HIV/AIDS RELATED RISK PRACTICES AMONG THE USERS OF SELECTED DROP-IN-CENTERS OF DHAKA: A CULTURAL STUDY

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Registration No: 159

Session: 2013-2014

A thesis submitted in partial fulfillment of the requirements for PhD degree

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September 2017

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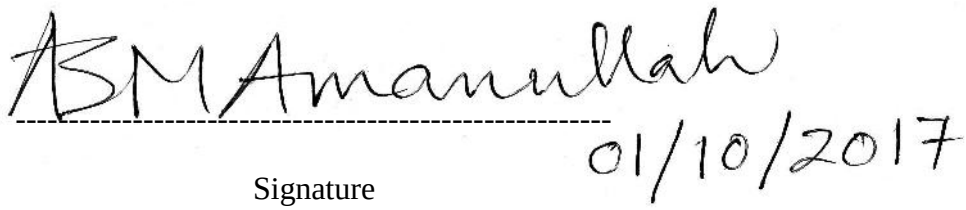

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DECLARATION OF THE RESEARCHER

I, do hereby honestly declare that the dissertation titled **"HIV/AIDS Related Risk Practices Among the Users of Selected Drop-in-Centers of Dhaka: A Cultural Study"** is the outcome of my endeavor and research of couple of years.

The materials used in this work is self-collected and original, and were never submitted for any diploma or degree in any University or Institute and published in any journal, book or any from.

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Re-registration: 106
Session: 2010-2011
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Session: 2013-2014

ACKNOWLEDGEMENTS

The success of this thesis has become possible through the assistance from a number of people, all of whom I cannot acknowledge. First, I am grateful to my supervisor Professor Dr ASM Amanullah, an internationally acclaimed AIDS researcher, who has encouraged and guided me by providing several books and research papers regarding my study. His support, criticism, intellectual guidance and comments helped me to successfully accomplish this study. It was an immense contribution from his part with providing plenty of his valuable time, without which, it would be hard for me to complete the thesis in due time. I feel myself very fortunate to have learned a lot of relevant information from him.

I also like to show my special gratitude to some honorable teachers of my department who always provided me related ideas and encouraged me to conduct the study successfully. They contributed significant inputs into the development of necessary ideas which the thesis contains.

I especially like to thank Dr. A.I. Mahbub Uddin Ahmed PhD, a renowned sociologist, for his discussion on postmodern theories of sexuality and health. In addition, I am grateful to him for his methodological discussions regarding various quantitative aspects, which facilitated the statistical analysis of this thesis.

I am highly indebted to Professor Dr Monirul Islam Khan, Professor Dr Nehal Karim and Professor Dr Shah Ehsan Habib of the Department of Sociology. Without their help and guidance, it would not have been possible on my part to complete this thesis. I express my heartfelt thanks to them.

I also like to express my sincere gratitude to Dr Md. Anisur Rahman, DPM, National AIDS/STD Program (NASP), Directorate General of Health Services, Ministry of Health and Family Welfare (MoHFW), Gulshan, Dhaka; Dr Lima Rahman, PD, HIV/AIDS Sector, Mr Anup Kumar Basu, PM, Save the Children, Gulshan, Dhaka; Dr Rupali Shishir Banu, Team Leader, GFATM-HIV Program, Care Bangladesh, Kawranbazar, Dhaka; Mrs Rahima Begum, President, Durjoy Nari Shangha, Mohammadpur, Dhaka; Mr Shale Ahmad, ED and ASM Rahmat Ullah Bhuiyan, Global Fund Program Manager, Bandhu Social Welfare Society, Kakrail, Dhaka, for their valuable cooperation they rendered during my investigations.

Most significantly, I am very much indebted to the officials of sample NGOs, who helped me substantially by providing me the lists of their DICs and beneficiaries, and thus facilitated the sampling procedure.

Finally, I owe my special thanks to all the respondents who took their time respond to my queries and without whose support and patience, it would have been very difficult to conduct my fieldwork successfully.

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September, 2017
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CONTENTS

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ACRONYMS AND ABBREVIATIONS

AIDS	: Acquired Immune Deficiency Syndrome
AVERT	: AVERTing HIV and AIDS
BDHS	: Bangladesh Demographic and Health Survey
CSWs	: Commercial Sex Workers
DIC	: Drop-in-Center
FSWs	: Female Sex Workers
GFATM	: Global Fund to Fight AIDS, Tuberculosis and Malaria
GoB	: Government of Bangladesh
HAPP	: HIV and AIDS Prevention Project
HIV	: Human Immunodeficiency Virus
IDU	: Injecting Drug Users
IoM	: Institute of Medicine
MDG	: Millennium Development Goals
M&E	: Monitoring and Evaluation
MOHFW	: Ministry of Health and Family Welfare
MSWs	: Male Sex Workers
NASP	: National AIDS/STD Program
NIPORT	: National Institute of Population Research and Training
NRCS	: Nigerian Red Cross Society
PLHIV	: People Living with HIV/AIDS
STDs	: Sexually Transmitted diseases
TGs	: Transgender
UNAIDS	: United Nations Program on HIV & AIDS
UNESCO	: United Nations Educational Scientific and Cultural Organization
UNICEF	: United Nations Children's Fund
UNGASS	: United Nations General Assembly Special Session
WHO	: World Health Organizations

Abstract

A Drop-In-Center (DIC) is one of the interventions for HIV/AIDS prevention in Bangladesh where various necessary services are provided to high-risk groups. The purpose of this study was to assess the HIV/AIDS related risk practices among the DIC users, such as, FSWs, IDUs, MSWs and TGs of selected Drop-in-Centers in the Dhaka City. In the study, a total of 416 FSWs, IDUs, MSWs and TGs were taken as sample from 16 DICs by following a simple random sampling technique. Surveys, Case Studies and FGDs were conducted to collect required data from the study participants. The result of the study demonstrated that the majority (70 percent), as observed among the FSWs and their clients, used condoms while having sex to avoid infection of STDIs/STDs and HIV; whereas, almost all (99 percent) of the FSWs reported that they knew how to conduct safe sexual intercourse with their customers. Surprisingly, about 23 percent of the FSWs confessed that they had female condoms while having sex with their clients; and vaginal sex was the most performed form of sex as stated by 84 percent of the FSWs. The findings of the study also pointed out that an overwhelming majority of the IDUs (98 percent) used drugs daily. Similarly, 98 percent of the IDUs reported that they used needle syringe to inject drug into their bodies. Not only they injected drugs, but 66 percent of them also shared needles and syringes with other users. On the contrary, about 28 percent of the MSWs said that they had intercourse with various customers. Shockingly, around one-third of them (27 percent) confessed that they used condoms while having sex. Moreover, just half of the TGs said that they used drugs 3 to 5 days in a week. The results on their sexual behavior proved that 98.60 percent of the TGs had sex with other general clients, TGs, MSWs and FSWs; and 83 percent of them reported that they used condoms with their partners. This study told that DICs provide various necessary facilities, such as, treatment, condoms, lubricants, sleeping place, medical checkup, blood test, counseling facilities, etc. for FSWs, IDUs, MSWs and TGs. The qualitative findings were supported by the quantitative findings of this study. In this study, except male and female SWs, all other risk practicing groups were seem somewhat as self-efficacious in dealing with their sexual partners. FSWs and MSWs were less interested to follow safe practices due to some socio-cultural and economic reasons. Similarly IDUs were more interested to share needles with other users. So, any development or health programs, for high risk population of Bangladesh needs to address several extraneous factors and other local socio-cultural discourses, such as, power relationships, gender, stigma, discrimination, labelling, construction of sexuality, etc, in eradicating any sorts of risk practices related to emerging and re-emerging contagious diseases in a less resourced setting.

Keywords: HIV/AIDS, FSWs, IDUs, MSWs, TGs, DICs, Risk Practices, Condom Use, Psychological Theories, Cultural Theories.

CHAPTER ONE

CHAPTER ONE
INTRODUCTION

1.1 Introduction

It is observed in most parts of the globe that, unprotected sex is the major cause of HIV infections (UNAIDS, 2006), which, poses a serious threat to mankind (Huda and Amanullah, 2013). HIV infection is a development problem as well (Amanullah and Huda, 2012a), which has increased among young people aged 15 to 24 (UNAIDS, 2012). A recent UNAIDS report on the global AIDS epidemic says that globally, 34.0 million [31.4 million–35.9 million] people were having HIV in the end of 2011. It also informs that an estimated 0.8% of the adults aged 15-49 years globally are having with HIV, although the burden of the epidemic continues to vary considerably between regions and countries (Asekun-Olarinmoye, et al, 2011). For example, sub-Saharan Africa (SSA) is the most AIDS affected region in the world, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide (UNAIDS, 2012). In terms of a particular country, South Africa is one of the countries heavily affected by HIV/AIDS (Mueller-Debus, Thauer and Börzel, 2009). It is reported to have the largest population living with the disease, over 5 million people infected, followed by Nigeria in the second place (Global AIDS Report for South Africa, 2012).

Outside Africa, it is considered that Asia remains a potential breeding ground for HIV epidemic (Rodrigo and Rajapakse, 2009). Although the regional prevalence of HIV infection is nearly 25 times higher in sub-Saharan Africa than in Asia, almost 5 million people are living with HIV in South, South-East and East Asia combined (UNAIDS, 2012). In 2010, an estimated 3.5 million people were living with HIV/AIDS in the South-East Asia Region. Five countries (namely, India, Indonesia, Myanmar, Nepal and Thailand) account for the majority (99%) of HIV infections. However, the overall HIV prevalence among the adult population is very low (0.3%) in this region (WHO, 2011).

In Bangladesh, the first case of HIV/AIDS was detected in 1989 (NASP and MoHFW, 2010). Though the overall prevalence of HIV in Bangladesh is less than 1% (NASP, 2011), however, the HIV prevalence is increasing and high levels of HIV infection have been found among the injecting drug users (Amanullah and Huda, 2012b; UNAIDS 2012; Habib, Amanullah and Hasan, 2001; Amanullah and Chowdhury, 2005). In 2011, the

National AIDS and STD Program (NASP) informed that there were 445 newly reported cases of HIV and 251 new AIDS cases, out of which 84 people had died. Thus, the cumulative number of reported HIV cases to date in Bangladesh stands at 2,533, AIDS cases at 1,101 and death toll at 3,258, according to the (UNAIDS country progress report, 2012). However, the actual number of HIV/AIDS cases is still unknown due to limited and incomplete surveillance facilities (Mondal, et al, 2009) in the country.

With the aim of preventing HIV/AIDS amongst the youth in Bangladesh the Global Fund provided grants in the Round–2 (2004-2009). Moreover, to reduce the spread of HIV/AIDS infection, and for care and support program amongst the high-risk segment and risk-exposed youth, Global Fund provided grants support in the Round–6 (2007-2012). Based on the satisfactory level of completion of the Round-2, the Global Fund awarded Bangladesh with additional 6-year fund termed as "Rolling Continuation Channel (RCC)" (2009-2015). With an opportunity of scale and scope changes, the RCC will cover new interventions for transgender and males having sex with males (Global Fund, 2009). The Ministry of Health and Family Welfare of the Government of Bangladesh is the recipient of the fund for the National AIDS/STD Program, and Save the Children-USA, Bangladesh Country Office is the Management Agency for the complete implementation process. Under the programs, 13 consortiums were formed which consist of 62 NGO (national & international) partners including relevant government departments, corporate/business sector and research organizations for effective, multi-dimensional and target oriented interventions (Global Fund, 2009).

Save the Children, USA as the Management Agency in collaboration with the National AIDS/STD Program is mainly responsible for fund administration, technical support, coordination, monitoring and evaluation, procurement processing and documentation and dissemination and presentation. This collaboration process is being implemented under the leadership and cooperation of Ministry of Health and Family Welfare, Government of Bangladesh and is operationally managed by the Country Coordinating Mechanism (CCM) Interventions for prevention and containment of HIV/AIDS amongst high-risk population and vulnerable young people in Bangladesh have made commendable progress (Bhuyain, 2000). To create mass awareness about HIV/AIDS and as per the demands of the adolescents and youth, a branding campaign was launched through an attractive slogan 'Banchtey Holay Jantay Hobay' – (to live you need to know). This message was seriously broadcast by TV and Radio channels with simultaneous exposures in the print

media. This jingle was pre-tested for comprehension and efficacy amongst the youth and approved by the MoHFW (Global Fund, 2009).

The Drop-In-Center is one of the interventions measures against HIV/AIDS infection in Bangladesh, where necessary health services are provided for HIV/AIDS high-risk groups. The first fixed Drop-In-Centers were set up in Bangladesh by CARE Bangladesh and its 64 partners, from 1996 to 2005 through a project called SHAKTI funded by DFID, UK, and managed 182 DICs in 30 districts (Bahauddin and Uddin, 2010). A Drop In Center is a safe place where clients (IDUs or female sex workers) can gather without fear of prejudice and discrimination for getting STIs management, discussion on their problems, receiving materials for safer sex, condoms and lubricants, consultation on reproductive health, limited General Health (GH) services, abscess management, sharing each other's views, counseling, bating and recreational facilities, toilet facilities, etc. A DIC is also used for providing training to the target groups, such as, FSWs, IDUs, MSWs and TGs on HIV, STIs and other issues, (e.g. adult literacy, IGA, etc. (Bhuyain, 2000). This study, therefore, examined the risk practices among them and the services provided by DICs for these risky and vulnerable groups in order to mitigate the risks posed by them.

1.2 Outline of the thesis

The thesis has been divided into eight different chapters so that the reader can identify the parts of the study, or see the relationship between the parts to one another. To serve the purpose, the thesis clearly indicates the title of each chapter along with its sections and sub-sections. In the first chapter, enough background has been given to make clear to the reader why the problem was considered worth investigating. It also includes the introduction, objectives and hypotheses as well as the definitions of the major concepts employed in the study. In the second chapter, attempt has been made to provide a balanced review of the available existing literatures regarding the risk practices of HIV/AIDS in different countries of the world. The third chapter is about theoretical framework containing some theories of sexuality as well as social learning theories and models which have been used in this study.

The third chapter is followed by a methodological chapter, which provides clear explanations regarding the design of the study. Then comes a chapter of empirical presentation where all the results have been presented in a logical sequence and split into

readily identifiable sections. In addition, some statistical associations have been explored in bivariate analysis in the same chapter. The qualitative findings of the study are presented in the chapter six. Finally, the interpretation of the major research findings has been made in the next chapter of discussion. Moreover, this chapter summarizes and recapitulates the main points of the study.

1.3 Objectives of the study

1.3.1 General Objective

1.3.2 Specific objectives

a. To understand the socio-demographic background of the drop-in-center users in the Dhaka city
b. to assess the risk practices related to HIV/AIDS of drop in center users in the urban Dhaka area;
c. to assess the HIV/AIDS vulnerability of the service users in the urban Dhaka area;
d. to understand the perception of HIV/AIDS among the drop-in-center users; and
e. to understand the relationship between the socio-demographic profiles of the FSWs, IDUs, MSWs and TGs and their risk practices related to HIV/AIDS.

1.4 Research Questions:

a. What are the socio-economic characteristics of DIC users of the Dhaka City?
b. What are the HIV/AIDS related risk practices among the drop in center users of the Dhaka City?
c. To what extent, the DIC users of the Dhaka City are vulnerable of contracting HIV/AIDS?
d. What is the perception of DIC users on HIV/AIDS related risk practices and on DIC services?

1.5 Rationale of the study

This study is meant to examine the risk practices of HIV/AIDS among the FSWs, IDUs, MSWs and TGs. Therefore, the results of the study will have its own contribution to those who want to know the demographic and socio-economic factors that shape the risk practices of HIV/AIDS. Many literatures suggest that the socio-demographic factors have considerable influence on the risk practices of HIV/AIDS, which shape the attitudes of the subjects. Research on risk practices of HIV/AIDS among FSWs, IDUs, MSWs and

TGs is one of the serious neglected issues in Bangladesh. A few studies, which were carried out earlier in Bangladesh focused only on the risk practices of HIV/AIDS of CSWs. Besides, HIV/AIDS related risk practices among the users of DIC were not focused issue in Bangladesh. So, it might serve as a reference for other researchers to study such problems in depth, in the study area besides fulfilling the literature gap.

1.6 Scope of the study

This study is an exploratory type of research work. It has been conducted on the FSWs, IDUs, MSWs and TGs who are the DIC users in the Dhaka City. For this study primary data were collected from the FSWs, IDUs, MSWs and TGs in 16 DICs in the Dhaka City. It did not involve any sort of longitudinal design; rather cross-sectional design has been used. HIV/AIDS related risk practices and sexual behavior of them, their knowledge about HIV/AIDS, services provided by DICs for them were explained by using both the quantitative and qualitative techniques. For this reason, some hypotheses are formulated by reviewing literatures and forming theoretical framework. As far as I know, this study is the first one in its nature in Bangladesh. Therefore, the findings of the study will be helpful not only for the academicians, but also for the policy planners and development workers.

1.7 Operational definitions of the study

Human Immunodeficiency Virus (HIV)

HIV is the virus that causes the Acquired Immune Deficiency Syndrome (AIDS).

AIDS

AIDS stands for Acquired Immune Deficiency Syndrome. It is a health condition that results from the deficiency in the human body's immunity following HIV infection. HIV attacks the human body by breaking down its immune system that is essential for fighting diseases. Over a period of time, the immune system weakens and the body loses its natural ability to fight diseases. At this stage, various diseases affect the infected person.

DIC

DIC stands for Drop-In-Centers. A Drop-In-Center is one of the interventions for HIV/AIDS prevention in Bangladesh where health services are provided for HIV/AIDS high-risk groups.

Knowledge

In this study, knowledge is defined as the basic information and understanding of HIV/AIDS. This study focuses on whether CSWs, TGs, MSWs and IDUs understand the difference between HIV/AIDS, risk factors, modes of transmission, Voluntary Counseling and Testing.

Risk practices

Practices are actions/ risk behavior. This study focuses on the risk behaviors of the whether CSWs, TGs, MSW and IDUs to understand the difference between HIV/AIDS, risk factors, modes of transmission, Voluntary Counseling and Testing.

CHAPTER TWO

CHAPTER TWO
REVIEW OF LITERATURE

2.1 A historical account of research on female sexuality

2.1.1 Female's sexuality based on patriarchal and biological perspectives

In the reviewed literature, some authors indicate the scarcity of recent research on sexuality that is female based and feminist (Baber & Allen, 1993). Historically, it is observed that research regarding female's sexuality has been based on the patriarchal and biological perspectives, and on the experience of Euro-American, class-privileged, heterosexual men (Baber & Allen, 1993; Osmond & Thorne, 1993; Tiefer, 1995). Though important research on female's sexuality though, exists from as early as the late 1800s (Brecher, 1969). Blackwell presented the Victorian/Judeo-Christian views of sexual repression in her works. In one of her best known works titled, "Essays in Medical Sociology"(1894, 1902), she proposed that sexual education need to consist, for the most part, in enlarging and intensifying an innate sense of shame concerning sexual feelings and acts. For example, she considered masturbation, as a cause of an illness and fornication as the attempt to divorce the moral and physical elements of human nature. She mentioned orgasm as a special act for males, although she acknowledged that the ability of women to experience 'spasms' (as she referred to female orgasms) in married sexual intercourse usually came with time. Clearly, Blackwell made a distinction between the orgasm of males and the possibility of women experiencing 'spasms' only after getting used to marital intercourse (Brecher, 1969).

2.1.2 Psychology of sex

Literature in the late 1800s was not always as much influenced by Victorianism, as Ellis's work, "Studies in the Psychology of Sex" (1936) demonstrates. Ellis's findings anticipated many of the findings of more recent researchers, such as, Kinsey and Masters and Johnson. His findings regarding female sexuality included: that women experience sexual desire; that orgasm in females is similar to that experienced by males; that multiple orgasmic capacity is common in women; that frigidity is, in its majority, psychological in nature; and that the repression of sexuality in girls and adolescents is one of the major factors in adult frigidity. The most important aspect of Ellis studies, though, is that he emphasized sexuality as a normal as opposed to a deviant phenomenon. Dickinson (1932) also documented the detrimental effects of a Victorian/Blackwellian upbringing and

referred to that upbringing as a debilitating sexual disease for women. In his interviews with patients, Dickinson discovered that sexual frustration was very common among the married women that they had come to divorce sex from love they felt for their husbands in order to save the marriage together. He further showed that the few that had escaped the consequences of a Victorian upbringing were likely to suffer from that of their husbands. His common phrase was that "it takes two people to make a frigid wife" (as quoted in Brecher, 1969, p.169).

A generation later, Leah Cahan Schaefer (1964) discovered the same findings as those reported by Dickinson. Women born in the 30s and 40s had been reared much as Dr. Blackwell had recommended as that sex was taboo and shameful except in marriage. All the women in Schaefer's study were experiencing guilt, anxiety, and shame towards their sexuality. Their knowledge of sexuality was full of misconceptions and fears of the dangers of pregnancy. Schaefer drew a conclusion that while the repression of masturbation and childhood sexuality did not prevent sexual activity, it spoiled enjoyment of future sexual and marital experiences (Schaefer, 1964).

2.1.3 Sexual factors in marriage

Women also worked on transforming female sexuality from a shameful and immoral experience into a legitimate and pleasurable experience. Wright, a gynecologist, fought to destroy sexual frustration in women by instructing them about their sexuality. Her two books, ‘The Sexual Factor in Marriage’ (1930, 1966) and more on ‘The Sexual Factor in Marriage’ (1947, 1959), explicit by explained to women how to masturbate and secure orgasm in marriage. In these books, Wright used a pseudoscientific approach to instruct women in masturbation and the attainment of orgasm during coitus. Many considered it a primer in sexual instruction for women (Brecher, 1969).

2.1.4 Studying sexuality with an evolutionary perspective

Further Mary Jane Sherfey (1963), studied sexuality with an evolutionary perspective. She wrote one of the best anatomical descriptions of the female sexual anatomy to date including parts, such as, the clitoris and the curare ("legs" of the clitoris similar to those of the penis), bringing to light the complexities of the female clitoral system. By performing this, she broke the myth of an inadequate sexual anatomy proposed by Freud. She tried to explain sexual repression in terms of history and anthropology (socio-cultural-historical reasons) and predicted the unleashing of female sexual repression due to reasons, such as, scientific advancement, contraceptive developments, and the then

"new" movement towards social equality. Sherfey also narrated the evolutionary nature of the multiorgasmic capacity in females and presented historical reasons for the introduction of circumcision and the conversion from matriarchy to patriarchy.

2.1.5 Studying female's bodies and sexual capacities

A psychologist called Niles Newton (1955), studied female's bodies and sexual capacities that included reproduction, childbirth, and especially, sexual pleasure. She was the foremost person to focus in a study on the feelings and emotions towards sexuality. In her monograph, entitled “Emotions: a study of women's feelings toward menstruation, pregnancy, childbirth, breastfeeding, infant care, and other aspects of their femininity”, discussed those "other" aspects of femininity, namely sexuality and feelings towards sexual intercourse. Niles and her husband, a professor of gynecology, also studied breastfeeding as a physical and psychological process (Newton & Newton, 1967). They reported that breastfeeding was seen by some women as a reminder of nudity and sexuality, and that feeling towards the last two were directly related to feelings towards breastfeeding. They also studied the "let down reflex" (the process that causes breast milk to flow in breastfeeding), and related it to the orgasmic capacity of females. Both the breastfeeding and orgasm reflex, they found, were triggered by oxytocin and could be easily inhibited by psychological factor, such as, anxiety. This connection to oxytocin helped explain the fact that some women could be brought to orgasm with only breast stimulation and that others become sexually aroused while feeding their babies (Newton & Newton, 1967).

2.1.6 Using scientific methods in sexuality research

Alfred Kinsey has been regarded as the first researcher to use scientific methods in sexuality research. Being trained in the natural sciences, he applied the rigor of basic sciences to interviewing people about their sexual behaviors. Another important predecessor of Kinsey was Katherine Davis (1929), well known for her book entitled “Factors in the Sex Life of 2200 women”. She also utilized statistical methods to analyze data on the sexuality of women in the early 20th century. Kinsey, Pomeroy, Martin & Gebhard's “Sexual Behavior in the Human Female” (1953) focused on the sexual experience of women. Their work documents the rarity of female frigidity, women's capacity for orgasm, the diversity of orgasmic responses, lack of orgasm for many women, more occurrence of orgasm in masturbation than in intercourse, and a re-evaluation of masturbation as legitimate and distinct source of female pleasure. Kinsey

renewed the interest in research on female sexuality and is still regarded by many as the most complete and reliable collection of data on the topic ever gathered (Brecher, 1969).

2.1.7 Observational study of physiological sexual responses

Possibly the next most significant researchers are William Masters and Virginia Johnson. Masters and Johnson (1966) actively introduced laboratory work into sexuality research by employing an observational study of physiological sexual responses. Besides examining the physiological processes in the human sexual response, they also mentioned the psychological aspects of sexual response and how psychological "hang-ups" lead to the three major forms of sexual inadequacy in our culture: female frigidity, impotence, and premature ejaculation in the male. Moreover, they provided ethically sound methods by which other therapists could effectively treat these conditions in the majority of the cases. Masters and Johnson showed a model of human sexual response that was parallel, similar, but distinct for both genders. This model is the basis of the physiological understanding of sexual response today.

2.1.8 Study on female sexuality

In 1976, Shere Hite published the results of a nationwide study on female sexuality. In this study, she asked women to know about their experiences and thoughts about several sexual behaviors. These included masturbation, orgasm, intercourse, clitoral stimulation, lesbianism, and sexual slavery, among others. In her book, 'The Hite Report' she reported that women had been told how to feel about sex, but never asked how they felt about it (p.xi). So she set out to ask women questions about how they felt, liked and thought about sex. This study also took into consideration about women's feelings and experiences, and it still asked them particular questions about specific behaviors. Women had a chance to speak out about what they were asked, but probably they remained silent about those topics that the questionnaire did not cover.

With few exceptions, the reviewed research focuses on the biology of sexual behavior rather than on sexual meanings, feelings, and influences. It was also primarily quantitative (even when interviews were performed), with the exception of Schaefer's interviews (1964) and Hite's (1976) study which utilized qualitative methods of analysis and reporting. It is clear from the review that these researches were not women centered or feminist; rather they were based on a biological approach to sexuality (Tiefer, 1995) guided by a heterosexist definition of sexuality. However, these researches could not be

overlooked though, because they showed how female sexuality had been an investigated and important topic through this century.

2.2 Male and female condom use

Condoms are more likely to be used in sexual relations outside marriage than relations between, married partners, especially, women continue to acquire HIV from their spouses" (United Nations, 2005). "By emphasizing, for an example, condom use as a method to prevent HIV transmission, education can increase the sense of personal responsibility associated with HIV infection, thereby, contributing to the stigma that often accompanies illnesses perceived to include an element of personal control" (De Bruyn, 1998). Maharaj and Cleland (2005) also indicated that "research in diverse settings has shown that condoms are often regarded as more appropriate for non-marital than in marital relationship, in countries with generalized epidemics, only 8% of the married contraceptive users report condom use, and this rate has shown no increase over the last 20 years." This kind of resistance creates a barrier because the partners are not faithful to each other the where vulnerability is high. Sometimes, a partner might be unwilling to introduce a condom to a relationship that existed long time and there was no form of protection used. There may be many questions, e.g., why now? This discourages people to take initiatives (Maharaj and Cleland, 2005).

Another research was conducted by Schneider et al. (2009) on the truck drivers in Andhra Pradesh, India. The findings of the study showed that 29.1% of the truck drivers reported having sex with a commercial sex worker in their lifetime, with nearly a third of those (11.1% of the total sample) having sex with a commercial sex worker within the last six months. About 59.1% of the men who had visited a female sex worker (FSW) reported 'always' using a condom with commercial sex workers in the past six months. At baseline, 2.1% of the sample was found to be HIV-infected, with 3.2% reporting a previous STIs diagnosis and 8.5% reporting genital symptoms (burning urination, genital discharge, or genital ulcers/sores) in the past 12 months (Schneider, et al. 2009).

2.2.1 Prevention and early management of HIV infection

Prevention programs are necessary to be introduced in the community and at the workplace because the more people are aware that there is no cure for AIDS and prevention is presently the only source of protection then they might use one of the preventative methods to remain safe from contracting HIV.

Condom usage is considered as another type of prevention measures. So, the condom dispensers are placed at the workplaces to make the resources accessible to retain the valuable employees in the organization for business opportunities. Lindegger (1995) stated that "negative perceptions about condoms were revealed by many of the studies, especially among men, with fear of partner's reaction and desire to have children given as primary reasons for the resistance". The fact is that women are married for childbirth then, it will be difficult to use a condom when the need arises, and culturally a man is recognized, if he bears children. Unfortunately, fear of stigma and discrimination is preventing millions of people, who are probably HIV positive from being tested. People also afraid of knowing their HIV status because a positive diagnosis has been traditionally been seen as a death sentence.

China conducted a KABP survey on over 6,000 respondents in 2008. The survey was conducted in six Chinese cities targeting four main groups (migrant workers, youths, white & blue collar-workers). Nearly, 30% of them did not know how to use condoms, only 19% of them said they would use a condom if they had sex with a new partner. Nearly, 11% of the respondents had sex with people who were not their spouses, girl friends or boyfriends during the past six months. Total number of 42% of those respondents had not used condoms. A total number of 30% of the responded that HIV positive children should not be allowed to study at the same schools with uninfected children. Nearly, 65% of them would be willing to live in the same household with an HIV–infected person, and 48% of the interviewees would be unwilling to eat with an HIV-infected person. More than 48% of the respondents thought that they could contract HIV from a mosquito bite (UNAIDS, 2008).

"A study published in the journal of Acquired Immune Deficiency Syndromes observed that discordant heterosexual couples were found as the following: less than 2% of those who consistently and correctively used condoms became HIV infected. Nearly 15% of those who used condoms inconsistently became HIV infected. Ten percent of people who never used condoms became HIV infected" (Equal Treatment, 2006).

