Fernandez, I.,Verghis, S. and Vink, M. (2002) Sexual behaviour and vulnerability of migrant workers for HIV infection, *Culture, Health and Sexuality*, 4 (4), 459-473

Wood, E., Chan, K., Montaner, J. S., Schechter, M. T., Tyndall, M., O'Shaughnessy, M. V. and Hogg, R. S. (2000b) The end of the line: has rapid transit contributed to the spatial diffusion of HIV in one of Canada's largest metropolitan areas? *Social Science and Medicine*, 51 (5), 741-748

Wood, E., Tyndall, M. W., Spittal, P. M., Li, K., Hogg, R. S., O'Shaughnessy, M. V. and Schechter, M. T. (2002) Needle exchange and difficulty with needle access during an ongoing HIV epidemic, *International Journal of Drug Policy*, 13 (2), 95-102

Wood, E., Yip, B., Gataric, N., Montaner, J. S. G., O'Shaughnessy, M. V., Schechter, M. T. and Hogg, R. S. (2000a) Determinants of geographic mobility among participants in a population-based HIV/AIDS drug treatment program, *Health & Place*, 6 (1), 33-40

Wood, W. B. (1988) AIDS north and south: diffusion patterns of a global epidemic and a research agenda for geographers, *The Professional Geographer*, 40 (3), 266-279

Yang, X. (2006) Temporary migration and HIV risk behaviors in China, *Environment and Planning A*, 38 (8), 1527-1543

Yiannakoulias, N., Svenson, L. W. and Schopflocher, D. P. (2005) Diagnostic uncertainty and medical geography: what are we mapping? Commentary, *The Canadian Geographer*, 49 (3) 291-300

Young, L. and Ansell, N. (2003) Fluid households, complex families: the impacts of children's migration as a response to HIV/AIDS in Southern Africa, *The Professional Geographer*, 55 (4), 464-476

Zannat, M. (2008) AIDS patients deprived of proper care, *The Daily Star*, April 18, Dhaka

Zierler, S. (1997) Hitting hard: HIV and violence, In N. Goldstein and J. L. Manlowe (eds) *The gender politics of HIV/AIDS in women: perspectives on the pandemic in the United States*, New York University press, New York

Zierler, S., Krieger, N., Tang, Y. et al (2000) Economic deprivation and AIDS incidence in Massachusetts, *American Journal of Public Health*, 90 (7), 1064-1073

Appendices

Appendix 1: Question Themes for Different Stakeholders

Appendix 1.1

IDI and FGD themes for CSW

- Everyday life at brothel
- CSW's daily income
- Physical sufferings
- Dream and frustration
- Sorrows and sadness
- Identity and stigma
- Rights and empowerment
- HIV knowledge
- Risk coping and safety practice
- Perception about Condom use
- Risky and safe place and violence
- Women trafficking
- Bonded and street girls
- Border women and health risk
- Conservative society and sexuality

Appendix 1.2

IDI, PO and FGD themes for DU

- Everyday withdrawal
- Sufferings and drug impact on body
- Needle sharing
- Drug money collection
- Sexual life of addicts
- Blood sale
- Recovery and relapse
- Reason of addiction
- Blamed lives
- Negative identity
- Discrimination for addicts
- HIV consciousness
- Risk coping and treatment
- Drug taking place and stigma
- Addicts mobility and health risk

Appendix 1.3

IDI and FGD themes for TW

- TWs multi sexual relation
- Condom use and preference
- Mobility and risk behaviour
- HIV/AIDS knowledge
- Risk minimization techniques
- Preferring places for sex
- Role of Indian truckers at border
- Indian truckers' risk practice
- Reason of choosing BD girls
- Types of health problem

Appendix 1.4

IDI themes for HIV+

- Sorrows and anger
- Scaring HIV identification
- Devotion to God
- Dream and frustration
- Expectation
- HIV positive's identity
- Societal negligence
- Stigma and discrimination
- Hidden HIV+ in country
- Unidentified sources

