



# SOCIAL ACTION

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To stop HIV/AIDS, not only the NGOs, but also the Government sector, political parties, different social institutions, and religious institutions should all work together in a more extended way.....

--Wahida Banu



Wahida Banu

Ms. Wahida Banu, the chairperson of the HIV/STI Networks of Bangladesh is working to stop HIV/STI in our country for a long time. She is also the chairperson of Shishu Adhikar Forum. She is working as Executive Director of a national NGO named APARAJAY BANGLA. Recently she visited YPSA and gave some valuable comments to Social Action. The interview was taken by Muhammed Ali Shahin.

Can you please tell us about the present status of HIV/ AIDS in country?

In the present global context, we can consider HIV/AIDS as one of the major concerns. But Bangladesh is fortunate that the rate affected by HIV/AIDS is lower than others. For this, if we feel full satisfaction or sit relaxed, then it would be a big mistake for us because there are so many causes that can spread HIV/AIDS in Bangladesh. One of the major reasons is that Bangladesh has several borders with India and Myanmar. Since all South Asia is in high risk of HIV/AIDS, it is a very dangerous situation for us. Because the visitors and the people who visit one country to another within Asia, they do not come back or return by diagnosing themselves. So HIV/ AIDS can easily spread in our country.

Compared to other countries in Asia, what is the position of Bangladesh? Please tell us your comments.

Bangladesh is in lower risk of HIV/AIDS. The number of HIV affected people is not that much in Bangladesh. The total number of affected in Bangladesh is low when compared to India, which is on the rise. On the other side China, and Thailand is also in the high risk of HIV/AIDS. This is very much alarming for us. It is the time to stop HIV/AIDS by making people aware about this. We have to disseminate the information about HIV/AIDS to all level of people.

Who are at high risk of HIV/AIDS in our country?

In Bangladesh IDUs (Injecting Drug Users) are at high risk of HIV/AIDS. Besides them street based sex workers, and brothel based sex workers are also in risky position. On the other side young people are also at high risk because they have interaction with all three categories of risky groups.

How you define the role of NGOs in our country?

Our young people are the future of our country. We have to save them from HIV/AIDS.

In our country so many NGOs are working to prevent HIV/AIDS. They are working to prevent HIV among MSM (Male Sex with Male) group, Hizra group, and street based sex workers. The organizations are working according to their capacities. These organizations have some limitations. They are working with the donor based fund. If the fund stops, their program will be stopped. But we have to work for a long time on the issue. For this the organizations need to achieve their sustainability. The donor can help for achieving this. To stop HIV/AIDS, not only the NGOs, but also Government sector, different social institutions, and religious institutions should all work together in a more extended way.

Please say something for Social Action readers?

We all have to develop a self awareness mechanism in our mind that we will save ourselves; we will save our society, and also our nation. We all have to hold this understanding in our mind. That will be the spirit to make a real change.

# Editorial

The percentage of HIV infection is very low in our country; the reputed number of affected persons by HIV/AIDS is only 674. It does not mean that we can be relaxed about HIV/AIDS. Because there are so many reasons to spread HIV virus in our country. Superstitions in the society, Lack of knowledge about HIV/AIDS, Open boarder, Drug addiction, frustration among the young people etc these are the major causes to spread HIV/AIDS in the country very rapidly if we don't take measure immediately. The movement to stop HIV/AIDS has already started in our country. Now we have to carry it to its ultimate goal. We all have to work together to stop these dangerous

## HIV/AIDS Global Summary

The Acquired Immune Deficiency Syndrome (AIDS) has become a worldwide epidemic since it was first reported in 1981. The Human Immunodeficiency Virus (HIV) is spread through bodily fluid exchange such as blood, semen, vaginal fluid and breast milk. HIV disables the immune system so that an infected person obtains AIDS. There is no cure for the disease which impacts individuals first but in the long run has shown to devastate households, and entire communities. In 2005, an estimated 40 million people were living with the illness of which only approximately 5% are living in industrial countries of North America, Europe, Australia, and New Zealand (UNAIDS).

The Acquired Immune Deficiency Syndrome (AIDS) has become a worldwide epidemic since it was first reported in 1981. The Human Immunodeficiency Virus (HIV) is spread through bodily fluid exchange such as blood, semen, vaginal fluid and breast milk. HIV disables the immune system so that an infected person obtains AIDS. There is no cure for the disease which impacts individuals first but in the long run has shown to devastate households, and entire communities. In 2005, an estimated 40 million people were living with the illness of which only approximately 5% are living in industrial countries of North America, Europe, Australia, and New Zealand (UNAIDS).

## HIV/AIDS in Bangladesh

By the end of 2003, WHO and UNAIDS estimated the number of people living with HIV in Bangladesh at approximately 13,000. High-risk groups showed low levels of risk perception and condom use, with high rates of risk behaviour and symptoms associated with sexually transmitted infections (STI). Bangladesh's proximity to India and Myanmar (countries with high and rapidly growing HIV endemicity) combined with increased population movement and the activity of migrant and transport workers, plays a large role in sustaining Bangladesh's vulnerability to HIV/AIDS.