CHAPTER THREE

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 Introduction

Based on the social nature of sexual scripts, and the assumption of the physiological construction of sexuality (Baber, 1994, p.60; Baber & Allen, 1993, pp.68-70; Fine, 1993, pp.75-99; Laws & Schwartz, 1977), a Health Belief Model was basically used for this study. Moreover, other models and theories of health behavior, which currently exist in the fields of health communication are: the Theory of Reasoned Action, the Theory of Self-Efficacy, AIDS Risk Reduction Model, etc. (Islam, 2002:144). Under the health communication intervention programs, these models and theories constitute a framework for identifying the critical factors underlying the roles of health related behavior (IoM, 2002:28).

3.2 The Health Belief Model

The Health Belief Model (HBM) has been used for a wide range of health behaviors and subject populations. The understanding of an individual of him or herself, and his or her ability to change behavior is the focus of HBM. Among different models in the public health and health psychology, which are exercised to explain health behavior, the HBM furnishes us the most appropriate theoretical framework where we can study how persons like scavengers, different health workers, sanitarians who directly come into contact with solid wastes, and think about its treatment process and its health consequences (Health, 1995:164).

The HBM is considered as a social-cognitive model developed in the 1950's by the U.S. Public Health Service. It is always used to elucidate and predict health related behaviors (Rosenstock, 1966). It has been often used to visualize a variety of preventative health behaviors, such as, parents' immunization behavior, dieting, driving under the influence, and sexual risk behavior. The basic components of the Health Belief Model are taken from a well-established body of psychological and behavioral theory whose various models hypothesize that behavior depends mainly upon two variables:

(1) The value placed by an individual on a particular goal; and

(2) the individual's estimate of the likelihood that a given action will achieve that goal (Naidoo and Wills, 2000:222).

According to the health-related behavior, these correspond to: (1) the desire to avoid illness (or if ill, to get well); and (2) the belief that a specific health action will prevent illness. As for example, if a person's goal is to avoid a health problem resulting from any improper practices or health behaviors, he or she must feel personally vulnerable (perceived susceptibility) to a problem judged to be potentially serious (perceived severity), and he or she must estimate that specific action will benefit him or her in reducing the health threat (perceived benefit), and it will not involve overcoming obstacles (perceived barriers). As Rosenstock has described this model, "The combined levels of susceptibility and severity provided the energy or force to act and the perception of benefits (less barriers) provided a preferred path of action" (Rosenstock, 1966). For instances, when applied to parents' immunization behavior, the HBM suggested that simply having knowledge and awareness about infectious diseases would not necessarily result in increased visits to a hospital for vaccinations. In lieu of, the model has specified four related elements that should be present for knowledge about disease to be translated into preventative action. First, an individual must perceive that he or she is susceptible to an infectious disease. Secondly, that person must also perceive that the disease is a serious condition. Thirdly, he or she must believe that there are benefits in taking preventive action. Finally, the individual must also perceive that any potential barriers to taking preventive actions are outweighed by potential benefits. (Islam, 2002:144)

A diagram of the HBM is presented in the figure below:

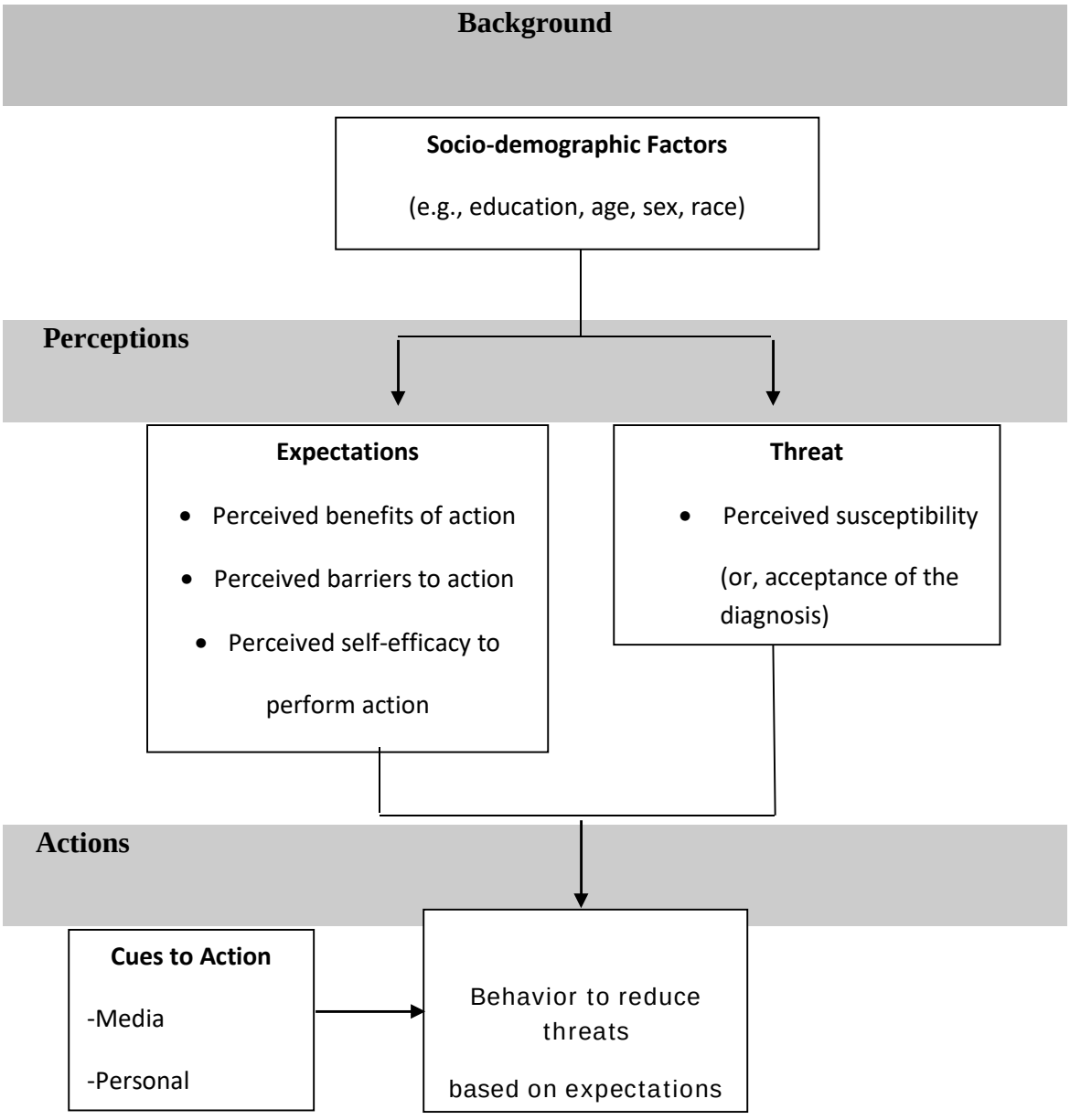


Figure 3.1: A schematic outline of the Health Belief Model proposed by Rosenstock, et. al., 1990.

A number of relevant studies were also done to relate the variables in HBM to adolescent HIV/AIDS-risk (usually sexual) behavior, parents' immunization behavior and other health behaviors. None was remarkably successful, but most models accounting for only a fraction of the variance. Though, some researchers still believes that addressing these variables is a desired role for health education. In relevant studies, it was found that socio-demographic variables were related various health behaviors (Amanullah, 2002).

Although, the HBM has been extensively used in the studies of health behaviors, the critics of the model have pointed out a variety of limitations. A lack of uniformity was observed in testing the model; especially in the way variables were operationalized. The tools used to measure HBM components were not refined or standardized. Moreover, the model did not apply any numeric coefficients to the concepts of susceptibility, severity, benefits, and barriers, nor does it delineate the specific nature of the relationships among the variables (Rosenstock, 1990).

Nonetheless most studies treated the model as additive and tested only direct relationships between the variables and the health-related behavior of interest. Another problem with the HBM was a lack of consistency in the application and testing of the model. All variables were not included in all the studies. For example, identifying and measuring the concept of cues to action was problematic. Cues can be manifest in nature, it may take place in a fleeting manner, and an individual may or may not consciously remember events that trigger action. It was found in the retrospective studies, the nature and importance of cues was more difficult to evaluate because research participants were questioned about behaviors performed in the past. For these and other reasons, the variable "cues" was not included in many studies based on the HBM. This variable was not involved in this study also. As these cues were vague in nature, and involved a lot of psychological factors (Harrison, 1992)

As the HBM is a psychosocial model, it is responsible for only as much of the variance in health behaviors those can be explained by attitudes and beliefs that are clear to and consciously evaluated by individuals. Other factors related to the individual, such as, demographic variables, personality factors, social support, or previous health experiences may play a role in influencing behavior, but they are not an explicit part of this model (Janz, 1984).

In lieu of, they are thought to influence the major variables in the model. Moreover, the concepts reflective of the larger social structure, such as, institutional or public policy, poverty, and social isolation, which may affect access to health care, are not included in the HBM. However, this sort of criticism could be also directed to most psychosocial models (Islam, 2002).

3.3 Cultural Theory of risk

The Cultural Theory of Risk, simply known as Cultural Theory, consists of a conceptual framework and an associated body of empirical studies that attempt to explain the societal conflicts over risks. On the other hand theories of risk perception emphasizes on economic and cognitive influences. The Cultural Theory asserts that structures of social organization endow individuals with perceptions that reinforce those structures in competition against alternative ones. Originating in the work of anthropologist Mary Douglas and political scientist Aaron Wildavsky, Cultural Theory has given rise to a diverse set of research programs that span multiple social science disciplines, and that have been in recent years used to analyze policymaking conflicts generally (Douglas, 1992a).

The two features of Douglas's work tell us the basic structure of The Cultural Theory. The first one of these is a general account of the social function of individual perceptions of societal dangers. Douglas professed that individuals tend to associate societal harms, from sickness to famine to natural catastrophes, with conduct that transgresses societal norms. She debated that this tendency, played an indispensable role in promoting certain social structures, both by imbuing a society's members with aversions to subversive behavior, and by focusing resentment and blamed on those who defied such institutions (Douglas, 1992a, 1996b).

The second important feature of Douglas's work is a particular account of the forms that competing structures of a social organization assume. Douglas affirmed that cultural ways of life and affiliated outlooks could be characterized (within and across all societies at all times) along two dimensions, which she called "group" and "grid" (Douglas, 1970c). She further said that a "high group" way of life exhibited a high degree of collective control, whereas, a "low group" one exhibited a much lower one and a resulting emphasis on individual self-sufficiency. A "high grid" way of life was characterized by conspicuous and durable forms of stratification in roles and authority, whereas a "low grid" one reflected a more egalitarian ordering (Rayner, 1992).

Although developed in Douglas's earlier work, these two strands of her thought were first consciously woven together to form the fabric of a theory of risk perception in her and Wildavsky's book (1982), *Risk and Culture: An Essay on the Selection of Technical and Environmental Dangers*. Focusing largely on political conflict over air pollution and

nuclear power in the United States, *Risk and Culture* attributed political conflict over environmental and technological risks to a struggle between the adherents of competing ways of life associated with the group–grid scheme: an egalitarian, collectivist (“low grid”, “high group”) one, which gravitated toward fear of environmental disaster as a justification for restricting commercial behavior productive of inequality; and individualistic ("low group") and hierarchical ("high grid") ones, which resisted claims of environmental risk in order to shield private orderings from interference, and to defend established commercial and governmental elites from subversive rebuke (*Mamadouh, 1999).*

This argument was systematized in later works in Cultural Theory. In these cases, group–grid gave rise to either four or five discrete ways of life, each of which was associated with a view of nature (as robust, as fragile, as capricious, and so forth) that was congenial to its advancement in competition with the others (*Mamadouh, 1999; Thompson, Ellis & Wildavsky, 1990).*

3.4 Social Construction Theory

In the Social Construction Theory, as in most feminist approaches, the idea of an objectively knowable truth does not exist. Knowledge is constructed through social interpretation and the inter subjective influences of language, family, and culture (Hoffman, 1990). The basic contention of social constructionism is that reality is socially constructed, that is, what we perceive as reality has been shaped through a system of social, cultural and interpersonal processes. Four assumptions are made by social constructionists: (1) the way we go about studying the world is determined by available concepts, categories, and methods; our concepts often make us incline toward or even dictate certain lines of inquiry while precluding others, making our results the products more of our language than of empirical discovery; (2) the concepts and categories we use vary considerably in their meanings and connotations over time and across cultures; concepts are assumed to relate to permanent human experiences or functions; (3) the popularity or persistence of a particular concept, category, or method depends more on its usefulness (political usefulness particularity) than on its validity; and (4) descriptions and explanations of the world are themselves forms of social action and have consequences (Gergen, 1985, pp.266-275).

The Social Construction Theory explores an evolving set of meanings that are continuously created from people's interactions. The development of concepts is a social phenomenon, a fluid process that can only evolve within a cradle of communication (Hoffman, 1990). It is only through the interaction of the socio-cultural processes with the intrapersonal self (ideas, beliefs, history) that the construction of knowledge is nurtured. This theory places an emphasis on the individual's active role in constructing reality, while being guided by her/his culture (Tiefer, 1987, 1995).

Persons construct their own knowledge in their lives facilitated by the prevalent discourses in their societies and cultures, and their own life experiences. Through social constructionism, researchers can look for diverse meanings of sexuality within and between social groups (Thompson, 1992). Social construction theorists argue that physically identical sexual acts may have different social and personal meanings depending on how they are defined and understood in their different cultures and historical periods (Vance, 1991). Besides influencing the way individuals define and act on their behaviors, socio-historical constructions also organize and give meaning to collective sexual experience through, for instance, constructions of sexual identities, definitions, ideologies, and regulations (Vance, 1991). It is interesting to argue then, how it is that sexuality has been "repressed" and "liberated" through time, if it is only a construction of the expression of a biological potential.

3.5 Foucault on sexuality

Foucault in his “History of Sexuality: An Introduction” published in 1978 stated that there was no such thing as an internal force or drive, sexuality that could be manipulated in such ways. He said that what could be manipulated were ideas and definitions, a potential regulator of the ways in which sexuality could be thought of, defined, and expressed. He argued that sexualities were constantly produced, changed, modified, and the nature of sexual discourse and experience changed accordingly (Foucault, 1978).

His insights into institutions, such as, schools, hospitals and prisons (1973, 1979, 199) rang true and were illuminating about how power was exercised, and control was maintained. It could be argued that some of his views on discursive power, for example, the power of disciplines to label, and thus control people, were a rewriting of labeling theory, but he took the idea further. The idea that power was most effectively exercised when its operation was concealed was also a telling one. However, Foucault’s discussion

of power was problematic. He switched between using 'power' to mean a process which happened in all interactions and using 'power' to refer to the holders of dominant power in an ideology or a political system. He did actually distinguish at times between the two, and called the latter his theory of governmentality.

In the second sense of 'power', moreover mentioned that they could coherently discuss on people being on the side of resistance rather than power (the goodies, if they were committed to the unseating of despots), but in the first sense—which he frequently reminded us was the one he intends—such a claim would make no sense, as there is no single side that power was on (Morrow 1995, p. 25). Power is everywhere and inescapable. There are also two more fundamental problems that make Foucault's work unsuitable as a base for an empirical sociological approach to sexual conduct. One is that he suffers from acute gender-blindness (Jackson 1999, p. 20); he is simply not interested in women. This leads to incapability to theorize homosexuality. The other problem has been ably argued by Morrow (1995). Foucault is an explicit antirealist.

Further Morrow observed that he 'selectively applies relativism to the discourses of others but conveniently exempts his own discourse from any relativism' (p. 22). When dismissing or refuting views with which he does not agree, Foucault uses such words as 'errors', which implies the existence of an objective reality about which one can be mistaken. An epistemological relativist has no grounds on which to convince people that his or her view on a matter of fact is correct. Morrow argued that, 'Foucault at some level is aware of the danger of an anti-realist stance for his own views, as he does not hold to his position consistently … he smuggles realist assumptions into his account in order [for it] to remain viable' (p. 21). Morrow used Woolgar and Pawluch's (1985) term 'ontological gerrymandering' for this maneuver. However, he assumed that all social constructionism was antirealist, and therefore, vulnerable to this objection.

3.6 The Theory of Reasoned Action

The Theory of Reasoned Action elucidated how and why attitude had impact on behavior, why people's beliefs changed the way they acted. The theory stated that a person's behavior was determined by their attitude towards the outcome of that behavior and by the opinions of the person's social environment. Main constructs of this theory were attitudes, subjective norms and intentions. Attitudes in this case were beliefs that a person accumulated over his life time, formed from direct experiences and outside

information, and others inferred or self-generated. If a person had positive belief about the outcome of his behavior then he was said to have positive attitude, and if a person had negative beliefs about the outcome of his behavior, he was said to have negative attitude. A person's subjective norms were his beliefs about what others would think of the behavior. They were perceptions about how family and friends would perceive the outcome of the behavior and the degree to which this influenced whether the behavior was carried out. Intentions were the probability that the individual would perform the behavior. The intention was influenced by the attitude and the subjective norm, and the behavior was the transmission of the intention into action (Ajzen & Fishbein, 1980, p 4-6).

3.7 Theory of Self-efficacy

Bandura's social learning theory support that people learn more from one another through observation, imitation and modeling. According to Bandura (1977), people observed others behaviors, attitudes and outcomes of those behaviors. Modeling effects produce learning mainly through their informative function. If people observed positive desired outcomes in the observed behavior, they were more likely to model, imitate, and adopt the behavior themselves. This theory was used in this study to explain how the respondent with no HIV/AIDS education got information about HIV/AIDS, and how it impacted their behavior. In this case, it assumed that in the application of social learning theory through peer education extra-curricular programs, media-television and radio, and other unsystematic means, the respondents were encouraged to observe and imitate the behavior of their peer educators and others, see positive behavior modeled and practiced, increase their own capability and confidence and implement new skills with support from the environment.

3.8 AIDS Risk Reduction Model (ARRM)

The AIDS Risk Reduction Model (ARRM) was introduced in 1990 that provided a framework for explaining and predicting the behavior change efforts of individuals, specifically in relationship to the sexual transmission of HIV/AIDS. It was developed by J.A. Catania. It propounded that change was a process, and that individuals used to move from one step to the next one as a result of a given stimulus. The ARRM was a three stage model that incorporated several variables from other behavior change theories, including

the Health Belief Model, "efficacy" theory, emotional influences, and interpersonal processes. The stages as well as the hypothesized factors that influenced the successful completion of each stage were as follows (Catania, Kegeles and Coates, 1990):

Stage 1: Recognition and labeling of one's behavior as high risk

Hypothesized influences:

- knowledge of sexual activities associated with HIV transmission;
- believing that one was personally susceptible to contracting HIV;
- believing that having AIDS was undesirable; and
- social norms and networking.

Stage 2: Making a commitment to reduce high-risk sexual contacts and to increase low-risk activities

Hypothesized influences were:

- costs and benefits;
- enjoyment (e.g., would the changes affect my one's enjoyment of sex?);
- response efficacy (e.g., would the changes successfully reduced risk of HIV infection?);
- self-efficacy;
- knowledge of the health utility and enjoyability of a sexual practice, as well as social factors (group norms and social support), were believed to influence an individual's cost and benefit and self-efficacy beliefs.

Stage 3: Taking action

This stage was broken down into three phases: 1) information seeking; 2) obtaining remedies; and 3) enacting solutions. Depending on the individual, phases might occur concurrently or phases might be skipped.

Hypothesized influences were:

- social networks and problem-solving choices (self-help, informal and formal help);
- prior experiences with problems and solutions;
- level of self-esteem;
- resource requirements of acquiring help;
- ability to communicate verbally with sexual partners'; and
- sexual partners' beliefs and behaviors.

In addition to the above mentioned stages and influences, listed above, the authors of the ARRM (Catania, et. al., 1990) identified other internal and external factors that might motivate individual movement across stages. For instance, aversive emotional states (e.g., high levels of distress over HIV/AIDS, or alcohol and drug use that blunted emotional states) might facilitate or hinder the labeling of one's behaviors. External motivators, such as, public education campaigns, an image of a person dying from AIDS, or informal support groups, might also cause people to examine and potentially change their sexual activities (Catania, et. al, 1990).

CHAPTER FOUR

CHAPTER FOUR

METHODOLOGY

4.1 Introduction

Both quantitative and qualitative methods including Survey, Case Study and Focus Group Discussion were used to conduct this study. The decision to use multiple methods was taken because their appropriateness for examining different facets of phenomena under this study was pre-tested. Moreover, the use of multiple methods permitted triangulation of the data to improve the validity of the findings and enabled greater inferences from the results.

4.2 Study population

This study evaluated the socio-economic background of the DIC users, such as, FSWs, IDUs, MSWs, TGs, their exposure to mass media, HIV/AIDS-related awareness and knowledge, sexual behavior and risk practices, clients' attitudes and behaviors, prevention and treatment of HIV/AIDS and the services provided by the DICs in Dhaka City for the study population. Though the general target population indicated all the FSWs, IDUs, MSWs, TGs living in the Dhaka City, however, the study specified the FSWs, IDUs, MSWs, TGs residing in some DICs, namely, Lalbag DIC, Darus Salam DIC, SK Das Road, Sutrapur DIC, Mohammadpur DIC, Doyagonj Sutrapur DIC, Gulisthan DIC, Adabor DIC, Nayabazar DIC, Kamrangirchor DIC, Jatrabari MSW & TG DIC, Lalbag MSW & TG DIC, Hazaribagh IDUs DIC, Moulavibazar IDUs DIC, Kamrangirchor FSW DIC and Lalbag FSW DIC.

4.3 Study site

The study was conducted at sixteen DICs in the Dhaka City. The DICs were as mentioned below:

Table 4.1: List of DICs in the Dhaka City

Sl. N.	**Name of DICs**
01	Lalbag DIC
02	Darus Salam DIC
03	SK Das Road, Sutrapur DIC
04	Mohammadpur DIC
05	Doyagonj, Sutrapur DIC
06	Gulisthan DIC

07	Adabor DIC
08	Nayabazar DIC
09	Nayabazar DIC
10	Kamrangirchor DIC
11	Jatrabari MSW & TG DIC
12	Lalbag MSW & TG DIC
13	Hazaribag IDUs DIC
14	Moulavibazar IDUs DIC
15	Kamrangirchor FSW DIC
16	Lalbag FSW DIC

4.4 Sampling procedure and sample size determination

The study was carried out among the FSWs, IDUs, MSWs, and TGs in the Dhaka City. A total of 115 FSWs, 134 IDUs, 96 MSWs, and 71 TGs were selected as sample from 16 DICs in the Dhaka City following simple random sampling. First, the lists of FSWs, IDUs, MSWs, and TGs were collected from the authorities in order to gather data from them. Then each participant of this study was picked up by using the lottery method. Therefore, each respondent had the same probability of being chosen. Finally, randomly selected respondents were interviewed by using predesigned semi-structured questionnaire. The sample sizes for FSWs, IDUs, MSWs, and TGs were 115, 134, 96, and 71 respectively. In case of absent respondents, the researchers moved to next available respondents.

4.5 Data collection methods

In social science research, various types of data collection methods are used, which have different advantages and disadvantages; and with given this fact, it seems to make a sense for the sociological researchers to use a number of different methods in their research, since a weakness in one method could be avoided by using another method that is strong in the area where the first is weak. A combination of different methods give us a much more rounded picture of the phenomenon that is being studied. Therefore, both quantitative and qualitative data collection methods were used in this study.

The decision for using both the quantitative and qualitative methods of data collection was taken because of their appropriateness for examining different facets of the phenomena under study, for triangulation of the data, and for adding breadth and depth to the examination of the issues being studied. These purposes are consistent with the suggestions made by Green, et. al. (1980) and Patton (1990) about the use of both the

quantitative and qualitative methods of research in a singular study. Such pluralism in methodology or triangulation is not aimed merely at validation but at deepening and widening one's understanding about the phenomena being studied.

The most common example of this is the recognition by the survey researchers that the formulation of questions for questionnaire or interview schedule is benefitted by using qualitative research methods (Patton, 1990). The aim of such mixing of methods is to reduce misreporting and cross-cultural confusion; and thus the qualitative element is designed to improve the main technique which is quantitative in this study. In the present study, case study and FGDs were used to supplement the quantitative findings.

4.6 Construction of interview schedule

For conducting the survey, four semi-structured interview schedules were developed for the four types of respondents. Each interview schedule had approximately five to seven sections, involving a little bit variation from one interview schedule to another. These had also some open and close-ended questions containing the information on:

- socio-demographic characteristics;
- exposure to mass media;
- HIV/AIDS-related awareness and knowledge;
- sexual behavior and risks practices;
- clients' attitudes and behaviors;
- prevention and treatment of HIV/AIDS; and
- services provided by the DIC in the Dhaka City for FSWs, IDUs, MSWs, TGs.

4.7 Pre-testing and finalization of survey instrument

Pre-testing and finalization of the interview schedule adhered to a few procedures. The researcher designed the draft interview schedule, and completed pre-testing. Based on pre-testing findings, the translation, consistency and integrity of the interview schedule were checked. The researcher then finalized the interview schedule and showed it to the supervisor for the final approval. After getting approval from the supervisor, the Bangla version of the interview schedule was printed; and later it was translated into English. During pre-testing of the survey instruments, the following issues were actively considered:

- the language necessary to address the sensitive issues;
- the sequencing of questions;
- the techniques or options for documenting the responses; and
- providing appropriate skips in the interview schedule.

4.8 Non-availability of the respondents

We tried our best to interview all the sample respondents to make the study a representative one. If the sample respondent was not available at the time of interview, at least two revisits were made to interview the sample respondent. However, there were cases of non-response from the respondents including cases of non-availability of the respondents in the selected DICs. In such a situation, the interviewer selected alternative respondents (male/female) so that the overall sample size could be achieved.

4.9 Data collection instrument

A questionnaire survey requires a literate target population for genuine data collection. It often becomes problematic because the participants are likely to stop answering the questions mid-way through the survey. Non-response rate is also high in the questionnaire survey. Hence, considering the drawbacks of using self-administered questionnaire, semi-structured interview schedule was used for conducting the survey. The interview schedule included four parts with a series of close- and open-ended questions. Besides, the researchers administered case studies and FGDs for this study.

4.10 Administering the fieldwork

The fieldwork for the present study was conducted for a period of 30 days during March and April 2016. The researcher himself administered the survey among the respondents according to the sampling plan set out earlier. Before approaching the sample respondents, the researcher took the permission from a DIC authority, informed the respondents about the purpose of the study, the topics under the study and the need for collecting data. The researcher then sought their cooperation to administer the survey.

4.11 Computerization and data management

The data collected through the survey were processed by using SPSS Windows program (version 16). Quantitative data processing involved the following steps:

- interview schedule registration and editing;
- editing verification;
- listing of open-ended responses and classification;
- coding and code transfer;
- verification of coding and code transfer;
- development of data entry structure (variable view);
- data entry and entry verification;
- entering data as per interview schedule structure in SPSS 16 version;
- verifying the logic and accuracy of the data as per filled up interview schedule;
- keeping and maintaining data backups;
- tabulating as per objective and requirements in Quantum (an upgraded version of SPSS), also tabulating data in SPSS 16 version;
- development of analysis plan;
- program development as per the analysis plan; and
- program running and report generation.

4.12 Analysis of data

Upon the successful completion of data processing, all the data were analyzed by using SPSS. The analysis was done at three stages: descriptive statistics, bivariate analyses. Firstly, the respondents' socio-demographic profiles, their exposure to mass media, HIV/AIDS-related awareness and knowledge, sexual behavior and risk practices, clients' attitudes and behaviors, prevention and treatment of HIV/AIDS and the services provided by DIC were analyzed with the help of univariate analysis. Since univariate analysis did not provide us a relationship or association between the variables, the relationships were examined at bivariate level. Test statistics like Pearson's chi-square and Cramer's V were used to measure the magnitude/strength of relationships among the variables.

4.13 Reliability and validity

Reliability and validity of data are central issues in all scientific measurements. Both concern how concrete measures or indicators are developed for constructs. Reliability tells us about an indicator's dependability and consistency. Validity tells us whether an indicator actually captures the meaning of the construct in which we are interested.

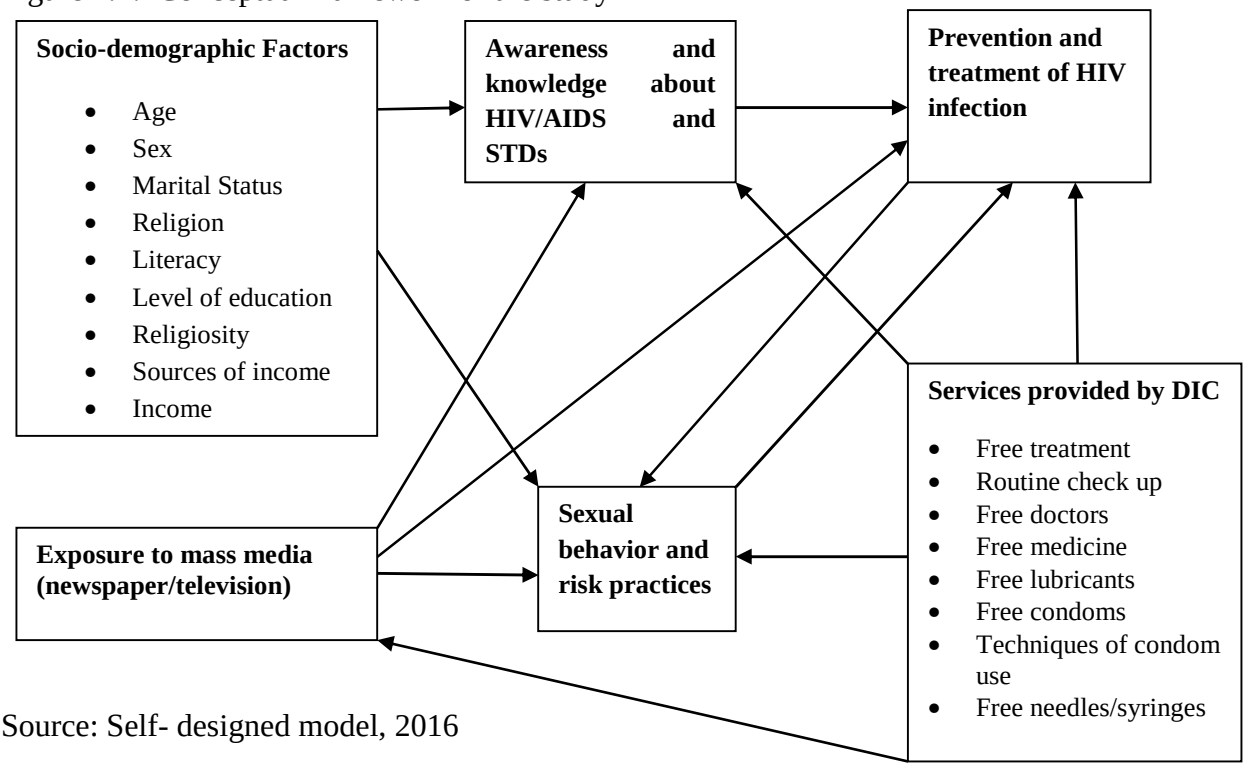
Perfect reliability and validity, however, are virtually impossible to achieve (Neuman, 1997:138).