Appendix 1.5

Interview themes for LCS and KP

- HIV prevention programs in BD
- CSW's empowerment
- DU's social integration
- 'Behaviour change' in HIV prevention
- Low HIV prevalence mystery
- HIV testing in field level
- HIV awareness campaign
- Stigma and discrimination towards HIV+
- Role of NGOs in HIV prevention
- Role of donors in HIV prevention
- HIV surveillance and planning
- Role of government
- Necessity of political commitment

Appendix 2: Detail Nature of Project Participants and Places

Participants/ Places	CSW					DU			HIV positive		TW		RP	Slum Dwellers (women)	Local healers	LCS	KP
	Brothel	Hotel	Residence	Street	Floating	Heroin User	IDU	Relatives	Patient	Relatives	Indian	Bangladeshi					
Jessore	x	x	x	x		x	x									x	
Benapole					x						x	x			x	x	
Khulna		x	x	x	x	x	x	x	x	x		x	x	x		x	
Fultola	x															x	
Baniashanta	x															x	
Dhaka																	x

Appendix 3: A List of People and related Organizations who helped in this Research

Name and Designation	Organization
A K M Anisuzzaman, Program Manager	Mukto Akash Bangladesh, Dhaka
A K M Mooniruzzaman, Center Manager	Jagorani Chakra, Jessore
A T M Zakir Hossain, Executive Director	JJS, Khulna
Afroza Akter, Executive Director	KMSS, Khulna
Amullya Damien Biswas, Program Officer	World Vision Bangladesh, Khulna
Anup Kumar Bosu, Deputy Program Manager	Save the Children-USA, Dhaka
Asif Hossain Apu, Managing Director	Bandhan, Jessore
Avra Saha, Sr. Program Officer-Prevention	FHI, Dhaka
Binoy Krisna Mallick, Executive Director	Rights Jessore, Jessore
Dr. Abu Jamil Faisel, Country Representative	Engender Health, Dhaka
Dr. Anwarul Azad, Divisional Consultant-TB	WHO, Khulna
Dr. Aurongojeb,	PKS, Benapole
Dr. Bidhan C Mistri,	RPDO, Jessore
Dr. Dipak Kumar Biswas, Director, Programme	HASAB, Dhaka
Dr. Halida H Khandaker, Executive Director	CAAP, Dhaka
Dr. Julia Ahmed, Deputy Executive Director	BWHC, Dhaka
Dr. Lazeena Muna, Advocacy Advisor	UNAIDS, Dhaka
Dr. M G Mostafa, Program Manager, BAP	SMC, Dhaka
Dr. M Moshiur Rahman, Project Manager	Ad-din Welfare Center, Jessore
Dr. Mahbubul Islam, National Professional Officer	WHO, Dhaka
Dr. Md Wazihullah Patwary, Team Leader	PIACT Bangladesh, Dhaka
Dr. Md. Mostafa Kamal, President	KMSS, Khulna
Dr. Md. Mozammel Hoque, Dp. Prog. Manager	NASP, Dhaka
Dr. Md. Shah Alam, Field Research Manager	ICDDR'B, Dhaka
Dr. Munir Ahmed, Team Leader-Operations	CARE Bangladesh, Dhaka
Dr. Niranjan Kumar Sikder, Deputy Civil Surgeon	Jessore
Dr. Syed Al-Amin, AIDS Specialist	Khulna
Farida Tun Nahar, Project Director	PKS, Jessore
Firoj Rahman, Center Manager	Ghoroni, Jessore
Habiba Akter, Executive Director	Ashar Alo Society, Dhaka
Ismat Bhuiya, Senior Programme Officer	Population Council, Dhaka
Jibon Kishore Roy, Project Manager	SHAD, Khulna
Josef Das, Project Manager	The Salvation Army, Jessore
Lia Sornokar, Project Officer	World Vision Bangladesh, Khulna
M A Haider Dipu, Organizing Secretary	Transport Association, Benapole
Mahboob Aminur Rahman, M&E Advisor	UNAIDS, Dhaka
Matiur Rahman, Add SP	Bangladesh Police, Jessore
Md Mostafizur Rahman, GIS Analyst	CEGIS, Dhaka
Md Tauhid, Bureau Chief	Samokal, Jessore
Md. Abu Taher, Program Development Officer	CARE Bangladesh, Dhaka
Md. Abul Hossain, DC	Bangladesh Government, Jessore
Md. Aktaruzzaman Sikder, Health Edu. Officer	Jessore
Md. Anamul Hoque, UNO	Bangladesh Government, Khulna
Md. Delwar Hossain, Center Manager	Jagorani Chakra, Fultola
Md. Enamul Hoque, District Manager	BRAC, Khulna
Md. Hasan Aref, Deputy Director	Jagorani Chakra, Jessore
Md. Jahangir, Center Manager	CARE Bangladesh, Benapole
Md. Masud Reza, Operations Researcher	ICDDR'B, Dhaka
Md. Rashidul Hasan, Project Manager	ACLAB, Jessore
Md. Sayeedur Rahman, Associate Team Leader	Padakhep Consortium, Dhaka
Md. Shah Alam Sardar, BHP	BRAC, Dhaka
Md. Shahnur Rahman, Center-in-charge	PIACT Bangladesh, Khulna