### Country Progress Indicators

Number of people living with HIV 11 000 (6400 – 18 000)  
 Adults aged 15 to 49 HIV prevalence rate <0.1 (<0.2)%  
 Adults aged 15+ living with HIV 11 000 (6400 – 18 000)  
 Women aged 15+ living with HIV 1400 (710 – 2500)  
 Death due to AIDS <500 (<1000)

# Stop AIDS

# Keep the Promise

## "What we are seeing is only the tip of the iceberg"

-Dr. A.Q.M.Serajul Islam

Practicing HIV/AIDS physician & Retired Professor &  
Head Department of Dermatology and STDs,  
Chittagong Medical College and Hospital, Bangladesh.



Dr. A.Q.M.Serajul Islam

Dr AQM Serajul Islam is one of Bangladesh's only HIV/AIDS specialist physicians. He works with the Ashar Alo Society (AAS) - a peer support centre for People Living with HIV/AIDS (PLA), and also runs his private practice where he offers his services free of charge to PHAs. He is well respected within the community and has extensive experience in this field. Based on his expertise Dr. AQM Serajul Islam discusses the present state of the epidemic in Chittagong and suggests needed measures that should be put in action.

**Social Action:** In your opinion what is the current situation of HIV/AIDS in Chittagong?

Dr. Serajul Islam: There is no definite data on the number of HIV+ people in Chittagong. Many are diagnosed through private labs and do not report their status to the proper authorities. Nothing is systematic. The only estimation I can give is based on the number of patients I see through AAS and my private practice. Right now I am privately taking care of 30 patients and AAS is taking care of 80. However, in my opinion the total number of people showing symptoms of HIV/AIDS in the greater Chittagong area is perhaps in the 300- 400 range. This range would be higher if we also considered HIV+ individuals who are asymptomatic. People infected with the virus can be asymptomatic for 3 - 7 years and this group is not coming for any care and support services.

**Social Action:** Do you think the problem with increase/decrease? If increase, among what group primarily?

Dr. Serajul Islam: The problem is definitely increasing. Right now infections are seen mostly among migrant workers, their wives, and children. However, it is important to remember that this group is one of the only groups that are systematically tested. I have seen HIV+ patients who have not ever left Chittagong even for a single day, but we don't know what the infection rates are among various groups. Right now we are catching the most infections rates among migrant workers. Also, based on the national sentinence evidence other vulnerable groups include injection drug users (IDU).

**Social Action:** What is the situation of the women and children left behind by the loss of an HIV+ husband?

Dr. Serajul Islam: AAS has 8 children in its care and there is already an orphan problem that is increasing day by day. Women are in a very bad situation. When their husbands die they become very insecure in terms of income and other social factors. Sometimes they do not inherit their property and are removed from their late husband's house. They must return to their father's house. Some who live far away can not come to the centres for care & support treatments since their husband is not there to take them anymore. The constraints are financial but mostly social since they do not have independence.

**Social Action:** How easy is it for PLAs to attain medical and psychological help?

Dr. Serajul Islam: It is not at all easy. PLAs do not know where to go to get help in the public sector. There may be only 10 HIV physicians in the whole country and they are mostly in the private sector. Furthermore, we are not even

giving the training for the management of the HIV disease to our young doctors. As for psychological support there should be more social help groups but they are not in place.

**Social Action:** What is the cost associated with care?

Dr. Serajul Islam: The government does not provide ARVs and they are not always free for PLAs. NGOs are giving free medicare service to some extent. At AAS consultation is free as well as some medicines that are supplied by donor agencies. If a patient is very poor AAS does try to give the medicine free of cost. But in general some drugs are subsidised and some are not. The cost varies, but is generally around 7 500 Tk per month at minimum.

**Social Action:** What do you think the government is doing to aid the situation? Is the initiative enough?

Dr. Serajul Islam: To sum it up: what government is doing in aid of the situation is not at all satisfactory. These are mainly for two reasons:

1. Their services are limited to HIV/AIDS awareness programmes through NGOs. They shed most of the responsibility to these NGOs and the donor agencies and think that their only role is to coordinate the efforts.
2. The government is not giving due importance to the greatness of the epidemic in Bangladesh. They need to realise that what we are seeing is only the tip of the iceberg. The initiative is not enough and in some places not at all.

**Social Action:** What should the government do?

Dr. Serajul Islam: At first, they should properly assess the HIV/AIDS situation in Bangladesh taking help from all the NGOs working in this field. With this information they should have short term and long term planning. For the short term the government should set up enough public care and support services for PHAs across the nation. Since AntiRetroviral (ARV) therapies are not available in the government sector there should be an initiative to make them available for the people who need it right away. There should also be available public facilities and labs for viral load counts. There are not enough centers or in most places not any at all. The long term plan should include initiatives for what needs to be done in 2, 5, & 7 years time. Good planning for prevention of and dealing with HIV/AIDS will help the future situation.