Validity of the data was also enhanced through the processes of piloting and by crosschecking of information between different sources and participants. According to Blaxter, Hughes & Tight (2000), "validity has to do with whether your methods, approaches and techniques actually relate to, or measure, the issues you have been exploring". The questionnaire was pilot tested with a group of respondents. It was completed within approximately 20-30 minutes; and the contents were evaluated for proper understanding. This led to the restructuring of a few questions. In addition, in order to improve the reliability and validity of measures for the present study, the following steps were undertaken:

- the constructs were clearly conceptualized so that each measure could indicate one and only one concept; otherwise, it would be impossible to determine which concept was being indicated; and
- attempts were made to measure constructs at the most precise level possible.

4.14 Conceptual framework

Figure 4.1: Conceptual framework of the study



Source: Self- designed model, 2016

4.15 Ethical consideration

Social researchers must consider the right of the subjects involved in any study (Baker, 1999). The respondents have a right to privacy. It is up to them to decide when and to whom to reveal information. A social researcher must uphold and defend this right. Thus, in order to carry out a research project, the researchers must consider the ethical aspects of their studies. In this study, ethical standards were maintained in every stage. While collecting information, the respondents of this study were informed clearly that the information they provided during the survey, case studies and FGDs would be kept in strict confidence. Only the researcher would have access to the questionnaires. The questionnaires would then be destroyed upon completion of the data analysis. The name and addresses of the respondents were not recorded anywhere in the questionnaire. Also, their identity was not linked to the study at any point of time or stage of the study. Besides, participation of the respondents was voluntary. The respondents could agree to answer questions or refuse to participate at any time.

4.16 Limitations of the study

It is perhaps the first study done about HIV/AIDS related risk practices among the users in the DICs. Despite all the efforts made to obtain relevant information, the findings of the study, the conclusion and recommendations should be considered in the light of the following limitations:

- the study was limited to some DICs in the Dhaka City; consequently, the findings could not be generalized to the respondents of the whole country;
- the sample respondents of the study did not provide all responses to the questions in the questionnaire; and
- some of the respondents stopped answering the questions in midway of the questionnaire conduction.

CHAPTER FIVE

CHAPTER FIVE

FINDINGS OF THE STUDY

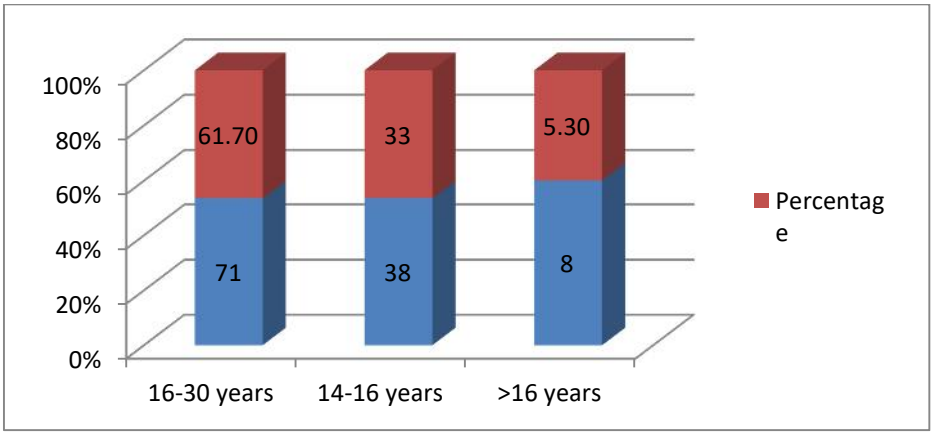
Section A: Female Sex Workers (FSWs)

5.1 Socio-demographic profile of FSWs

The distribution of the respondents by selected socio-demographic characteristics include age, level of education, marital status, religion, religiosity, monthly income, source of income etc.

The Female Sex Workers' (FSWs) ages are shown in the following figure. It reveals that more than three-fifths of the respondents' ages are between 16 to 31 years, whereas one-third of the respondents fall in the category of 14-16 years. This study also reveals that a few respondents (5.30%) are more than 16 years of age.

Figure 5.1: Distribution of FSWs by age



Source: Field Survey 2016

Education level is another key constituent of the FSWs. It affects many aspects of their lives. Some previous studies have shown that educational attainment has strong influence on the FSWs' HIV/AIDS related risk practices. In this study, according to the survey findings, a little less than half of the respondents (44.30%) have completed primary level of education, whereas a significant number of them (40.0%) do not have any schooling. On the other hand, 15.70 percent of the respondents failed to complete SSC.

Of the respondents surveyed, a good number of the participants (40.0%) are married whereas a little more than 35 percent of the respondents have reported themselves as divorced as shown in the following table. One-tenth of the FSWs are separated. With respect to having a child, this study demonstrates that maximum number of the FSWs (53.7%) have one child only, whereas a little more than one-fifth of the respondents have two children. This study also finds that 17.6 percent of the participants had no child at all.

Table 5.1: Distribution of the respondents by FSWs' background characteristics

Respondents' background	**Number**	**Percentage**
Education		
No education	46	40.0
Primary	51	44.3
SSC incomplete	18	15.7
Can you read		
Yes	55	47.8
No	60	52.2
Marital status		
Married	46	40.0
Unmarried	7	6.1
Divorced	41	35.7
Widowed	5	4.3
Separated	12	10.4
Abandoned	3	2.6
Others	1	0.9
Do you have any child?		
No	19	17.6
One	58	53.7
Two	25	23.1
More	6	5.6
Income (in Taka)		
< 10,000	17	14.8

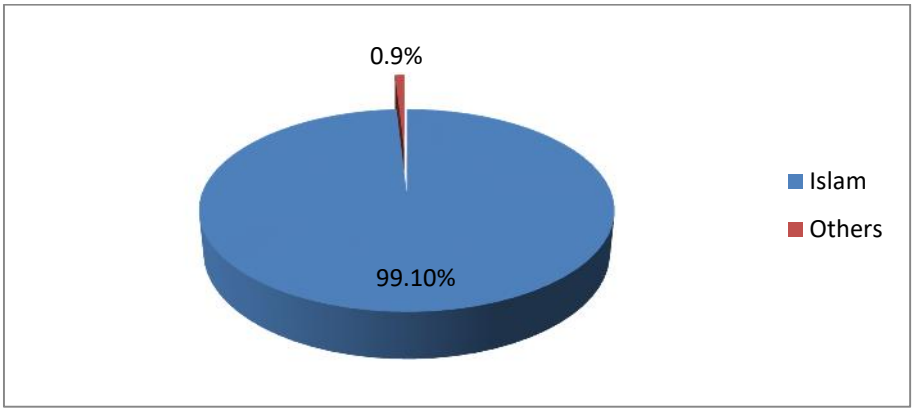
10,000-14,999	21	18.3
15,000-19,999	28	24.3
20,000-24,999	9	7.8
25,000-29,999	9	7.8
30,000+	31	27.0
Source of income		
Sex working	100	87.0
Sex working with service/job	12	10.4
Sex working with business	3	2.6

Source: Field Survey 2016

This study has also assessed the FSWs' monthly incomes and found that a considerable number of respondents' monthly incomes are more than Taka 30,000. Out of the total respondents in the sample, as many as 24.3 percent of the respondents are in the income group of Taka 15,000-19,999 taka and 18.3 percent of them earn Taka 10,000 to 14,999 per month. The majority of the FSWs (87.0%) have reported that their main source of income as sex working.

About 99 percent of the respondents are predominantly Muslims since Bangladesh is predominantly a Muslim country, and only a very few number of the respondents, 0.9 percent, have identified themselves as the followers of other religions including Hinduism.

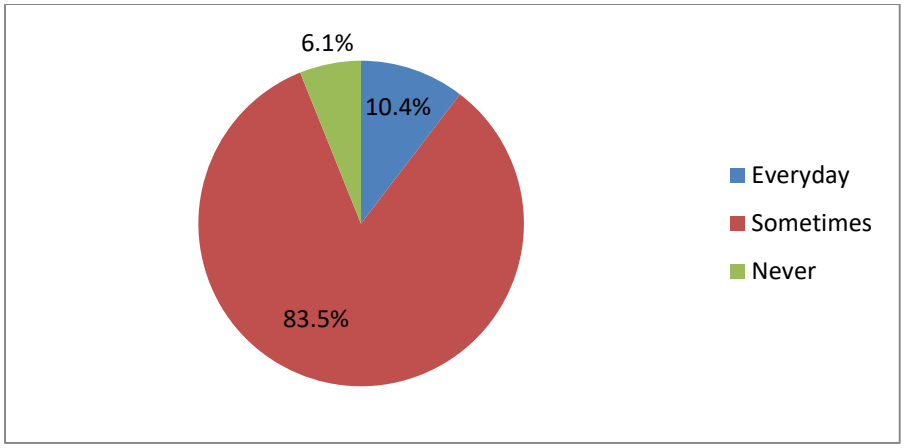
Figure 5.2: Distribution of FSWs by religious affiliation



Source: Field Survey 2016

The findings of the study reveal that an overwhelming number of the respondents (83.50%) perform religious activities sometimes. Around one-tenth of the study subjects, 10.4 percent, attend religious activities regularly; whereas a trifling number of the respondents (6.1%) never perform religious activities.

Figure 5.3: Distribution of FSWs by religiosity

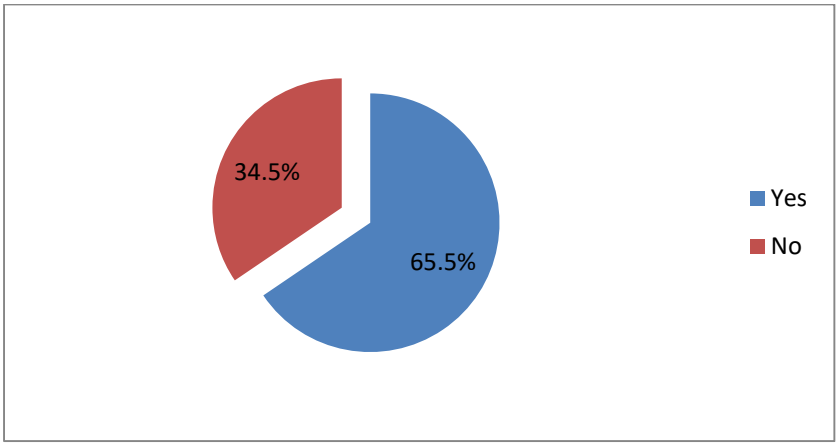


Source: Field Survey 2016

5.2 FSWs' exposure to mass media

The respondents were asked whether they could read newspapers or not. The findings of the study demonstrate that an overwhelming number of the respondents (65.5%) read newspapers, whereas those who do not read newspapers only constituted 34.50 percent of them. In term of frequency of reading newspapers, this study also shows that 30.60 percent of the respondents have told that they read newspapers daily while 27.8 percent of the participants have reported that they read newspaper 3 to 5 days in a week. The percentage of the respondents who read newspapers once in a week is slightly higher than those who had read newspapers 3 to 5 days in a week.

Figure 5.4: Distribution of FSWs by exposure to mass media



Source: Field Survey, 2016

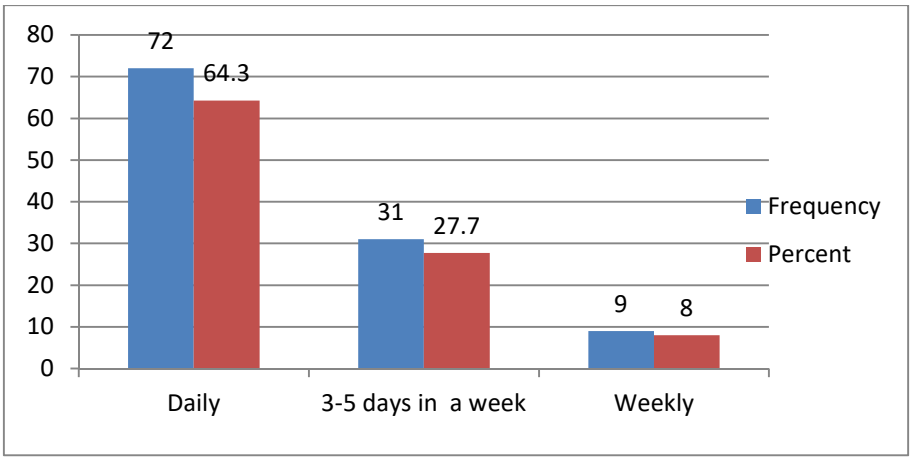
Table 5.2: Distribution of FSWs by frequency exposure to mass media

How often do you read newspaper/magazine		
Daily	11	30.6
3-5 days in a week	10	27.8
Weekly	13	36.1
Monthly	2	5.6
Do you watch TV		
Yes	112	97.4
No	3	2.6

Source: Field Survey 2016

Television is one of the most powerful and vibrant media in the present era. This study has also evaluated FSWs' exposure to television. The results of the study show that an overwhelming number of them (64.30%) have exposure to television; whereas just 31 percent of the participants have told that they watch television 3 to 5 days in a week. Frequency of watching television is quite higher than that of reading newspaper, 64.30 percent of the respondents have told that they watch television daily as depicted in the following figure.

Figure 5.5: Distribution of FSWs by frequency of watching television

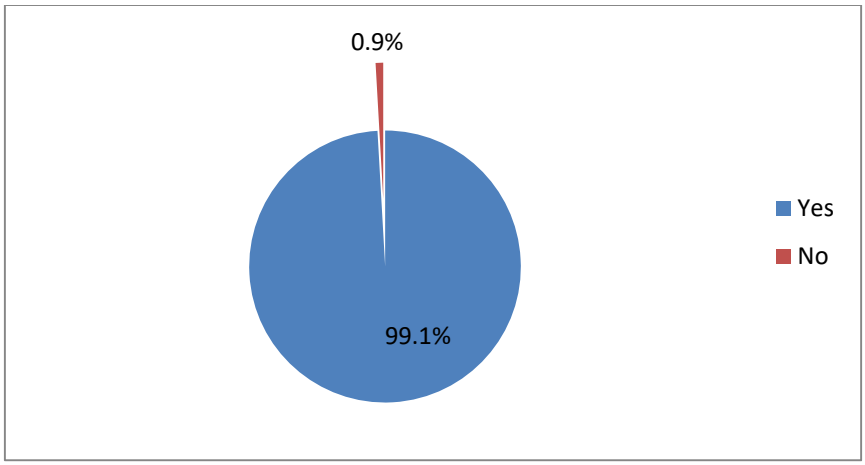


Source: Field Survey 2016

5.3 FSWs' awareness and knowledge about HIV/AIDS

In this study, the information on knowledge about HIV was also collected through survey. The findings of the study show that almost all FSWs (99.1%) have heard of HIV while only 0.9 percent of the respondents reported that they did not heard of HIV.

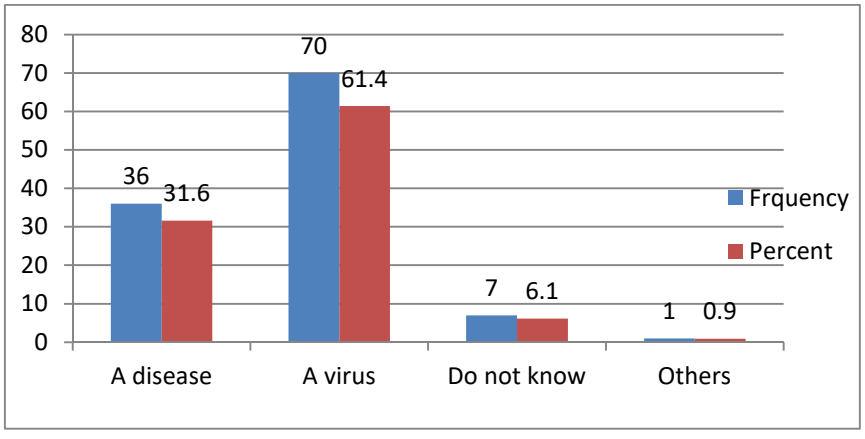
Figure 5.6: Distribution of FSWs by whether respondents heard of HIV



Source: Field Survey 2016

When the respondents were asked regarding what HIV was then an overwhelming number of the participants (61.40%) said that HIV is a virus while 31.6 percent of them replied that HIV is a disease. Only 1.2 percent of them said that they did not know about the issue. A trifling number of the respondents (1 out of 595) answered that HIV is a foreign disease.

Figure 5.7: Distribution of FSWs by what HIV is



Source: Field Survey 2016

This study has also evaluated the sources of HIV/AIDS information. The results of the study display that a significant number of the respondents have mentioned a DIC (95.60%) as their main source of HIV information followed by television (57%), by seminar/workshop (55.3%), by NGO workers (35.1%), and through poster/billboard (17.5%).

The respondents were asked about how HIV infection did spread. The findings of the study demonstrate that 95.3 percent of the respondents have reported that HIV infection spread through unsafe physical relation (95.3%) followed by sharing of infected needles/syringes (77.6%), blood transfusion (72.9%), mother to child (56.1%), kissing (19.6%) etc.

As observed in the table 7, 96.30 percent of the respondents have said that HIV infection can be protected through safe sexual relation, by using germ free needles/syringes (82.20%), receiving germ free blood (62.6%), taking the advice of doctors (53.30%), creating mass awareness (4.70%), following religious norms (2.80%), etc.

Table 5.3: Distribution of FSWs by sources of HIV/AIDS information

Source of HIV information		
TV	65	57.0
Radio	5	4.4
News paper	11	9.6
Poster/Billboard	20	17.5
Doctor/health worker	9	7.9
Seminar/workshop	63	55.3
DIC	109	95.6
NGOs worker	40	35.1
Cinema/drama	9	7.9
Clients	3	2.6
Others	1	.9
Sources of AIDS information		
TV	61	53.5
Radio	2	1.8
Newspaper	7	6.1
Poster/Billboard	15	13.2
Doctor/health worker	51	44.7
Seminar/workshop	110	96.5
DIC	39	34.2
NGOs worker	9	7.9
Cinema/drama	1	.9
Others	4	3.5

Source: Field Survey 2016

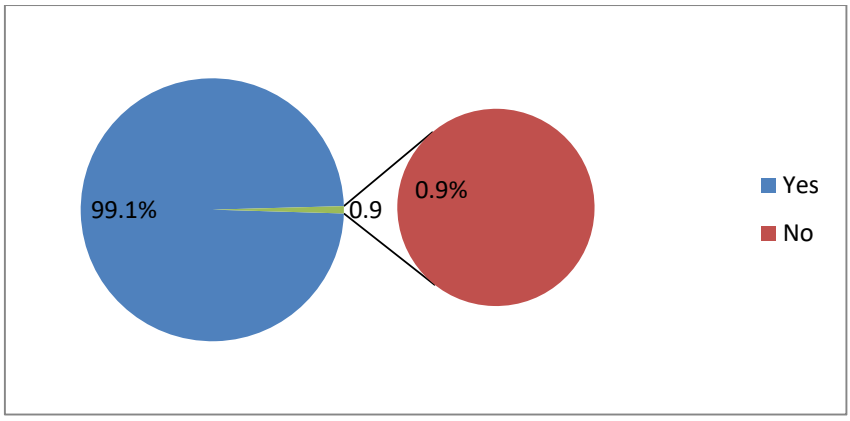
Table 5.4: Distribution of FSWs by ways of HIV infection and protection

How does HIV infection spread	**Frequency**	**Percent**
Unsafe physical relation	102	95.3
Sharing of infected needles/syringes	83	77.6
Mosquito/insect bites	3	2.8
Blood transfusion	78	72.9
Mother-to-child	60	56.1
Male sex with male	2	1.9
Sex with FSWs	7	6.5
Kiss/handshake	21	19.6
Sex with HIV infected people	4	3.7
How can HIV infection be protected		
Protected sexual relation	103	96.3
By using germ free needles/syringes	88	82.2
By receiving germ free blood	67	62.6
By following religious norms	3	2.8
Creating mass awareness	5	4.7
Taking the advice of doctors while having child	57	53.3
Others	2	1.9
Do not know	2	1.9

Source: Field Survey 2016

To evaluate the knowledge of the FSWs, they were asked whether they heard of AIDS or not. In response, an overwhelming number of them (99.10%) said that they heard of AIDS while only a negligible proportion of them (0.9%) reported in the negative manner.

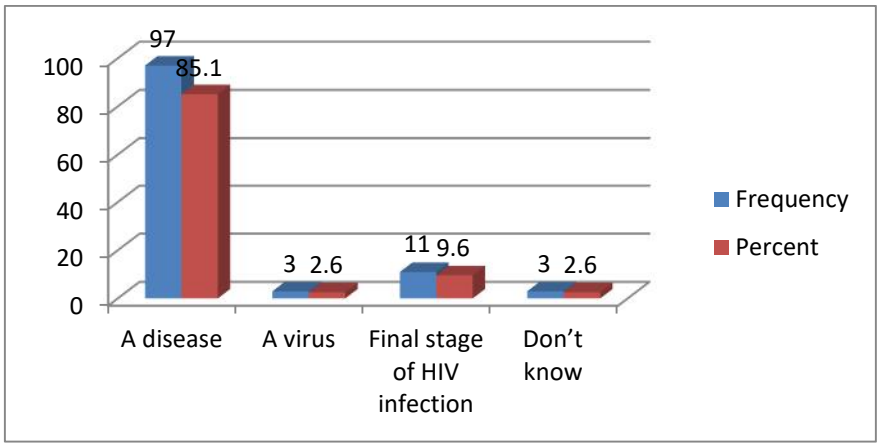
Figure 5.8: Distribution of FSWs by whether they heard of AIDS



Source: Field Survey 2016

FSWs were also asked if they knew what AIDS was. The findings of the study demonstrate that a significant number of the respondents have said that AIDS is a disease while around one-tenth of the participants have stated that AIDS is the final stage of HIV infection. Only 2.6 percent of them have claimed that it is a virus.

Figure 5.9: Distribution of FSWs by what AIDS is



Source: Field Survey 2016

The multiple responses of the main sources of information about AIDS were the seminar/workshop (96.5%), television (53.5%), doctor/health worker (44.70%), DIC (34.2%), poster/billboard (13.2%), newspaper (6.10%), NGO workers (7.90%) etc.

The main signs/symptoms of HIV infection as reported by the participants were recurring fever for more than 2/3 months (62.2%) followed by rapid weight loss (43.2%), dry cough for more than 2/3 months (42.3%), profound and unexplained fatigue (43.2%), diarrhea lasting more than a week (27.9%), white spots or unusual blemishes on the tongue, in the mouth, or in the throat (27%), memory loss, depression, and other neurological disorders (15.30%), etc.

Table 5.5: Distribution of FSWs by signs and symptoms of people living with HIV/AIDS

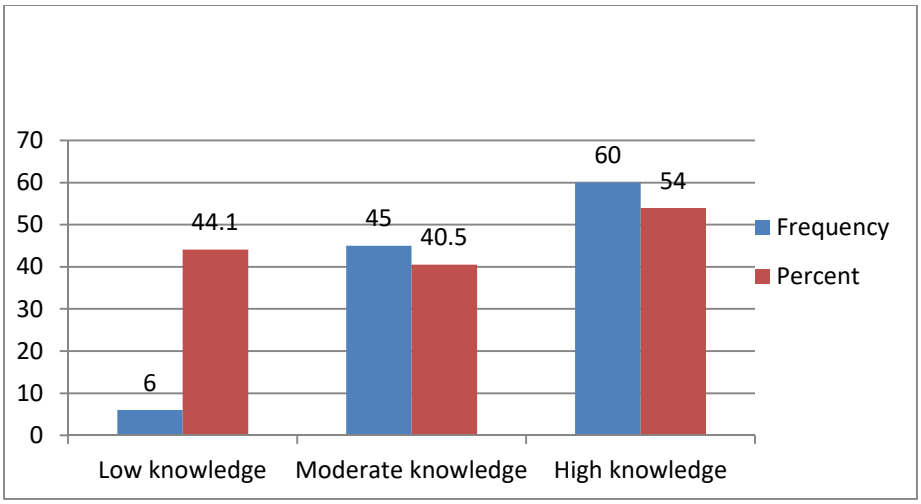
Signs and symptoms of People Living with HIV/AIDS		
Rapid weight loss	48	43.2
Dry cough for more than 2/3 months	47	42.3
Recurring fever for more than 2/3 months	69	62.2
Profound and unexplained fatigue	48	43.2
Swollen lymph glands in the armpits, groin, or neck	11	9.9
Diarrhea lasting more than a week	31	27.9
White spots or unusual blemishes on the tongue, in the mouth, or in the throat	30	27.0
Memory loss, depression, and other neurological disorders	17	15.3
Don't know	5	4.5
Do you know any HIV/AIDS infected people		
Yes	67	60.4
No	44	39.6
If any HIV/AIDS infected people, Will you keep it secret		
Yes	50	45.0
No	61	55.0

Source: Field Survey 2016

The respondents were asked whether they knew any HIV infected person or not. Approximately three-fifths of the respondents (60.4%) reported that they knew HIV infected persons, as the results of the study demonstrated. A little less than half of the respondents (45.0%) said that they would keep it secret if they come to know HIV infected people.

The figure 5.10 shows the pooled knowledge of the respondents about HIV/AIDS and STDs. It also demonstrates that only 46.80 percent of the FSWs have moderate knowledge about HIV/AIDS while 44.10 percent of them have showed low knowledge about the subject. Again, nine percent of the FSWs (36.7%) are found with high knowledge.

Figure 5.10: Distribution of FSWs by pooled knowledge about HIV/AIDS

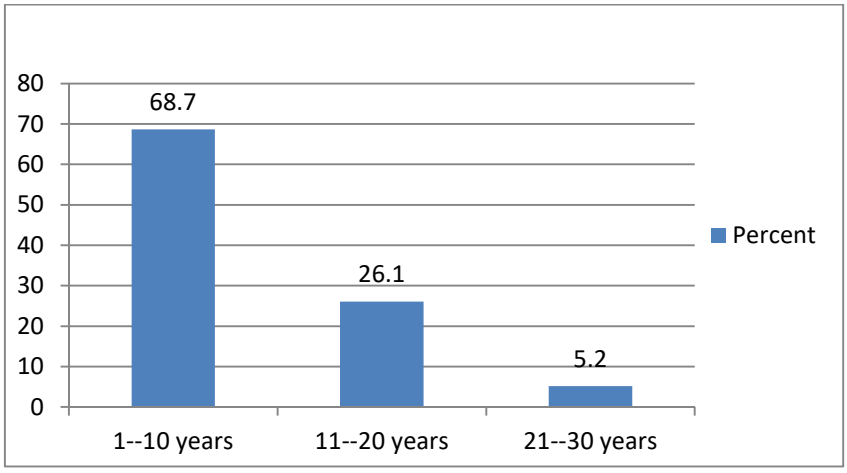


Source: Field Survey 2016

5.4 Attitudes and behaviors of FSWs and of their clients

The findings of the study reveal that a substantial number of the respondents have been working as sex workers for 1-10 years whereas around one-fourth of the participants have reported that they have been in this profession for 11-20 years. A negligible number of the respondents have informed that they have been involved in sex work for 21 to 30 years.

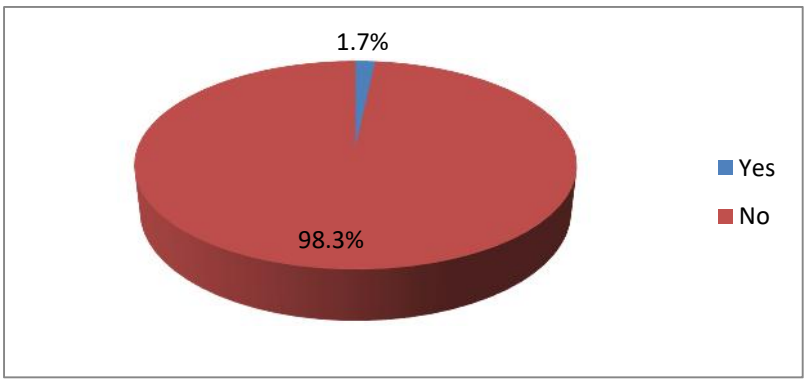
Figure 5.11: Distribution of FSWs by sex working experience of FSWs



Source: Field Survey 2016

The FSWs require legal documents/license to carry out their sex profession. But an overwhelming proportion of the respondents (98.30%) have informed that they do not have any legal documents to conduct their sex profession. In addition, only 1.7 percent of the participants said that they have had legal document to continue their profession.

Figure 5.12: Distribution of FSWs by whether they have legal documents or not



Source: Field Survey 2016

This study has also evaluated a good number of factors that motivate the respondents to get involved in this profession. The findings of this study display that 38.3 percent of them have reported that they get trapped by dalal or agent to be engaged in this profession followed by financial necessity (13.0%), family disorder (11.3%), easy way of earning (11.3%), forced by someone (11.3%), convinced by someone (7.8%), etc. A considerable number of the respondents (27.0%) have informed that they have been doing various types of jobs, followed by unemployed (25.2%), housewife (22.6%), housemaid (16.5%), and student (8.7%).

Though the clients of different ages come to visit the FSWs; they permit the young clients aged between 20 to 30 years most by, as reported by 60.9 percent of the respondents. Moreover, the second preference of them is to have sex with the adolescents (21.7%) whose ages are less than 20 years, whereas, the middle aged clients (31-50 years) constitute to be 17.4 percent of the total respondents in terms of their preferences to carry out intercourse.

