OVERLOOKED!
LET'S KNOW THYSELF!

A qualitative study on Cultural Factors in Transmission, Prevention, Care and Treatment of HIV and AIDS in Bangladesh

United Nations
Educational, Scientific and
Cultural Organization

Dhaka Office

Tony Michael Gomes

2011

OVERLOOKED!
LET'S KNOW THYSELF!

A qualitative study on Cultural Factors in Transmission, Prevention, Care and Treatment of HIV and AIDS in Bangladesh

The opinions expressed in this document are the responsibility of the author and do not necessarily reflect the official position and views of UNESCO

United Nations
Educational, Scientific and
Cultural Organization

Dhaka Office

Tony Michael Gomes

2011

This study report is an attempt to identify the facts and factors behind our cultural and social dispositions that influence HIV infections with an objective to think out of the box and dig into issues which contribute to the epidemic in our daily urban and rural lifestyles. The study revealed with strong evidence that the people of Bangladesh value their traditional practices but increasingly yield to significant pressure of mixed western culture, and many of these traditions and practices have a bearing on sexual relations, and therefore HIV transmission.

Published by:
United Nations Educational, Scientific and Cultural Organization

UNESCO Dhaka Office

Published in:
June 2011
Dhaka, Bangladesh

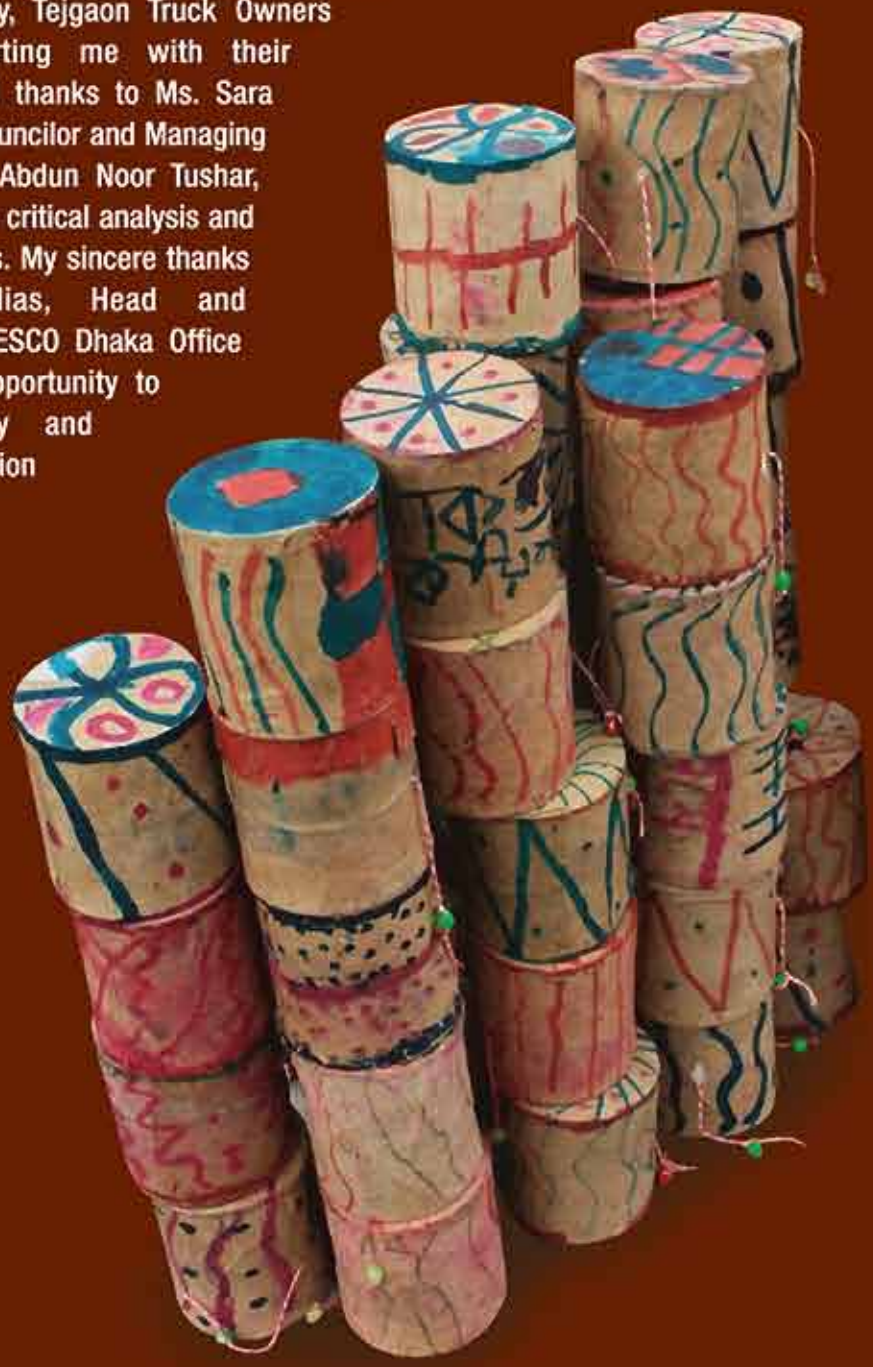
Concept and Photography
Tony Michael Gomes
Ashikur Rahman

ISBN: 978-984-33-3551-7

Copies available from
UNESCO Dhaka
House # 122, Road# 1, Block# F, Banani , Dhaka-1213, Bangladesh
E-mail: HYPERLINK "mailto:dhaka@unesco.org"dhaka@unesco.org
website: HYPERLINK "http://www.unescodhaka.org"www.unescodhaka.org

Acknowledgement

This report could not have been written without the guidance and oversight of Ms. Mahfuza Rahman, Project Officer, UNESCO Dhaka Office. I also extend my sincere gratitude to the people I have met during the study and organizations like Ashar Alo Society, Bangladesh Women Health Coalition, Organization of Development Program for the Under Privileged, American International University, University of Dhaka, Bandon - Cultural Youth Organization, Badda Rickshapuller Shomity, Tejgaon Truck Owners Shomity for supporting me with their members. My special thanks to Ms. Sara Zaker, Psychosocial Councilor and Managing Director, Asiatic and Abdun Noor Tushar, Media Analyst for their critical analysis and supportive suggestions. My sincere thanks to Mr. Derek Elias, Head and Representative of UNESCO Dhaka Office for giving me the opportunity to conduct this study and allowing this publication for dissemination.



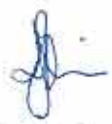
Foreword

Despite the success Bangladesh has witnessed in staying ahead of the AIDS epidemic, it becomes increasingly clear that there is no time for complacency nor rest. Bangladesh has a high prevalence of many behavioral patterns that are fueling the epidemic in other parts of the South Asian region. This study report is an attempt to identify the facts and factors behind our cultural and social dispositions that influence HIV infections with an objective to think out of the box and dig into issues which contribute to the epidemic in our daily urban and rural lifestyles. The study revealed with strong evidence that the people of Bangladesh value their traditional practices but increasingly yield to significant pressure of mixed western culture, and many of these traditions and practices have a bearing on sexual relations, and therefore HIV transmission.

Understanding and experiencing pubertal changes, and coping with such changes, youth are often influenced by social and environmental factors. In Bangladesh, sex and sexual health education are not included in the school curriculum. The majority of people have to depend on friends and peers for such information. National data indicates that as many as 22% of youth are engaged in premarital sex and less than one third of such sexual acts are protected by condoms. In addition to their easy access to sex workers and pornography, their low perceived risk for HIV and STIs and high levels of misconceptions regarding transmission and prevention of HIV, renders youth more vulnerable to acquisition and transmission of HIV and AIDS.

The study is expected to guide us in analyzing different cultural, social and behavioral contexts which have a direct contribution to risk factors of various "most at risk" populations, especially youths and adolescents which need to be addressed by the concerned officials as well as civil society. The results of the report will be useful for implementing HIV and AIDS and STI prevention and management projects targeting the various "most at risk" populations of Bangladesh.

I express on behalf of UNESCO Dhaka our gratitude to Mr. Tony Michael Gomes and his team for the dedication and commitment to carry out the study. I also wish to thank all the agencies and individuals who have contributed their valuable time, thoughts and hard work to make the study richer and more meaningful.

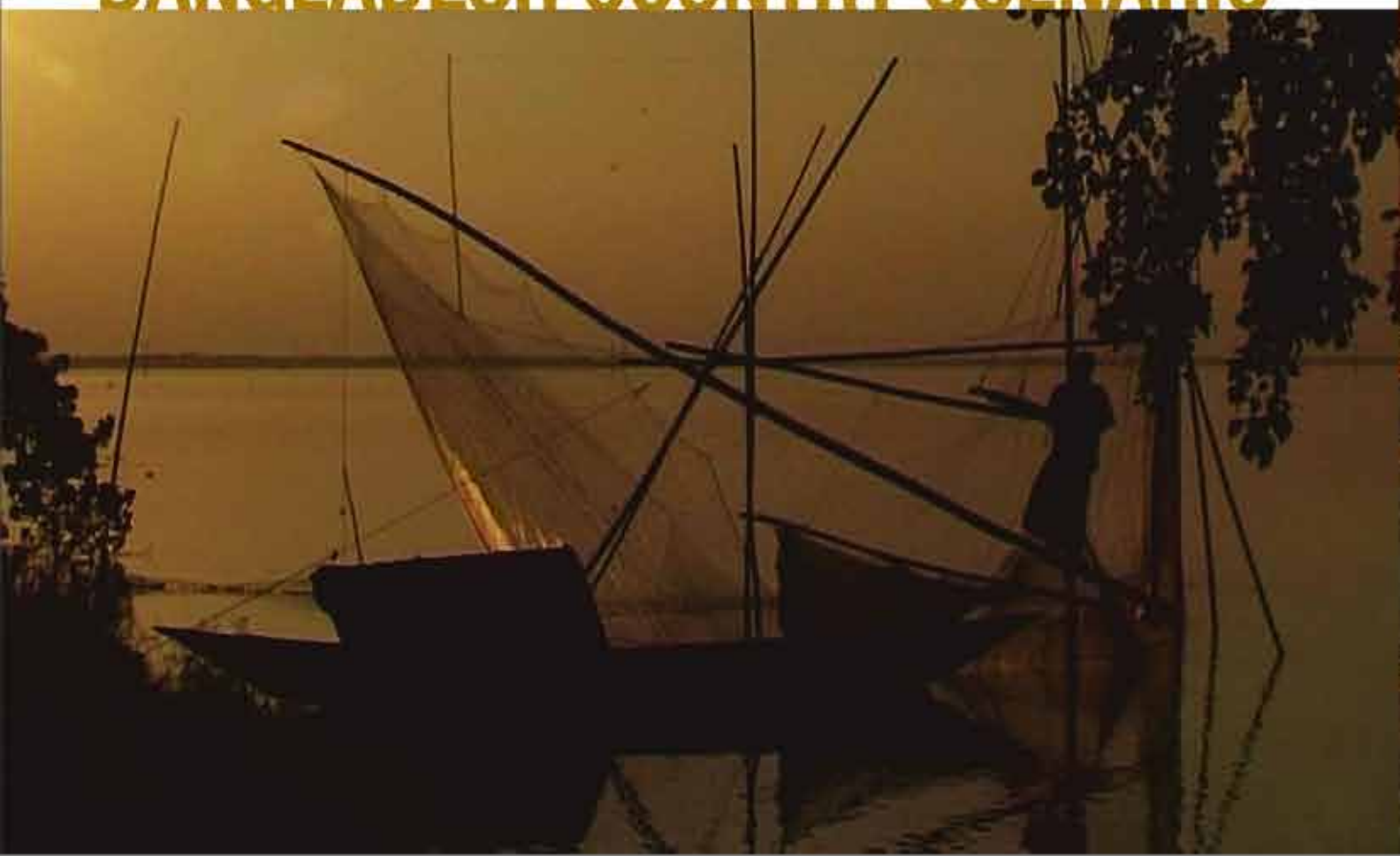


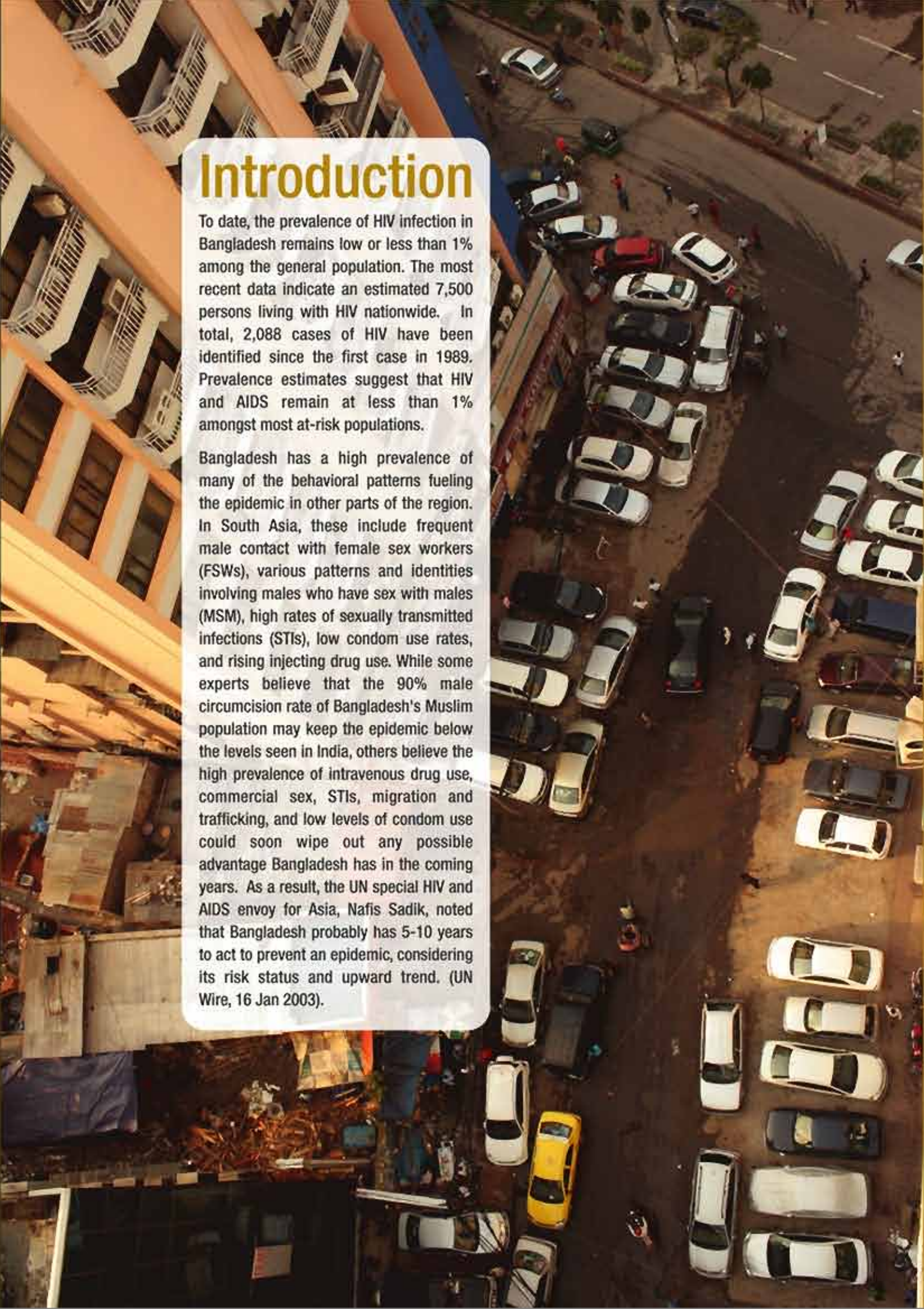
Derek Elias
Head and Representative
UNESCO Dhaka Office

Table of Content

Chapter 1

An overview of
BANGLADESH COUNTRY SCENARIO





Introduction

To date, the prevalence of HIV infection in Bangladesh remains low or less than 1% among the general population. The most recent data indicate an estimated 7,500 persons living with HIV nationwide. In total, 2,088 cases of HIV have been identified since the first case in 1989. Prevalence estimates suggest that HIV and AIDS remain at less than 1% amongst most at-risk populations.