## HIV/AIDS Mainstreaming – Pioneering Protocols in Bangladesh

Sonali Srivastava, YPSA Intern

“If we don’t talk about HIV and good practices it will explode. Let’s be prepared for it”  
- Julius Otim

During Julius Otim’s 4 years experience in the domain of HIV/AIDS he has worked with many transnational organizations such as SAVE Foundation, UNICEF Uganda, Save the Children US, and UN/IOM. He has worked in both Zambia and his home country of Uganda. Julius is now in Dhaka on a 2 year placement through VSO on HIV/ AIDS mainstreaming.

“HIV has not exploded in Bangladesh yet” says Julius whose emphasis on the word ‘yet’ underlines the need for policies to effectively pioneer how various systems will operate. HIV mainstreaming will set up frameworks and shape HR and employment policies for PLAs. Through VSO Julius acts as an advisor to VSO’s partner organisations as well as the Bangladeshi Government. Through capacity building these partner organisations are in position to pass on the information to the community at large.

Due to numerous risk factors the potential of HIV/AIDS exploding within Bangladesh is enormous. These risk factors include:

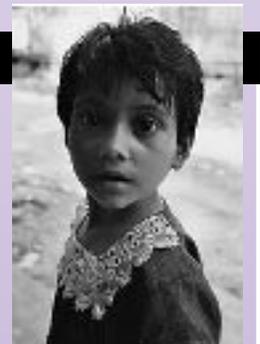
- a. Sex workers in Bangladesh have the most number of clients in South Asian countries
- b. IDU population is above 2 million
- c. Widespread poverty
- d. Free movement between borders

When asked to compare Bangladesh’s present situation to Uganda’s past Julius asserts that “what Bangladesh is right now is what Uganda used to be in the 1980’s”. The stigma of the virus and denial of it being a problem characterises beliefs within the community. However, Julius is also quick to point out the positive similarities in present day. These include a strong commitment from the government and its willingness to discuss the issue, as well as support by transnational organizations like UNICEF, VSO, CIDA, CARE, and HELP (just to name a few). When asked if anything has surprised him about the HIV/AIDS situation in Bangladesh he says that whereas HIV/AIDS is constructed as ‘sexual disease’ between man and woman in Uganda, in Bangladesh it is constructed as more of an ‘IDU disease.’ This illustrates the changing face of HIV/AIDS and its cultural adaptations.

Julius hopes to encourage the government to open more VCT centres around Bangladesh, and plans to look at HR policy manuals and documents to have them address PLAs. The next set of issues on the horizon for Bangladesh include mapping trends of HIV, predicting what it will be 10 years from now, and figuring out how it will be combated.

Julius thinks that the commitment shown by the Bangladeshi government at this early stage has been impressive. Yet still Julius wonders and leaves a pressing query “Will acknowledgment go into implementation? That is the only question”.

**No one is out of risk...**



# Education and Empowerment: HIV/AIDS Prevention among Street Based Sex Workers

Mai Ngo, YPSA Intern

YPSA has not yet identified any sex workers with HIV or AIDS. Though alarmingly, each sex worker can be diagnosed on average with one to three STIs per year, the predominant one being syphilis.

YPSA's program 'HIV/AIDS Prevention among Street Based Sex Workers' accomplishes dual tasks: educating sex workers about sexually transmitted infections (STIs), HIV and AIDS, while empowering them as marginalized women.

Currently, there are approximately 2000 sex workers in the Chittagong City Corporation (CCC) area, and YPSA works with 1200 of them. YPSA chooses high risk groups to implement its HIV/AIDS prevention methods. Especially in the CCC region, street based sex workers are at high risk due to the city's port, with its proximity to HIV prevalent countries such as India, Myanmar, and Thailand.

YPSA has not yet identified any sex workers with HIV or AIDS. Though alarmingly, each sex worker can be diagnosed on average with one to three STIs per year, the predominant one being syphilis. The results are supported by Bangladesh's Ministry of Health (MoH). For example, the MoH found in central Bangladesh sex workers had 0.5 percent prevalence of HIV; in contrast those same sex workers had 42.7 percent prevalence of syphilis[1]. These statistics prove STI prevention is important in the fight against HIV/AIDS, as transmission of STIs means a higher risk and spread of HIV.

Prevention methods for sex workers include two Integrated Health Centers (IHCs), bi-weekly clinical sessions, STI diagnoses, cost-free medicine (although this does not include anti-retrovirals), strategic behavioural change (SBC) sessions, and counseling. In addition, the IHCs implement voluntary counseling and testing (VCT) as a strategy to ensure that the sex workers can freely choose whether or not they want to be tested. The ability for the women at the IHC to make their own decisions is essential.

According to the World Health Organization (WHO), successful HIV/AIDS programming should empower women to improve a woman's capability to "organize, make choices and decisions, take positions of leadership, and shape their own destinies"[2].