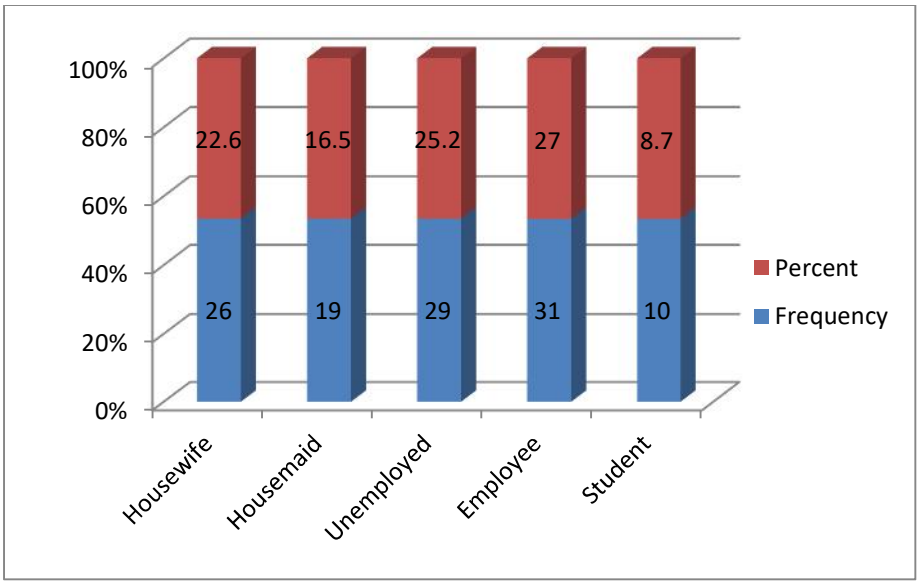
With regard to the professions of their clients, a significant number of FSWs have reported that their customers are mostly service holders (59.1%), followed by students (56.5%) rickshaw pullers (50.4%), businessmen (44.3%) bus/truck drivers (40%), factory workers (34.3%), police (25.2%), etc.

Table 5.6: Distribution of FSWs by attitudes and behaviors

How long have you been working as a sex worker?		
1-10	79	68.7
11-20	30	26.1
21-30	6	5.2
Do you have a legal document		
Yes	2	1.7
No	113	98.3
What factors that have motivated you to enter into this profession		
Financial Necessity	15	13.0
Family disorder	13	11.3
Easy way of earning	13	11.3
Forced by someone	13	11.3
Trapped by dalal/agents	44	38.3
Sexual abuse by house owner	2	1.7
Taken by husband	6	5.2
Convinced by someone	9	7.8
What are the professions of your clients?		
Factory worker	40	34.8
Rickshaw puller	58	50.4
Bus/truck driver	46	40.0
Police	29	25.2
Musclemen	12	10.4
Businessmen	51	44.3
Student	65	56.5
Teacher	4	3.5
Service holder	68	59.1
Others	25	21.7

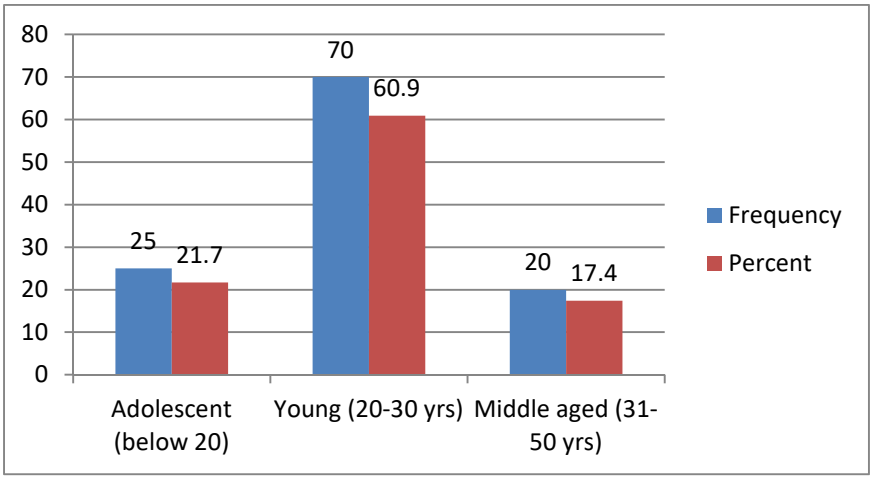
Source: Field Survey 2016

Figure 5.13: Distribution of FSWs by their previous professions



Source: Field Survey 2016

Figure 5.14: Distribution of FSWs by their types of clients



Source: Field Survey 2016

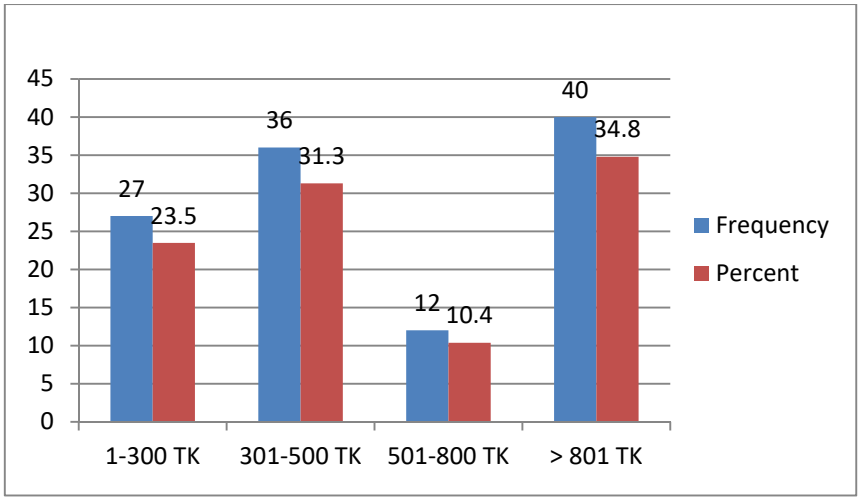
The FSWs receive some amount of money at the exchange of intercourse with their clients and their charges ranges from Taka 50 to Taka 1000. The results of the study demonstrate that a significant number of the FSWs (35.7%) have reported that the ranges of money they receive from their clients are 50 to Taka 199 whereas around one-third of the respondents (30.4%) have informed that they get Taka 301-500 from their clients. In addition, 18.3 percent customers have said that they charge more than Taka 500 for intercourse. Similarly, their per day income vary from person to person. This study reveals that 34.8 percent of the FSWs' per day income were more than Taka 800 whereas for those who have reported that their daily income are Taka 301-500 made up 31.3 percent of the total participants. A little more than one-fifth of the respondents (23.5%) have said that they earned up to three hundred taka per day. Only a negligible number of FSWs (10.4%) said that they earn Taka 501-800 on daily basis. Most importantly, an overwhelming proportion of FSWs (84.3%) have reported that if they are unwilling to maintain sexual relationship, their clients force them to do intercourse with them. Likewise, a significant number of the respondents (73.0%) have said that their clients take decision in terms of beginning sex with them, whereas 20.9 percent of them have informed that both parties including FSWs and clients play a role concerning taking decision while they are beginning to carry out intercourse with each other.

Table 5.7: Distribution of FSWs by the clients' behaviors

How much do you charge for encounter?		
Taka 1-99	4	3.5
Taka 100-199	41	35.7
Taka 200-299	35	30.4
Taka 300-399	14	12.2
Taka 500+	21	18.3
If you are unwilling to maintain sexual relationship, do your clients force to do so?		
Yes	97	84.3
No	18	15.7
Do your clients pay you properly		
Yes	101	87.8
No	14	12.2
If no, Why?		
By Force	9	64.3
Local Mastan	5	35.7

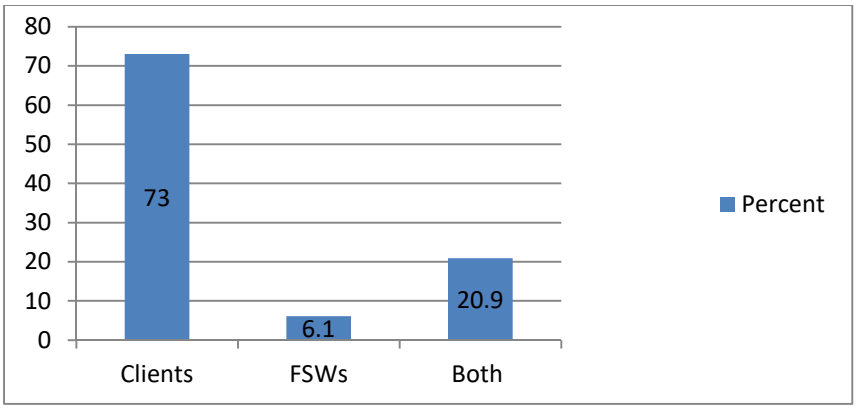
Source: Field Survey 2016

Figure 5.15: Distribution of FSWs by per day income



Source: Field Survey 2016

Figure 5.16: Distribution of FSWs by decision makers of beginning sex



Source: Field Survey 2016

5.5 Sexual behavior and risk practices by FSWs

One of the important objectives of this study was to assess the FSWs' risk practices. They were asked whether they knew how to have safe sex or not. In response, an overwhelming 99.1 percent of them reported that they knew how to conduct safe sexual intercourse with their clients. The number of clients they encountered ranged from 1 to7 per day. This study also showed that more than half, i.e., 54.8 percent of the respondents said that they had 1-3 clients every day, whereas approximately one-fifth of them informed that they took 3-5 clients per day. The majority of the respondents (74.0%) said that their clients used condom while having sex with them whereas a little more than one-fourth of them reported in the negative manner about this issue. All the respondents said that they requested their clients to use condom while having sex with them, for several reasons namely, avoiding the infection of STIs/STDs and HIV.

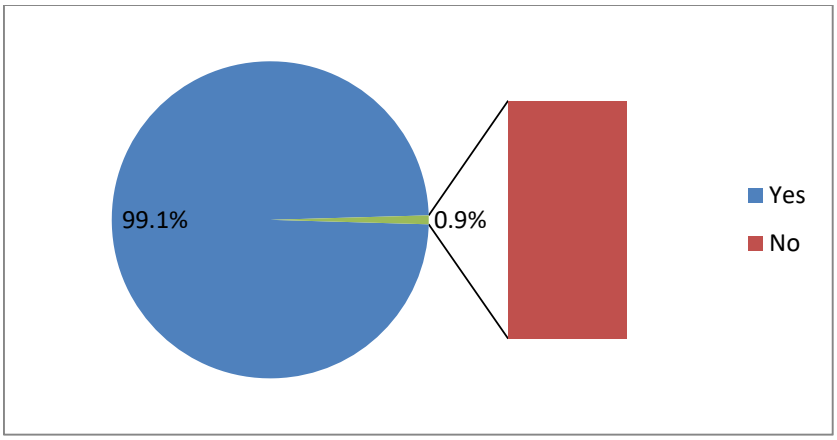
This study also found out that the use of female condom was significantly lower than that of male condom, only 22.6 percent of the FSWs said that they used female condom while they were having sex with their clients. Another overwhelming number of the respondents (93.9%) said they had checked the expiry date of condom before they used it. DICs provided them with condoms as reported by 65.2 percent of the FSWs. Vaginal sex was the most performed form of sex as stated by 84.3 percent of the respondents. Interestingly, almost all the respondents (99.10%) knew how to have sex with them. With respect to having sex with female, this study found out that only 7.0 percent of the participants said they had sex with females.

Table 5.8: Distribution of FSWs by sexual behavior

Do you know how to make safe sex		
Yes	114	99.1
No	1	0.9
How many clients do you have per day		
<1	10	8.7
1-3	63	54.8
3-5	24	20.9
>5	18	15.7
Do you request your clients to use condom?		
Yes	31	100.0
If yes, Why		
STIs/STDs	28	90.3
HIV/AIDS	2	6.5
Both	1	3.2
Do you use female condom?		
Yes	26	22.6
No	86	74.8
Don't know	3	2.6
What form of sex do you usually have with your clients?		
Vaginal	97	84.3
Multiple	18	15.7
Do you know how to use condom properly?		
Yes	114	99.1
No	1	0.9
Do you make sexual intercourse with female?		
Yes	8	7.0
No	107	93.0
Do you check the expiry date of condoms?		
Yes	108	93.9
No	3	2.6
Don't know	4	3.5
From where, Do you get condoms?		
Clients	1	0.9
DIC authority	75	65.2
Health workers	1	0.9
Dispensary	1	0.9
Multiple response	37	32.2

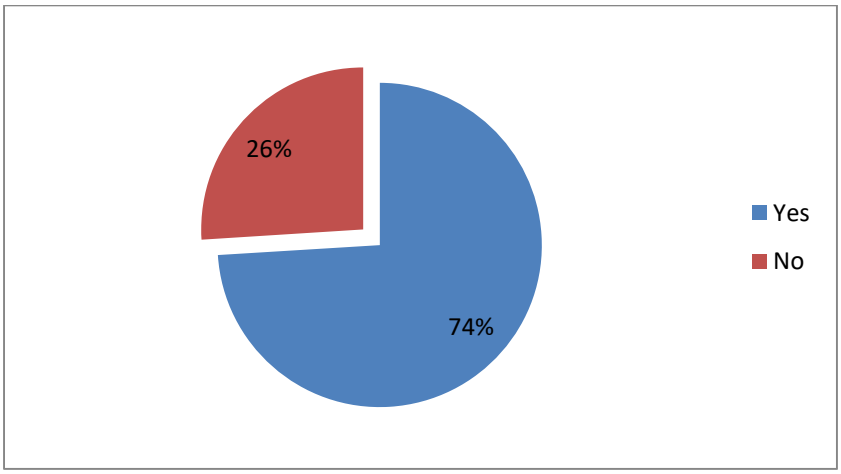
Source: Field Survey 2016

Figure 5.17: Distribution of FSWs by how to make sex



Source: Field Survey 2016

Figure 5.18: Distribution of FSWs by whether clients use condom or not

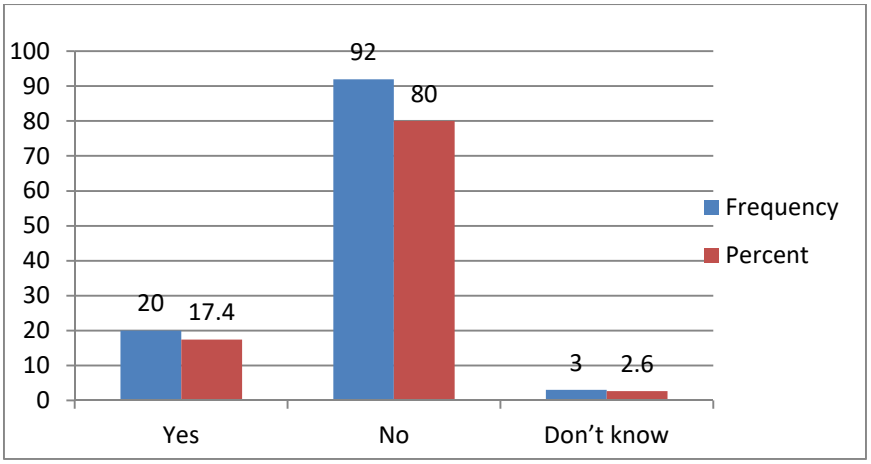


Source: Field Survey 2016

5.6 Prevention and treatment of diseases of FSWs

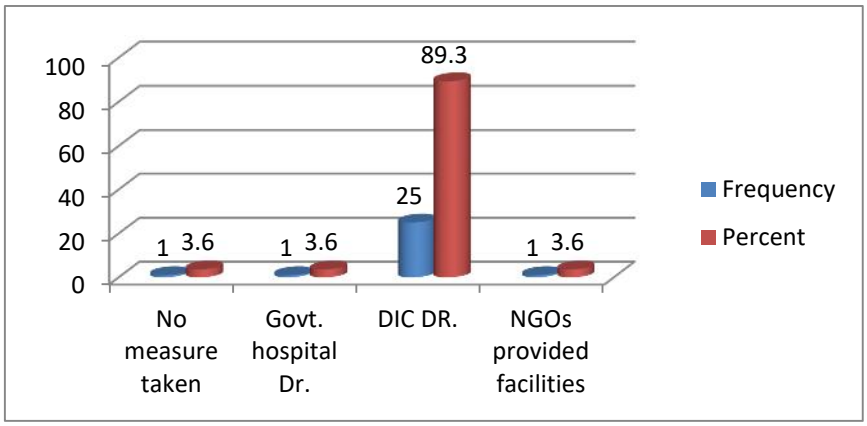
Nowadays, HIV/AIDS and STDs are very serious types of infectious diseases prevailing around the world. The respondents were asked whether they had received any curative measures for HIV/AIDS from a DIC. The majority of them (80%) informed that they did not get any curative measures for this infectious disease. Only 17.4 percent of them reported in the affirmative manner. They were also asked what types of treatment they had received. An overwhelming proportion of the respondents (89.30%) informed that they had received treatment from DIC doctors and the doctors provided free treatment for them as reported by 99.10 of the FSWs.

Figure 5.19: Distribution of FSWs by whether they take any curative measures for HIV/AIDS



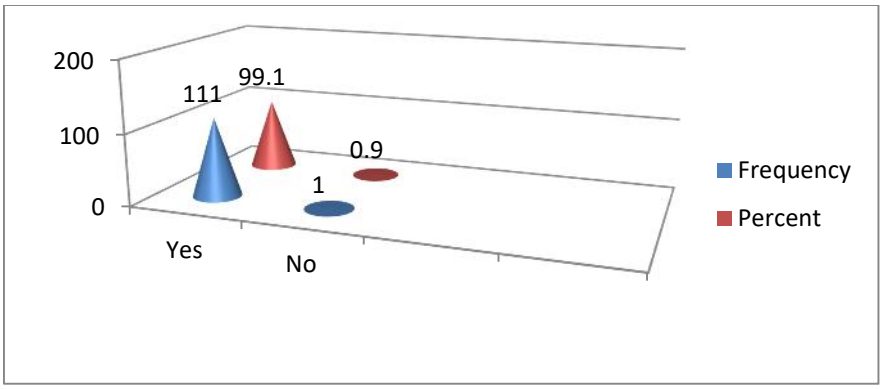
Source: Field Survey 2016

Figure 5.20: Distribution of FSWs by type of treatment



Source: Field Survey 2016

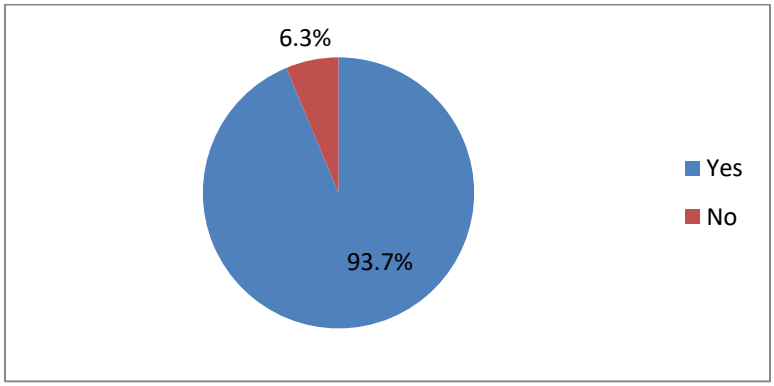
Figure 5.21: Distribution of FSWs by whether doctors provide free treatment or not



Source: Field Survey 2016

DICs provided free counseling for the FSWs. This study examined the free counseling services of DICs. The findings of the study reveal that 93.70 of the respondents informed that they were satisfied with the counseling provided by DICs.

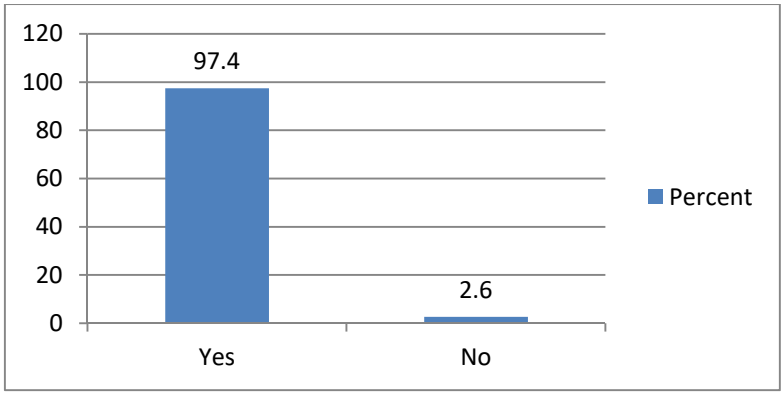
Figure 5.22: Distribution of FSWs by whether they are satisfied with counseling



Source: Field Survey 2016

The FSWs were asked whether DIC authority taught the techniques of using condoms or not. The results of the study demonstrate that an overwhelming number of the respondents (97.40%) informed that DIC authority had taught them the techniques of using condoms.

Figure 5.23: Distribution of FSWs by whether DICs teach the techniques of using condom



Source: Field Survey 2016

Table 5.9: Distribution of FSWs by illness and treatment

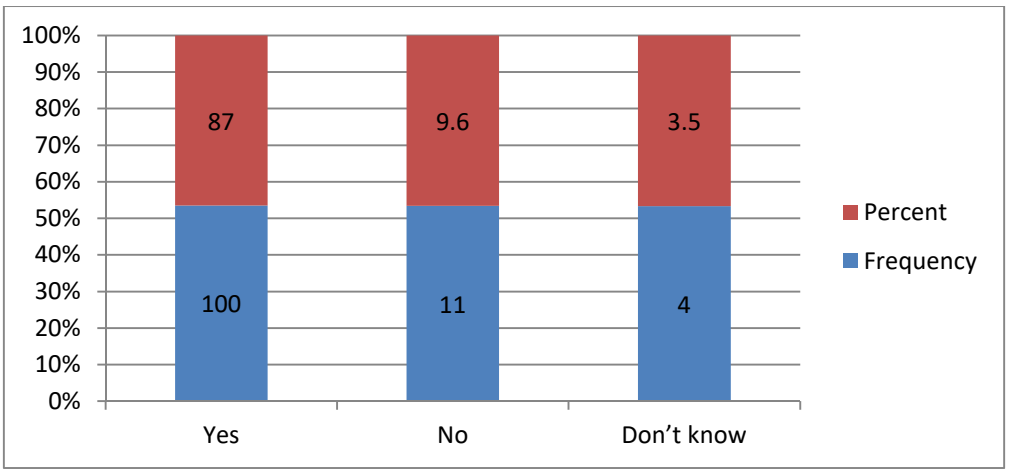
Now do you feel any kind of illness?	**Frequency**	**Percent**
Yes	46	40.0
No	69	60.0
Do you have any of these symptoms of sexual disorder?		
Discharge of fluids	5	4.3
Pain when urinating	6	5.2
Itchy/rash on genital	1	.9
Pain at intercourse	2	1.7
Pain in lower abdomen	2	1.7
Others	2	1.7
No	87	75.7
Multiple response	10	8.7
Did you seek treatment?		
Yes	28	100.0
Do you know what kinds of service are provided by DICs?		
Yes	112	97.4
No	3	2.6
Does the doctor do routine checkup?		
Yes	108	96.4
No	1	0.9
Don’t know	3	2.7
Do you get free medicine from here?		
Yes	101	87.8
No	12	10.4
Don’t know	2	1.7
Is the medicine provided by DIC sufficient?		
Yes	40	39.6

No	61	60.4
Do you get the required condom from DIC?		
Yes	87	75.7
No	20	24.3
Do you get lubricants from DIC?		
Yes	108	93.9
No	5	4.3
Don't know	2	1.7
Do you get any kind of treatment of STDs from here?		
Yes	112	97.4
Don't know	3	2.6
Does DIC provide you any kind of counseling?		
Yes	111	96.5
No	2	1.7
Don't know	2	1.7

Source: Field Survey 2016

The following Figure 5.24 presents results of whether they had received any kind of training or not. The results of the study demonstrate that just 87 percent of the total respondents informed that they had got training on various subjects, namely, HIV/AIDS, STDs, beauty parlor, human rights, knitting, etc. a negligible number of them (9.60%) replied in negative manner.

Figure 5.24: Distribution of FSWs by whether they received training from DIC or not

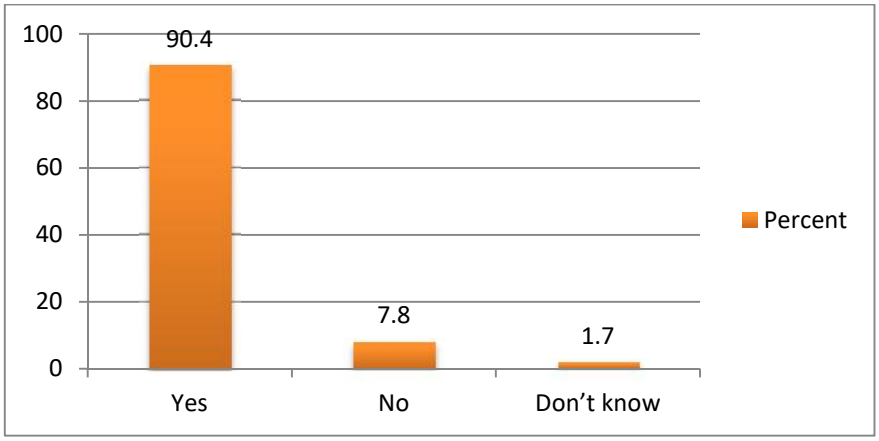


Source: Field Survey 2016

5.7 Services provided by DIC for FSWs

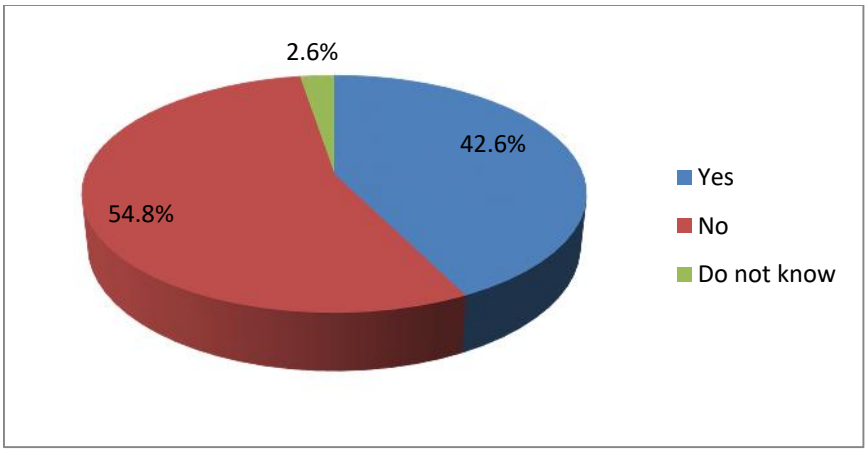
DICs provide various facilities for the FSWs. This study has also evaluated the services, which are provided by DICs for the welfare of FSWs. The findings of the study reveal that a significant number of them informed that DICs provides various facilities for doing well to them. For example, 100 percent of the respondents informed that DICs provided sleeping facility for them. The findings of the study also reveal that DICs provided free blood test facility, as reported by 90.4 percent of the FSWs. It is observed that 42.6 percent of the respondents informed that they got foods from them. But at the same time, a considerable number of the participants (83.7%) reported that foods provided by DICs were not sufficient for them. A few participants informed that it did not give any facility for them.

Figure 5.25: Distribution of FSWs by free blood test facility



Source: Field Survey 2016

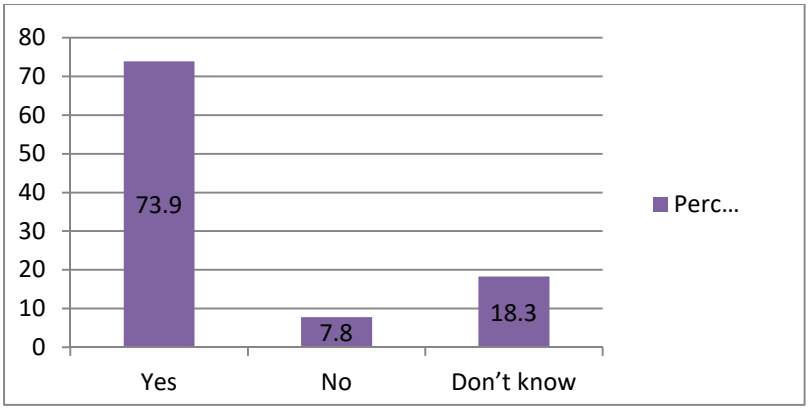
Figure 5.26: Distribution of FSWs by whether they get food from DICs



Source: Field Survey 2016

DICs provide not only foods, doctors, treatment facilities but also provide access to newspapers, television etc. The results of the study also display that nearly three-fourths of the respondents informed that it provided newspapers/ magazines facility for them while 98.3 percent of them stated that it also provided the opportunity of watching television. Overall, the perception of them towards DIC facilities was good as reported by the three-fourths of the study subjects (70.4%).

Figure 5.27: Distribution of FSWs by whether they get newspaper or not



Source: Field Survey 2016

Table 5.10: Distribution of FSWs by services provided by DIC

Services provided by DICs	Frequency	Percent
Does a DIC send you for blood test elsewhere?		
Yes	38	33.0
No	58	50.4
Don't know	19	16.5
In the last 12 months, did you receive any HIV/STIs preventive service from DICs?		
Yes	41	35.7
No	66	57.4
Don't know	8	7.0
Is the food provided by DICs sufficient?		
Yes	8	16.3
No	41	83.7
Do you get the opportunity to watch TV from here?		
Yes	113	98.3
No	2	1.7
Last of all, what is your remark about the services of DICs?		
Good	81	70.4
Moderate	34	29.6

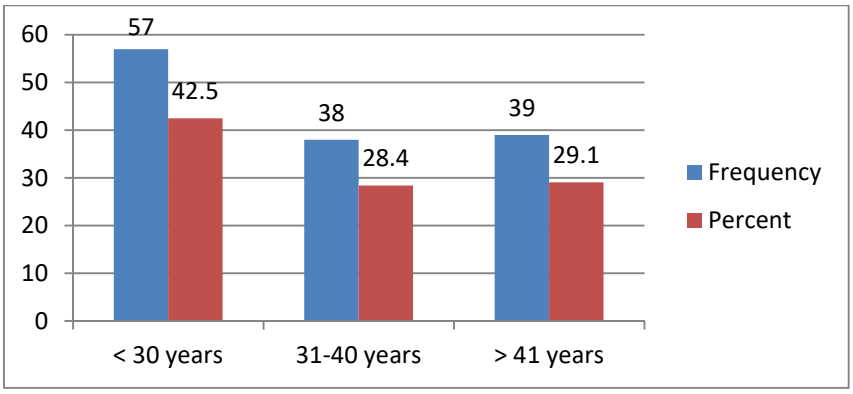
Source: Field Survey 2016

Section B: Injecting Drug Users (IDUs)

5.8 Socio-demographic profile of IDUs

The respondents' ages are depicted in the following figure. It is clear from the figure that more than two-fifths of the respondents' ages are less than 30 years, whereas a little less than one-third of the respondents fall in to the category of 31-40 years. This study also reveals that a considerable number of the respondents (29.1%) are more than 41 years of age. Female respondents are proportionately higher in the in the group of less than 30 years.