Bangladesh has a high prevalence of many of the behavioral patterns fueling the epidemic in other parts of the region. In South Asia, these include frequent male contact with female sex workers (FSWs), various patterns and identities involving males who have sex with males (MSM), high rates of sexually transmitted infections (STIs), low condom use rates, and rising injecting drug use. While some experts believe that the 90% male circumcision rate of Bangladesh's Muslim population may keep the epidemic below the levels seen in India, others believe the high prevalence of intravenous drug use, commercial sex, STIs, migration and trafficking, and low levels of condom use could soon wipe out any possible advantage Bangladesh has in the coming years. As a result, the UN special HIV and AIDS envoy for Asia, Nafis Sadik, noted that Bangladesh probably has 5-10 years to act to prevent an epidemic, considering its risk status and upward trend. (UN Wire, 16 Jan 2003).

And now in 2011, the vast majority of documented HIV and AIDS cases in Bangladesh are the result of heterosexual intercourse. Transmission modes also include intravenous drug use (IDU), parent to child transmission (PMTCT), blood transfusion, and male to male intercourse; populations at greatest risk include sex workers, migrant workers, and IDU, as well as their family members. Surveillance of urban IDU in Dhaka City found HIV prevalence increased to 8% by 2006 from 1.4% six years prior, effectively creating an epicenter for the epidemic.

BANGLADESH	
Overall Profile:	
Population	164 million
Life expectancy at birth	67 years
Population living below poverty line	36%
Unemployment rate	5%
Women and Girls Profile:	
Average age at first marriage (female)	19 years
Modern contraceptive prevalence	48%
Maternal mortality ratio	570
HIV Profile:	
HIV prevalence (general)	< 0.1%
HIV prevalence (15-25 years)	< 0.1% (female) and < 0.1% (male)
Concentrated Epidemic	PWID > 7% in specific pockets of Dhaka City
Estimated Number of MARPs	PWID : FSW : 74,300 PLHA : 7,500
Number of People living with HIV	2,088
Number of People new Infected in 2011	343
Total Number of HIV infected people develop AIDS	231
Total Number AIDS death 2010	37
Total number ART receive	523

The first case of HIV in Bangladesh was detected in 1989. Even prior to this first case, the Government of Bangladesh had become active and formed the National AIDS Committee (NAC) in 1985 in anticipation of an epidemic. The NAC is a high-profile body with the President as Chief Patron and the Minister of Health and Family Welfare as the Chairperson. Since then, many programs have been created and expanded for HIV prevention which are being executed by innumerable nongovernmental organizations (NGOs). Second generation surveillance (UNAIDS/WHO, 2000) was installed to monitor the epidemic and several research studies and surveys have been carried out among Most At Risk Populations (MARPs) as well as the general population to better understand the situation in Bangladesh. Efforts have also been underway to model the future course of the epidemic. The responsibility for coordination of all these activities lies with the National AIDS/STD Program (NASP) which is under the Directorate General of Health Services (DGHS).

Purpose of this Study

This report is an attempt to identify the facts and factors of our cultural and social elements that influence HIV infections. The results of this report will be useful for the government, NGOs, and those who are implementing HIV, AIDS and STI prevention and management projects targeting different most at risk population (MARPs) of Bangladesh. The key objective of this study is to think out of the box and dig into issues which are socially and culturally dominating our daily urban and rural lifestyles. This study involves different categories of young people especially from urban and rural and semi rural settings who seem to be the driver of the current cultural and social changes.

More specifically the goals of this study are:

a) To identify and document the various social and cultural reasons which lead and increase the vulnerability of HIV infection, particularly within the community or country.

b) To identify and document the various cultural contexts of STI treatment and the treatment seeking behaviors of the client/partner group, particularly men.

C) To create evidence of cultural myths and misconceptions which exist within the community regarding Transmission, Prevention, Care, and Treatment of HIV and AIDS in Bangladesh.

This study proposal has been conceptualized and developed by the author of this report aiming to have UNESCO country support to document and analyze the key facts and factors that influence the overall socio-cultural contexts that make people vulnerable to HIV and STI infections. Also to look back to the cultural changes which have crystal clear impact on the traditional beliefs. Taking cultural approach means considering a population's characteristics - including lifestyles and beliefs. This is indispensable if behavior patterns are to be changed on a long-term basis, a vital condition for slowing down or for stopping the expansion of the epidemic.

The study revealed the strong evidence that the people of Bangladesh strongly value their traditional practices but may not hold it due to significant pressure and dominance of the mixed western culture and many of these traditions and practices have a bearing on sexual relations and therefore HIV transmission. However, the study did not provide any understanding as to why some cultural institutions such as marriage, religion, formal education do not have a positive impact to mitigate the overall vulnerability of AIDS. Such information, when available, would provide the basis for designing culturally relevant interventions to modify sexual behavior in the combat against HIV and AIDS.

This study aims at providing in-depth information on the inter-linkages between culture, tradition and HIV and AIDS regarding its spread, treatment and care. This is done for the family, the community and institutional levels. The intention of this initiative is to create a comprehensive analysis which will be widely available so that it can be used as a local and national strategy development tool to fight against AIDS.

Conceptual Context of the Problem

Though the concentrated epidemic is spreading among the Injecting drug users (IDUs) in few geographical pockets of the country but according to the identified cases of people living with HIV, the major mode of HIV infection is heterosexual transmission, accounting for about 70% of the cases. Sexual practices, within the family institution as well as outside the family have a lot to do with the culture of society and its traditions. Heterosexual behavior forms a major component of the problem. However the role of traditional culture and its impact on a rapidly changing society have not been well studied and documented in Bangladesh. Secondly, and as already observed in other part of the world, the AIDS epidemic in Bangladesh may be significantly depleting the most productive human resources, particularly those in the 13 - 40 age group. In this age-group, the female children of 13 - 20 years and boys/young men of 16 - 35 years are particularly vulnerable. These same groups are also at the centre of a dynamic culture, and their behavior is constantly responding to new sets of norms, values and beliefs. From this point of view, there is a need to study the inter-linkages between culture/ traditions and HIV and AIDS in Bangladesh.

Methodology

The main aim of this section is to describe the methodological issues in detail. This qualitative study employed a mixed method approach. During the first phase, secondary sources were critically reviewed. In other words, the review and compilation of existing documents and materials related to the inter linkage between culture and HIV and AIDS prevention and control, preceded actual field work. In the second part, in-depth interviews with selected persons representing different categories of the population were conducted to ascertain details of their experiences and observations related to culture and HIV and AIDS.

Literature Review

This phase has involved the collection of relevant literature on the interface between social and cultural factors and HIV and AIDS in Bangladesh. The literature was sourced from several resource centers whose collections are devoted to this topic. This included different research publications, journals, annual reports, small studies, and situational assessments and post evaluation studies. Most of the reading materials were collected from different national and international organizations including UN agencies. In addition, material was accessed through personal contact.

This qualitative study has been conducted from September 2010 to December 2010 in several locations around Dhaka, Shylet and Chittagong. A qualitative interview method was used with questions that were guided yet broad-ranging to minimally direct both the data collector and the respondent in identifying and sharing in-depth experiences and observations related to culture and HIV and AIDS.

Key Respondents:

a) Most at risk populations
   i. Female Sex Worker
   ii. Injecting Drug User
   iii. People Living with HIV and AIDS (male and female)
   iv. Male Having Sex with Males
   v. Client of Sex workers (Truckers, Rickshapullers, Small entrepreneurs)
b) College - University Youths
c) University Instructors
d) Civil Society Representatives
e) Film Makers
f) TV Celebrities
g) Journalists
h) HIV and AIDS Experts

Qualitative data collection:

- Consultation meeting with the HIV experts as well as cultural experts to discuss the methodology parts and getting suggestions for reading materials and existing information.
- A semi-structured questionaire has been used to take the in-depth interviews of the participants. It was used in order to conduct interview individually.
- An FGD guideline questionaire was developed and introduced to the groups through the topic for discussion with the most at risk populations, client of sex workers and youth populations. Probing questions were spontaneously asked by the facilitators for more in-depth information.

FGDs

Participating Groups	Number of FGDs
Female Sex Worker	3
Injecting Drug User	1
People Living with HIV and AIDS (male and female)	4
Male Having Sex with Males	1
Client of Sex Workers (Truckers, Rickshawpullers, Small entrepreneurs)	3
College - University Youths	4
Total	16

IDIs

Participating Groups	Number of IDIs
Female Sex Worker	4
PLHA	4
College - University youths	5
University Instructors	2
Civil Society Representatives	3
NGO Workers	3
Film Makers	2
TV Celebrities	4
Journalists	2
HIV and AIDS Experts	4

Limitation of the Study:

This qualitative study ends with limited sample size and still believes that it may have opened the window but may not allow total access to the sky. It's quite difficult and a risky matter to analyze culture of a country having a thousand years of historical cultural, social and religious background.

Relating culture with HIV and AIDS together, this study didn't allow us to uncover more on blood transmission and other modes of transmission but purely focused on sex and sexuality issues.

In the literature review art we have gone through lots of documents, reports and surveillance but there are studies on risky behaviors, for example, that do not analyze and provide knowledge as to why an individual should take risks in activities which can lead to death and or total eradication of a family. Again this study may not help you to have the answer.

Chapter 2

DEFINING MOST at RISK POPULATIONS (MARPs)

Fortunately, in Bangladesh, surveillance has been in place since 1998 and multiple studies have been conducted that allow for the identification of MARPs and their specific vulnerabilities to HIV. The data are consistent with the three main MARPs common to the Asian model of the epidemic: drug users, female sex workers and males who have sex with males (MSM). At the same time, ongoing assessments by different organizations are identifying new groups (Client of sex worker, Migrant worker, Youths etc) that may have particular vulnerability.

This chapter aims to give a general view regarding MARPS along with specific definitions and vulnerabilities.

Female Sex Worker (FSW)

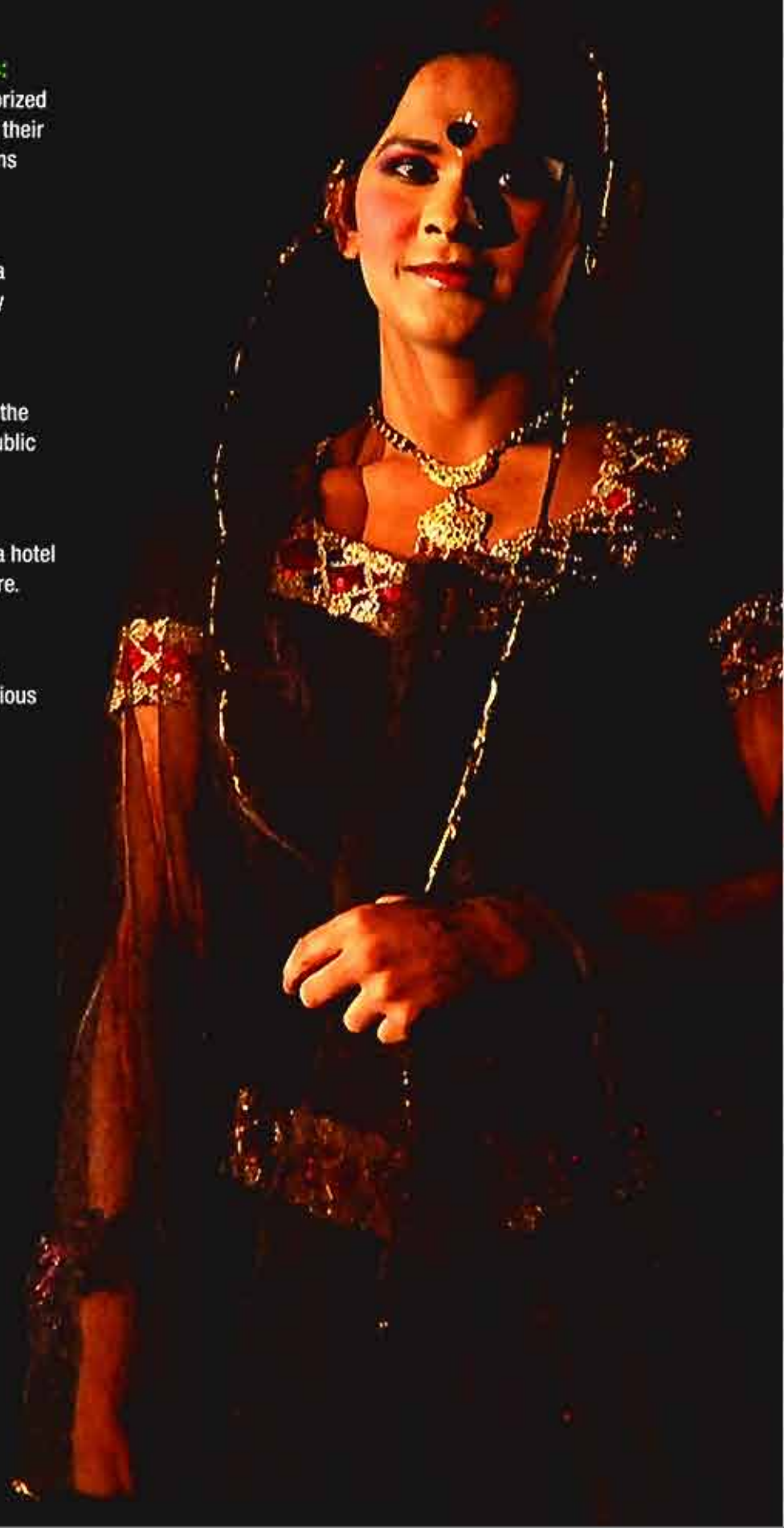
Definitions of female sex workers:
Generally, female sex workers are categorized based on the venues where they contact their clients and where they sell sex. Definitions used in surveillance are shown below.