Md. Zillur Rahman, Add. SP	Bangladesh Police
Milon Kanti Barua, Program Head	BRAC, Dhaka
Mizanur Rahman Tota, Bureau Chief	Inquilab, Jessore
Mizanur Rahman, Center Manager-Treatment	Padakhep Consortium, Jessore
Mohammad Shakil Mansoor, Project Coordinator	IOM, Dhaka
Mohsin Millon, Upazila Correspondent	NTV, Benapole
Momtaz Khatun, Executive Director	Asroy, Khulna
Ms Bakul, Center Manager	Padakhep Consortium, Jessore
Ms. Mukti, Executive Director	Mukto Akash Bangladesh, Dhaka
Mukul Kanti Biswas, Program Officer	CARE Bangladesh, Dhaka
Nasimul Hoque Rony, Center Manager	KMSS, Khulna
Nazmul Ahsan, Chairperson	LOSAUK, Khulna
Nilufa Yesmin, Project Officer	ASARR, Khulna
Parvez Sazzad Mallick, Senior Advisor	GTZ, Dhaka
Pinaki Roy, Staff Correspondent	The Daily Star, Dhaka
Probhati M Costa, Program Officer	World Vision Bangladesh, Khulna
Professor Md. Nazrul Islam, Former VC	BBSMMU, Dhaka
Provash Ch Biswas, Project Manager	World Vision Bangladesh, Khulna
Rebeka Sultana	UNFPA, Dhaka
S K Zaman, Team Leader	RPDO Consortium, Dhaka
S M Habib, Staff Reporter	ATN Bangla, Khulna
S M Kamrujjaman Chunnu, Chairman	Jessore Municipality, Jessore
Sabina Yesmin, Regional Counselor	InHealth, Khulna
Safiqul Islam, Center Manager	SMC, Benapole
Shafiqul Haque, Program Officer	SMC, Khulna
Shahidul Islam Milon, Project Officer	RPDO, Jessore
Shaikh Golam Mostofa, Center-in-charge	PIACT Bangladesh, Khulna
Shamim Rabbani, Team Leader	Padakhep Consortium, Dhaka
Swapan Guha, Chief Executive	Rupantar, Khulna
Syed Ghulam Rahman, Medical Officer	Asroy, Khulna
Syed Taposh, Site Coordinator	UNDP, Jessore
Victor Mondal, Project Manager	The Salvation Army, Dhaka