Figure 5.28: Distribution of IDUs by ages



Source: Field Survey 2016

This study unveils that an overwhelming proportion of the respondents (98.5%) are Muslims since Bangladesh is a predominantly Muslim country. But only a few numbers of the respondents, (1.50%) had identified themselves as the followers Hinduism.

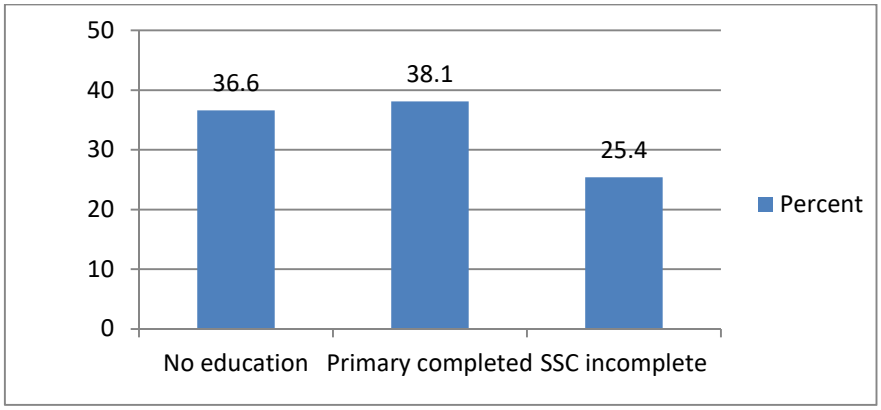
Education level is one of the most crucial constituents of the IDUs. It affects many aspects of their lives. Studies have shown that educational attainment has strong influence on the IDUs' HIV/AIDS related risk practices. According to the survey findings of this study, two-fifths of the respondents (38.10%) have completed primary level of education, whereas a considerable number of them (36.6%) do not have any schooling. Moreover, 25.4 percent of the respondents have failed to complete their SSC. Educational attainment is found to be slightly higher among the female respondents.

Table 5.11: Distribution of IDUs by their background profile

Respondents' background	**Number**	**Male**	**Number**	**Female**	**Total No.**	**Total %**
Religion						
Islam	112	98.2	20	100.0	132	98.5
Hinduism	2	1.8	0	0.0	2	1.5
Can you read						
Yes	56	49.1	10	50.0	66	49.3
No	58	50.9	10	50.0	65	50.7

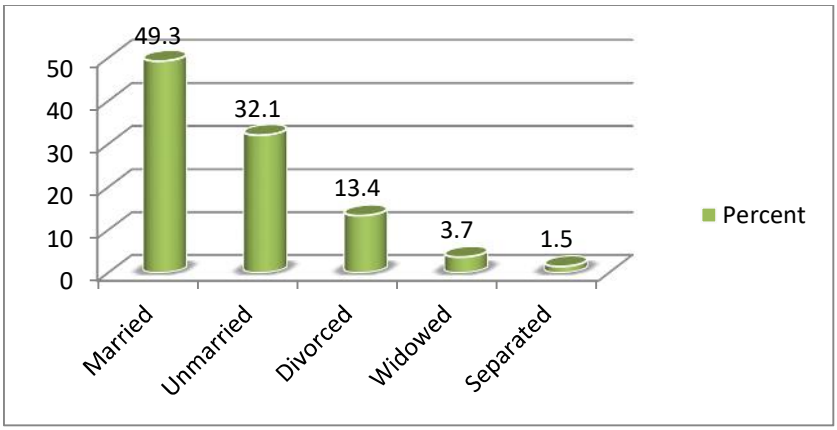
Source: Field Survey 2016

Figure 5.29: Distribution of IDUs by education level



Source: Field Survey 2016

Figure 5.30: Distribution of IDUs by marital status



Source: Field Survey 2016

Among the respondents surveyed, a good number of them (49.3%) were married whereas about 32.10% of them reported themselves as unmarried. A little higher than one-tenth of the IDUs were divorced. A higher number of the female IDUs were married than their male counterparts. With respect to having child, this study demonstrates that a significant number of IDUs (39.40%) had two children only, whereas about 28% of the respondents had only one child. This study also out found that 22.7% of the participants had more than two children.

This study has also assessed the IDUs' monthly incomes and it has been found that a considerable number (30.6%) of the respondents' monthly income were less than Taka 10,000. Out of the total respondents in the sample, as many as 24.3% of the respondents were in the income group of Taka 10,000-14,999 and 20.1% earned Taka 15,000 to 19,999 per month. More than one fifth of the IDUs (22.40%) reported that their main source of income was daily labor followed by business (19.40%), sex working (10.40%), snatching (10.40%), etc.

Religiosity is considered as one of the key socio-demographic determinants of the IDUs. The findings of the study have found out that an overwhelming number of the respondents (62.7%) used to perform religious activities sometimes. Nearly 28% of them never attended religious activities, whereas a trifling number of them (9%) need to perform religious activities regularly.

Table 5.12: Distribution of IDUs by socio-demographic characteristics

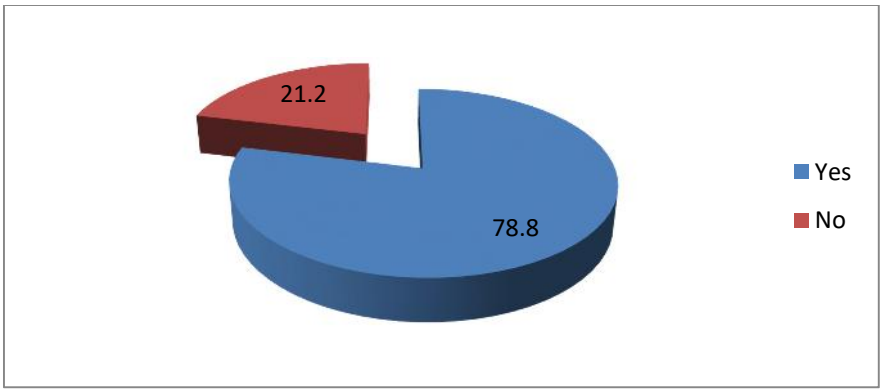
Do you have any child?						
No	4	6.5	2	50.0	6	9.1
One	19	30.6	0	0.0	19	28.8
Two	24	38.7	2	50.0	26	39.4
More	15	24.2	0	0.0	15	22.7
Income (in Taka)						
< 10,000	37	32.5	4	20.0	41	30.6
10,000-14,999	29	25.4	2	10.0	31	23.1
15,000-19,999	23	20.2	4	20.0	27	20.1
20,000-24,999	11	9.6	2	10.0	13	9.7
25,000-29,999	5	4.4	2	10.0	7	5.2
30,000+	9	7.9	6	30.0	15	11.2
Source of income						
Tokai	7	6.1	0	0.0	7	5.2
Thief/snatcher	14	12.3	0	0.0	14	10.4
Daily Labor	28	24.6	2	10.0	30	22.4
Beggar	3	2.6	1	5.0	4	3.0
House owner	2	1.8	0	0.0	2	1.5
Business	25	21.9	1	5.0	26	19.4
Rickshaw puller	18	15.8	0	0.0	18	13.4
Service holder	7	6.1	1	5.0	8	6.0
Others	10	8.8	1	5.0	11	8.2
Sex worker	0	0.0	14	70.0	14	10.4
How often do you offer religious activities?						
Everyday	8	7.0	4	20.0	12	9.0
Sometimes	73	64.0	11	55.0	84	62.7
Never	33	28.9	5	25.0	38	28.4

Source: Field Survey 2016

5.9 IDUs' exposure to mass media

The respondents were asked whether they need to read newspapers or not. The findings of the study demonstrate that an overwhelming number of the respondents (78.8%) need to read newspapers, whereas those who did not read newspapers were only 21.20 percent of them. In term of frequency of reading newspapers, this study also shows that 38.50% of the respondents informed that they need to read newspaper daily while 40.4% of them reported that they read newspapers 3 to 5 days in a week. Further, 17.3% of the respondents stated that they need to read newspapers once in a week.

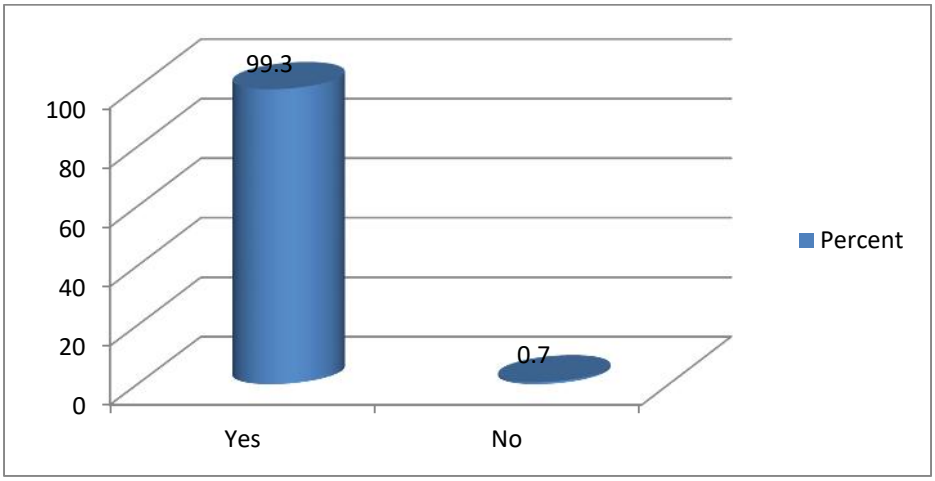
Figure 5.31: Distribution of IDUs by exposure to radio



Source: Field Survey 2016

Television is considered as one of the most powerful and vibrant media in the present day world. This study has also evaluated IDUs' exposure to television. The results of the study show that an overwhelming number of them (99.30%) have exposure to television, whereas 62.4% of them informed that they used to watch television daily. Frequency of watching television is higher among the female respondents.

Figure 5.32: Distribution of IDUs by exposure to television



Source: Field Survey 2016

Table 5.13 : Distribution of IDUs by exposure to mass media

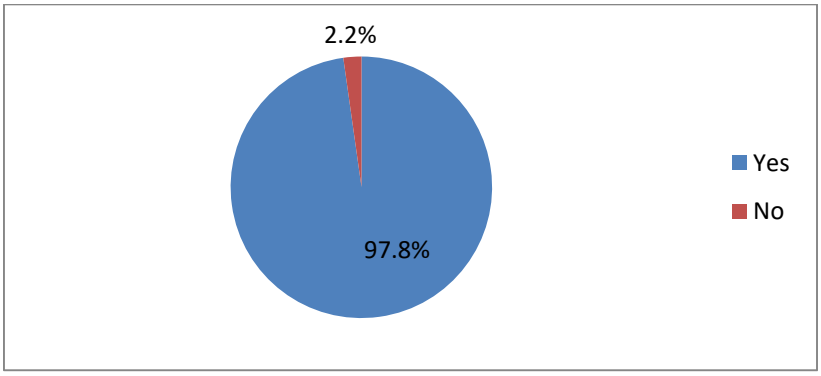
Exposure to Mass Media	Number	Male	Number	Female	Total N	Total %
How often do you read newspaper/magazine?						
Daily	17	39.5	3	33.3	20	38.5
3-5 days in a week	17	39.5	4	44.4	21	40.4
Weekly	6	18.6	1	11.1	9	17.3
Monthly	1	2.3	1	11.1	2	3.8
Do you watch TV?						
Yes	113	99.1	20	100.0	133	99.3
No	1	0.9	0	0.0	1	0.7
How often do you watch TV?						
Daily	69	61.1	14	70.0	83	62.4
3-5 days in a week	35	31.0	4	20.0	39	29.3
Weekly	9	8.0	2	10.0	11	8.3

Source: Field Survey 2016

5.10 IDUs' awareness and knowledge on HIV/AIDS

During this study period the information on knowledge about HIV was also collected through survey. The findings of the study show that almost all IDUs (97.8%) heard of HIV while only 2.2% of the respondents reported that they did not hear of HIV.

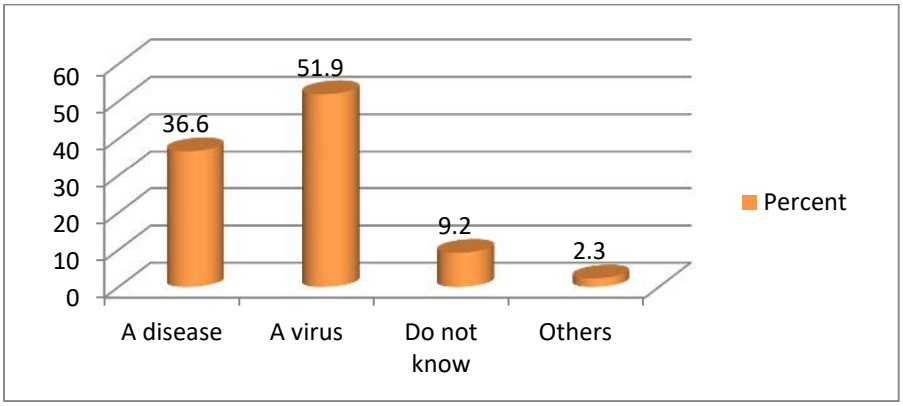
Figure 5.33: Distribution of IDUs by whether they heard of HIV



Source: Field Survey 2016

When the respondents were asked what HIV was. Then a considerable number of them (51.9%) informed that HIV is a virus while 36.6% of them replied that HIV is a disease. Only 9.2% of them informed that they did not know about the issue.

Figure 5.34: Distribution of the respondents by what HIV is



Source: Field Survey 2016

This study has also determined the available sources of information on AIDS. The results of the study clearly display that a significant number of the respondents mentioned DICs (92.4%) as their main sources of HIV information followed by television (66.4%), NGO workers (40.5%), newspapers (21.4%) seminars/workshops (19.8%), posters/billboards (11.5%) and doctors/health workers (6.1%), etc.

Table 5.14: Distribution of IDUs by sources of information on HIV

Source of information about HIV	Number	Male	Number	Female	Total N	Total %
TV	75	67.6	12	60.0	8	66.4
Radio	0	0.0	1	5.0	1	0.8
News papers	23	20.7	5	25.0	28	21.4
Poster/billboard	14	12.6	1	5.0	15	11.5
Doctor/health worker	7	6.3	1	5.0	8	6.1
Seminar/workshop	18	16.2	8	40.0	26	19.8
DIC	103	92.8	18	90.0	121	92.4
NGOs worker	49	44.1	4	20.0	53	40.5
Cinema/drama	4	3.6	0	0.0	4	3.1
Clients	2	1.8	0	0.0	2	1.5
Others	5	4.5	0	0.0	5	3.8

Table 5.15: Distribution of IDUs by spread of HIV infection

Spread of HIV infection	Number	Male	Number	Female	Total N	Total %
Unsafe physical relation	89	89.0	18	94.7	107	89.9
Sharing of infected needles/syringes	71	71.0	16	84.2	87	73.1
Mosquito/insect bites	10	10.0	0	0.0	10	8.4
Blood transfusion	47	47.0	18	94.7	65	54.6
Mother to child	29	29.0	10	52.6	39	32.8
Male sex with male	2	2.0	0	0.0	2	1.7
Sex with FSWs	5	5.0	0	0.0	5	4.2
Kiss/handshake	5	5.0	1	5.3	6	5.0
Sex with HIV infected people	13	13.0	1	5.3	14	11.8
Do not know	13	13.0	0	0.0	13	10.9
How can HIV infection be prevented?						
Protected sexual relation	80	80.0	14	73.7	94	79.0
By using germfree Needles/syringes	78	78.0	17	89.5	95	79.8
By receiving germ free blood	41	41.0	15	78.9	56	47.1
By following religious norms	4	4.0	2	10.5	6	5.0
Creating mass awareness	3	3.0	1	5.3	4	3.4
Taking the advice of doctors in terms of having child	10	10.0	2	10.0	12	10.1
Others	7	7.0	1	5.3	8	6.7

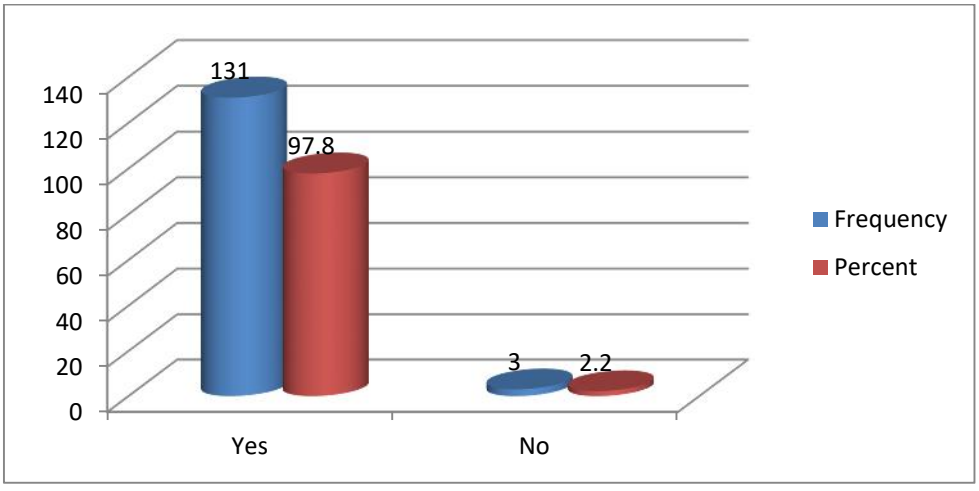
Source: Field Survey 2016

The respondents of the study were asked how HIV infection did spread. The findings reveal that 89.9% of the respondents reported that HIV infection could spread through unsafe physical relation. The female respondents were more likely to report that HIV infection could spread through unsafe physical relation. The second dangerous way of spreading HIV infection was sharing of infected needles/syringes (73.1%) followed by blood transfusion (54.6%), mother to child (32.8%), having sex with HIV infected people (11.8%), mosquito/insect bites (8.4%), etc.

As observed from the Table-7, a significant number of the IDUs (79.8%) has informed that HIV infection could be prevented by using germfree needles/syringes followed by protected sexual relation (79.0%), by receiving germ free blood (47.1%), taking the advice of doctors in terms of having child (10.1%), creating mass awareness (3.4%) etc.

To examine the knowledge of the IDUs, they were asked whether they heard of AIDS or not. In response, an overwhelming number of them (97.8%) answered that they had heard of AIDS while only a negligible proportion of them (2.20%) told that they did not.

Figure 5.35: Distribution of IDUs by ever heard of AIDS



Source: Field Survey 2016

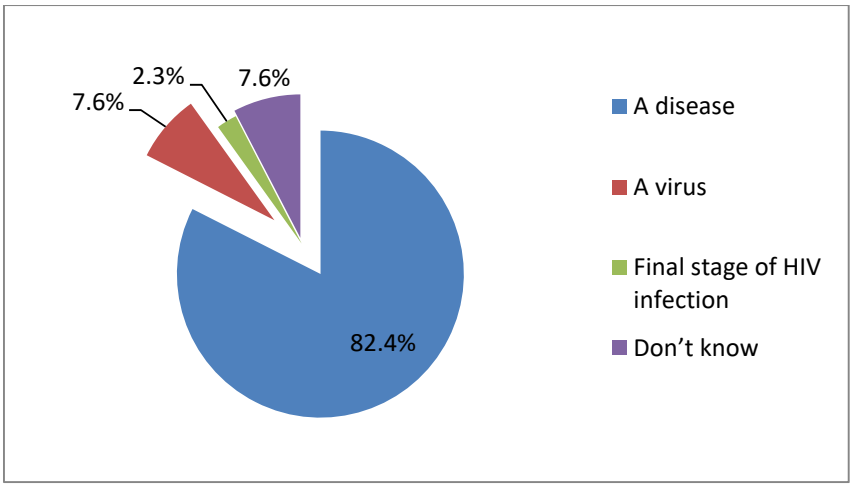
Table 5.16: Distribution of IDUs by sources of information on AIDS\

Source of information about AIDS	Number	Male	Number	Female	Total N	Total %
TV	73	65.8	12	60.0	85	64.9
Radio	1	0.9	1	5.0	2	1.5
Newspaper	12	10.8	2	10.0	14	10.7
Poster/billboard	14	12.6	6	30.0	20	15.3
Seminar/workshop	102	91.9	19	95.0	121	92.4
DICs	42	37.8	7	35.0	49	37.4
NGOs worker	3	2.7	1	5.0	4	3.1
Cinema/drama	0	0.0	1	5.0	1	0.8
Others	2	1.8	1	5.0	3	2.3

Source: Field Survey 2016

IDUs were also asked if they knew what AIDS is. The findings of the study demonstrated that a significant number of the respondents (82.4%) answered that AIDS is a disease while nearly one-tenth of them (7.6%) stated that AIDS is a virus. The percentage of the respondents who answered that AIDS is the final stage of HIV infection constituted on 2.3% of the total respondents. Only 7.6% of them answered that they did not know about the subject.

Figure 5.36: Distribution of IDUs by what AIDS is



Source: Field Survey 2016

The multiple responses of the main sources of information on AIDS were the seminar/workshop (92.4%). The second important source of AIDS information was television (64.9%) followed by DIC (37.4%), poster/billboard (15.3%), newspapers (10.70%), NGO workers (3.1%), etc.

The main signs/symptoms of HIV infection reported by the participants were rapid weight loss (42.1%) followed by recurring fever for more than 2/3 months (24.0%), memory loss, depression, and other neurological disorders (21.5%), profound and unexplained fatigue (17.4%), white spots or unusual blemishes on the tongue, in the mouth, or in the throat (14.0%), diarrhea lasting more than a week (13.20%), etc. A significant number of them told that they did not know about the sign and symptoms of the disease.

Table 5.17: Distribution of IDUs by signs and symptoms of people living with HIV/AIDS

Signs and symptoms of people living with HIV/AIDS	**Number**	**Male**	**Number**	**Female**	**Total N**	**Total %**
Rapid weight loss	39	38.2	12	63.2	51	42.1
Dry cough for more than 2/3 months	18	17.6	6	31.6	24	19.8
Recurring fever for more than 2/3 months	24	23.5	5	26.3	29	24.0
Profound and unexplained fatigue	18	17.6	3	15.8	21	17.4
Swollen lymph glands in the armpits, groin, or neck	11	10.8	1	5.3	12	9.9
Diarrhea lasting more than a week	8	7.8	8	42.1	16	13.2
White spots or unusual blemishes on the tongue, in the mouth, or in the throat	13	12.7	4	21.1	17	14.0
Memory loss, depression, and other neurological disorders	25	24.5	1	5.3	26	21.5
Don’t know	40	39.2	3	15.8	43	35.5
Others	2	2.0	0	0.0	2	1.7

Source: Field Survey 2016

The respondents were asked whether they knew any HIV infected persons or not. Approximately three-fifths of the respondents (62.0%) reported that they knew HIV infected persons, as the results of the study demonstrate. Further, more than two-fifths of the respondents (43.8%) said that they would keep it secret if they knew HIV infected people. In addition, a considerable proportion of the participants (65.3%) said that they were in great risk of contracting HIV. They mentioned several causes of behind this perception, including using needles and syringes (35.4%), not using condoms (2.50%), multiple sex partners (2.50%), etc.

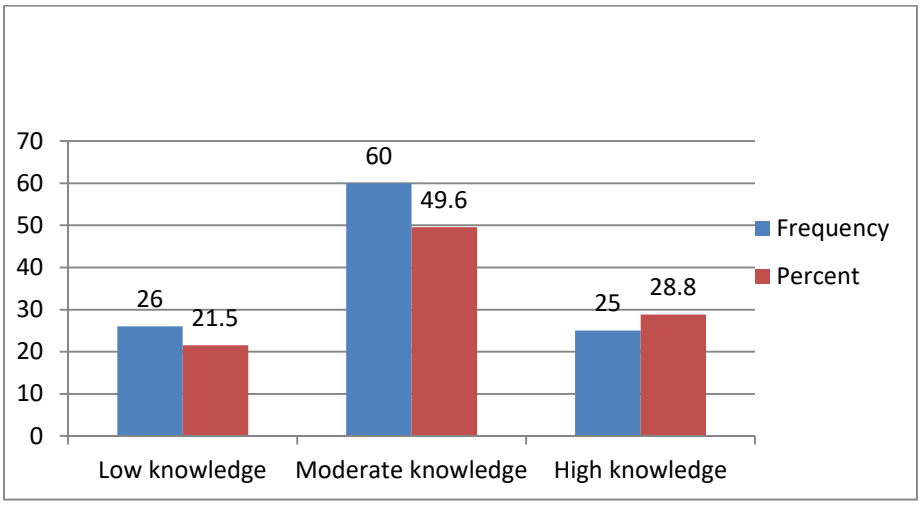
Table 5.18: Distribution of IDUs by awareness and knowledge on HIV/AIDS

Awareness and knowledge on HIV/AIDS	**Number**	**Male**	**Number**	**Female**	**Total N**	**Total %**
Do you know any HIV/AIDS infected people?						
Yes	61	59.8	14	73.7	75	62.0
No	41	40.2	5	26.3	46	38.0
If you know any HIV/AIDS infected people, will you keep it secret?						
Yes	40	39.2	13	68.4	53	43.8
No	62	60.8	6	31.6	68	56.2
Do you think that you are in risk of contracting HIV?						
Yes	68	66.7	11	59.9	79	65.3
No	34	33.3	8	42.1	42	34.7
Do you think your own chances of getting HIV?						
Small	22	32.4	1	9.1	23	29.1
Moderate	24	35.3	5	45.5	29	36.7
High	20	29.4	3	27.3	23	29.1
Do not know/not sure	2	2.9	2	18.2	4	5.1
Why do you think so (if yes)?						
Multiple sex partners	2	2.9	0	0.0	2	2.5
Not using condoms	1	1.5	1	9.1	2	2.5
Intercourse with sex worker	1	1.5	0	0.0	1	1.3
Using needles and syringes	28	41.2	0	0.0	28	35.4
Other	0	0.0	1	9.1	1	1.3
Multiple response	36	52.9	9	81.8	45	57.0
Why do you think so (if no)?						
Avoiding sex	1	2.9	0	0.0	1	2.4
Avoiding sex with sex-worker	1	2.9	0	0.0	1	2.4
Not using needles and syringes of others	1	2.9	0	0.0	1	2.4
No blood transfusion without testing blood	1	2.9	0	0.0	1	2.4
Multiple Responses	30	88.2	8	100.0	38	90.5

Source: Field Survey 2016

The Figure 10 demonstrates the pooled knowledge of the respondents on HIV/AIDS and STDs. It also demonstrates that only 49.60% of the IDUs have moderate knowledge about HIV/AIDS while 28.80% of them have shown high knowledge about the subject. Moreover, 21.50% of the IDUs were found with low level of knowledge on HIV/AIDS and STDs.

Figure 5.37: Distribution of IDUs by pooled knowledge on HIV/AIDS



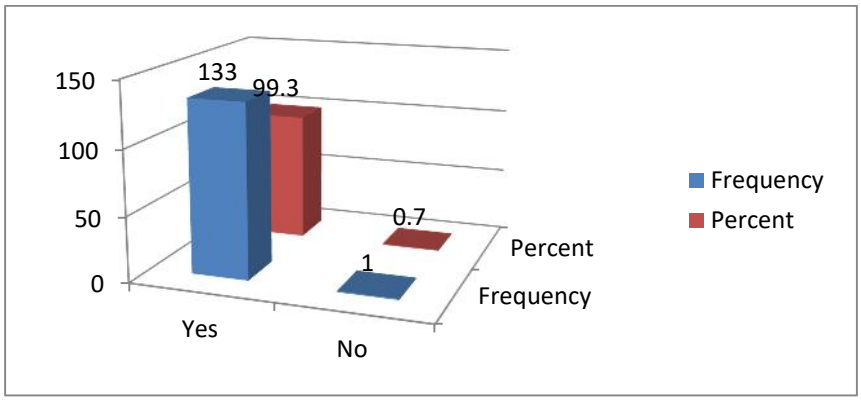
Source: Field Survey 2016

5.11 Attitudes and behaviors of IDUs and of their clients

The findings of the study confirm that consumption of drugs is higher among the IDUs. The study further demonstrates that an overwhelming number of the respondents (99.30%) confessed that they had consumed drugs while only 0.70% told that they did not have drugs. They mentioned various types of drugs including injecting drugs (94.7%). The second dangerous drug which was consumed by IDUs was **ganja** (61.70%), Tablets (53.40%), yaba (38.3%), heroine (31.6%), phensidyl (28.60%), alcohol (19.50%), etc., were other drugs. They got these drugs from various sources including markets (19.50%), other IDUs (5.30%), multiple sources (51.90%), etc.

The respondents were also asked how often they consumed drugs in a week. In response, the majority of them (97.7%) reported that they had drugs daily while only 2.3% of them reported in the negative manner. They used a needle/syringe to inject any illegal drug into their body as reported by an overwhelming number of the respondents (97.8%). Not only they injected drugs into their body by using needle/syringes, but they also shared those with others as stated by a significant number of them (65.6%).