Brothel based sex workers:
Those who were contacted by clients in a brothel setting, with the sex act generally taking place in brothels.

Street based sex workers:
Those who were contacted by clients on the street, with the sex act taking place in public spaces or other venues.

Hotel based sex workers:
Those who were contacted by clients in a hotel setting, with the sex act taking place there.

Casual sex workers:
Those who were selling sex either in the street, residence or hotel during the previous month and had either one or more main sources of income.



Female Sex Workers (FSWs) were originally organized in hierarchical brothels in Bangladesh, but increasingly are dispersing to hotels, residences and perhaps other locales. In 1998, there were 18 registered brothels in the country but by 2000, some of these were closed by government authorities, largely due to the "spotlight effect" of HIV and AIDS intervention efforts. Gradually there has been a shift in the mode of operation of sex work in the country to street-based, lodging house or hotel-based and residence-based, with an increase in violence and stigma-driven harassment against FSWs (Jenkins & Rahman, 2002). This new form of sex work has taken control away from some of the traditional structures run by madams, pimps, with the involvement of local authorities and police. One implication of this decentralization of commercial sex work is the increased difficultly in accessing and organizing floating sex workers for health and other interventions.

Risk behaviors

Female sex workers' risk behaviors can be disaggregated as follows:

- Brothel-based FSWs have an average of 16 clients per week and street-based FSWs have between 8 and 11 clients per week. Hotel-based FSWs have an average of 40-70 clients in a week. These estimates are generally lower than observed in previous rounds, but still represent a high level of risk for HIV infection among FSWs and their partners.
- FSWs report significant events of group sex in the previous month (vaginal/anal/oral).
- Condom use among FSWs is the lowest in Asia (see Figure 2, below): only 2% for brothel and street-based and 4% for hotel-based (4th Round NHBS).
- There seems to be little correlation between use of condoms and condom access.

Associated with these HIV related risk factors for FSWs is the continued prevalence of active syphilis among street and hotel-based sex workers, ranging from 3% to 12% across sentinel sites. This prevalence serves as an indicator for the potential spread of HIV infection due to behavioral risk. In addition, the transmission of HIV can be amplified in the presence of other untreated STDs, such as active syphilis.

Injecting Drug User (IDU)

In Bangladesh, the discourse on HIV related to drug misuse is restricted to smoking or inhaling and injecting of opiate and opioid drugs. Various definitions have been used to distinguish smokers from injectors and even the definitions used in serological and behavioral surveillance vary as shown below:

Injecting drug users:

Those who injected drugs within last two months and were accessible through public injecting spots.

Heroin smokers:

Those who were primarily heroin smokers and had not injected more than six times in the previous six months.

HIV infection in drug users

Serological surveillance for HIV, hepatitis C (HCV) and syphilis has been conducted regularly among drug users, especially among IDUs, since 1998. During the 8th round of serological surveillance conducted in 2007, a total of 6,508 drug users were sampled from 28 different cities amongst whom the overall prevalence of HIV was 1.2%. HIV was detected in drug users from six cities (Figure 1); HIV prevalence was very low in all cities other than in Dhaka where the rate has gradually increased among male IDUs over the years. This group, which has been sampled through the needle/syringe programme (NSP) since 1999-2000, has consistently had the highest HIV rates among any population group in Bangladesh. A concentrated epidemic was first recorded in this group in 2006 (7%).

40000 PEOPLE ARE IDU NOW!

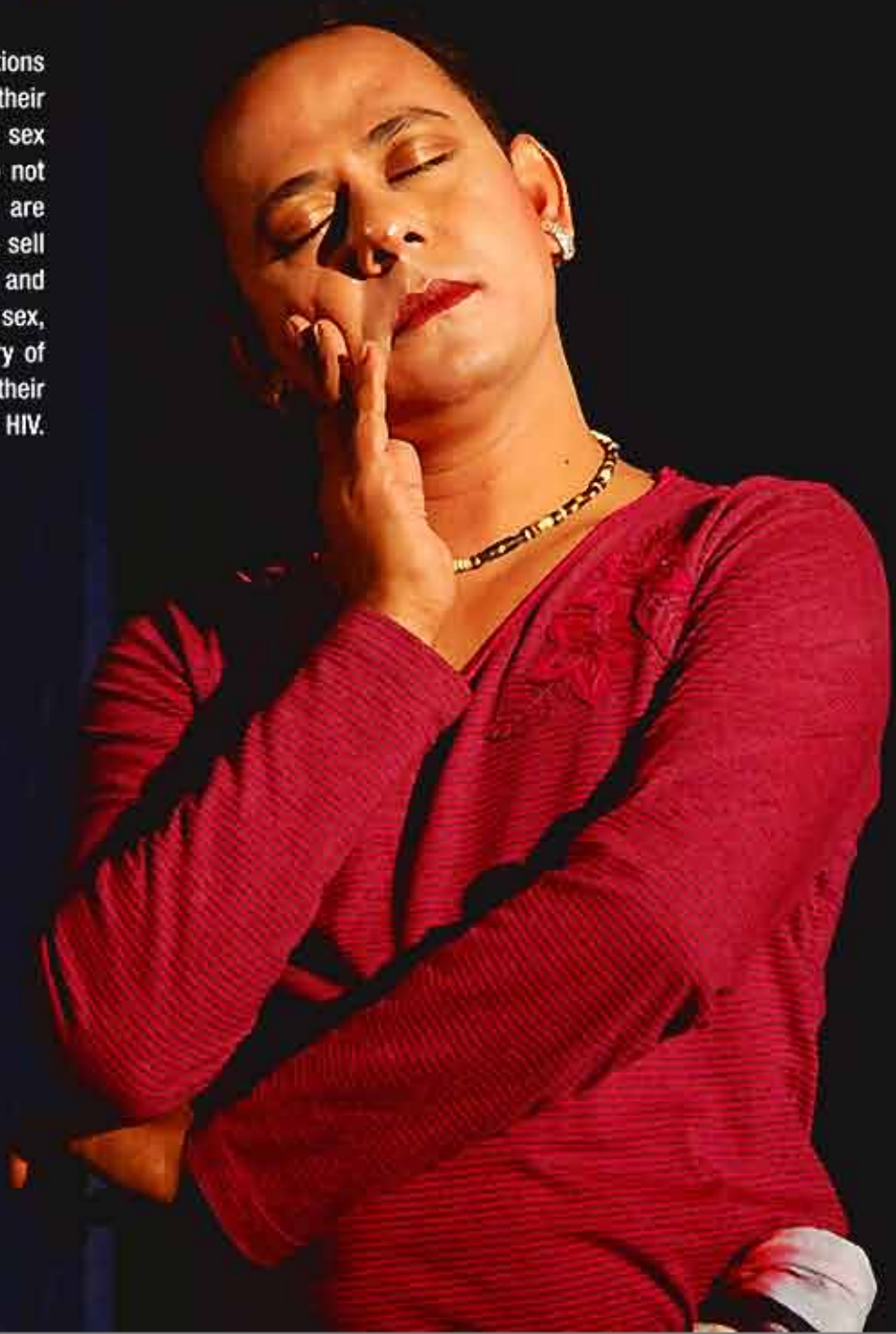
Risk Behaviors:

- Cost sharing ensuring needle sharing among most of the injecting drug users. Most of the cases drug users are purchasing drugs with group contribution. Therefore, IDUs share their drug and feeling together using one syringe.
- Drug use often begins during adolescence, with a mean age of 15 years for those starting to use drugs (nicotine, alcohol, cannabis, phensedyl).
- Heroin use generally begins later, with heroin users reporting a mean age of 24 years when they began smoking heroin.
- Many individuals transition from less harmful to more harmful drug using behaviors, with 10 to 20% of drug users start to inject each year (4th Round NHBS).
- 87% of current IDUs had been heroin smokers where there are always scopes for interchanges of groups depending on the availability of drugs.

Male Having Sex with Males (MSM)

Definitions of males who have sex with males

MSM comprise at least two populations that are quite different in terms of their behaviors and risks, namely male sex workers (MSW), and MSM who do not sell sex. Among all males who are involved in male to male sex, some sell sex and some do not, some buy sex and some do not. Among MSM who sell sex, where possible a separate category of MSW may be identified because of their greater risk for and vulnerability to HIV.



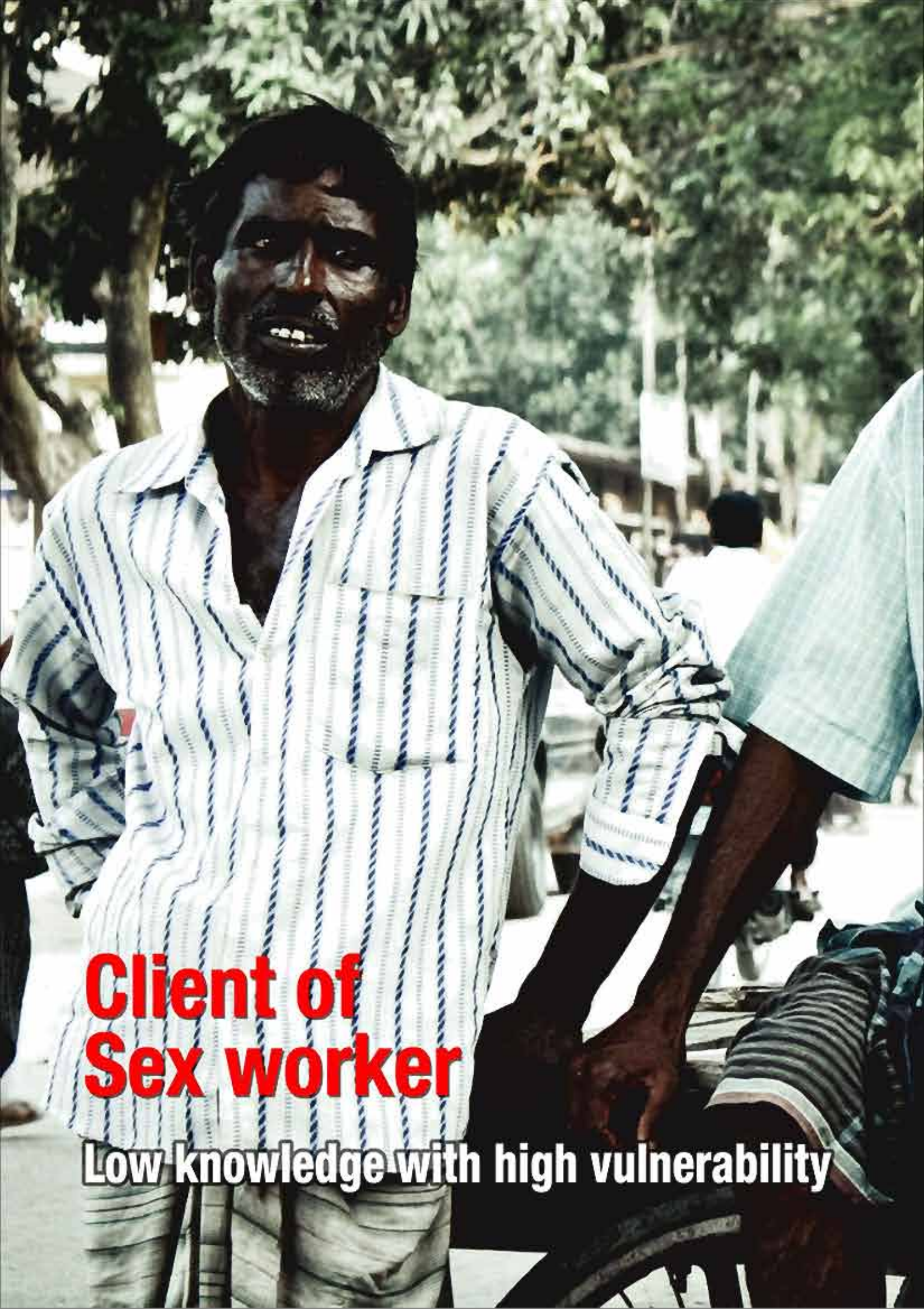
Male sex workers:

Males who are selling sex to other males

Non-sex workers:

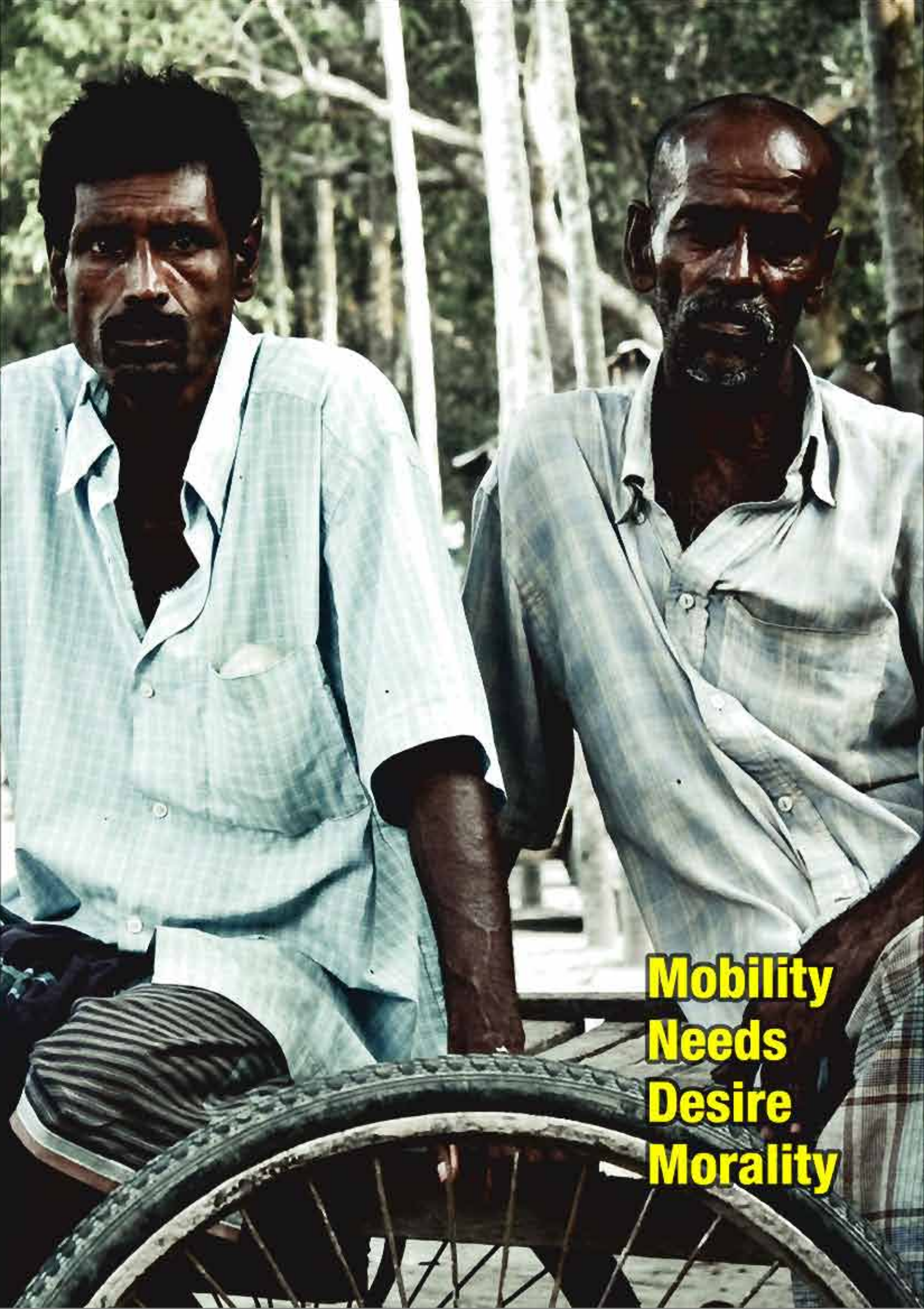
Males who had male sex partners but did not sell sex