YPSA's prevention program concentrates widely on peer education. Sex workers are given opportunities for leadership by becoming peer educators. Peer educators are sex workers themselves, and are chosen from within the community. HIV/AIDS program officer Ms. Luftun Nahar Kochi points

out that "friend to friend" reaches more sex workers due to their intimate knowledge of the vulnerable population.

The successes of the IHC include 125 sex workers using the VCT services, an increase in correct condom use, and knowledge of how HIV spreads and treatments of STIs. Most importantly, Ms. Luftun

Nahar Kochi declares that sex workers' "negotiation power is increased" with clients. In accordance with WHO, empowering these marginalized women to make their own choices is perhaps one of the most vital steps towards the fight against HIV/AIDS.

Why empower marginalized women?

In 2004 UNAIDS found 50 percent of women living with AIDS, and that "gender inequality and poor respect for the human rights of women and girls is a particular critical factor in the HIV/AIDS epidemic"[3]. There is no doubt that YPSA's HIV/AIDS prevention program increases equality, by enabling women to make their own decisions and take on leadership roles.

It is not without its obstacles. YPSA must convince the pimps because there is resistance among them. Pimps do not always agree with YPSA's education because they fear a decrease in clients and control when sex workers become vocal, and want to use condoms.

YPSA realizes the challenges that lie ahead. There needs to be equal concentration on direct (i.e., sex workers) and indirect (i.e., clients) beneficiaries. YPSA has already begun increasing their attention to clients by running three to four day long male health camps. The camps include VCT, STI, health and referral services to clinics. The clients range from rickshaw pullers to truck drivers, as well as students to small business men.

YPSA accesses vulnerable groups such as sex workers, and empowers them through education. However, the clientele who use sex workers indicates that marginalized groups are not the only ones at risk. As the program that pioneered the fight against HIV/AIDS in Chittagong continues to evolve, it will attempt to urge the general population to take notice and more importantly, responsibility.

[1] Human Rights Watch. Ravaging the Vulnerable: Abuses Against Persons at High Risk of HIV infection in Bangladesh, 15 (6), 2003.

[2] WHO. Integrating Gender into HIV/AIDS programmes, p.28, 2003.

[3] UNAIDS. Operational Guide on Gender: HIV/AIDS Rights Based Approach, p.7, 2005.

## Rehabilitation: Changing Health, Changing Lifestyles

(Jointly with Farhana Idris, IHC Manager)

YPSA's rehabilitation strategies in the Integrated Health Centers (IHCs) for sex workers are not only impacting health and behavior – they are changing lifestyles.

(See Page 6)

## Rehabilitation...

(From Page 5)

Initially it  
was very  
difficult ...  
but now  
there is a  
positive  
change in  
their  
lifestyles.

Sufia, age 40, recalls her favourite memory as a child. She was an actress in Jatra, a staging drama team that traveled and performed in different places. When her mother forced her to leave to become a maid, Sufia did not know that she would be entering the lucrative hardships of sex work.

Sufia has been a street based sex worker (SBSW) for 25 years. Three years ago she adopted a young girl who had lost her parents. In the IHC mother and daughter can be seen smiling as Sufia wraps her little girl in a small, red sari. Sufia's dreams for her child are ones shared by most parents in the general population. She would like to send her daughter to school to receive an education.

Sufia's own mother had a different vision for her daughter. With no husband (he had married another woman), Sufia's mother turned to sex work. At the age of 15, Sufia was sold by her mother to a police officer's house where he employed her as a maid, and sex worker. Young Sufia ran away to stay with her father's second family. However, she was emotionally and physically abused by her stepmother.

Her only brief escape from her harsh life was with her uncle. He tried to send Sufia to school for one month, but the education fees were too high. Once more, Sufia left to find work. Today she, like her mother, is a sex worker.

Children of SBSW do not always become sex

workers. It depends highly on the individual, and whether the sex worker receives rehabilitation. Although some mothers may use daughters as income, as in Sufia's case, most do not want this. According to IHC manager Farhana Idris, commercial sex workers who live in the street are more likely to have their young daughters enter sex work, because they are not exposed or rehabilitated to any other lifestyle.

Rehabilitation at the IHC focuses on peer education and strategic behavioural change (SBC). Farhana says SBC's main goal is "to change the risk behavior of sex workers". SBC informs sex workers on risks without a condom, and averts them to STIs, HIV and AIDS.

Behaviour change, however, takes time and is a continuous counseling process. In addition to counseling sessions, the IHC also provides the women with a safe, welcoming environment. Farhana emphasizes, "The sex workers expect some good behavior and some importance – we make sure to receive them cordially."

Farhana has spent four years building a relationship of mutual respect and trust between her staff and the IHC clients. Initially, the women were very aggressive, vulnerable and short tempered. Some women had resorted to cutting themselves to find "mental peace", and some were beaten by the police or pimps.