Figure 5.38: Distribution of IDUs by whether they consume drugs or not



Source: Field Survey 2016

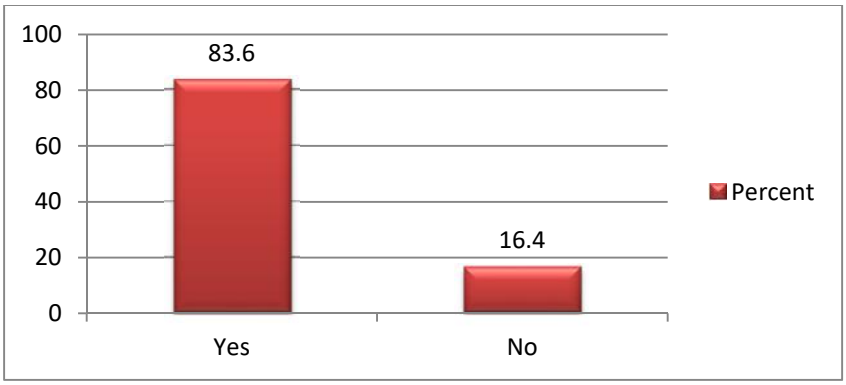
Table 5.19: Distribution of IDUs by clients' attitudes and behaviors

Clients' Attitudes and Behaviors	Number	Male	Number	Female	Total N	Total %
What kind of drugs						
Phensidyl	26	22.8	12	63.2	38	28.6
Heroin	34	29.8	8	42.1	42	31.6
Alcohol	19	16.7	7	36.8	26	19.5
Ganja	74	64.9	8	42.1	82	61.7
Yaba	40	35.1	11	57.9	51	38.3
Tablet	57	50.0	14	73.7	71	53.4
Injection	109	95.6	17	89.5	126	94.7
Others	8	7.0	4	21.1	12	9.0
Sources of drugs						
From other IDUs	6	5.3	1	5.3	7	5.3
Buy from markets	21	18.4	5	26.3	26	19.5
Friends	1	0.9	0	0.0	1	0.8
Others	27	23.7	3	15.8	30	22.6
Multiple responses	59	51.8	10	52.6	69	51.9
Do you ever use a needle/syringe to inject any illegal drug into your body?						
Yes	113	99.1	18	90.0	131	97.8
No	0	0.0	2	10.0	2	1.5
Refused to answer	1	0.9	0	0.0	1	0.7
How often do you use drug in a week?						
Daily	110	97.3	18	100.0	128	97.7
3-5 Days in a week	3	2.7	0	0.0	3	2.3
Did you ever share the needle/syringe with others?						
Yes	74	65.5	12	66.7	86	65.6
No	36	31.9	6	33.3	42	32.1
Refused to answer	3	2.7	0	0.0	3	2.3

Source: Field Survey 2016

The following figure depicts the results on whether the respondents had ever tested HIV to see if they had HIV. The results of the current study display that a considerable number of them replied that they had tested HIV to see if they had HIV while nearly 16% of them informed in the negative manner. Further, an overwhelming proportion of the participants (95.5%) claimed that they wanted to test HIV.

Figure 5.39: Distribution of IDUs by ever tested HIV



Source: Field Survey 2016

This study has also evaluated the sexual behavior of the respondents. The results of the study demonstrate that more than four-fifths (81.30%), of the respondents stated that they had sex with someone in their life. The sexual partners of them were CSWs (40.40%), MSM (6.40%), multiple partners (63.20%), etc. While they were having sex they used condom as reported by 54.10% of them. Moreover, 44.0% of them informed that they did not use condoms while they were doing sexual intercourse with their partners.

Table 5.20 : Distribution of IDUs by clients' attitudes and behaviors

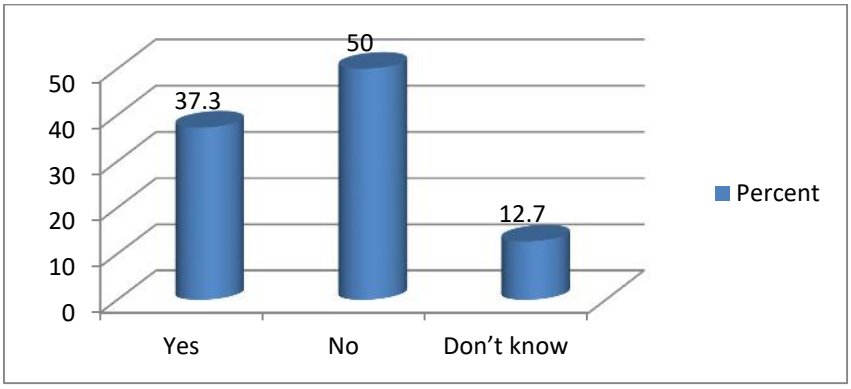
Clients' Attitudes and Behaviors	**Numbe r**	**Male**	**Number**	**Female**	**Total N**	**Total %**
Would you want to be tested for HIV/AIDS?						
Yes	108	94.7	20	100.0	128	95.5
No	4	3.5	0	0.0	4	3.0
Do not know/not sure	2	1.8	0	0.0	2	1.5
Have you donated blood to any other person?						
Yes	47	41.2	6	30.0	53	39.6
No	67	58.8	14	70.0	81	60.4
Have you ever had sex with anyone?						
Yes	90	78.9	19	95.0	109	81.3
No	24	21.1	1	5.0	25	18.7
If yes, with whom did you do sex?						
SW	44	48.9	0	0.0	44	40.4
MSM	2	2.2	5	26.3	7	6.4
Multiple responses	44	48.9	14	73.7	58	63.2
Did you use condom while performing sexual intercourse?						
Yes	48	53.3	11	57.9	59	54.1
No	40	44.4	8	42.1	48	44.0
Don't know	2	2.2	0	0.0	2	1.8

Source: Field Survey 2016

5.12 Prevention and treatment of diseases of IDUs

This study also examines the prevention and treatment of HIV/AIDS of the respondents since they are supposed to be high-risks groups. The respondents were asked if there was any curative measure for HIV/AIDS or not. The findings of the study reveal that just half of the respondents replied that there was no curative measure for HIV/AIDS, whereas for those who replied that there was a curative measure for HIV/AIDS, represent 37.30% of the total respondents. Only 12.7% replied that they did not know about this issue. Female respondents were more likely to reply that there was a curative measure for HIV/AIDS than their male counterpart did.

Figure 5.40: Distribution of IDUs by whether there is a curative measure for HIV/AIDS



Source: Field Survey 2016

The IDUs were asked to reply that how much they felt the risk of being affected with HIV/AIDS. The results of the study demonstrate that approximately three-fourths of the respondents replied that they felt moderate risk of being affected with HIV/AIDS while 20.90% of them felt high risk. Further, nearly one-third of the IDUs responded that they did not feel any risk at all. The percentages of the female respondents who did not feel any risk at all were slightly bigger than those of their male counterparts.

During the time of conducting the survey, the respondents were asked whether they felt illness or not. In response, a little more than half of them, (51.5%), replied that they felt illness while rest of them replied in the negative manner. They were also asked if they

had any symptoms of sexual disorder. The results of the study display that they mentioned some symptoms, namely, pain when urinating (9.7%), discharge of fluids (2.20%), itching/rash on genital (1.5%), etc. They sought treatment for these diseases as stated by 66.70% of the participants. The results of the present study reveal that a good number of the respondents, (52.50%), sought treatment from DIC doctors while same number of them (15%) said that they went to medicine shops and government hospitals for treatment of these problems.

Table 5.21: Distribution of IDUs by prevention and treatment

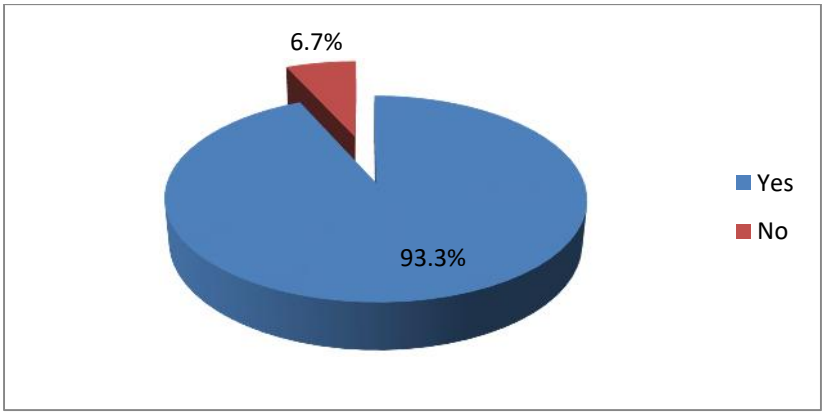
Prevention and Treatment	**Numbe r**	**Male**	**Number**	**Female**	**Total N**	**Total %**
How much do you feel the risk to be affected by HIV/AIDS						
No risk	38	33.3	7	35.0	45	33.6
Less risk	14	12.3	1	5.0	15	11.2
Moderate	35	30.7	6	30.0	41	60.6
High risk	24	21.1	4	20.0	28	20.9
Do not know	3	2.6	2	10.0	5	3.7
Now do you feel any kind of illness?						
Yes	61	53.5	8	40.0	69	51.5
No	53	46.5	12	60.0	65	48.5
Do you have any of these symptoms of sexual disorder?						
Discharge of fluids	2	1.8	1	5.0	3	2.2
Pain when urinating	13	11.4	0	0.0	13	9.7
Itchy/rash on genital	2	1.8	0	0.0	2	1.5
Pain at intercourse	4	3.5	1	5.0	5	3.7
Others	10	8.8	0	0.0	10	7.5
No	61	53.5	13	65.0	74	55.2
Multiple responses	22	19.3	5	25.0	27	20.1
If yes, did you seek treatment?						
Yes	33	62.3	7	100.0	40	66.7
No	20	37.7	0	0.0	20	33.3
Places/persons of receiving treatment?						
Govt. hospitals	6	18.2	0	0.0	6	15.0
Private hospitals	0	0.0	1	14.3	1	2.5
Medicine shops	5	15.2	1	14.3	6	15.0
Peer workers	4	12.1	0	0.0	4	10.0
DICs	17	51.5	4	57.1	21	52.5
NGOs provided facilities	1	3.0	1	14.3	2	5.0

Source: Field Survey 2016

5.13 Services provided by DICs for IDUs

DICs provide various facilities for the IDUs. This study also evaluates the services, which are provided by DIC for the welfare of IDUs. They were asked whether they knew the various kinds of services provided by DICs for them. The findings of the study reveal that a significant of respondents (93.30%) reported that they knew about the kinds of services provided by DICs for the wellbeing of the IDUs.

Figure 5.41: Distribution of IDUs by whether they knew about DIC services



Source: Field Survey 2016

The respondents were asked if they got any kind of treatment from the DICs. In response, a significant number of them, (86.60%), replied that they received treatment from DICs and the doctors from the DICs provided free treatment as reported by most of the respondents (94.80%). Moreover, a great number of the respondents (84.50%) stated that doctors did routine check-up for them. Similarly, 72.40% of the IDUs replied that they received free medicines from the DICs. But this medicine was not sufficient for them as stated by 47.4% of them.

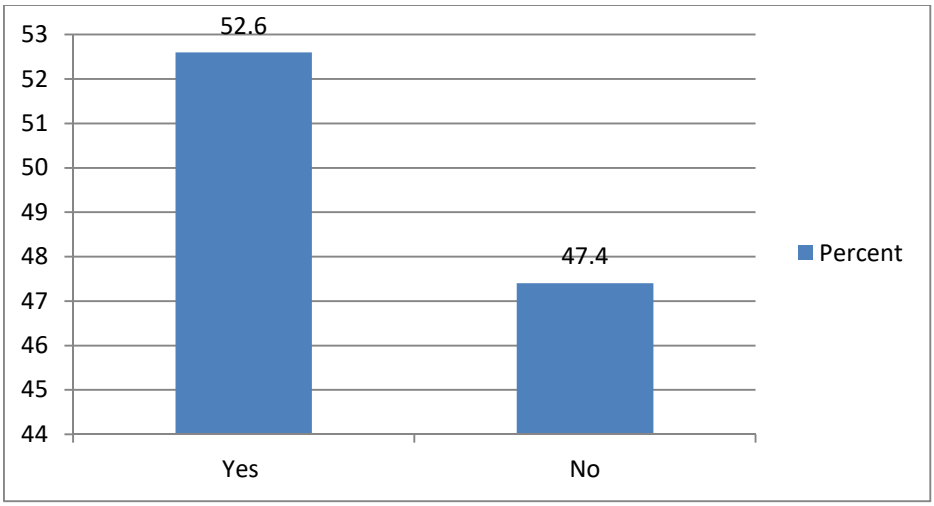
The IDUs were asked whether they got lubricants and needles/syringes from the DICs. In response, 47.8% and 78.4% of the respondents informed that they received lubricants and needles/syringes. They were not only given free condom but they were also taught the techniques of using those condoms as informed by 72.40% and 74.60% of them respectively.

Table 5.22: Distribution of IDUs by services provided by the DICs

Services provided by DICs	Number	Male	Number	Female	Total N	Total %
Do you get any type of treatment from the doctors?						
Yes	97	85.1	19	95.0	116	86.6
No	10	8.8	0	0.0	10	7.5
Don't know	7	6.1	1	5.0	8	6.0
If yes, does the doctor provide free treatment?						
Yes	91	93.8	19	100.0	110	94.8
No	5	5.2	0	0.0	5	4.3
Don't know	1	1.0	0	0.0	1	0.9
Does the doctor do routine checkup						
Yes	80	82.5	18	94.7	98	84.5
No	12	12.4	1	5.3	13	11.2
Don't know	5	5.2	0	0.0	5	4.3
Do you get free medicine from there?						
Yes	79	69.3	18	90.0	97	72.4
No	28	24.6	1	5.0	29	21.6
Don't know	7	6.1	1	5.0	8	6.0
Do you get lubricants from DICs?						
Yes	51	44.7	13	65.0	64	47.8
No	32	28.1	4	20.0	36	26.9
Don't know	31	27.2	3	15.0	34	25.4
Do you get needles/Syringes from DICs?						
Yes	86	75.4	19	95.0	105	78.4
No	20	17.5	1	5.0	21	15.7
Don't know	8	7.0	0	0.0	8	6.0
Did they teach techniques of using condoms?						
Yes	81	71.1	19	95.0	100	74.6
No	16	14.0	1	5.0	17	12.7
Don't know	17	14.9	0	0.0	17	12.7

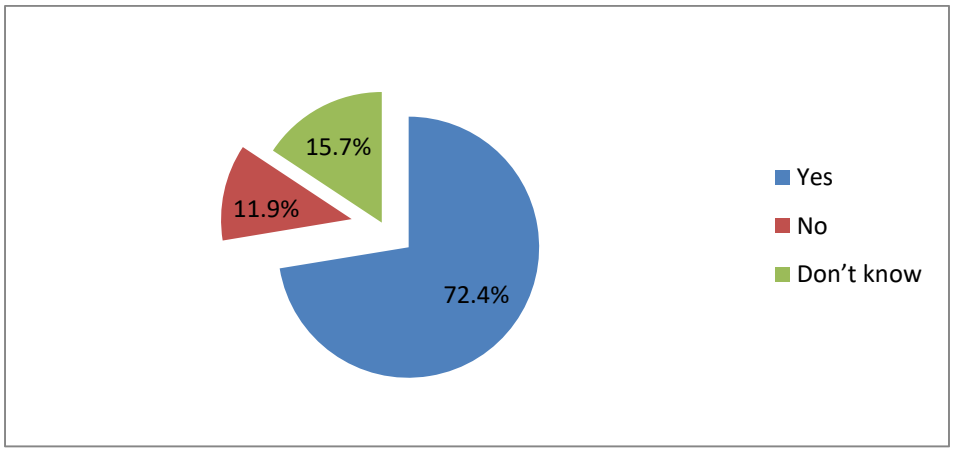
Source: Field Survey 2016

Figure 5.42: Distribution of IDUs by whether medicine is sufficient or not



Source: Field Survey 2016

Figure 5.43: Distribution of IDUs by whether they get required number of condoms

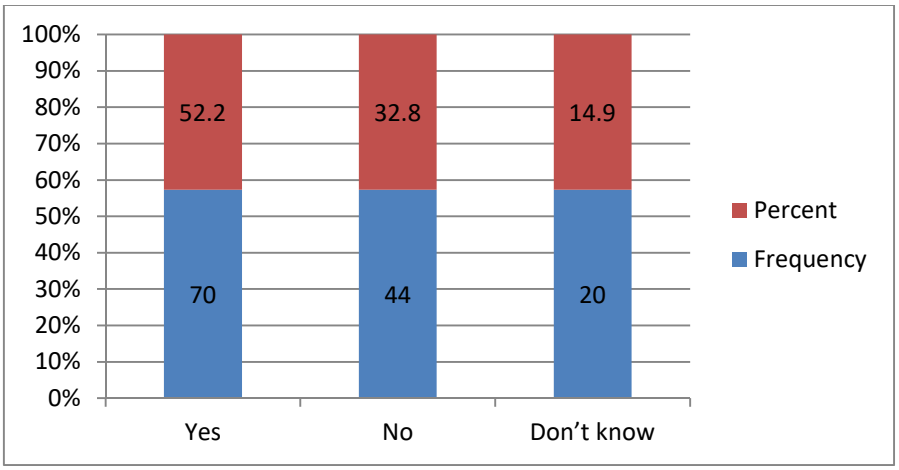


Source: Field Survey 2016

5.14 Training of IDUs

The IDUs generally suffer from various STDs due to their unsafe sexual behavior. The respondents of this study were asked whether they were provided any kind of treatment by the DICs. The results of the study demonstrate that a little more than half of the participants informed that DICs provided treatment for STDs.

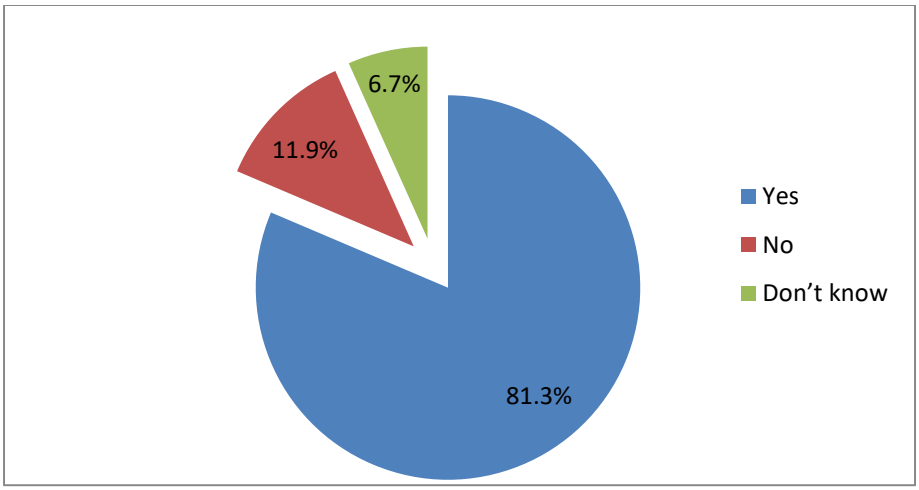
Figure 5.44: Distribution of IDUs by whether they get STDs treatment or not



Source: Field Survey 2016

Sometimes the IDUs require counseling for solving various crises in their life. The following figure presents that a good number of the respondents (81.30) informed that the DICs provided counseling for them while only 11.90% of them replied in the negative manner. A few respondents (6.70%) replied that they did not understand what the question meant. Moreover 87.20% of them replied that they were satisfied with free counseling provided by the DICs.

Figure 5.45: Distribution of IDUs by whether DICs provide counseling or not

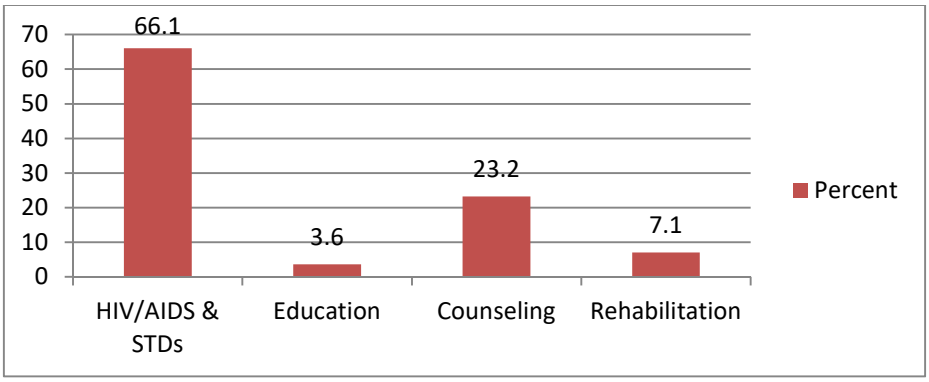


Source: Field Survey 2016

The respondents were asked if they received any kind of training provided by the DICs. The results of the study demonstrate that nearly half (49.30%), of them informed that they did not receive any training from the DICs while 41.80% of them replied in the affirmative manner. Further an overwhelming 96.4% of them claimed that they did not understand the subjects of training.

The DICs provide training for the respondents on various subjects. The results of the study demonstrate that two–thirds of the respondents informed that they received training on HIV/AIDS followed by counseling (23.20%), rehabilitation (7.10%), education (3.60%), etc.

Figure 5.46: Distribution of IDUs by subjects of counseling



Source: Field Survey 2016

The DICs provide various kinds of facilities for the welfare of the IDUs. This study evaluates the kinds of facilities provided by the DICs for them. The results of the study reveal that the DICs provided free blood test facility, HIV/STIs preventive service, free food for them, watching TV, opportunity for sleeping, free newspaper/magazine as reported by 81.3%, 26.9%, 41.0%, 92.5%, 90.3%, 54.5% of them respectively. But a good number of respondents (54.50%) replied that they did not get food from DIC while 63.6 percent of the respondents said that the food provided by DIC was not sufficient for them. Finally, 63.40% of them had a good perception towards the services of the DICs was good.

Table 5.23: Distribution of IDUs by facilities provided by DICs

Facilities provided by DIC	Number	Male	Number	Female	Total N	Total %
Are you satisfied with the counseling?						
Yes	76	64.4	19	100.0	95	87.2
No	14	15.6	0	0.0	14	12.8
Have you received any kind of training from DIC?						
Yes	46	40.4	10	50.0	56	41.8
No	56	49.1	10	50.0	66	49.3
Don't know	12	10.5	0	0.0	12	9.0
Did you understand the subjects of training?						
Yes	44	95.7	10	100.0	54	96.4
No	2	4.3	0	0.0	2	3.6
Does a DIC provide the facility of free blood test?						
Yes	89	78.1	20	100.0	109	81.3
No	8	7.0	0	0.0	8	6.0
Don't know	17	14.9	0	0.0	17	12.7
Does a DIC send for blood test elsewhere? If yes, Do they provide any?						
Yes	21	18.4	11	55.0	32	23.9
No	47	41.2	8	40.0	55	41.0
Don't know	46	40.4	1	5.0	47	35.1
In the last 12 months, did you receive any HIV/STIs preventive service from DICs?						
Yes	28	24.6	8	40.0	36	26.9
No	75	65.8	12	60.0	87	64.9
Don't know	11	9.6	0	0.0	11	8.2
Do you get any foods from there?						
Yes	45	39.5	10	50.0	55	41.0
No	63	55.3	10	50.0	73	54.5
Don't know	6	5.3	0	0.0	6	4.5
If yes, is the food provided by DICs sufficient?						
Yes	17	37.8	3	30.0	20	36.4
No	28	62.2	7	70.0	35	63.6
Do you get the opportunity to watch TV from there?						
Yes	104	91.2	20	100.0	124	92.5
No	10	8.8	0	0.0	10	7.5
Do you get the opportunity to sleep/rest there?						
Yes	102	89.5	19	95.0	121	90.3
No	1	0.9	0	0.0	1	0.7
Don't know	11	9.6	1	5.0	12	9.0
Do you get any magazine/newspaper/advertisement?						
Yes	58	50.9	15	75.0	73	54.5
No	18	15.8	3	15.0	21	15.7
Don't know	38	33.3	2	10.0	40	29.9
Last of all, what is your remark about the services of DICs?						
Good	69	60.5	16	80.0	85	63.4
Bad	10	8.8	0	0.0	10	7.5
Moderate	35	30.7	4	20.0	39	29.1

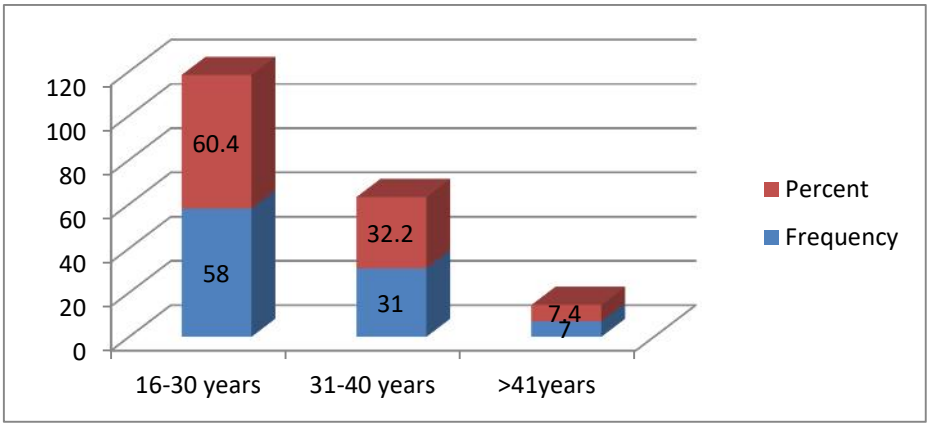
Source: Field Survey, 2016

Section C: Male Sex Workers (MSWs)

5.15 Socio-demographic description of MSWs

The Male Sex Workers' (MSWs) ages are presented in the following figure. It reveals that more than three-fifths of the respondents' ages are between 16 to 30 years, whereas nearly one-third of the respondents fall in to the category of 31-40 years. Further, this study has found out that a few respondents (7.4 %) are more than 41 years of age.

Figure 5.47: Distribution of MSWs by age



Source: Field Survey 2016

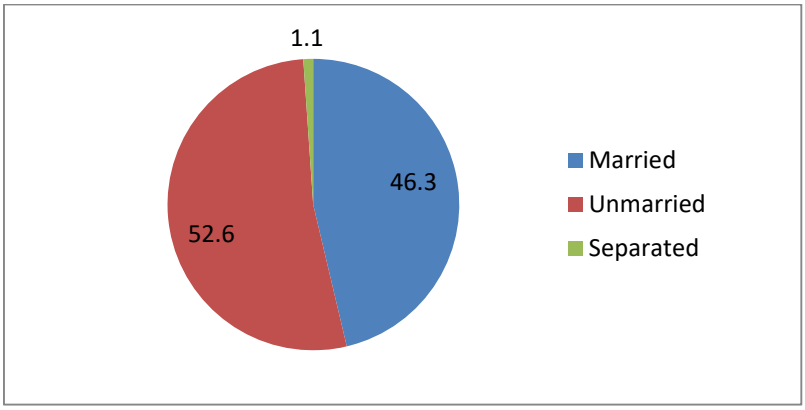
Table 5.24: Distribution of MSWs by background characteristics

Respondent background	**Number**	**Percentage**
Religion		
Islam	91	94.8
Hinduism	5	5.2
Education		
No education	9	9.4
Primary	32	22.9
SSC incomplete	65	67.7
Can you read?		
Yes	80	83.3
No	16	16.7

Source: Field Survey 2016

The findings of the study display that more than half of the participants (52.60%) are unmarried whereas a little less than half of the respondents (46.230%) have reported themselves as married as stated in the following figure Moreover, a few of the MSWs have been identified as separated.

Figure 5.48: Distribution of MSWs by marital status

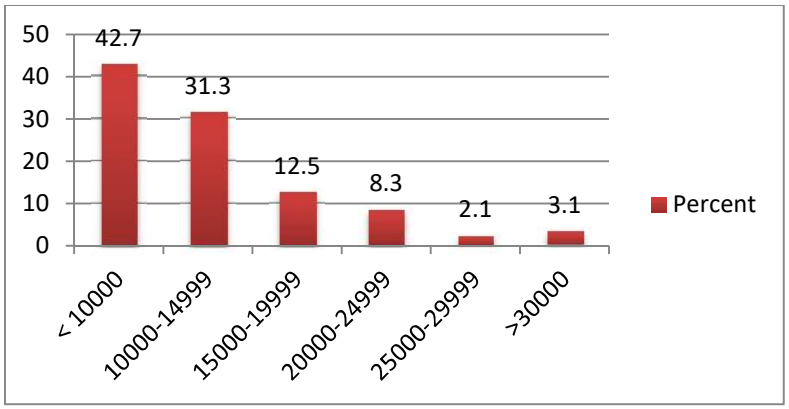


Source: Field Survey 2016

This study also assesses the MSWs' monthly income it had been found that a considerable number of the respondents' monthly income was less than Taka 10,000. Out of the total respondents in the sample as many as 31.3% of them are in the income group of Taka 10,000-14,999 and 12.5% of them earned Taka 15,000 to 19,999 per month. A few respondents (8.30%) income was Taka 25,000-29,999. With respect to the occupation of the respondents, this study had found that a considerable number of respondents (56.3%) occupations were job with SWs, followed by business with SWs (17.7%), day labor with SWs (7.30%), sex working (7.3%), part time job with SWs (2.10%), etc.

With respect to having a child, this study demonstrates that a maximum number of the MSWs (40.9%) have two children only whereas nearly one-third (31.8%) of them have one child. This study has also found out that 18.20% of the participants reported that they had no children at all.

Figure 5.49: Distribution of MSWs by income



Source: Field Survey 2016

Table 5.25: Distribution of MSWs by background characteristics

Background characteristics	Frequency	Percent
Do you have any child?		
No	4	9.1
One	14	31.8
Two	18	40.9
More	8	18.2
Occupation		
SW	7	7.3
Business with SW	17	17.7
Job with SW	54	56.3
Day Labor with SW	7	7.3
Taka collection with SW	2	2.1
Others with SW	7	7.3
Part time job with SW	2	2.1
Source of income		
S ex working	7	7.3
Business with SW	17	17.7
Job with SW	54	56.3
Day Labor with SW	7	7.3
Taka collector with SW	2	2.1
Others with SW	7	7.3
Part time job with SW	2	2.1
How often do you offer religious activities?		
Everyday	11	11.5
Sometimes	72	75.0
Never	13	13.5

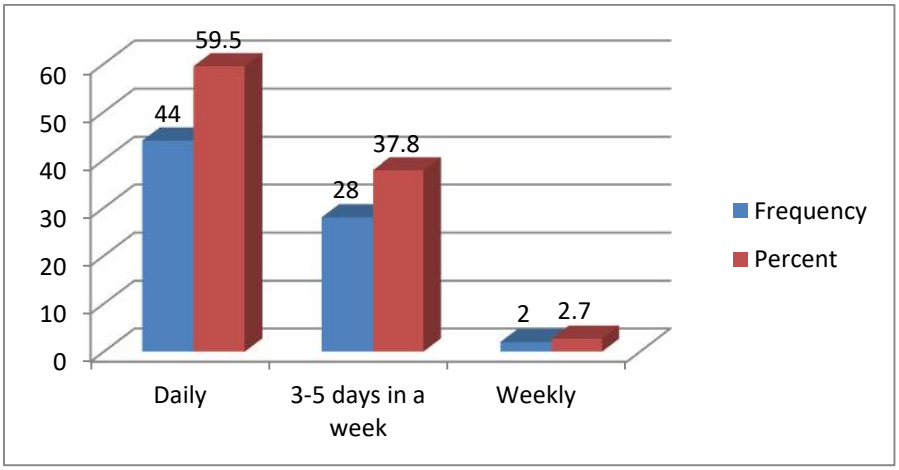
Source: Field Survey 2016

The findings of the study reveal that three-fourths of the respondents (75.0%) performed religious activities sometimes. Nearly one-tenth of the study subjects, 11.5%, attended religious activities regularly, whereas 13.5 percent of them never performed religious activities.