- 'Kothi' - feminized males who prefer to be receptive partners and often play the part of 'female' in their emotional, physical and social interactions with other males-some cross dress or use feminine make up.
- 'Panthi' - usually insertive "manly" partners and most often the sex partners of kothi.
- 'Parik' - the male lovers of kothi; all parik are panthi, but not all panthi are parik.
- 'Do-parata' - they can act both as insertive and receptive partners based on the demand of their partners, irrespective of their own preferences.
- 'Gays' - similar to westernized homosexuals, engaging in emotional and sexual relationships with other men, but do not like to be categorized as MSM (Rouf, 2007).
- 'Bisexual' - have sex with both men and women. In Bangladesh, as in many other countries, the majority of MSM do not call themselves "gay" and their male to male sexual behaviour is hidden especially from their families and close friends. Like gays, bisexual men, also object to the term "MSM" (Rouf, 2007).



Client of Sex worker

Low knowledge with high vulnerability


Mobility
Needs
Desire
Morality

Male Client of Female Sex Worker

Regular non-commercial client of Sex worker

According to the recent report, most women who will become infected with HIV will have been exposed to HIV during sex with a husband or boyfriend who had been infected during paid sex or when injecting drugs (Commission on AIDS in Asia, 2008). The report also highlights the importance of male clients of female sex workers in driving the epidemic. The number of men who buy sex and the frequency with which they do so are key factors related to the development of an epidemic. Thus, understanding and addressing the needs and behaviors of sexual partners of MARPs is extremely important for HIV prevention programs. To date, only a few research studies have been conducted in Bangladesh to address such partners. These findings are brought together in this section.

Male Sex Partners of Female Sex Workers

Female sex workers have two types of sexual partners, their clients and their regular, non-commercial sex partners. They are both discussed below.

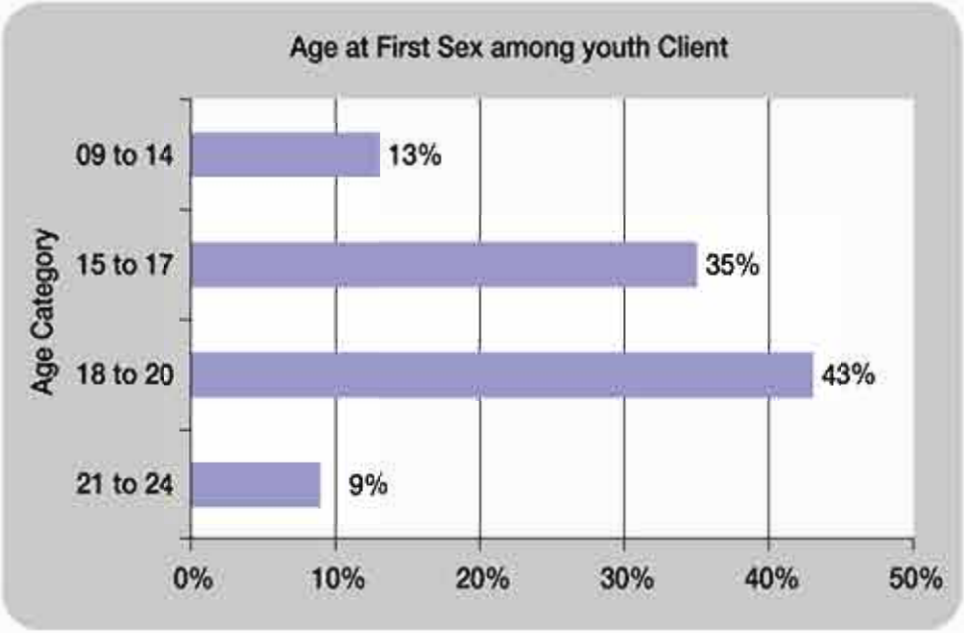
Clients of female sex workers

A nationally representative sample of males aged 18-49 years showed that approximately 10% of adult men in Bangladesh bought sex from sex workers in the last year (Chowdhury et al., 2006); such proportions are comparable to figures available from many countries in the region (Carael, Slaymaker, Lyerla, & Sarkar, 2006). Reaching clients of sex workers is challenging and in three separate surveys conducted with male clients of female sex workers have provided some insight into their behaviors, infection relevance rates and have allowed triangulation with data obtained from female sex workers.

Youth Male clients of female sex workers (Findings from Survey among the Youths)

Youth client survey conducted for phase 1 of GFATM round 2 (National AIDS/STD Program & Save the Children USA, 2007). 1,013 youth aged 15-24 years, visiting female sex workers in nine hotels in Dhaka were surveyed. Among the nine hotels, six were under HIV intervention programs while the other three were not. All youth clients visiting the selected hotels for buying sex were enrolled if they consented to interviews and provided a blood and urine sample after the sex act. Laboratory tests for STIs (N. gonorrhea, C. trachomatis, T. vaginalis, syphilis and herpes simplex virus 2 [HSV2]) were conducted. Qualitative in-depth interviews were also conducted with clients.

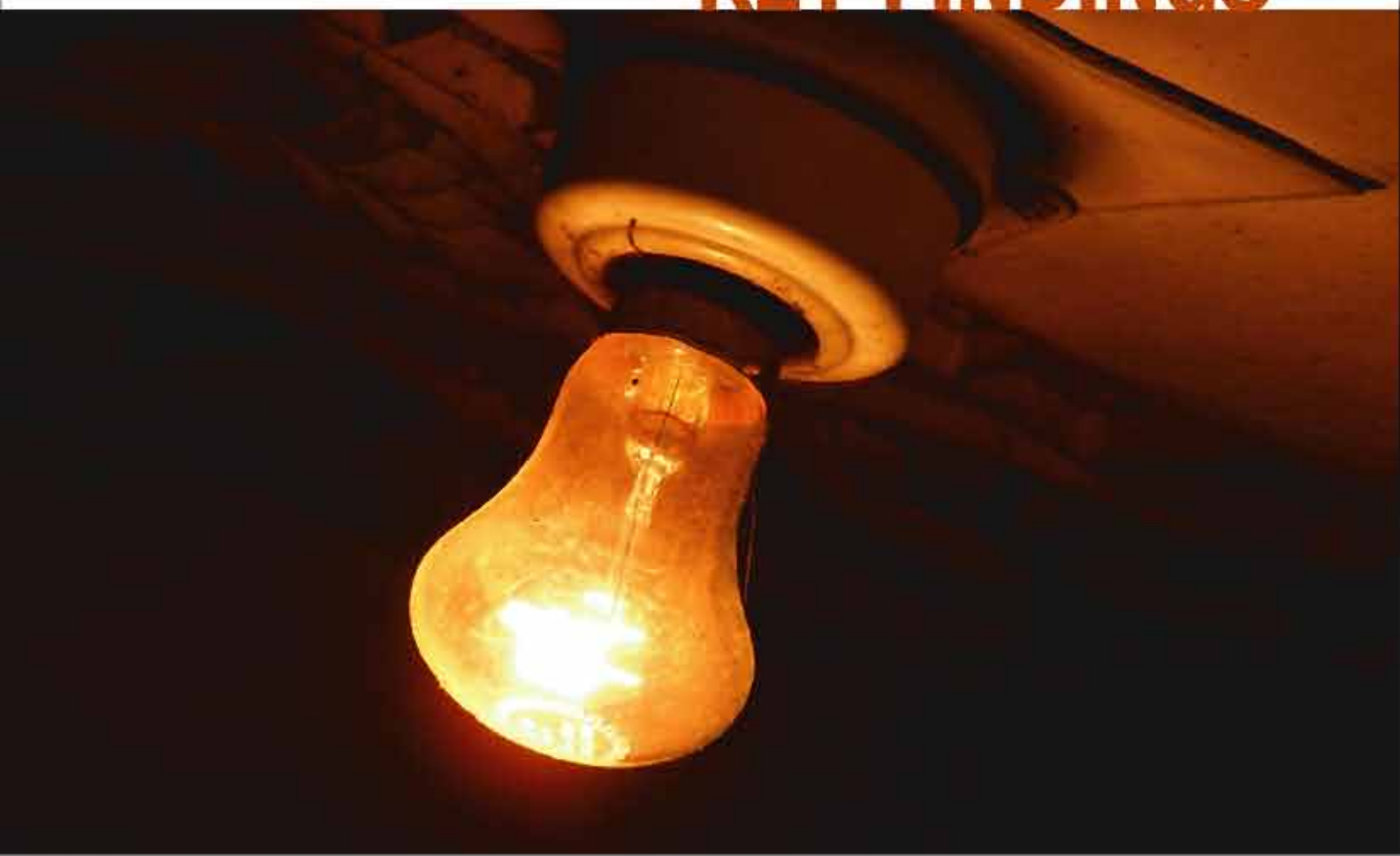
Some socio-demographic characteristics of clients differ depending on the venue where sex is purchased. Notably, close to half of the clients of street based sex workers were below 25 years of age, compared to just 30% of clients in brothels and hotels. Most had less than 10 years of schooling and very few earned more than Taka 10,000 a month, except among clients in hotels.



According to the "National survey on social, behavioral and biomedical risk factors adolescent and youth clients of female sew worker", approximately half of the respondents had their first sexual exposure before the age of 18 years. Female sex workers (46%) were the single most common sex partner in such exposures. More than one third of youth in the survey had their first sexual experience in hotels, but almost half of the first sexual exposures took place in respondents' own house or the house of someone known to the respondent. More than 80% of the respondents reported that their first sexual exposure was influenced by peers or friends and peers or friends accompanied them during such exposure. Around 7% of the respondents enrolled in the survey have never visited a sex worker. Most of the respondents (92.1%) preferred hotels for sex acts in last one year. The risk of STIs and HIV and AIDS acquisition increases with the number of unprotected sexual encounters with susceptible partners and attempts were made to estimate the proportion of youth who are part of the core group that visits sex workers frequently. More than 45% of the youth reported that they visit hotels at least once in a month. Around two thirds of the respondents reported that they buy sex from FSWs in hotels as they feel hotels are confidential and safe for sex.

Chapter 3

KEY FINDINGS



Reasons behind having a Sex driven Society

Socio-Cultural Fact and Factors

The thrust of the inquiry was to ask each key informant about norms, values, beliefs and practices) closely associated with sexual behavior and ascertain to what extent these have been modified over time and explore the implications of these changes for HIV spread and care for AIDS patients. Interaction with the key informants was organized around Six themes:

- Culture of Bangladesh and the trends of changes
- Reasons behind cultural changes that makes society vulnerable
- Specific beliefs and perception of multiple sexual partners (either concurrently or serially)
- Acquisition of knowledge about sex (sources, quality of information)
- Treatment seeking behavior
- Perception and ethical perspective regarding pre and extra marital relationships.

This chapter is going to critically analyze and describe the results that have come out as key findings of the study. This chapter is going to start with the very basic brief note on the basic identity of our Bangla culture and its outlook that has been easily perceived and describe by the respondent of this study. This document tried to make this chapter as same as possible with respondents responses.

The Cultural Identity of Bangladesh

Since her independence, Bangladesh, as a country, has a very strong cultural background and heritage. Bangladeshis are proud to be sons of this soil and always have an intention to promote Bangladeshi culture. Bangla culture has a very strong and influential power that leads specific traditional events, behavior, and social bonds. The culture as a whole is quite unique and well recognized in any other part of the world. This Bangla culture includes colorful dresses, foods, events, literature, social attitude of hospitality and above all a country of secularism with high level of practicing religious values and norms. It's quite difficult to segregate and define the culture from its population's personal religious values and norms but it says that it's a complete blending of Bangali values with religious norms.

There was a believe that due to the above mentioned facts and factors Bangladeshis may not be under threat for the epidemic of HIV and AIDS or any other Sexually transmitted diseases. But previous chapters described the existence of the HIV virus and its rapid transmission in Bangladesh.

Defining each of these elements of culture in relation to sex and sexuality creates a complicated trend of cultural changes which has never been observed and or documented in any way. The traditional dress of Bangla culture is quite attractive for both male and female in terms of representing their personality representing the hard working population of Bangladesh. Dresses like Lungi, Fatua, Kurta, Payjama, Panjabi, Shirts and Pants commonly represent the personality of Male. Similarly Shari and Kamiz along with traditional jewelries beautifully express the internal beauty and innocence of a Bangali woman. Though Bangladesh is a secular country, having a harmony between Hindus, Muslims, Buddhists and Christians, people are very religious and sincere enough to practice their religion maintaining norms and values. These religious values also nurtured the overall social bonds, mutual respect and sharing. People used to have an institutional basis from the religious institutions as well as from the traditional schooling system. Philosophy, ethics and Socio-Cultural norms has been transformed from generation to generation through these cultural, religious and educational institutions where sex and sexuality was considered as a topic not to be discussed openly.

Impact of Capitalism-Corporate dominance in interpersonal choices

All the educated respondents were asked to define major cultural factors that influence sex and sexuality and related ethics, values and practices and most of the respondents described that the surface of our Bangla culture is being highly affected which has also caused a massive change in the internal beliefs of urban lifestyles. Respondents expressed that silently the socio-cultural context of this subcontinent has been changed due to a transition to postmodernism with the dominance of capitalism.