After many repetitive SBC sessions (e.g., how to negotiate with clients for condom use), and a lot of patience, there is a significant change. For example, all of the peer educators' children attend school. Farhana explains the IHC's greatest achievement, "At the beginning the peer educators did not know how to write. Now they can write their own names. Now every peer educator and some girls have savings. Initially they said 'our life is gone – we can do nothing'. Now they think they can do something and change other girls; now they can realize and think about the future."

Sufia shares her thoughts about the IHC's important rehabilitation component. She thinks it feels good that there is a place where she can receive free treatment of STIs, and share her feelings with others. When asked if Sufia's own daughter might enter sex work, she responds adamantly, "I will try my best, try to my death to protect my daughter from the pimps and mishappenings."



Sex workers can be rehabilitated

## Young People and HIV/AIDS Risk in Bangladesh

Mohammad Zahad Hasan, Divisional Coordinator, Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) Project  
Sonal Srivastava, Canadian YPSA Intern.

There is no definite data on how many young people have HIV/AIDS but it is estimated that out of the total number of people infected 50% are young people. Young people (15-24 years) are vulnerable to HIV infection due to injection use, unprotected sex, and blood transmission. Most of the drug users are young people. This group often visit sex workers sometimes due to curiosity and sell their blood for money. A lot of them have no



Young People are vulnerable to HIV infection

idea of a condom and no conception of reproductive health issues. Social barriers prevent young people from even buying condoms. There is no policy about condom selling since previously they were strictly used

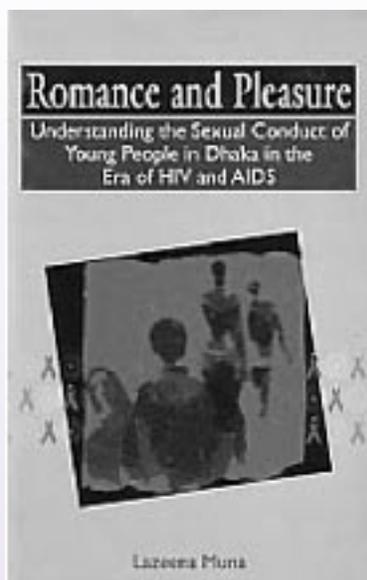
as a tool in family planning. People feel shy to ask for them and it is not uncommon for shopkeepers to ask why it is being bought with questions about their marital status. If you advise young people to wear a condom in front of their guardian it is definitely not received well! There is also a lack of health facilities young people can go to for STIs. Right now, the biggest challenge is access of condoms to youth.

In Bangladesh, awareness messages are usually going to sex workers, drug users, men having sex with men (MSM), rickshaw pullers, and nobody is thinking of the young people since they are not so easily typecast. GFATM was awarded to Bangladesh in 2004 and funds were given to especially fight HIV/AIDS and TB. Save the Children USA was chosen to manage the project and Bangladesh was especially thinking of reaching its young people. Challenges include redefining who is affected by HIV/AIDS. Previously, even accessing young people was a challenge because community leaders and teachers were not well aware of HIV/AIDS. There is still some resistance from the 'gate keepers' because a lot of them do not want to acknowledge that this problem can affect young people.

YPSA has been involved in mainly 3 areas to impact its youth. 1) Life skills training where reproductive health training, drug abuse information, and HIV/AIDS awareness is given. 2) Creating an environment for discussing HIV/AIDS by holding advocacy meetings with community members. 3) Initiating youth friendly services for young people with existing NGOs, government and private health facilities. YPSA hopes to continue this project with hopes of helping their youth fight the epidemic.

### Slogans of the World AIDS Day

- 2006 : Stop AIDS. Keep the promise
- 2005 : Stop AIDS. Keep the promise
- 2004 : Woman, Girls, HIV and AIDS
- 2003 : Live and let Live
- 2002 : Live and let Live
- 2001 : I Care.....Do you?
- 2000 : AIDS- Men Make a Difference
- 1999 : Listen, Learn, Live!
- 1998 : Force for Change



Lazeena Muna, PhD in Population Health (London School of Hygiene and Tropical Medicine) is a prominent Bangladeshi anthropologist and public health specialist. She is the Advocacy Advisor for HIV/AIDS at UNAIDS established in Dhaka. Her research interests centre on adolescent health issues since she found that this group faces the brunt of several social afflictions including: STI infections, abortion, suicide, and violence against women. She became interested particularly with HIV/AIDS and adolescents in 1995/96. She has also recently written a book 'Romance and Pleasure: Understanding the Sexual Conduct of Young People in Dhaka in the Era of HIV and AIDS'.

## Sexuality, Condoms, and HIV/AIDS

(Article based on Interview with Dr. Lazeena Muna)

Sonali Srivastava, YPSA Intern

After speaking with Dr. Muna, it became clear that Bangladesh has to reform the way HIV is socially constructed in order for their prevention and care programs to become effective. Currently the Bangladesh government receives grants to prevent the spread of the virus. They do this by distributing to funds to various NGOs who then employ peer educators who then disperse condoms into the field to sex workers and their clients. However as Dr. Muna stresses, the entire culture of care and prevention already needs to be in place in order to address HIV prevention correctly and consistently. UNAIDS plans to address the culture of prevention as one of the challenges in next year's work plan.