5.16 Exposure to mass media of MSWs

This study examines the respondents' exposure to mass media including newspaper/magazine, television, etc. With regard to access to newspapers, the respondents were asked whether they read newspaper or not. The findings of the study demonstrate that an overwhelming number of the respondents (92.7%) read newspaper. Regarding the frequency of reading newspapers, this study also displays that nearly three-fifths, (59.50%), of them replied that they used to read newspapers daily while 37.8% of them reported that they read newspapers 3 to 5 days in a week. Only a very few respondents (2.70%) informed that they read newspapers once in a week.

Figure 5.50: Distribution of MSWs by exposure to newspaper



Source: Field Survey 2016

Nowadays, television plays an important role in making people aware of various issues. This study also evaluates the MSWs' exposure to television. The results of the study show that an overwhelming number of them (99.0%) had exposure to television whereas just 1 out of 96 participants said that he/she did not have exposure to television. Regarding the frequency of watching television, this study also finds out that 81.1% of the respondents used to watch television daily, whereas only 14.7% of the MSWs informed that they used to enjoy television 3-5 days in a week.

Table 5.26: Distribution of MSWs by exposure to mass media

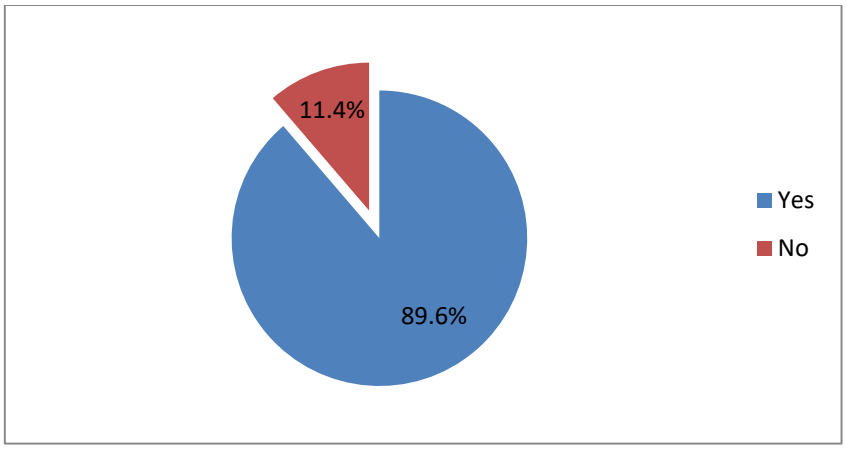
Do you read newspaper/magazines?		
Yes	74	92.7
No	6	7.3
Do you watch TV?		
Yes	95	99.0
No	1	1.0
How often do you watch TV?		
Daily	77	81.1
3-5 days in a week	14	14.7
Weekly	3	3.2
Monthly	1	1.1
N	96	100.0

Source: Field Survey 2016

5.17 Awareness and knowledge of MSWs about HIV/AIDS

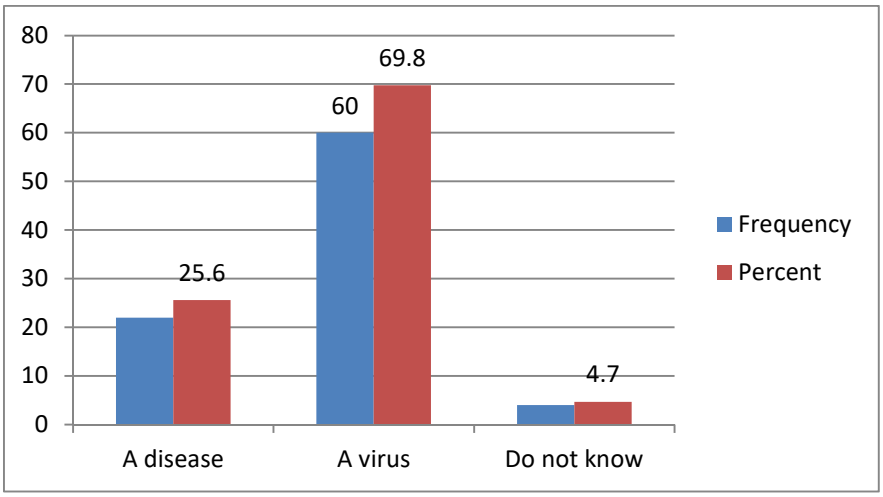
The information on knowledge on HIV was also collected through this survey in this study. The findings of the study show that an overwhelming number of the respondents (89.60%) informed that they had heard of HIV, whereas nearly one-tenth of them reported that they had not heard of HIV. A considerable number of the respondents (69.80%) provided correct replies that-HIV is a virus, followed by disease stated by 25.60% of them. Only 4.70% of them informed that they had not understood what the question meant to them.

Figure 5.51: Distribution of MSWs by ever heard of HIV



Source: Field Survey 2016

Figure 5.52: Distribution of MSWs by what HIV is



Source: Field Survey 2016

This study reveals that the MSWs had multiple sources of HIV/AIDS information. The results of the study display that a significant number of the respondents mentioned DICs (87.2%) as their main source of HIV information, followed by television (74.4%), NGO worker (37.2%), newspaper (31.40%), poster/billboard (12.8%), seminar/workshop (10.5%), radio (8.1%), etc.

Table 5.27: Distribution of MSWs by source of HIV information

Source of information about HIV		
TV	64	74.4
Radio	7	8.1
Newspaper	27	31.4
Poster/Billboard	11	12.8
Doctor/health worker	5	5.8
Seminar/workshop	9	10.5
DIC	75	87.2
NGO worker	32	37.2
Cinema/drama	4	4.7
Others	1	1.2

Source: Field Survey 2016

The respondents were asked about how HIV infection could spread. The findings of the study demonstrate that 95.3% of them reported that HIV infection could spread through unsafe physical relation (97.6%), followed by sharing of infected needles/syringes (69.5%), blood transfusion (61.0%), mother to child (39.0%), male sex with male (9.8%), ex with FSWs (8.5%) etc.

As observed from the Table 7, 95.10% of the respondents informed that HIV infection could be prevented through safe sexual relation, followed by using germfree needles/syringes (63.40%), receiving germ free blood (52.40%), taking the advice of doctors (17.10%), by following religious norms (7.30%), creating mass awareness (2.40%) etc.

Table 5.28: Distribution of MSWs by source of HIV infection

How does HIV infection spread		
Unsafe physical relation	80	97.6
Sharing of infected needles/syringes	57	69.5
Mosquito/Insect bites	4	4.9
Blood transfusion	50	61.0
Mother to Child	32	39.0
Male sex with Male	8	9.8
Sex with FSWs	7	8.5
Kiss/Handshake	1	1.2
Sex with HIV infected people	7	8.5
Don't know	2	2.4
How can HIV infection be protected		
Protected sexual relation	78	95.1
By using germfree Needles/syringes	52	63.4
By receiving germ free blood	43	52.4

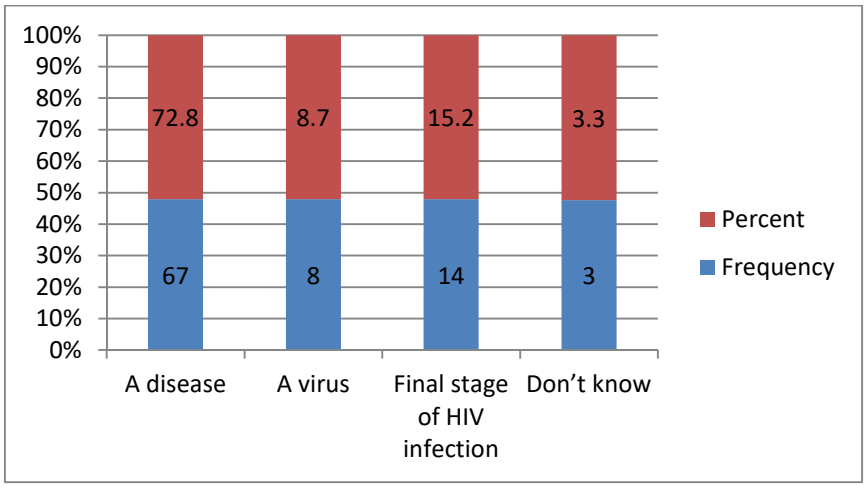
By following religious norms	6	7.3
Creating mass awareness	2	2.4
Taking the advice of doctors in terms of having child	14	17.1
Others	1	1.2

Source: Field Survey 2016

To evaluate the knowledge of the MSWs, they were asked whether they had heard of AIDS or not. In response, an overwhelming number of them (95.80%) replied that they had heard of AIDS while only a negligible proportion of them (4.20%) reported in the negative manner.

The MSWs were also asked if they knew what AIDS is. The findings of the study demonstrate that a significant number of the respondents (72.80%) replied that AIDS is a disease while nearly 15% of them stated that AIDS is the final stage of HIV infection. Only 8.70% of them claimed that it is a virus. In addition, 3.30% of them stated that they did not understand what the question meant to them.

Figure 5.53: Distribution of MSWs by what AIDS is



Source: Field Survey 2016

The multiple responses about the main sources of information on AIDS were the DICs as stated by 79.30% of them followed by television (73.90%), NGO worker (38.0%), newspaper (25.0%), radio (12.0%), seminar/workshop (10.90%), poster/billboard (7.60%), cinema/drama (6.50%), etc.

Table 5.29: Distribution of MSWs by sources of information about AIDS

Sources of information on AIDS		
TV	68	73.9
Radio	11	12.0
Newspaper	23	25.0
Poster/Billboard	7	7.6
Seminar/workshop	10	10.9
DIC	73	79.3
NGOs worker	35	38.0
Cinema/drama	6	6.5
Others	2	2.2

Source: Field Survey 2016

The main signs/symptoms of HIV infection as reported by the survey participants were rapid weight loss, (71.9%), followed by recurring fever for more than 2/3 months (47.2%), diarrhea lasting more than a week (38.20%), dry cough for more than 2/3 months (30.30%), memory loss, depression, and other neurological disorders (14.6%), profound and unexplained fatigue (12.40%), white spots or unusual blemishes on the tongue, in the mouth, or in the throat (9.0%), etc.

Table 5.30: Distribution of MSWs by signs and symptoms of people living with HIV/AIDS

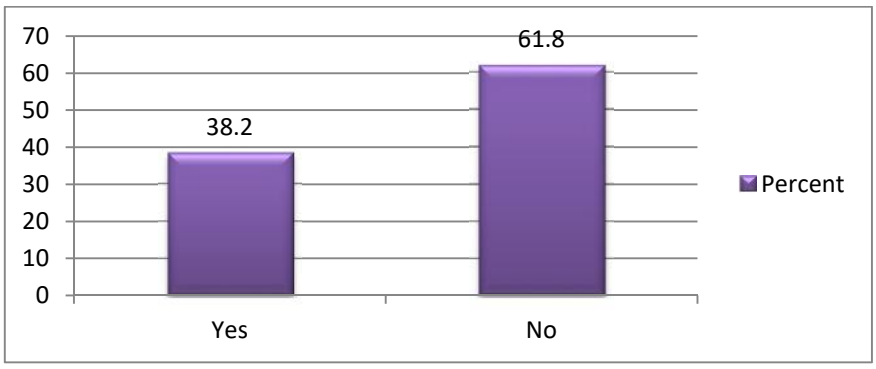
Signs and symptoms of people living with **HIV/AIDS**		
Rapid weight loss	64	71.9
Dry cough for more than 2/3 months	27	30.3
Recurring fever for more than 2/3 months	42	47.2
Profound and unexplained fatigue	11	12.4
Swollen lymph glands in the armpits, groin, or neck	8	9.0

Diarrhea lasting more than a week	34	38.2
White spots or unusual blemishes on the tongue, in the mouth, or in the throat	8	9.0
Memory loss, depression, and other neurological disorders	13	14.6
Don't know	17	19.1
Others	1	1.1
If you know any HIV/AIDS infected people, will you keep it secret?		
Yes	49	55.1
No	40	44.9
Do you think that you are in risk of contracting HIV?		
Yes	48	53.9
No	38	42.7
Do not know/not sure	3	3.4
Do you think your own chances of getting HIV?		
Small	24	50.0
Moderate	10	20.8
High	12	25.0
Do not know/not sure	2	4.2

Source: Field Survey 2016

The respondents were asked whether they knew any HIV infected person or not. More than half of them (55.1%) reported that they knew HIV infected persons, as the results of the study demonstrate. More than half of them (53.90%) informed that they would keep it secret if they knew HIV infected people.

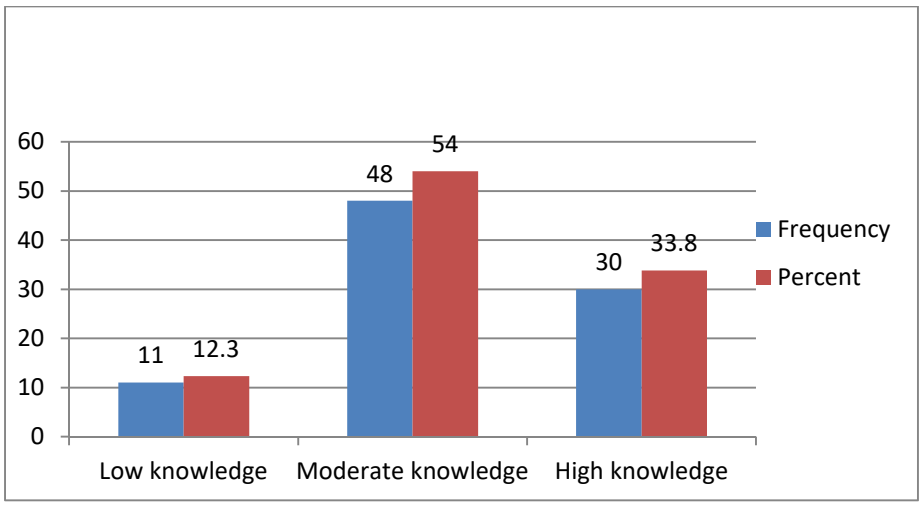
Figure 5.54: Distribution of MSWs by whether they know any HIV infected people



Source: Field Survey 2016

The Figure 10 shows the pooled knowledge of the respondents about HIV/AIDS and STDs. It also shows that only 54.0 percent of the MSWs had moderate knowledge about HIV/AIDS while 33.80% of them showed high knowledge about the subject. However, 12.30% of the MSWs were found with low-level knowledge.

Figure 5.55: Distribution of MSWs by pooled knowledge about HIV/AIDS



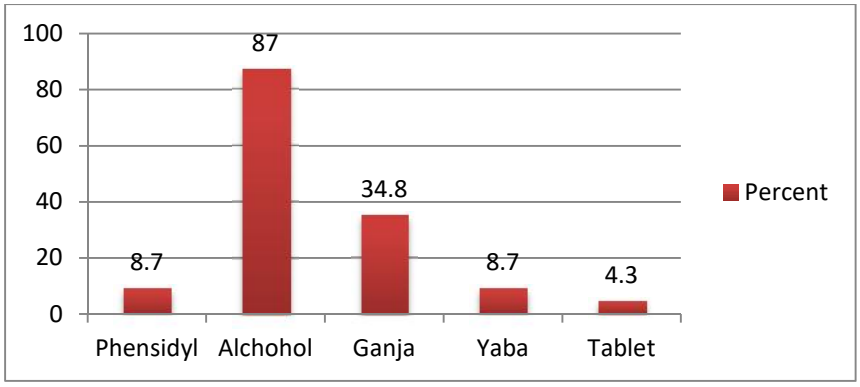
Source: Field Survey 2016

5.18 Attitudes and behaviors of MSWs and their clients

This study evaluates the MSWs' patterns of drug consumption. The findings of the study demonstrate that an overwhelming number of the respondents (76.0%) stated that they did not consume drugs while only 24% told that they had drugs. They mentioned various types of drugs including injecting drugs (94.7%). Secondly the drug which were consumed by the IDUs were alcohol (87.0%), ganja (34.8%), yaba (8.7%), Tablet (4.3%), etc. They got these drugs from various sources including friends (73.9%), markets (17.4%), etc. it is observed that 87.50% of them informed that they did not use a needle/syringe to inject any illegal drug into their body.

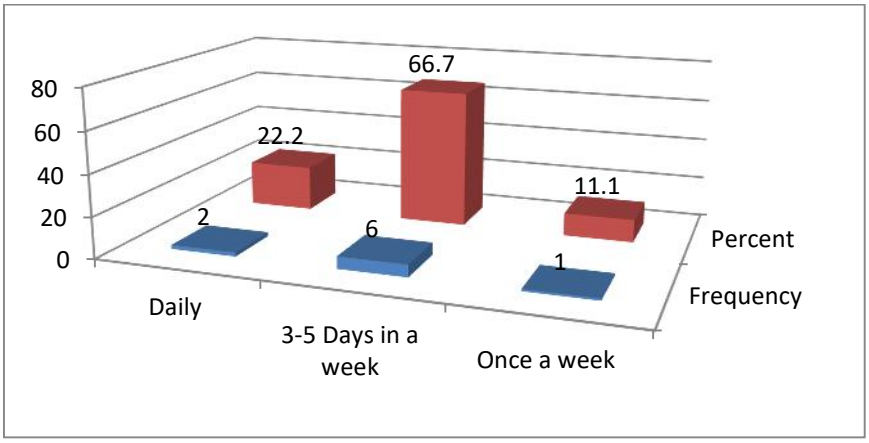
The respondents were also asked how often they used to consume drugs in a week. In response, the majority of them (66.70%) replied that they had drugs 3-5 days in a week while only 22.2% of them reported that they consumed drugs daily. A significant number of the participants (75.0%) informed that they had tested HIV to see whether they had had HIV or not. Similarly, the majority of them (89.6%) informed that they wanted to test HIV.

Figure 5.56: Distribution of MSWs by types of drugs consumed by them



Source: Field Survey 2016

Figure 5.57: Distribution of MSWs by frequency of consuming drugs



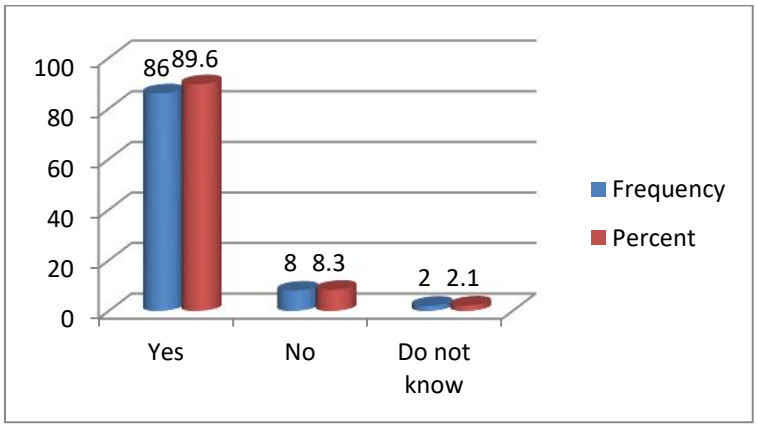
Source: Field Survey 2016

Table 5.31: Distribution of MSWs by consumption of drugs

Do you consume any kind of drug?		
Yes	23	24.0
No	73	76.0
Do you get the drugs?		
Buy from market	4	17.4
Friends	17	73.9
Others	2	8.7
Do you ever use a needle/syringe to inject any illegal drug into your body?		
Yes	9	9.4
No	84	87.5
Refused to answer	3	3.1
Did you ever share the needle/syringe with others?		
Yes	1	11.1
No	8	88.9
Have you ever been tested to see if you have HIV?		
Yes	72	75.0
No	24	25.0

Source: Field Survey 2016

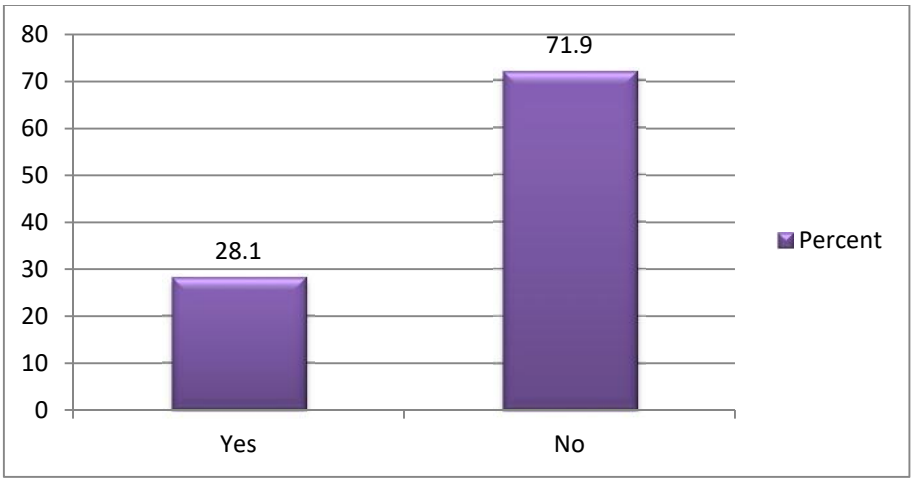
Figure 5.58: Distribution of MSWs by whether they want to test HIV



Source: Field Survey 2016

The respondents were asked whether they had sex with anyone. In response, nearly three-fifths of the study subjects reported that they did not have sex with anybody while only 28.10% of them that they had intercourse with somebody. The results of the study reveal that they had sex with various persons including MSWs (72.0%) followed by SWs (9.7%), transgender (5.40%), etc. The majority of the participants also reported (72.0%) that they used condoms while they were having sex.

Figure 5.59: Distribution of MSWs by ever had sex with anyone



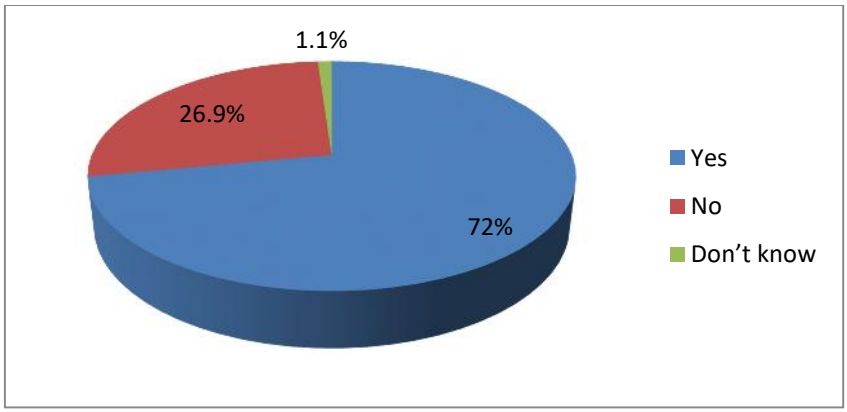
Source: Field Survey 2016

Table 5.32: Distribution of MSWs by whether they donated blood or not

Have you donated/sold blood to any other person?		
Yes	27	28.1
No	69	71.9
If yes, with whom did you do sex?		
Hizra/TG	5	5.4
SW	9	9.7
MSM	67	72.0
Multiple response	12	12.9

Source: Field Survey 2016

Figure 5.60: Distribution of MSWs by whether they use condom while performing sex or not



Source: Field Survey 2016

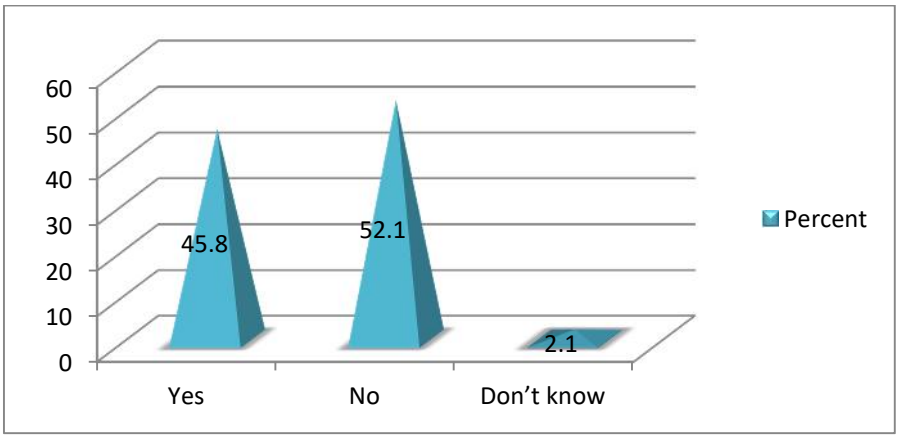
5.19 Prevention and treatment of diseases of MSWs

This study examines the prevention and treatment of HIV/AIDS of the respondents since they are in high risks groups. They were asked if there was any curative measure for HIV/AIDS or not. Hence, the findings of the study depict that more than half of the respondents (52.1%) replied that there was no a curative measure for HIV/AIDS, whereas for those who replied that there was curative measures for HIV/AIDS were 45.8% of the total respondents. Only 2.1% replied that they did not know about this issue.

The MSWs were asked how much they felt the risk of being affected by HIV/AIDS. The results of the study demonstrate that approximately one-third of the respondents (36.5%) replied that they felt no risk of being affected by HIV/AIDS while 34.4% of them felt less risk. Further, 14.6% of them stated that they did not feel risk at all. Moreover, the results of the study also demonstrated that a good number of the respondents (74.0%) stated that they did not feel any kind of illness during the time of survey.

They were also asked if they had any symptom of sexual disorder. The findings of the study display that the majority of the participants (64.6%) reported that they did not have any symptoms of sexual disorder. Some of them mentioned some symptoms, namely, pain when urinating (7.3%), blood from anus (7.3%), discharge of fluids (4.2%), pain at intercourse (2.1%) etc. They sought treatment for these diseases as stated by 67.6% of the participants. The results of the current study reveal that a good number of the respondents, 56.5%, sought treatment from DIC doctors while 17.4% of them said that they got treatment from peer workers for these problems. Furthermore, 13.0% of the respondents reported that they received treatment from medicine shops.

Figure 5.61: Distribution of MSWs by whether there is any curative measure for HIV/AIDS



Source: Field Survey 2016

Table 5.33: Distribution of MSWs by whether they feel the risk to be affected by HIV/AIDS

How much do you feel the risk to be affected by HIV/AIDS?		
No risk	35	36.5
Less risk	33	34.4
Moderate	14	14.6
High risk	9	9.4
Do not know	5	5.2

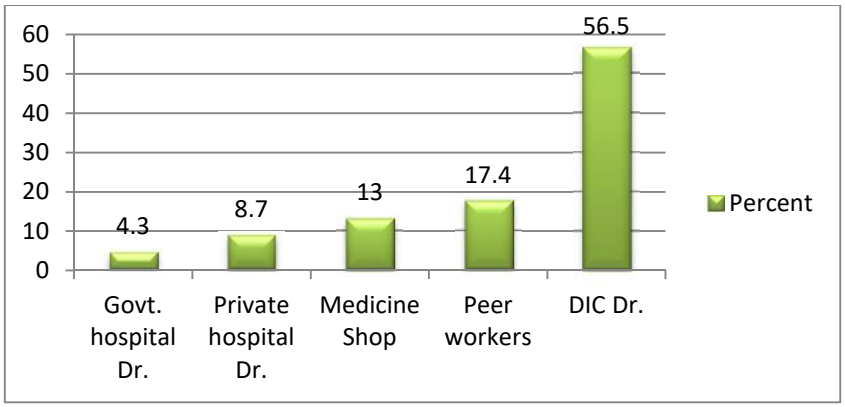
Source: Field Survey 2016

Table 5.34: Distribution of respondents by illness and symptoms

Now do you have felt any kinds of illnesses?		
Yes	25	26.0
No	71	74.0
Do you have any of these symptoms of sexual disorder?		
Discharge of fluids	4	4.2
Pain when urinating	7	7.3
Itchy/rash on genital	1	1.0
Pain at intercourse	2	2.1
Pus/blood from anus	2	2.1
Pain in lower abdomen	7	7.3
No	62	64.6
Multiple response	11	11.5
If yes, did you seek treatment?		
Yes	23	67.6
No	11	32.4

Source: Field Survey 2016

Figure 5.62: Distribution of MSWs by doctors



Source: Field Survey 2016

5.20 Services provided by DICs for MSWs

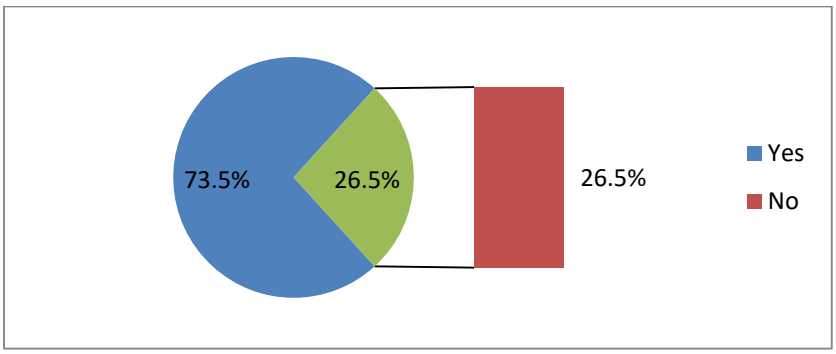
The DICs provides various essential services for MSWs. This study evaluates these services, which are being provided by the DICs for the welfare of the MSWs. They were asked whether they knew about the services provided by the DICs for them. The findings of the study reveal that a significant number of the respondents (87.50%) replied that they knew the kinds of services provided by the DICs for the wellbeing of the IDUs. Further, 90.60% of the MSWs replied that they received treatment from the doctors while 98.90% of them stated that the treatment was provided free for them. Similarly, an overwhelming 97.70% of the participants reported that doctors made routine check-ups for them regularly. As expected, as many as 86.50% of the MSWs replied that they got free medicine from the DICs while 73.50% of them claimed that medicine received from the DICs was sufficient to meet the demands of them.