The impact of capitalism on culture and society has been a matter of great debate ever since its emergence in Europe as an economic system in the late 1700s. The impact of capitalism on culture and society is an issue that really stands apart from all of the other socio-economic concerns.

In many ways, the cultural impacts of capitalism overshadow all other considerations of the system. It is capitalism's impact on society that has shaped Western Civilization for the past 200 years.

Discussing the impact of capitalism on culture can be difficult. In what way is "capitalism" responsible for a given aspect of culture? Indeed can any aspect of culture be a product of "capitalism"? Yes, certain aspects of culture and society can be said to be products of "capitalism", but defining how and why something is said to be a product of capitalism is very important.

Some of the key concepts relating to an analysis of the effects of capitalism on culture are profit motive, commodity, human desire, and the market economy. The capitalist system is based on private ownership and consolidation of the means of production, where the production of commodities is guided by profit motive to satisfy human desires.

"It's nothing but capitalism that teaches us that to be smart it's important to look sexually attractive and ethically flexible. Because it always creates Desire" - 24 year old university student (female). Most of the urban youths believe that this pressure of capitalism is one of the major cultural causes that influence premarital relationships, physical relationships and unsafe sex which make youths vulnerable to HIV and AIDS and other sexual complications.

Simultaneously managing frustration, psychological desire, mental stress drug use has come up as a solution in style. In most of the cases alcohol has identified as one of the easiest choices for rural and urban youths. Starting with cigarettes youth often try to experiment other inhaling drugs which they have identified as COOL as well as a part of style and fashion for creative work.

Marketing of Products through Sexual Sensation

Traditionally, many religions have developed as efforts to limit the overloading of natural desire mechanisms. What the capitalist system does is it provides a profit motive for sellers to exploit human desires for personal gain? The unleashing and deepening of human passion and desire creates demand, and that demand moves products off the shelf to satisfy those wants, thus creating profits for sellers.

The commercialization of sexuality, since sex is a fundamental human desire, is a primary result of the capitalist market system. Sexuality is marketed directly, but sexual cues are also heavily associated with non-sexual products in capitalist market cultures as well. By associating sexual cues with products, such as for perfume, male shaving cream, garments products, and even extremely male products for example, the biological desire triggers are stimulated.

The marketing of sexuality to teenagers is perhaps one of the most controversial products of the capitalist system. Because sex is one of the most primal and strongest forms of desire, sexuality is one of the most effective marking tools, and a highly sexually active culture is a culture more open to overall consumerism, and thus a highly sexually charged culture is encouraged by capitalism. These trends of cultural changes are highly admitted by all most all the youth respondents (urban). Most of the respondents have identified and explained that commercialization of sexuality through different products, entertainment and fashion is one of the key reasons to create accelerated sexual desire which the generation could not control and/or may not learnt to control. They believe this is something that needs to be managed through a learning process.

During puberty, people are particularly strongly impacted by sexual marketing and this encourages sellers in a market system to target preteens and teens with highly sexual media. This is not just in the context of advertisements, but all media, including music, movies, books and stories, etc. Increasing sexual branding increases overall consumerism. Now in Bangladesh, even the health products and services are also branded with a sensational mood. Keep your body fit with our product! It makes you sexy! Interestingly all these commercials use the word "Sexy" intentional rather than using healthy.

The study has given options to the respondents to analyze the reason behind this marketing strategy even in family products and interestingly some of the respondent analysed that within the family the key decision makers for any purchase is male. And men are always considered smarter and more knowledgeable enough about any products than women. On the other hand the economical power structure gives the leading position with the rights of decision making. As a result the culture of our corporate industry has been changed and habituated with Sensational Brandings of products.

This factor has been identified as one of the key factors that influenced our new generations' perspective regarding sex-sexuality and its misleading effects upon different groups.

Capitalistic Society Created a Culture of Sexual Desire

In addition to promoting a culture of work, capitalism also promotes a culture of desire.

The marketplace is effectively limited by how much people want. This leads to a natural tendency in a market system for the sellers in the system to work to increase human desire, leading to the creation of more and stronger wants, and thus expanding the market.

While marketing is the most direct expression of this phenomenon, it really pervades the entire culture and is reflected in general entertainment, personal attitudes, religious values, the education system and government policy.

The development of the culture of desire created by market capitalism has actually been one of the biggest, if not the biggest, change in Bangladeshi society since the birth of the country. Many senior Bangladeshis still believe we are a culturally sensitive society which has barriers in exposing sexual information, messages regarding condom and family planning. But in practical cases we the society have been changed a lot and receiving the culture of capitalism and also receptive to culture dominated by sensational sexual appearances.

Most of the respondents aged above 35 years expressed their views that from the early childhood there was no scope of discussing sex and sexuality issues even if with all the class mates. The total issues of puberty during the adolescent period were full of fears without any constructive advice from neither family members nor from educational or health institutions. The total factors of puberty were a real challenge for all adolescents to understand and manager their sexual and reproductive health. But now taking the hand of capitalism Sanitary Napkin has different brands to attract the consumer. It means sexual health is no longer a hidden issue for modern generation.

Defining the cultural difference most of the respondents highlighted that up to mid 80's people were conservative enough to keep their sexual needs and desires hidden. But slowly the country's culture has changed in a drastic way along with the availability of information technology.

Portrayal of "WOMEN" as a "Product"

"Women in Media - Equal participation vs Women as a Product" has been a prolong debate among the FGD participants. It has been identified that in this south Asian region a common trend in marketing strategy has been introduced and accepted that women are being portrayed as a product. It is not at all the product but what the clients actually see are the sexy model of the advertisement and her appearance. All most all the respondents of the study expressed their views that right now media is promoting this strategy in every single opportunity they have in hand. In every form of marketing in media, women are portrayed as a product. This "Product" is not for sale but it catches the client on behalf of the real product.

In entertainment the situation is almost the same. Some people may differ with the critical perspective of this analysis but it has came up as a significant feedback from the male respondent that in our entertainment media now females are used as a product for attraction and it is not really reflecting women empowerment or equal participation of women. There are lots of TV shows where women are misused and/or overused just because of creating sensational presentation. Some of the respondents have made this comment that in our entertainment women need not to be qualified for her task (Specially in hosting TV shows, announcements) but she must have an attractive face along with appealing figure.

Simultaneously, all most all male respondents expressed their views that portrait of women in TV commercials, Billboards, posters, leaflets and magazines are very much purposive and mass people may like those materials but don't respect those women who have been used as a product. Respondents have identified that using female models along with any product made that sexually attractive for male consumers.

"Corporations are using beautiful sexy models in their advertisements. They may not know that clients are more interested to buy and use those models rather than their products" - Humayn Azad"

Dominance of Sexual Sensation in Film and Media

Respondents expressed that the current trends of entertainment industry is extremely dominated by sexual sensations. Respondents from the clients of sex workers group (truckers, rickshawpullers and small entrepreneurs) said that they like hindi films just because of its songs, visualization of songs and of course the erotic Item Songs. It's clearly understandable that the current trends are dominated by Indian film which is running to catch Hollywood. This competition of changing the originality has a direct impact on the entertainment industry. Respondents from urban settings clearly mentioned that now our film and media are under strong pressure of sky culture and we are almost forgetting our originality.

It's been mentioned by some of the media personalities that our film industry is suffering from unexpected pornography, erotic sequences which have been called as "CUT Piece". But if we critically analyze, we may understand that the total entertainment industry was suffering during the late 80's and the key target audiences of our Bangla film was none but the low income groups where sex is the only way of entertainment. The producers have to come up with their investments and for that they had to go through Cut Pieces.

The basic cause was the desire that has been created by Indian Films and the local video library who were promoting pornography. Respondents have identified that films and TV dramas are promoting few common factors which have a clear impact on our culture:

- Females wearing over exposed dresses regardless of their character in the story
- Item Songs (erotic Songs)
- Extra large Rape Sequences
- Promotion of Pre and Extra Marital Relationships
- Promotion of sex as a result of love and it is justified
- Promotion of sex as a give and take matter to achieve something
- Losing virginity is not a big deal

The very witty example has come up from an in-depth interview with a film maker which quickly describes the paradigm shift of our society. Up to late 90's in a rape sequence the common dialog of the heroine attacked by a villain that "I will kill my self but will not let you take my virginity". But now in the same sequence we enjoy the dialogue "You can only have my body but not my soul".

Many of the respondents described how pornographic films influenced them to visit sex workers. Viewing pornography aroused their sexual desire, they searched for ways to fulfill the desire, and friends helped them to fulfill their desires. One respondent said:

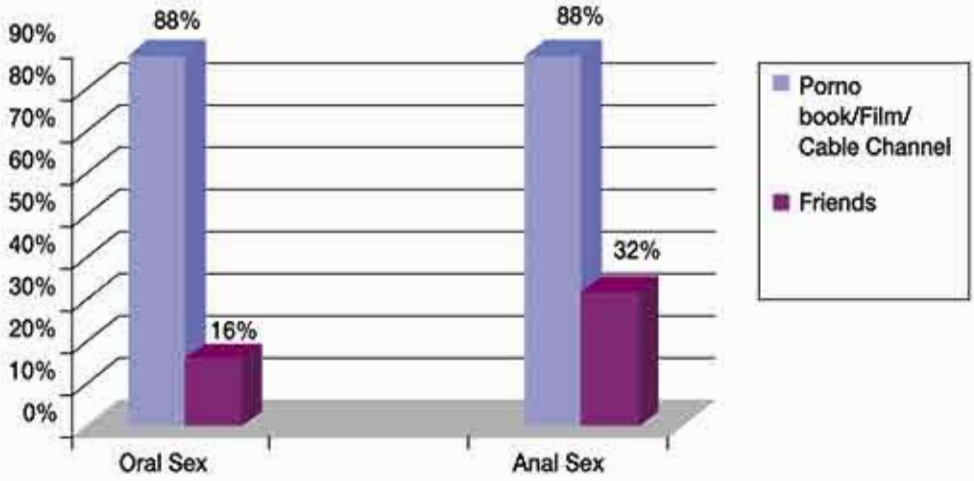
"One day four of my friends were watching a porno-film (3x) ... we became extremely crazy...(matha-mutha kharap haiya gache), ... we came out on the road. We knew from a senior friend that sex girls are available at streets ...then we reached the main road, we saw a street sex worker then we managed her by 10 Taka and I experienced my first sex..." (A respondent's first sex with FSW at the age 13)

Some of the respondents expressed the inverse analysis. Respondents said that Film and media are the mirror of the society. Therefore, we can understand our social changes by analyzing our media approaches. Respondents came with a common example of the film "Bachelor" where the extra and pre marital relationships were highlighted in a way that it has been already adapted by the society. The film was a blockbuster which means that the people of urban settings have accepted that story as their own. As a follow up the director Sarwar Faruki came up with his next one titled "Third Person Singular Number" where the story was nothing but a typical journey of a woman who faces several indecent proposals for sexual relationships from different age groups. This film has a sequence where one of her boy friends who helped her lot for her social settlement and job was buying condoms from a shop, and preparing his room to have sex. Respondents from university students have expressed that this is the recent reflection of our society and these are real facts. The film maker was interviewed through this study and also expressed the same views that the film has correctly reflected the social characteristics of male dominated society where sex is nothing but an opportunity and everyone is looking for a chance. Finally the debate stuck to the point that whether Film exploits the society or reflects the society. But this study got a common finding from this discussion that now the entertainment industry is suffering from the dominance of sexual sensation which leads generations to of loose their own values, culture and making them behave in a risky manner.

Porno Books, Magazine and Films are the source of sex education:

Most of the youth respondent said that Porno books, magazines films are the main information source of sex and sexuality related information and exposure. Most of the youths of urban are in some way exposed to these porno books and films. Even now private cable channels are also one of the key sources of sexual exploration. Youths of rural settings does not have frequent access to porno films but has access to porno magazines and books.

Source of Information about different sexial Practices



According to the national survey* a significant percentage of youth are well exposed to these materials and consider those as their basic information source on sex and sexuality. The data shows that 88% youths learn about different sexual practice like ORAL sex and ANAL sex from porno books, magazines and films. And some of them are also learning from their friends unfortunately who are also equipped with wrong information and practices. It clearly indicate that lack of proper information, education initiatives leading youths to wrong message and information and also considering pornography as a education material.

** "National survey on social, behavioral and biomedical risk factors adolescent and youth clients of female sew worker"*

Multimedia Cell Phone an open, easy access to pornography

Most of the respondents identified Multimedia Cell Phone as the key element of an open, easy access to pornography. This Multimedia phone includes facilities of still picture and video recording and projection facilities. Through these facilities people can record and share videos. Also people can have clippings of video files. Therefore, whenever they wish to enjoy video clippings they can enjoy. Nowadays, cell phone is recognized as a major instrument for communication and information. Using this multimedia phone technology young generations are recording their hidden lifestyle, sexual activities. Also people are having porno clips in these cell phones and enjoying their desires whenever however they want. It has reduced the pain of organizing videos, private rooms and televisions to enjoy pornography which was a practice even in early 90's. Multimedia phone offers the facility of sharing data through infrared and Bluetooth facilities from one cell phone

to another which allows the user to share videos and pictures. Therefore, cell phone pornography is quite easy to collect and share.

Respondent says that there are a number of cases where youths are recording their sexual relationships and sometime using it for Blackmailing girlfriends for taking different advantages. In recent days metro people have experienced the worst use of this technology by viewing the pornography of famous celebrities. This private video of one female celebrity has been shared by her ex-boyfriend with the general masses which caused a serious social vibration in the media.

Questions were asked to different participants of this study about the reason for new generations involved in such immoral practices. Some of the respondents expressed their views that sex becomes a fantasy for a particular generation. Therefore, having pre-marital sex, becomes an easy thing for those who have facilities. A common psychology of human being is recording their memorable moments and sexual clips are the result of that.

"Multimedia phone made pornography available to us. It's quite available and young generation are making use of the facilities." - 21 years old college student, Shylet.

"I knew one of my friends used it for masturbation" - 29 years old NGO worker.

Some Hotel Based Sex Workers expressed that cell phone is the major element of their business. It makes things easier for them to get hotels, clients, and even information regarding police. Some of the hotel based sex workers explained that for more money some of the hotel based sex workers start residence based sex trade where cell phone is the only mode of communication with the clients.

This study got interesting findings from the hotel based sex workers regarding multimedia cell phones. Sex workers were asked about the reasons why they feel married people visited sex workers. They expressed the use of Multimedia cell phone in this way:

"Client came up with the mobile phone and showed sex video clips to me. Those are very different sex positions and he wants me to do that. First time I was not interested but he offered me extra money for those different sex positions."

- 24 years old HBSW from Dhaka.