"We're throwing condoms in the field rather than coming up with meaningful messages." Promoting condom use is not only an issue of its availability. The idea of what a condom is used for and what they are associated with needs to be reformed in the minds of policy makers and Bangladeshis. At the policy level, there is classic enmity between family planning and health measures. Traditionally, since condoms were tools for family planning there is resistance in associating them with attainment of sexual pleasure and prevention of illness. Individually, across countries sexuality is not usually associated with condoms because they were introduced from the public health arena. The bigger picture is that there is a clash between the sexual act and condom use. The sexual act signifies desire, expression of feelings, and biological emotion, and the condom is seen as a public health device in order to save people from either disease unwanted children. When people think of sex they think of pleasure and not safety from illness or death. Changing this thought is not so easy. It requires more than just providing sex workers and clients with condoms. Furthermore, this culture needs to be inspired from the top down and not the other way around. This means that the top government officials need to actively advocate and promote awareness themselves. Successful messages carry more weight when they are supported by top officials, as in the case in Thailand where the Health Minister distributed condoms presented in nice packages on street corners in an effort to positively reinforce condoms and safe sexual behaviour among all citizens.

Dr. Muna stresses the idea that Bangladesh should work on condom issues at all levels and not only in the field. Advocacy, policy makers, partner organisations, and funding agencies need to adopt the notion of including condoms in a meaningful manner. The message should not be limited to simply having sex workers distribute them and teaching others how to put them on during sex. Also, there is not much emphasis in developing the supporting materials used in prevention and awareness messages. The flipchart story in particular is especially puzzling since it is a story about one married couple and essentially talks about being faithful to one partner. "What is a sex worker going to do with being faithful?" This message not only neglects the realities of her living and work but also fails to offer any meaningful advice or message. The materials developed should be relevant. "We are literally not paying attention."

## Sexuality, Condoms, and HIV/AIDS

(From Page 8)

contrary to popular belief young people are not shy or afraid to discuss sexuality; which is considered a barrier in reaching this group

Sexual intercourse is frequently cited by various scientific researchers as the mode of HIV transmission in Bangladesh, but it is a complex scenario since groups are not isolated populations and often intermix. "If we neglect a sector we miss a major chunk to prevent HIV in Bangladesh." Injection Drug Users (IDU) are sexually active and often go to sex workers and donate blood. They can be married or unmarried, and their network of sexual activity is quite wide. The classifications of at-risk groups are constantly intersecting; they are fluid. The differing modes of transmission should be considered equally significant to assure that they obtain their share of importance. Furthermore, prevention messages as well as care and support need to be enforced at all levels including people who are already infected. "Strategies are all ad-hoc." Other than the distribution of condoms, strategies are simply not in place and this is dangerous.

of 25 female students 30-40% of them were already sexually active and some with multiple partners. Yet 90% of them were open to the idea of sexual relations before marriage even though they were not active right now. They expressed that being sexually active was their individual right. Most of the 28 male students were sexually active and with multiple partners. Dr. Muna would like to see more parents take positive steps to open up discussion about sex that could save their children from disease. They also need to understand that talking about it is not going to coerce their children into engaging in sexual activity. In fact, they will be more cautious and less likely to have multiple partners. There is a general idea in society that such talks promote sex and endanger young people's innocence. Although when speaking to parents individually a lot of them expressed the desire to teach their children of safe sex but often do not have the skills to initiate these types of discussions. "We should make parents skilled rather than blaming them!" Once again, these lessons are effectively inspired from the top down since the issues themselves become more normalised making it easier for the society at large to consider them. Despite this reasoning, it seems that no top official wants to take the risk of being negatively labelled by being the first to openly discussing sex which remains a taboo subject.

Future plans for UNAIDS also involve working on mainstreaming HIV/AIDS messages through radio and television. This is not only to promote and prevention and treatment messages but also to encourage the acceptance of HIV infected individuals in society and ensure their confidentiality, respect, and dignity. Bangladesh needs to realise and take to heart that the upcoming epidemic is very real and needs to be addressed immediately and properly. Society needs to adopt a more open philosophy to discussing not only HIV but sexuality in the greater sense. This open atmosphere needs to pervade all sectors of society and should begin with the top officials publicly adopting the philosophy of open communication. These officials in essence mirror society and are thus in place to set an influential example that will send out positive HIV message shockwaves penetrating the minds of all Bangladeshis. It seems that Bangladesh is presently on the cusp of dealing with the epidemic. It should make the choice to deal with the issue head on.



Young people are especially vulnerable to HIV due to their high risk activities. Based on research with Dhaka based college/university students aged 14-22, Dr. Muna points out that contrary to popular belief young people are not shy or afraid to discuss sexuality; which is considered a barrier in reaching this group. Out

# Backlight into Sex Work

Lutfun Nahar, HIV/AIDS Prevention Programme Officer

Majority of the street-based sex workers are homeless and living on the streets. If they are working independently sometimes they have to bribe the police or mastans to use the streets for sex or sleep.