"Client came up with his mobile phone and asked me to do some tough sex positions. I said I never saw such position and he asked me to buy a multimedia phone and learn those positions. He said it will create my demand"

- 27 years old HBSW from Dhaka.

Internet The Window of Uncensored Information

It has been identified as one of the major findings that the misusage of Internet as a window of uncensored information becomes a threat to the young generations as well as sexual active urban populations who have access to it. Now in modern world a person without cyber cable identity has low value within the society. Being updated as a smart and knowledgeable person we have to have access to internet for information and communication. But most of the respondents expressed that this window of information allow us uncensored websites, where free pornography, sexual net works and sex fantasy is quite easy to avail. The young generation is utilizing this opportunity of exploring different websites and psychologically over reacting on sex and sexuality issues. When the young respondents were questioned as to how many of them have ever browsed or looking for a site that give information about HIV and AIDS and other sexually transmitted diseases almost all the respondents admitted that they never felt interested to browse for such information. Respondents said their friends were also not interested about such websites but everybody used to visit sexual sites and spending time reading and writing sexual blogs. Respondent said that there are lots of Bangla porno sites and blogs which are quite famous among the urban youths as entertainment. Respondents believe that access to internet is another key reason for literate group to be over excited and become vulnerable regarding unsafe, unfaithful sexual relationships.

Home Alone!

It has been observed by most of the respondents that urban and rural lifestyle has changed a lot. Even up to late 80's Bangladeshis were very much family oriented and had a culture of maintaining joint families. That practice ensured an environment of teaching respect, ethics and norms from the elders. That culture also provides company and interaction among the family members. Joint family ensured the quality of enabling a healthy environment and stopped people from getting into unhealthy relationships

In modern lifestyle the joint family concept no longer exists in our society and socio-economic structures. People are more likely to have their individual family and becoming more and more self-centered. This new adaptation of lifestyle is a result of struggle for existence. Almost all the respondents have agreed that now parents are spending half the day at their office when the children are at home alone. Day by day they become technologically updated and become dependent upon the technologies like multimedia mobile phone, computer (with access to CD,DVD) and internet facilities. And this study has already discussed how misusage of these elements are making our young generation vulnerable for drug and sex. Psychological loneliness leads our youths to different

experiments which are quite risky and difficult to manage. No need to mention that most of the time parents could not monitor all these circumstances.

Some respondents said that it was easy for them to visit sex workers in hotels because of lack of supervision by their parents. From their adolescence, they felt that their parents would not monitor their movements and activities.

One respondent explained: "When I was a student of Higher Secondary School, I used to return home late at night, but my parents never asked why I was late. I took this opportunity and I eventually became accustomed to visit sex workers in hotels and homes" (A 24-year old graduate).

Having a space/venue for having physical relationship is a factor. Respondents are agreed that now it is quite easy to get a venue for the teenagers due to this home alone factor. Most of the cases are of teenagers taking the help of their close friends who have a secured venue for having sex with their girlfriends. Boys are taking the lead to arrange safe venues for dating with their girlfriends.

Respondents said that there is evidence of group sex in urban settings which clearly indicates the vulnerability of getting infected with HIV and other STIs.

Hotel Based Sex Culture Casual and Commercial Sex

According to our previous understanding, Hotel based sex work was very much well defined by different research, studies and surveillance done by FHI, ICDDR,B and Save the Children and other research organizations. But this study has also identified few new dimensions in hotel based sex trading. The usual scenario of Bangladeshi hotel based sex trade was always sex workers driven market. Hotel managers and pimps and middleman contracted sex workers for their hotels. There were reported cases that sex workers are not getting their due payments from hotel supervisors or pimps. But now the scenario has been changed. Now they have a significant ticketing system including a clear cut distribution of income. One session costs 400 taka from which the sex worker will get 140 taka and the rest will be distributed according to the hierarchy of hotel management staff.

Since thelast two decades we have findings that girls are trafficked or becomes victimsof men and forced to come to this profession. This study had an in-depth interview of a hotel based sex worker which can clearly explain the socio-economical factors that bring girls to this profession.

"I came to this hotel for last two days. First I came here in 2008. At that time I was picked by one of our neighbors. She told me that I have to work in Garments. But she brought me here. I was so shocked, sad and afraid. But they (hotel management) never touched me or even misbehaved with me. They told me "What's wrong with it? See how others are doing it. I was looking at the other girls and I was not moreattractive than others. After having the first client I felt that I can earn money and this is the easiest way". No one knows what I'm doing here. After 7 days I will be back to my village. I visit this hotel once in a year." - 27 years old HBSW.

The HBSW respondent informed that hotels become over crowded during any national festival. Especially the Bangla new year "Pohela Boishak" is the bumper day for hotel based sex workers. Other than that 31st nights, Independence Day and night before any political meetings make hotels over crowded. Because within these occasions lots of people have come from outside Dhaka to have fun.

Some of the respondents have disclosed their identities and shared that some of the college and university girls who are coming from rural settings struggling to survive in the city are also in this Hotel and resident based sex trade. They are not at all commercial sex workers but somehow they manage to get clients and get access to these hotels.

Another interesting finding is those couples who are not able to manage any secure place for having physical relationship also visit hotels. In those cases the management ensure the security and charge higher than regular clients visiting their hotels and having sex with their sex workers.

Government took some initiatives to ensure a protective environment in the city parks and pleasure places. Especially there are restrictions regarding couples sitting very closely in these city parks which leads those couples to have a good time in hotels which actually influence them to have a date ending with sex.

Visiting hotel based sex workers: The pressure or pleasure?

From the youth client survey it has came out that young people are one of the significant portions amongst the clients of sex workers in hotel settings. The answer of this study has discovered "why" young people are FSWs. That research identified that in addition to sexual pleasure and experience, clients visit hotel-based FSWs in response to contextual and structural factors that include peer-pressure, influence of pornographic materials and other sexually explicit programs in satellite television channels. Peers influenced most of the respondents visiting hotels for buying sex. Friends are the most common source of information about the hotel based sex trade. Some respondents stated that their friends had brought them to the hotel to meet with other friends and they were surprised to see the sex trade activities in hotels. Afterwards they did some experimentation and bought sex from sex workers. Some of the respondents said that the first time they visited a hotel to prove their masculinity, and then they were habituated to buying sex in hotels.

One respondent described his first experience:

"... One day a close friend of us told that there are hotels in area X where one can buy sex for only 250 Taka ... I was surprised!! ... Is it possible? ... Then some of us decided to go there. I was not sure whether I was capable of doing it; then I thought if my friend can, I have to do it ... then I experienced sex ... and enjoyed it! Since then, I am visiting hotels for having sex"

(First experience of a respondent at the age of 14 year).

Another respondent described how his friend influenced him to have sex with a hotel based sex worker:

"One day a friend took me to a hotel without informing me about anything ... I was to sit beside a sex worker ... I was ashamed ... I requested the girl and saying.. I never did it ... you need money, I am ready to pay money without touching your body ... then she replied, 'I will rather pay you ... your friend already told me not to let you go without having sex with me... so how can I say no to her as a young man" (A student's first experiences visiting a hotel).

Condom
The way we know it!

The word "CONDOM" is seems like one of the most culturally sensitive, stigmatized and confidential words in Bangladesh. Since late 70's through family planning interventions Bangladesh has been exposed to this method and subsequently promoted by the HIV and AIDS interventions for last twenty years. But unfortunately surveillance shows the truth that condom is not yet the popular family planning product in Bangladesh. Even pills and vasectomy are the mostly popular contraceptive regardless of its physical side affects than condom. Since then program specialists are struggling to know the reason why people don't like Condoms. There are several schools of thoughts in this regard. In early 2000 HIV intervention has come up with some of the practical reasons from clients. HIV and AIDS discovered that clients have negative perception regarding condoms due to some of the key misbeliefs like.

Client thinks that:

- Condoms reduced pleasure of Sex
- It reduce the duration of sex
- Condom is only for family planning
- It is expensive
- It is not available
- Socially it is odd for an unmarried male to buy it from any local shop.

National Study of Social, behavioral and biomedical risk factors of adolescents and youth clients of female sex workers (June 2007 by GFATM) has also tried to find out behavioral factors related to condom use by the youths.

This study has also tried to understand perception of youths and general males about condom and has come out with interesting findings.

- Some of the respondents said that people are stimulated by the pornography and looking to experience the same with sex workers. Having crtical observation respondents have identified that Pornographic materials do not have condoms in their story. This is one of the key reasons why the clients of sex workers are not motivated to have sex with condoms. In one word people do not use condom because it has not been used in any pornography.
- HIV intervention is ongoing in many hotels and we found that the sex workers in intervention hotels are convinced by these programs and ask their clients to use condoms. The clients also acknowledged the influence of sex workers: "Condoms were not used before, but now the sex workers of this hotel don't want to have sex without condoms. They (SWs) now always request for condoms. They often teach me about HIV and AIDS, such as HIV is a deadly and non-curable disease, and sex without condoms may transmit HIV and AIDS to me. Therefore, now I try to use condoms." A few informants stated that many attractive sex workers refuse clients if they refuse condoms:

  "One day, I offered a beautiful sex worker to have sex with me without condoms. She refused to have sex with me. She suggested me to have sex with other sex workers who do not use condoms." Some informants did not know how to use condoms before the sex workers gave them a lesson on correct use of condoms."

- Some informants claimed that social status of sex workers is important to their cleanliness. For example, if a sex worker is a current student or housewife, it is most unlikely that she suffers from STIs. Therefore, clients often have unprotected sex with such sex workers:

  "I always ask about the identity of a sex worker. I had sex with a university student. She is not like other sex workers, her status is high. She is clean and fresh. I did not use condoms." Some informants who engaged in sex without condoms considered the physical appearance and beauty of the sex workers: "when I get a beautiful, good looking, sexy sex worker, I never use a condom."

Chapter 4

Myths, Misconception, Disclosure, Stigma, Discrimination and Violence

Current social Myths and Misconceptions regarding HIV and STIs

PLHA respondents are the key respondents who have enlightened this chapter of existing myths and misconception of the society. PLHAs shared their real life stories with us and reveal some examples from their experiences.

In many cases, family members became fearful that HIV was contagious and could be transmitted through casual contact like holding hands and hugging, or through the sharing of bathrooms and kitchen utensils. Along with this, given that Bangladesh has a high prevalence of the disease malaria, the families of some PLHA also believed that HIV could be transmitted through mosquito saliva, similar to the transmission of the virus causing the disease malaria.

"If a person does not wash properly after sex then the semen will remain on skin. It will dry-up and will stretch the skin, eventually an itching sensation will occur and by itching, a sore will appear and at last it will end up as syphilis or gonorrhea"

"If I don't wash properly after sex, then the semen will remain on the skin and syphilis will occur because after a while the semen will dry-up and then the skin will be rough (tight) and eventually itching and sore will appear and gradually infection will go through flesh to blood and will affect the whole body then at last will end up as syphilis" (A 23 year old client visiting hotels for six months).

Some of the respondents believed that wet dreams are very harmful to health. They learned from their senior friends that only having regular sex could control wet dreams. Therefore they practiced sex with sex workers to reduce the frequency of wet dreams.

A few of the respondents reported that they were habituated to masturbation, and then they came to know that masturbation is harmful to the body. They also came to know that it might reduce sexual 'power' (capability), which might create sexual problems after marriage. One expression was:

The respondents could not identify a definite source of such conceptions, but said things like it is his experience: "I knew it by myself, once I was infected and learnt it …". The same respondent shared this information with his friends and advised them to keep clean.

Low Disclosure making High Risks for PLHAs

My uncle notified the police and other highly placed people in our community about my physical condition. They took my two children and me away and kept us locked in a room in the office for disabled people for 1 month and 2 days. During this time nobody spoke to us or fed us regularly. I then felt like strangling my two children and blaming it on the people who locked us up, so that they would set me free. (30-year-old female mainstream)

All my clothes have been burnt. They [mother and father-in-law] did not allow me to talk to anyone. When I used to cut vegetables they asked me not to because I had a nasty disease. They did not let me eat three times a day and made me work all the time. They didn't even let me go to my husband. (33-year-old female mainstream)

Friends

Many respondents feared sharing their HIV status with anyone outside their own families given that even family members had discriminated against them after finding out. However there were occasions when participants had decided to share their fears, pain and anxiety in search of support from their friends and neighbors and consequently had been more stigmatized and discriminated against. There were some PLHA who described having received support and help from both families and friends, but such cases were very rare among this participating group.

"Not too many friends know my positive status. And the ones who have found out do not keep in touch with me as often as they used to." (23-year-old female mainstream)

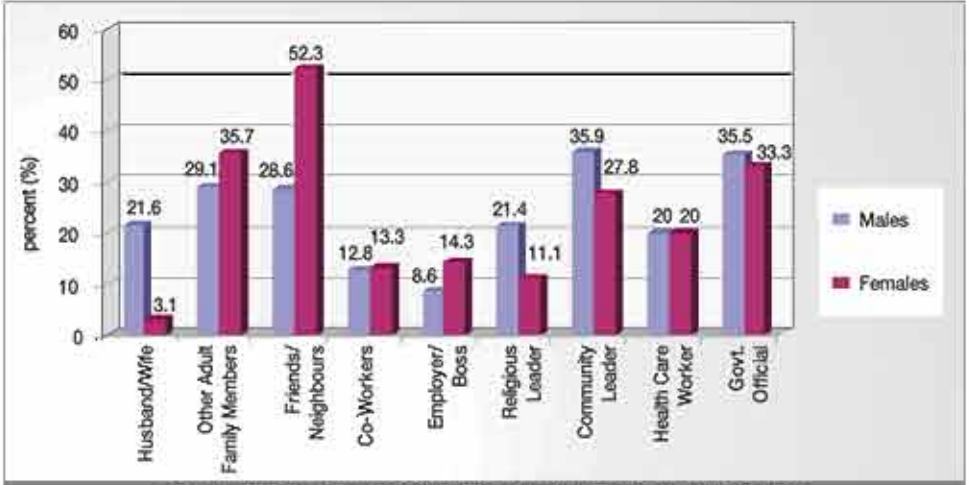
Neighbors

I have an HIV positive friend in Sylhet who could not walk down the roads in his village because of his positive status. People would say bad things when they saw him and would try to beat him up. He used to try not to get out of his house too often. (42-year-old male migrant worker)

My neighbors did not talk to me after I tested positive. I couldn't bathe in the same pond as them. They turned away their faces when they saw me. They did not allow me to keep my clothes with theirs. I couldn't drink water from the same tube well. I was asked to send someone else from my house to fetch water. (33-year-old female mainstream).

Culture of Stigma and Discrimination and Social Denial

PLHA faced stigma and discrimination either from the members of their own families or from outside their own families, (friends/neighbors, colleagues/boss, health care providers etc.) The following graph shows the discrimination experienced by the PLHA from specific people (husband/ wife, other adult family members, friends/neighbors, co-workers, employer/boss, religious leader, community leader, health care workers, govt officials).



The mentioned graph shows the Discrimination experienced by PLHA from specific people - Males vs Females

The above results suggest that the female PLHA faced the highest discrimination from their friends/neighbors while the male PLHA were discriminated mostly from the community leaders followed by government officials. The major findings from the above mentioned graph is the 1st bar which shows that 21.6% males who are positive and responsible for their partners infection are blaming their own wives for their infection. This has been the most hypocritical attitude of males in our society. On the other hand only 3 % wives are blaming their husbands for their infection.

A very small number of PLHA willingly disclosed their HIV status (12 out of 238) to religious leaders with only 1 facing discrimination. Similar results were found when PLHA willingly disclosed their HIV status to community leaders, with 9 PLHA willingly disclosing their HIV status and only two facing discrimination.

A very small proportion of the PLHA (19.7%) willingly informed the health care providers about their HIV status and among them, 4.3% faced very discriminatory behavior while 6.4% faced discriminatory behavior. PLHA also faced discrimination from health care givers (for example, a doctor, a

nurse, counselor, and laboratory technicians) in a sense that, these people did not maintain the privacy. Figure 3.4.2 shows the discrimination faced by the PLHA from health care givers regarding privacy problem.

A large proportion of PLHA willingly disclosed their HIV status to their social workers/counselors (57.6%) with none of them reporting any type of discrimination.

The results on disclosure and confidentiality about HIV and AIDS suggest that many of the PLHA faced discrimination after disclosing their HIV status and the discrimination level varied from individual to individual. Some of the PLHA faced discrimination from their closest ones (e.g. from their family members, their husband/wife/partners etc.) while others faced discrimination from outside their own families (e.g. friends/neighbors, religious leaders, co-workers/supervisors, health care providers, family planning workers etc.).

Respondents were asked whether they experienced any stigma and discrimination (verbal insults, harassed and/or threatened, physically harassed and/or threatened, sexual rejection etc.) from others in the last 12 months while involved in social gatherings or activities, religious activities or family activities. The following graph shows the numbers for each type of discriminatory matter regarding the respondents of HIV status.

The discrimination severity does not vary according to the gender of the respondents. Almost all of the discrimination types are same for both male and female.

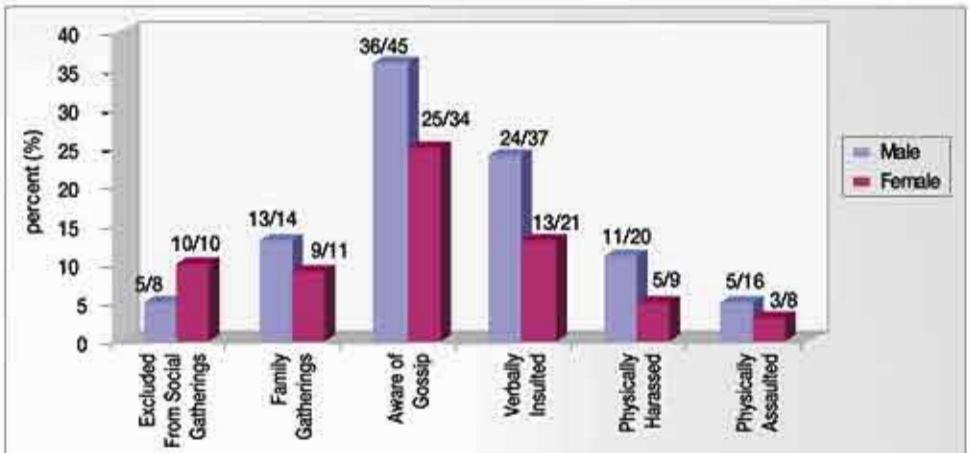


Fig.3.5.1: Discriminatory behavior faced by the PLHIV because of his/her HIV status

Stigma and discrimination affect the physical and mental well-being of PLHA and of their families. It prohibits entire families from being able to earn their regular income, from accessing health care services and from having their children adequately educated. As a result, this behavior hinders their participation in almost all kinds of communal and societal activities. It prohibits information seeking behavior that might result in a better understanding of PLHA and fosters a status quo and acceptance of discrimination. It prohibits loving relationships between family members and fosters gender discrimination and verbal and physical abuse within the family and within society.

PLHA blamed themselves for their HIV and AIDS status resulting in many feeling suicidal. Because of internal stigma more than three fourths have decided not to get married and were afraid that someone would not want to be sexually intimate with him/her after knowing HIV status.

Current social values regarding Blood Donation

All most all the respondents have agreed on the fact that blood donation is required. Strong personal motivation and volunteerism, however, is not present in our current society. Currently people are very cautious about their own benefits and saving blood for their family and friends. On call blood donation is still to get the appropriate response from community and particular circles. The national data says that Bangladesh requires 750,000 bags of blood per year to fulfill the country's demand but receives 400,000 only through different campaigns and events. Out of this figure a significant number of blood is from the professional donors who are often vulnerable to diseases. Respondents explain the reason behind this attitude and culture of non-responsiveness. Most of the respondents said that the organization has lost their quality of commitment to keep their promise for services as required. Therefore, a person who has experience before hand with blood bank is not continuing to donate their blood to the bank.

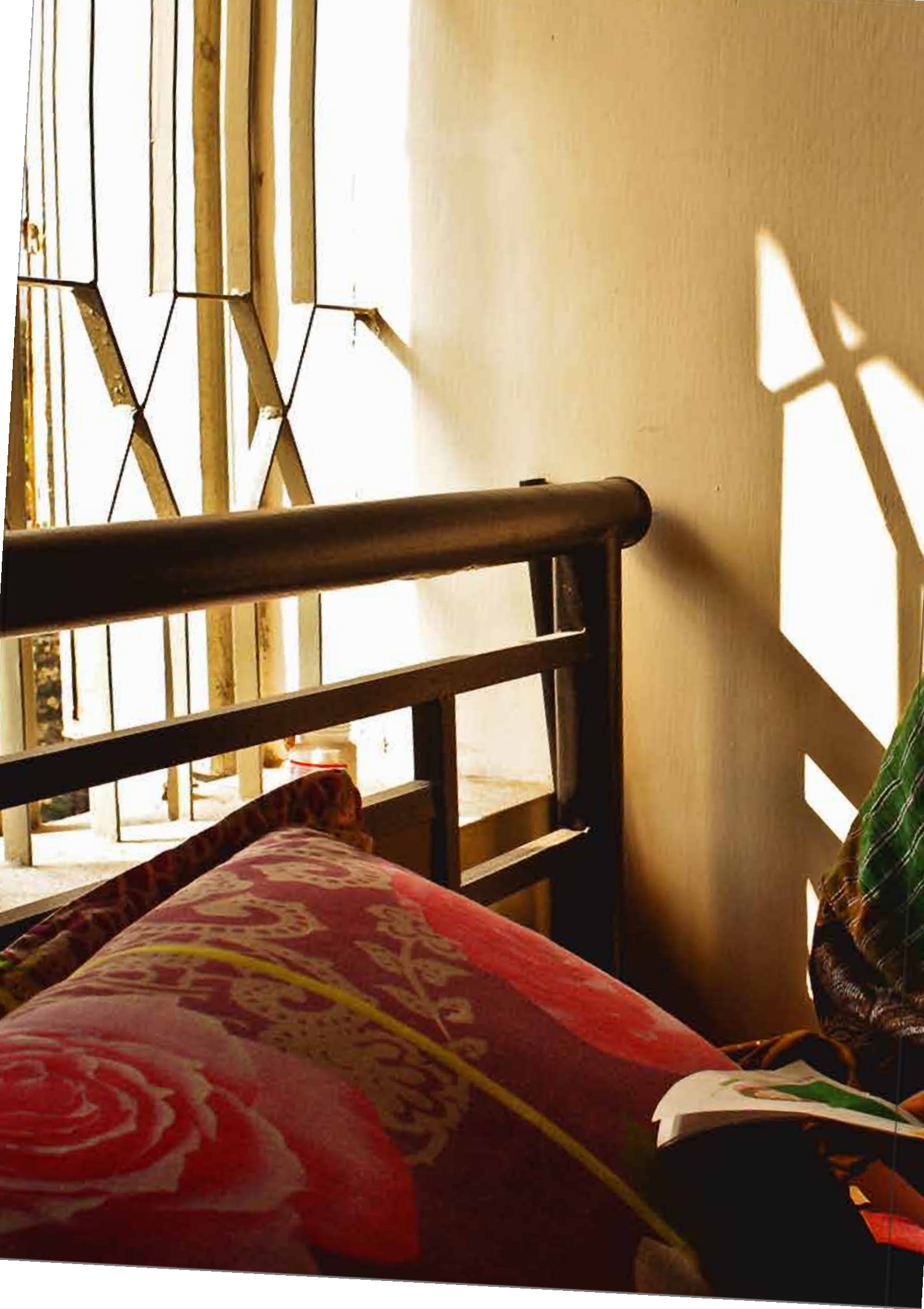
Discrimination from Health Care Givers

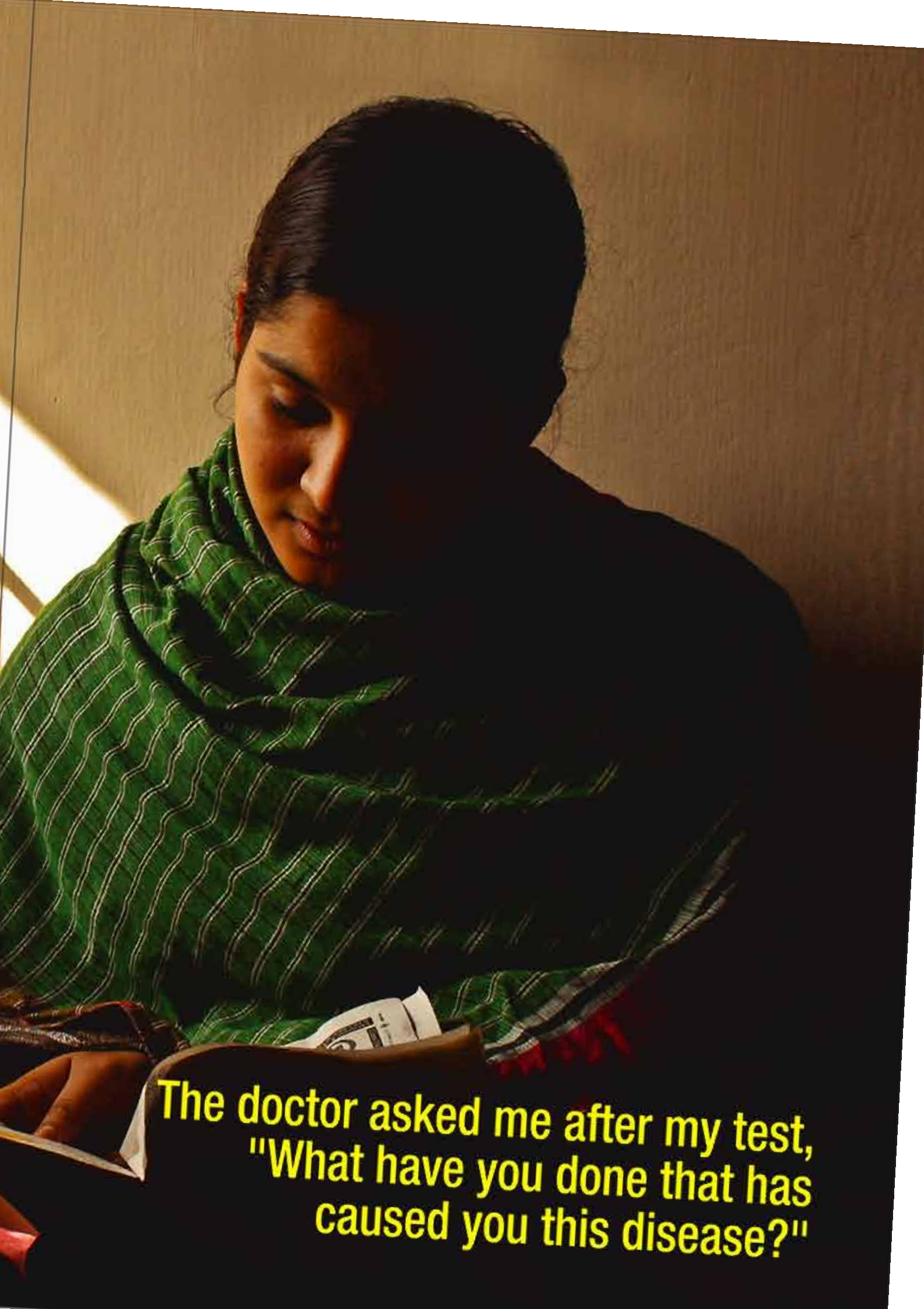
Loss of privacy in health care settings was a common complaint among the participants of this study. Even though there are only a handful of HIV testing centers in Bangladesh, most of the health care givers at these settings are not even trained to provide the required pre and post test counseling. Participants complained of nurses and other health care givers discussing their positive status amongst themselves even before the doctor had shared the information with the patient himself/herself. Participants have also indicated that nurses and other hospital staff wore gloves when it came to treating the PLHA.

In an effort to avoid discrimination and obtain access to dental and health care services, PLHA have admitted to hiding their HIV positive status. Many have also reported turning to tradition healers, homeopathy, religious healers etc. in search of finding a cure for HIV either simultaneously with seeking health services from a doctor, or after being mistreated or ignored by health care professionals in a hospital settings.

The doctor asked me after my test, "What have you done that has caused you this disease?" (30-year-old female mainstream)

A doctor misbehaved with my husband after receiving his test results. The doctor did not keep my husband's condition private, but also called me and told me that my husband had contracted this unfortunate disease due to his misdeeds while he lived abroad. I felt very bad because I liked my husband and had trusted him very much. (33-year-old female mainstream)




The doctor asked me after my test,
"What have you done that has
caused you this disease?"

Self-stigma among People Living with HIV and AIDS

Self stigma admitted the participants to thoughts of suicide on finding out their positive statuses. Their thoughts revolved around their families' and their own shame in testing positive for a disease that is commonly thought to only be transmitted through sexual relations. Being a conservative society with a Muslim majority population, not only are promiscuity and extra-marital affairs looked down upon, pre-marital sexual relationships are also severely frowned on. As a result many participants felt ashamed and were unable to share their distress about their positive status with even people closest to them.