For the past three years I've been working for YPSA on their HIV/AIDS prevention program amongst street-based sex workers in the Chittagong area. I have interviewed a number of sex workers, in order to hear their stories and obtain an overall assessment of our program and the social impact that it has had upon the women. The stories that these women have provided in explaining how they arrived at this profession are tragic and must be shared in order to demonstrate the degree to which choice was a factor in their entry into the sex trade.

Most girls usually enter this profession when they are in their late teens. The majority of them come to Chittagong from their villages, looking to earn income for themselves or their families. Many are promised jobs, such as household help or work in garments by friendly strangers upon arrival, but end up being tricked. The girls are often given sedative drugs, and when they regain consciousness they find that they have been raped by clients. The 'friendly' stranger usually reveals themselves to be a dalal, or another sex worker working for a dalal.

A number of girls who do not know anyone in the city end up being kidnapped upon arrival at the train station, and forced into sex work in this manner. They are often picked up by a dalal, or raped by mastans and then brought to a dalal. The police themselves are often perpetrators of these violent acts, rather than law enforcers. It is also quite common for dalals and mastans to recruit girls who are already working in garments for sex work. Many work shifts that end late at night, and when they are walking home they are raped or kidnapped.

Majority of the street-based sex workers are homeless and living on the streets. If they are working independently sometimes they have to bribe the police or mastans to use the streets for sex or sleep.

These trends clearly illustrate how most young girls enter sex work against their will and have very little choice in the matter. Most remain in sex work for two reasons. The first is that they are now 'spoiled' and stigmatized; their virginity has been taken from them before marriage. Not only do they consider themselves ruined, but society looks at them with shame. The second reason most stay in sex work is because they are unskilled to work in other professions and are unaware of their

economic options.

There are a number of steps that could be taken in order to prevent girls from being trapped into the sex trade, as well as inform them of their alternatives, if they should find themselves in the profession against their will. First of all young girls, particularly in rural areas require life skills education. Such a program would address issues relating to self confidence and girls would be given the skills that would enable them to be taken more seriously in school as well as at the workplace, which is particularly important given the nature of Bangladesh's male-dominated society.

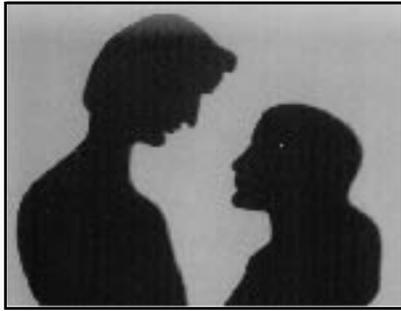
Female adolescents in rural areas should have access to vocational training so that they possess marketable skills when they arrive in urban settings, so that they may actually find other work. In addition, girls need to be provided with self-defense training, whether it is provided through their educational facilities or within the workspace. Girls would be able to protect themselves against violence, rape and kidnapping.

Many young girls who are now sex workers did not know what sex was until they experienced it. Many are uninformed as how to protect themselves against unwanted pregnancy and/or STIs and HIV/AIDS. The establishment of youth friendly health services is crucial in order to educate young people on sexual health issues.

The aforementioned services empower young girls to make informed decisions about their future on their own, protect themselves against harm whether it be physical abuse or a sexually transmitted infection, as well as provide them with tools that make them more employable in other fields. As a society we have a collective responsibility towards our younger sisters and we must make an effort to reduce their vulnerability towards harm, and facilitate their entry into the workforce.

Generally HIV survives in the liquid of the body such as blood, spam, breast milk, vaginal fluid

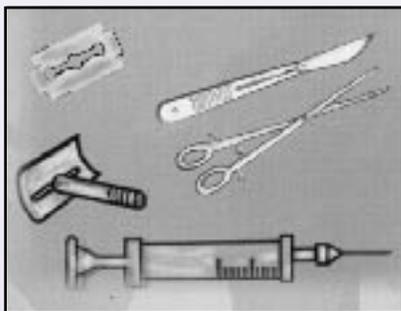
## How HIV spread?



Taking blood without proper laboratory test. HIV infected blood transfusion is a very much risky for spreading HIV.



Perform unsafe sex or sex without proper use of condoms or lubricants. HIV or sexually transmitted disease can spread between sex partners when one has infection.



Use syringe without free from germs. Reuse of the syringe, which is used by infected person can spread



Child can be exposed to HIV by breast feeding from infected mother or the child who are born from infected mother.

## HIV infection & Drug therapy

(From Page 12)

### Viral load

The viral load test indicates how much of the HIV virus is present in your blood, and how fast it is growing. The higher the viral load, the faster HIV is infecting and killing your CD4 cells. The lower the viral load, the better.

Doctor will look at these two things carefully. People whose CD4 count is low, and people whose viral load is high, are more likely to get sick sooner than people with a high CD4 count and low viral load.