"I felt that I am a bad person, a sinner. I felt like committing suicide." (32-year-old male migrant worker)

I felt like killing myself and my two kids many times because after having this disease, a lot of things started to happen to me which I never thought possible. (33-year-old female mainstream)

I think badly of myself now. Sometimes I think it is better to be dead than to live like this. (30-year-old male migrant worker)

Gender Dimensions of Discrimination

Female PLHA seem to be one of the marginalized groups described earlier, who are facing multiple forms of discrimination from society in Bangladesh. This is due to both structural and social injustices and inequalities that push women's statuses low down the ladder, as well as because of the HIV positive status of such participants. Women in Bangladesh have very low status in both the private and public spheres of society. Numerous studies have shown that discrimination against women are more prominent in families than against men. Married women who were infected by their husbands, i.e. majority of whom are male migrant workers in the case of Bangladesh, are often scorned, mistreated and even evicted from their in-laws home when their HIV status becomes known. xxviv On the other hand women who are divorced, separated, living alone or even those choosing to not to conceive are also looked down upon by the larger society.

Blaming Women a common picture of our Society A Case Study

" My husband was abroad for a long time before we got married. I heard he tested positive at that time and was sent back to the country, but he married me without revealing any of this. He became sick two months after our marriage and went to India for treatment. After he was sent back, I saw his medical report and realized that I could have become infected too.

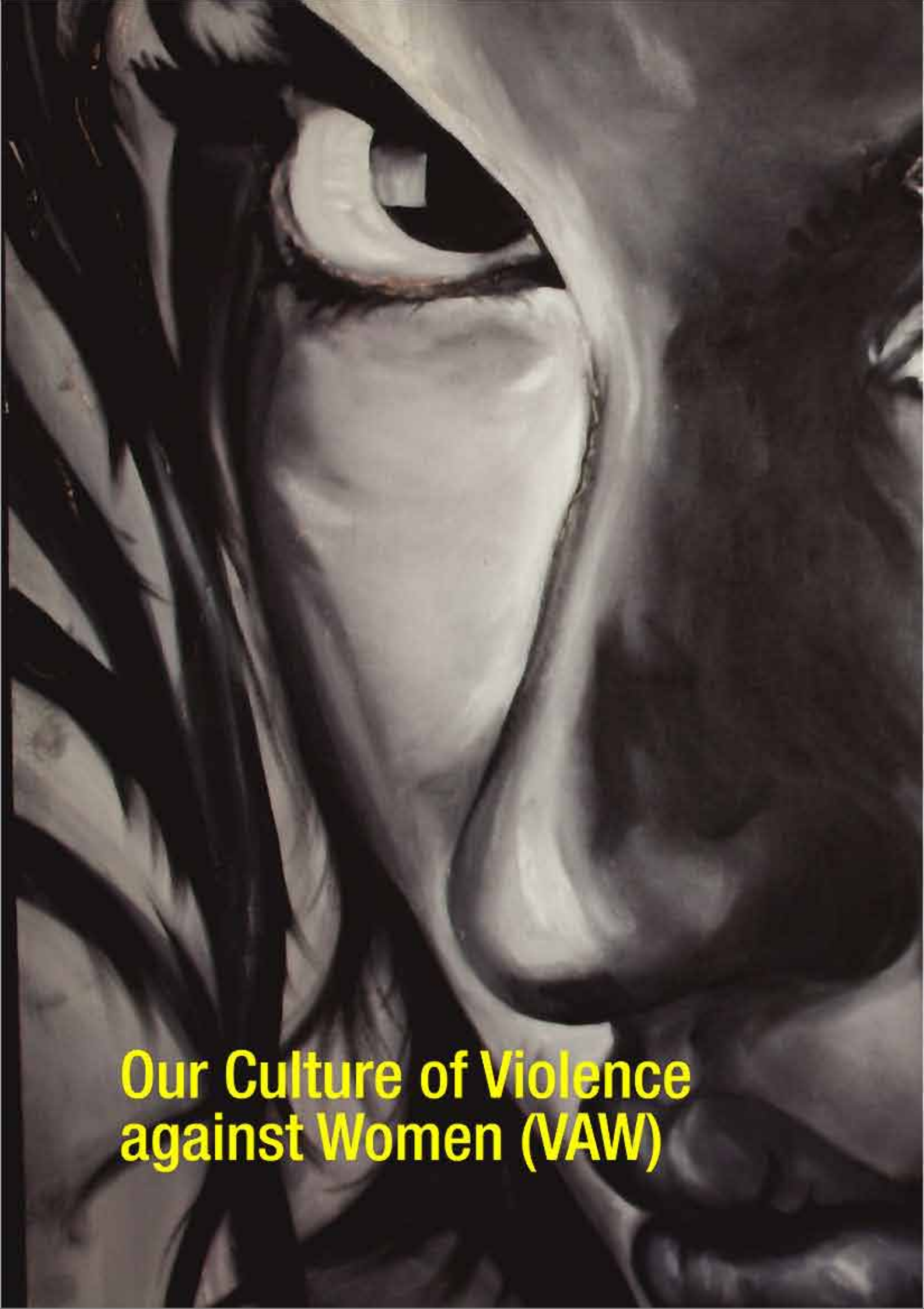
I started to become sick quite often. My in-laws would then scorn my health condition and ask my husband, "What kind of a wife have you brought home? She is always sick!" I became very worried after testing positive. I cried all the time and did not talk to anyone. I always thought about my child and worried about what would happen after I died. This feeling cannot be described in words.

After disclosure everyone in my in laws house started blaming me. They were just trying to prove that I was not faithful to my husband during his overseas period. I got divorced and have left my in-laws house. My husband used to torture me and the children in that neighborhood would not play with my child. My husband had gone around telling our previous neighbors about my positive status. They started making comments about me.

Once my child had become critically ill. When we went to the hospital, I informed the doctor that my child and I were both positive. I wanted the doctors to take precautions against becoming infected themselves. I hoped that my child would receive better service because I had already revealed our statuses, but the opposite ended up happening. The services became worse; they would not come near my child and wore gloves while treating my child. I had to explain to them that this was not a contagious condition.

I also face economic problems. I have been deprived of any property rights because I am HIV positive. I got nothing from my husband or in-laws. I need to take money from my brothers but even in-spite of having the money; medicine is sometimes still not available. Some medicines are very costly.

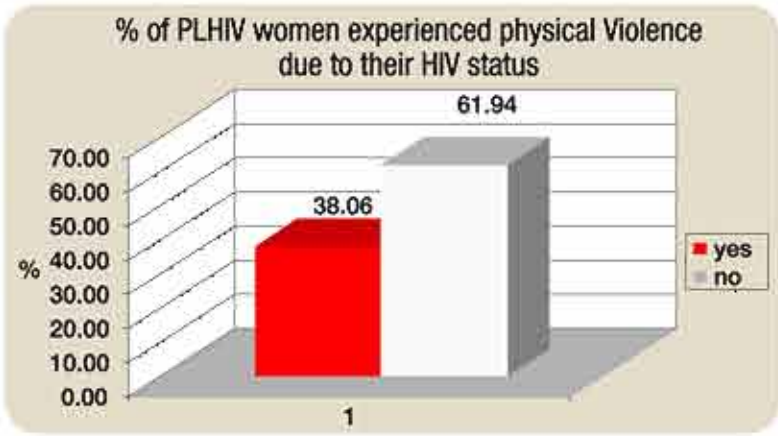
This case story highlights the typical gender biases and mental and emotional abuse young women face when infected by their husbands. Often in these cases, families refuse to accept that the men may be responsible and their anger is directed at the female. In some cases, it is reported that the female spouses also tend to keep silent even if they are infected by their husbands, as they don't believe they have many options open to them even if they were to leave their husbands. However, if the husbands are infected by their wives, it was mentioned that many choose to abandon their wives and leave them to manage on their own.



Our Culture of Violence against Women (VAW)

Violence against Women is one of the main causes of suffering and poverty in Bangladesh. It occurs within the domestic and working arenas, but remains largely under-reported and investigated. VAW is not the privilege of men and boys only, women can also be perpetrators of VAW. In Bangladesh, the two main root causes of VAW are: (1) the unfavorable policy and legal frameworks; and (2) the social and individual attitudes and behaviors. In addition, immediate protection given to women and girls who are victims of violence is inadequate.

Violence against Women



This graph shows the most important picture of the society and the current situation of PLHA women. The study directly asked the participants that after identified as HIV positive did you ever experienced physical violence? and 62% PLHA women assured that they have gone through direct physical violence from their husband, father in law, mother in law, brother in law, sister in law, own father and mother, brothers, Uncle, Aunt (Cha cha and Cha chi).

This graph shows the importance of addressing PLHA women to prevent violence, protect their rights and better treatment to let them lead their own lives as human beings.

Common dialogues, comments and Issues of Violence against HIV infected women

Physical and Mental Violence

- Family pressurizes to have no more children
- Father and brother in-law threatened to kill me
- Kicked me out from my father in laws house
- Blaming for husband's infection
- Isolated from the other relatives of the family
- Verbal assault from father in law's house. If I protest husband tortured me physically
- Family believes in religious treatments (PANI PORA) and if I protest verbal assault and physical torture by the family members.
- Brother in law forced husband to give divorce, on protesting that, he physically tortured me.
- Beating by hard stick, kicking, slapping on the face
- Burned the bed, pillow and other daily useable things
- No financial assistance from the husband
- No treatment
- Force to work hard even when I am physically sick
- You don't need treatment because you will die soon
- No treatment while sick
- After passing away of husband, they kicked me out from home
- Separated husband from her wife
- Husband often asked me a question "why don't you die? You are supposed to die. How long will you live?"
- Telling lies to visit doctor(Always scared while visiting doctors)
- Family members even hate her children too
- Do not give sufficient food to eat.

Mental Violence

- You don't need treatment because you will die soon
- Separated husband from her wife
- For any symptoms of OI or seasonal sickness, family members creating panic - " She is dying"
- No treatment while sick
- Threatening to kick out from home
- Blamed for her husband's infection
- In the village market, nobody gave us food even
- Kids were kicked out from the school
- No treatment while sick
- Threatening to kick out from home
- Telling lie to visit doctor (Always scared while visiting doctors).

Rights Violence

- No financial assistance from the family members
- Kicking us out from our parental property
- Kicking us out from our parental property because my husband is not earning anymore
- No financial assistance from the family members
- Taking away kids from their parents
- Husband even not taking care (when husband is negative).

Observations and Recommendations

Although it is difficult to address all forms of stigma and discrimination linked to HIV and AIDS, it is essential that efforts are made to address some of the key issues.

Current Beliefs on Sex and Sexuality

- Sex and sexuality is still not an issue for open discussion but one of the major elements of our entertainment.
- In modern world sexual sensation is a part of our culture. To compete with the modern world we have to be like them.
- Couples should not have sex before marriage but if they can't control themselves than at least they should not embarrass others.
- Men are polygamists and it's an open secret.
- Migrant worker's wife accept her husband's polygamy in abroad but not within his own place.
- Men require sexual diversity and entertainment. Marital sexual life becomes boring for men due to the absence of foreplay and lack of response from female partners which leads them to sex workers.
- Education regarding sex and sexuality does not exist in formal or informal education system of Bangladesh.
- Parents who are educated want to discuss about sex and sexuality issues with their children but confused where to start and how to manage and describe such sensitive words and factors.
- HIV infected woman does not need any treatment because she will die soon.

Recommendations

- Our Culture, Ethics and morality need to be in proportion to our formal and informal education system to promote and protect the originality of our Bangla culture.
- Sex, Sexuality and Sexual disease should have come into the education system from at least college and university level to help the next generation to protect and manage them.
- Studies on culture have identified some aspects of culture. As already pointed out, the women in general, and young women in particular, are extremely vulnerable to exploitation and ultimately HIV infection. Unfortunately the bulk of the institutions which have preventive and treatment programs do not specifically address the needs of youths regarding sexual and reproductive health and its management.
- Civil society participation is a necessary most to handle HIV and AIDS related stigma and discrimination
- Media has a vital role to protect and promote our cultural ethics, morals and their involvement is necessary in pushing sexual education and life skills of prevention approach.

Reference

- 20 Years of HIV in Bangladesh: Experiences and Ways Forward, UNAIDS, World Bank
- Stigma Index Report, UNAIDS 2009, AAS, BRAC, IPPF and UNAIDS
- Bangladesh National AIDS Committee (2010). UNGASS Indicators Country Report Template.
- Analysis of Social, Behavioral and Biomedical risk factors of adolescents and youth clients of female sex workers, GFATM, National AIDS/STD Program, Save the Children-USA(2007)
- Piecing it together for women and girls, Bangladesh Chapter, Gender based stigma and violence against positive women, IPPF, GIZ, UNAIDS
- Need Assessment on HIV related violence against women in Bangladesh, UNAIDS
- AIDS commission Report, UNAIDS
- National Presentation on HIV AIDS, NASP (2010)
- Behavioral Surveillance Survey(2006-2007), NASP, ICDDRB, FHI
- National AIDS/STD Program(2007). World AIDS Day, Souvenir: Take the lead; stop AIDS: keep the promise. Dhaka: National AIDS/STD Program, Directorate General of Health Services, MOHFW, Govt. of Bangladesh..
- Azim, T. et al.(2008). HIV and AIDS in Bangladesh. Journal of Health, Population and Nutrition. (3) p311-324.
- Azim T, Rahman M, Alam MS, Chowdhury IA, Khan R, Reza M et al.(2008). Bangladesh moves from being a low- prevalence nation for HIV to one with a concentrated epidemic in injecting drug users. Int J STD AIDS 19: 327-31.
- ICDDR,B (2008). The HIV/AIDS Programme. Draft Report on estimating numbers of those most affected by HIV/AIDS in different locations to support efficient service delivery, capacity building and community mobilization. Assignment 1: "Care and support for people most affected by HIV and AIDS." Package #910. GFATM Round 6.
- Powell-Cope, G.M., & Brown, M.A. (1992). Going public as an AIDS family caregiver. Social Science & Medicine , 34, 571_80.
- Green, D.A., Devi, S., & Paulraj, L.S. (2007). Care centre visits to married people living with HIV: An indicator for measuring AIDS-related stigma & discrimination. AIDS Care, 19(7): 910-915.
- De Bryun, T. (1998). "HIV/AIDS and Discrimination: A Discussion Paper". Montreal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society.
- Morrison, K. (2006). "Breaking the Cycle: Stigma, Discrimination, Internal Stigma and HIV". Geneva:UNAIDS.

Research Team:

S.M. Tanvir Saqlain
Aynin Sayeda Noore

design & concept: Milton Sikder & Md. Ali

Published by:

United Nations Educational, Scientific and Cultural Organization

UNESCO Dhaka Office

Published in:
June 2011
Dhaka, Bangladesh

Copies available from

UNESCO Dhaka
House # 122, Road # 1, Block # F, Banani, Dhaka-1213, Bangladesh

E-mail: dhaka@unesco.org
website: www.unescodhaka.org