### Anti- HIV or Antiretroviral drug

Anti-HIV drugs are also called antiretroviral drugs or antiretrovirals. They work because they attack the HIV virus directly. The drugs cripple the ability of the virus to make copies of itself.

There are 4 main groups of anti-HIV drugs:

- 1) Nucleoside reverse transcriptase inhibitors (NRTIs or "nukes")
- 2) Non-nucleoside reverse transcriptase inhibitors (NNRTIs or "non-nukes")
- 3) Protease Inhibitors (PIs)
- 4) Fusion or entry inhibitors

The following table shows how you can monitor your symptoms, CD4 count, and viral load to help decide whether it is time to start anti-HIV medications:

Symptoms	CD4 Count	Viral Load	Recommendation
AIDS-defining illness severe symptoms (such as unexplained fever or diarrhea for more than 2 to 4 weeks)	Any value	Any value	Start HIV drugs
No symptoms	Less than 200	Any value	Start HIV drugs
No symptoms	Higher than 200 but less than 350	Any value	Consider treatment but weigh the pros and cons
No symptoms	Higher than 350	Higher than 100,000	Most doctors will hold off on starting HIV drugs, but some will decide to treat
No symptoms	Higher than 350	Less than 100,000	Hold off on starting HIV drugs

Source : Center for HIV Information (CHI) at the University of California San Francisco (UCSF)

Don't neglect to  
HIV infected people  
They are part of our Society

# HIV infection & Drug therapy

## Use of Antiretroviral Agents in HIV Infection

Abdullah Al Shakir, Development Activist, YPSA

There is currently no effective vaccine to prevent HIV infection. Vaccines work by causing a person's immune system to recognize and react to specific germs if a person is exposed to one of those germs later.

For people infected with HIV, drug development helped to change the face of the disease. Drug therapy has helped to prolong and improve the quality of life for many individuals.

HIV is a retrovirus, so drug that target the virus are called antiretroviral drugs. It works by slowing the growth or inhabiting the replication of the virus. Although these drugs do not kill the virus, they effectively reduce the levels of HIV in blood.

### HIV test

The HIV test is designed to detect antibodies to HIV in your blood or saliva. Antibodies are "fighter cells" produced by your body when you have an infection. If you have HIV antibodies, then you have been infected with HIV. The HIV test does not tell you if you have AIDS or how long you have been infected or how sick you might be. It just tells you that you are infected with the virus.

### The window period

The window period is the time it takes for your body to produce HIV

antibodies after you have been exposed to HIV. In more than 99% of people, this period is between 2 and 12 weeks. In a very small number of people, the process takes up to 6 months.

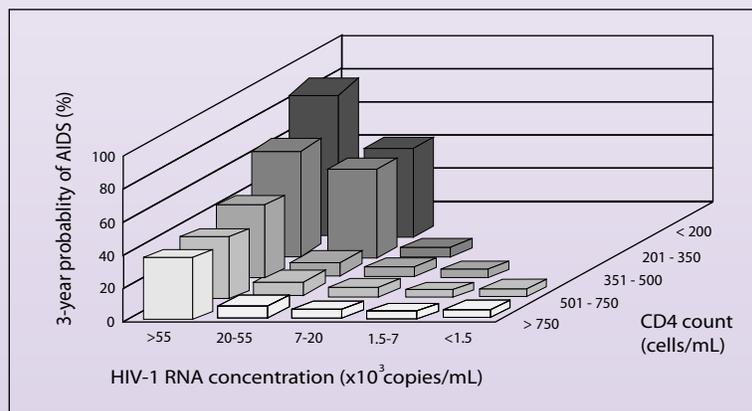
For example, someone had unprotected sex on Saturday



night. On Monday, he goes to get an HIV test. The test will almost certainly come back negative, even if he was infected with HIV on Saturday night, because his body has not yet had a chance to make antibodies.

The doctor may be able to perform a different kind of

### Prognosis According to CD4 Cell Count and Viral Load



Source: Department of Health and Human Services (DHHS) Panel on Antiretroviral Guidelines for Adults and Adolescents (a Working Group of the Office of AIDS Research Advisory Council. USA).

test called a Polymerase Chain Reaction (PCR) test that can detect actual virus in the blood. Immune system

The body's defense against infections and Cancer are called immune system.

### CD4 Cell

The virus and our immune system are at war with each other. The virus is trying to grow as fast as it can, and our body is trying to stop it.

CD4 cells play a major role in helping our immune system work properly. HIV causes disease by killing off

CD4 cells. It does this by infecting the cells and turning them into virus factories, a process that kills the cell. A test called the CD4 count can tell us how many CD4 cells we have. The higher the number, the better.

(See Page 8)



The context of SOCIAL ACTION reflects the writer's opinion. Consequently, their points of view and morality are not necessarily similar to those of YPSA. The articles and pictures contained in this publication could be republished and reprinted with proper recognition.

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