The findings of the study further indicates that more than four-fifths of the (84%) of the respondents reported that they got lubricants from the DICs. The percentage of them (72.90%) who reported that they were given required condoms from the DICs was slightly less than those who replied that they were also taught the techniques of using condoms (77.10%). An equal proportion of the respondents replied that they received treatment of STDs (81.20%) and counseling on various issues (81.20%).

Training is another important service provided by the DICs to make the MSWs well equipped with essential knowledge for daily life. The respondents of this study were asked whether they were provided any kind of treatment by the DICs. The results of the study confirm that a considerable number of the respondents (68.80%) reported in the affirmative manner, and among them, an overwhelming proportion (97.0%) stated that they understood the subjects of training. Further, 82.3% and 71.9% of them replied that the DICs provided facilities of free blood test and food for them, respectively. But the majority of them (79.7%) informed that the food was not sufficient for them. In addition to this, 70.8% of the MSWs informed that the DICs provided with an opportunity of sleeping for them.

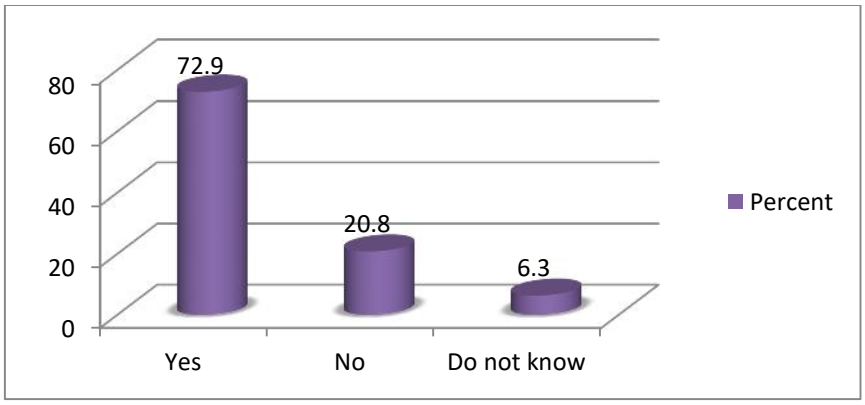
The DICs believe in the provision of media exposure for the MSWs. The findings of the study prove that 84.40% of them replied that they received free newspapers/magazine from the DICs while 12.5% of them reported in the negative manner. Finally, a question was asked about their attitudes towards the DICs. The results of the study display that nearly three-fourths of the respondents' (76.0%) attitudes were good towards the DICs.

Figure 5.63: Distribution of MSWs by whether medicine is sufficient or not



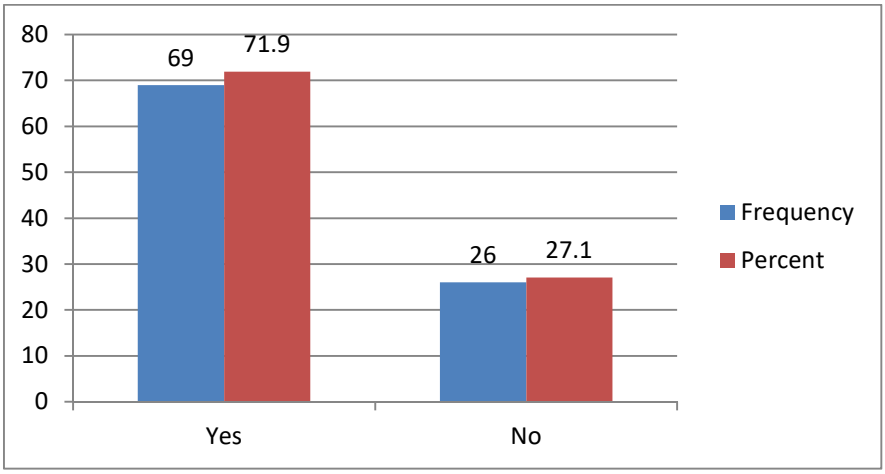
Source: Field Survey 2016

Figure 5.64: Distribution of MSWs by whether they get required condom or not



Source: Field Survey 2016

Figure 5.65: Distribution of MSWs by whether they get services from DIC or not



Source: Field Survey 2016

Table 5.35: Distribution of MSWs by services provided by DIC

Do you get any type of treatment from the doctors?		
Yes	87	90.60
No	9	9.40
If yes, does the doctor provide free treatment?		
Yes	86	98.9
No	1	1.1
Does the doctor do routine check-up?		
Yes	85	97.7
No	1	1.1
Don't know	1	1.1
Do you get free medicine from there?		

Yes	83	86.5
No	13	13.5
Is the medicine provided by a DIC sufficient?		
Yes	61	73.5
No	22	26.5
Do you get lubricants from a DIC		
Yes	81	84.4
No	13	13.5
Don't know	2	2.1
Did they teach techniques of using condoms?		
Yes	74	77.1
No	17	17.7
Don't know	5	5.2
Do you get any kind of treatment of STDs from there?		
Yes	78	81.2
No	18	18.8
Does a DIC provide you any kind of counseling?		
Yes	78	81.2
No	14	14.6
Don't know	4	4.2
Have you received any kind of training from a DIC?		
Yes	66	68.8
No	29	30.2
Don't know	1	1.0
Did you understand the subject of training?		
Yes	64	97.0
No	2	3.0
Does a DIC provide the facility of free blood test?		
Yes	79	82.3
No	1	1.0
Don't know	16	16.7
Does a DIC send for blood test elsewhere? If yes, do they provide any?		
Yes	53	55.2
No	9	9.4
Don't know	34	35.4
Do you get an opportunity to watch TV there?		
Yes	90	93.8
No	6	6.3
Do you get the opportunity to sleep/rest here?		
Yes	68	70.8
No	28	29.2
What is your remark about the services of a DIC?		
Good	73	76.0
Bad	3	3.1
Moderate	20	20.8
Last of all, do you want to say something about a DIC service? Please say…		

Source: Field Survey 2016

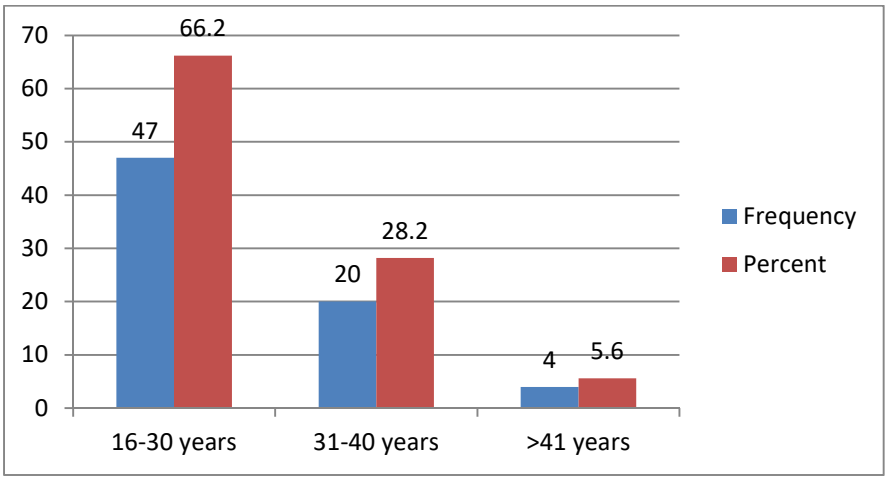
Section D: Transgender

5.21 Socio-demographic characteristics of transgender

This study evaluates the ages of the transgender (TG). The findings of the study reveal that nearly one-third (66.20%) of them ages were between 16 to 30 years, whereas one-fourth of the respondents fell in to the category of 31-40 years. This study also comes to find out that a few of the respondents (5.30%) were more than 41 years of age.

About 97.20% of the respondents were Muslims since Bangladesh is predominantly Muslim country, and only a few of the respondents, (2.8%), had identified themselves as the followers of other religions including Hinduism.

Figure 5.66: Distribution of TGs by ages



Source: Field Survey 2016

An education level is another key constituent of the TGs. It affects many aspects of them. Previous studies showed that educational attainment had strong influence on the TGs' HIV/AIDS related risk practices. In this study, according to the survey findings, a little less than half of the respondents (47.9%) reported that they failed to complete SSC, whereas a significant number of them (39.4%) completed primary level schooling. It further shows that 80.30% of the respondents replied that they could read.

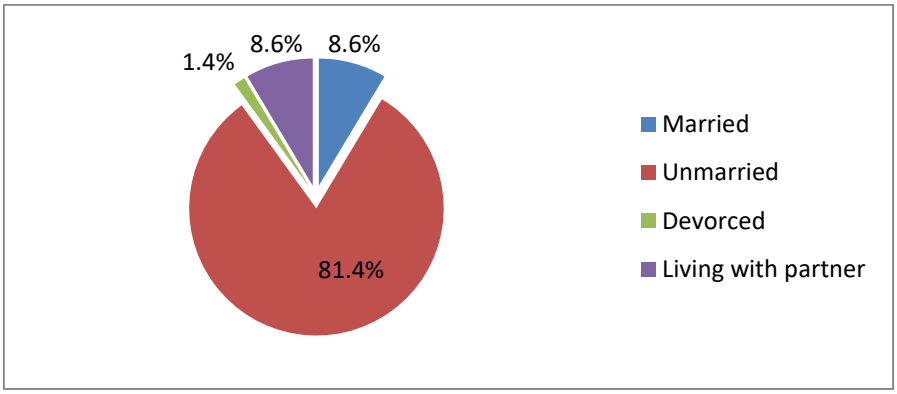
Table 5.36: Distribution of TGs by their background characteristics

Respondents' background	Number	Percentage
Religion		
Islam	69	97.2
Hinduism	2	2.8
Education		
No education	9	12.7
Primary	28	39.4
SSC incomplete	34	47.9
Can you read?		
Yes	57	80.3
No	14	19.7
Do you have any child?		
No	11	84.6
One	1	7.7
Two	1	7.7
Income(Taka)		
< 10,000	33	46.5
10,000-14,999	23	32.4
15,000-19,999	11	15.5
20,000-24,999	3	4.2
25,000-29,999	1	1.4

Source: Field Survey 2016

Marital status is another vital socio-demographic component of the TGs. The findings of the study demonstrate that an overwhelming number of the respondents (81.4%) were married, whereas a little less than one-tenth of the respondents reported themselves as married.

Figure 5.67: Distribution of TGs by marital status



Source: Field Survey 2016

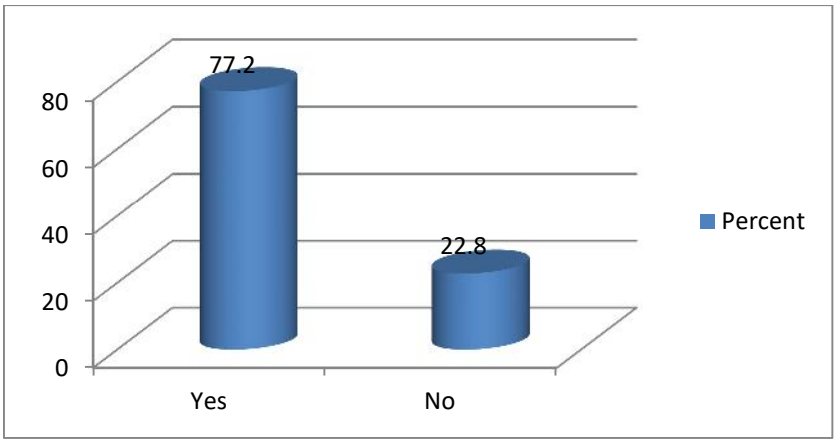
This study also assesses the TGs monthly income and comes to find out a considerable number of the respondents' monthly income (46.50%) was less than Taka 10,000. Out of the total respondents in the sample, as many as 32.4% of them were in the income group of Taka 10,000-14,999 and 15.5% of them earned Taka 15,000 to 19,999 per month. Moreover, nearly one-fifth of the TGs (23.9%) reported their main source of income as sex working while almost equal proportion of them (21.10%) had service as occupation followed by business (19.70%), Taka collection (16.90%), dancing (14.10%) etc.

The findings of the study further indicate that an overwhelming number of the respondents (77.5%) performed religious activities sometimes. On the other hand, 16.9% of them informed that they never attended religious activities, whereas a trifling number of them (5.6%) stated that they performed religious activities regularly.

5.22 Exposure to mass media of TG

The respondents were asked whether they read newspapers or not. The findings of the study show that an overwhelming number of them (77.20%) read newspapers, whereas those who do not read newspaper constituted only 22.80% of them. In term of frequency of reading newspapers, this study display that more than half, 52.3%, of the respondents informed that they read newspapers 3-5 days in a week while 29.5% of them informed that they read newspapers daily. Only 11.40 of them informed that they read newspapers weekly.

Figure 5.68: Distribution of TGs by exposure to newspaper/magazine



Source: Field Survey 2016

Table 5.37: Distribution of TGs by exposure to mass media

How often do you read newspaper/magazine?	**Frequency**	**Percent**
Daily	13	29.5
3-5 days in a week	23	52.3
Weekly	5	11.4
Monthly	3	6.8
Do you watch TV?		
Yes	70	98.6
No	1	1.4
How often do you watch TV?		
daily	52	74.3
3-5 days in a week	18	25.7

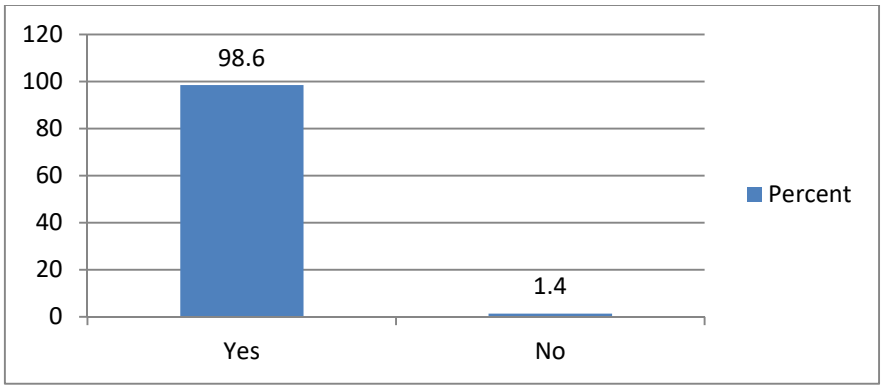
Source: Field Survey 2016

Television affects the respondents' knowledge and awareness of HIV/AIDS. This study evaluates TGs' exposure to television. The results of the study show that an overwhelming number of them (98.60%) had exposure to television. Similarly, 74.30% of them reported that they watched television daily, whereas about one-fourth (25.70%) of them informed that they watched television 3 to 5 days in a week.

5.23 Awareness and knowledge of TG about HIV/AIDS

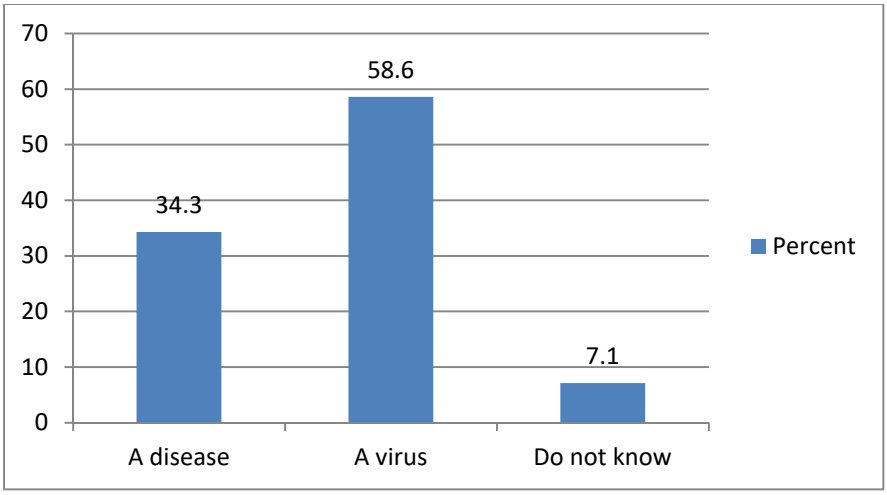
This study examines awareness and knowledge of the TGs. The findings of the study show that almost all the TGs (98.60%) had heard of HIV while only 1.4% of them reported that they did not hear of HIV. When the respondents were asked what HIV was, then an overwhelming number of them (58.60 %) replied that HIV is a virus while 34.3% of them replied that HIV is a disease. Only 7.1% of them informed that they did not know about the issue.

Figure 5.69: Distribution of TGs by ever heard about HIV



Source: Field Survey 2016

Figure 5.70: Distribution of TGs by what HIV is



Source: Field Survey 2016

Table 5.38: Distribution of TGs by source of information about HIV

Source of information about HIV	Frequency	Percent
TV	53	75.7
Radio	1	1.4
Newspaper	11	15.7
Poster/billboard	13	18.6
Doctor/health worker	2	2.9
Seminar/workshop	12	17.1
DIC	68	97.1
NGOs worker	27	38.6

Source: Field Survey 2013

Table 5.39: Distribution of TGs by HIV infection

Main causes of HIV infection		
Unsafe physical relation	62	95.4
Sharing of infected needles/syringes	44	67.7
Mosquito/insect bites	4	6.2
Blood transfusion	36	55.4
Mother to child	19	29.2
Male sex with male	6	9.2
Sex with FSWs	4	6.2
Sex with HIV infected people	2	3.1
Don't know	2	3.1
How can HIV infection be protected?		
Protected sexual relation	63	96.9
By using germfree needles/syringes	34	52.3
By receiving germ free blood	42	64.6
By following religious norms	1	1.5
Creating mass awareness	3	4.6
Taking the advice of doctors in terms of having child	20	30.8
Others	1	1.5

Source: Field Survey 2016

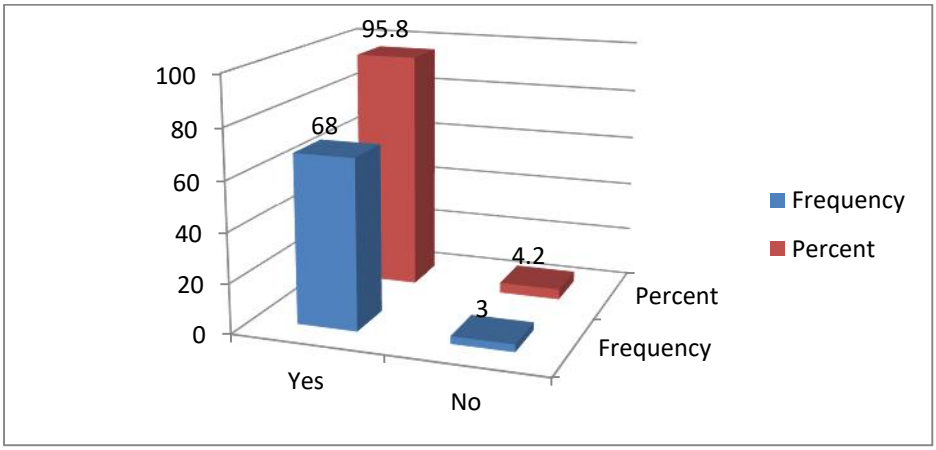
This study further evaluates the sources of HIV/AIDS information. The results of the study display that a significant number of the respondents mentioned that the DICs (97.10%) as their main source of HIV information, followed by television (75.70%), NGO worker (38.60%), and poster/billboard (18.60%), seminar/workshop (17.10%), newspaper (15.70%), etc.

TGs were asked how HIV infection spreads. The findings of the study reveal that 95.40% of the respondents replied that HIV infection spread through unsafe physical relation followed by sharing of infected needles/syringes (67.70%), blood transfusion (55.40%), mother to child (29.20%), male sex with male (9.20%), etc.

As expected, 96.90% of the respondents informed that HIV infection could be protected through safe sexual relation, receiving germ free blood (64.60%), using germfree needles/syringes (52.30%), taking the advice of doctors (30.80%), creating mass awareness (4.60%), following religious norms (1.50%), etc.

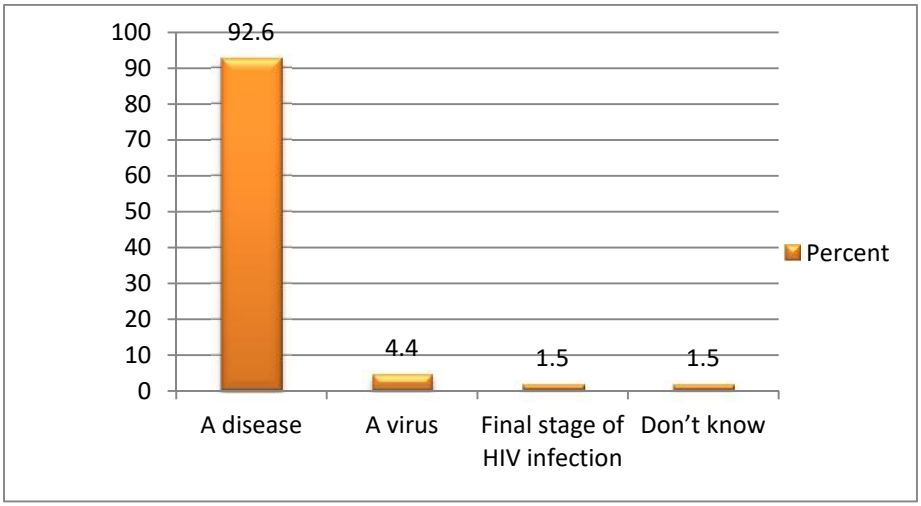
The TGs were also asked whether they heard of AIDS or not. In response, an overwhelming number of them (95.80%) told that they had heard of AIDS while only a negligible proportion of them (4.20%) reported in the negative manner. Moreover, a significant number of the respondents (92.60%) told that AIDS is a disease while only 4.40% of them claimed that it is a virus.

Figure 5.71: Distribution of TGs by ever heard about AIDS



Source: Field Survey 2016

Figure 5.72: Distribution of TGs by what AIDS is



Source: Field Survey 2016

The sources of HIV/AIDS information play a significant influence on AIDS knowledge. The multiple responses of the main sources of information about AIDS were the DICs (95.60%), followed by television (77.90%), NGO workers (39.70%), DICs (34.2%), poster/billboard (19.10%), seminar/workshop (16.20%), newspaper (11.80%), etc.

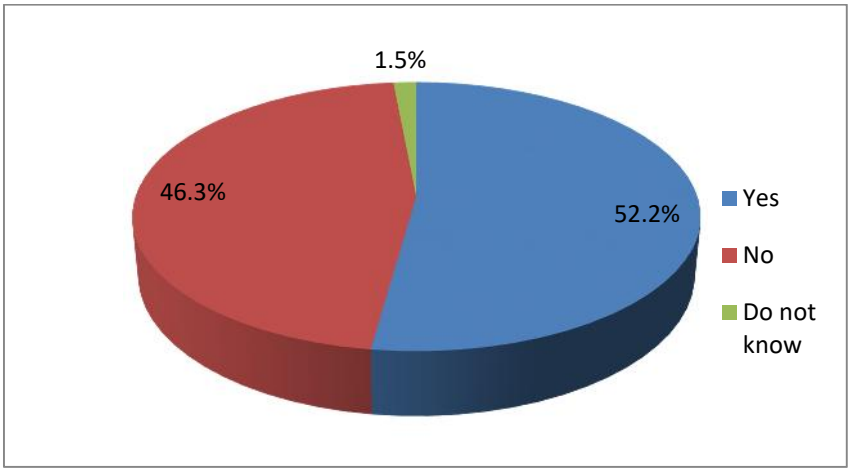
Table 5.40: Distribution of TGs by sources of information about AIDS

Source of information about AIDS		
TV	53	77.9
Newspaper	8	11.8
Poster/billboard	13	19.1
Seminar/workshop	11	16.2
DIC	65	95.6
NGOs worker	27	39.7
Cinema/drama	1	1.5

Source: Field Survey 2016

The TGs were asked whether they were in risk of contracting HIV or not. The findings of the study show that a significant proportion of the respondents (52.20%) replied that they were in risk of getting HIV while a considerable number of them answered in the negative manner.

Figure 5.73: Distribution of TGs by whether they are in risk of contracting HIV



Source: Field Survey 2016

This study further evaluates the signs and symptoms of HIV/AIDS. The findings of it demonstrate that a significant proportion of the respondents (61.20%) reported recurring fever for more than 2/3 months as one of the main symptoms followed by rapid weight loss (58.20%), dry cough for more than 2/3 months (40.30%), memory loss, depression, and other neurological disorders (14.90%), profound and unexplained fatigue (6%), etc.

They were also asked whether they knew any HIV infected people or not. The results of the current study suggest that nearly three-fourths of the participants (70.10%) reported that they did not know any HIV infected people while 29.90% of them replied in the affirmative manner. Moreover, 65.70% of the TGs told that they would keep it secret if they came to know any HIV infected people, as the results demonstrate. The results of the study indicate that more than one-third of the TGs (37.10%) informed that they were in high risk of contracting HIV, whereas for those who informed that they were in medium risk, which constituted 28.60% of the total respondents. The study further finds out some risk factors including multiple sex partners, intercourse with SWs without condoms behind the chance of getting HIV infections.

Table 5.41: Distribution of TGs by signs and symptoms of people living with HIV/AIDS

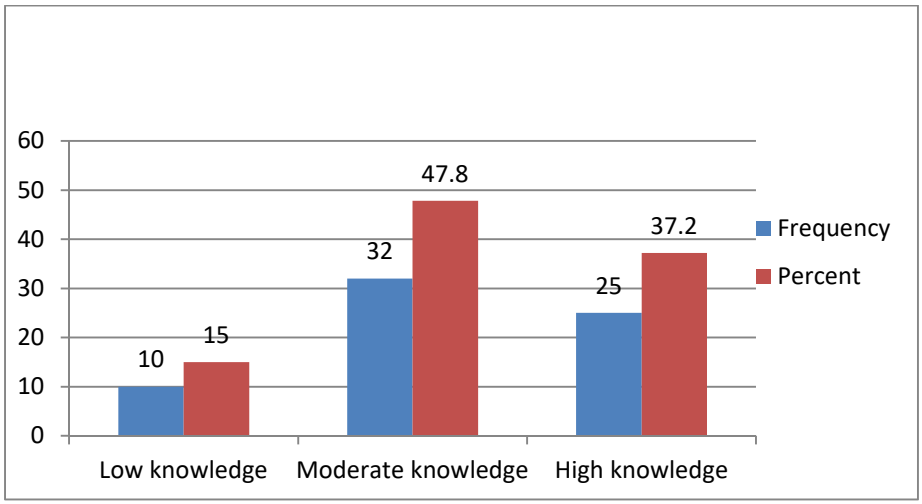
Signs and symptoms of people living with HIV/AIDS		
Rapid weight loss	39	58.2
Dry cough for more than 2/3 months	27	40.3
Recurring fever for more than 2/3 months	41	61.2
Profound and unexplained fatigue	4	6.0
Swollen lymph glands in the armpits, groin, or neck	7	10.4
Diarrhea lasting more than a week	34	50.7
White spots or unusual blemishes on the tongue, in the mouth, or in the throat	4	6.0
Memory loss, depression, and other neurological disorders	10	14.9
Don’t know	8	11.9
Others	3	4.5
Do you know any HIV/AIDS infected people?		
Yes	20	29.9
No	47	70.1
If you know any HIV/AIDS infected people, will you keep it secret?		
Yes	44	65.7

No	23	34.3
Do you think your own chances of getting HIV?		
Small	12	34.3
Moderate	10	28.6
High	13	37.1

Source: Field Survey 2016

The Figure-10 demonstrates the pooled knowledge of the respondents about HIV/AIDS and STDs. It also demonstrates that only 47.80% of the TGs had moderate knowledge about HIV/AIDS while 37.20% of them showed high knowledge about the subject. On the other hand, 15 percent of the TGs were found with low knowledge.

Figure 5.74: Distribution of TGs by pooled knowledge about HIV/AIDS

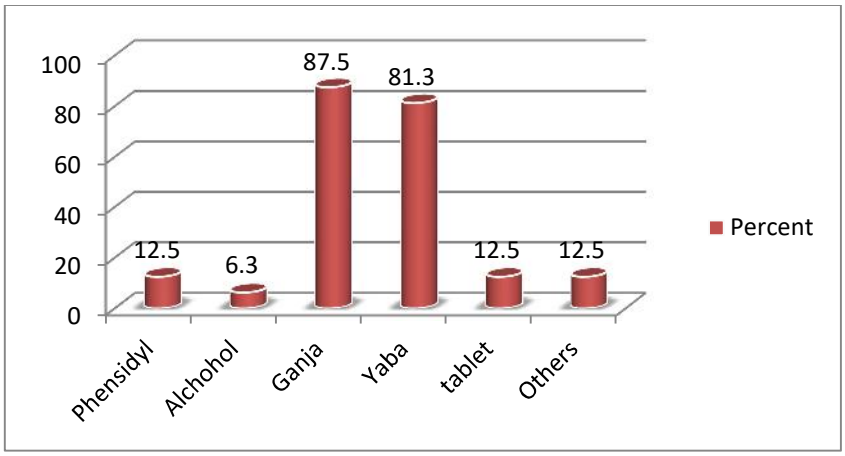


Source: Field Survey 2016

5.24 Attitudes and behaviors of TG and of their clients

It has been observed that consumption of drugs is lower among the TGs than the IDUs. The findings of the current study indicate that a significant number of the respondents (77.50%) stated that they did not consume drugs while nearly one-fourth of them told that they had drugs. They mentioned various types of drugs including ganja (87.50%). The other drugs which were consumed by the TGs were yaba (81.30%), tablet (12.50%), phensidyl (12.50%), etc. The findings of the study further show that the TGs got these drugs from various sources including friends (50%), markets (37.50%), IDUs (6.30%), etc.

Figure 5.75: Distribution of TGs by kinds of drugs



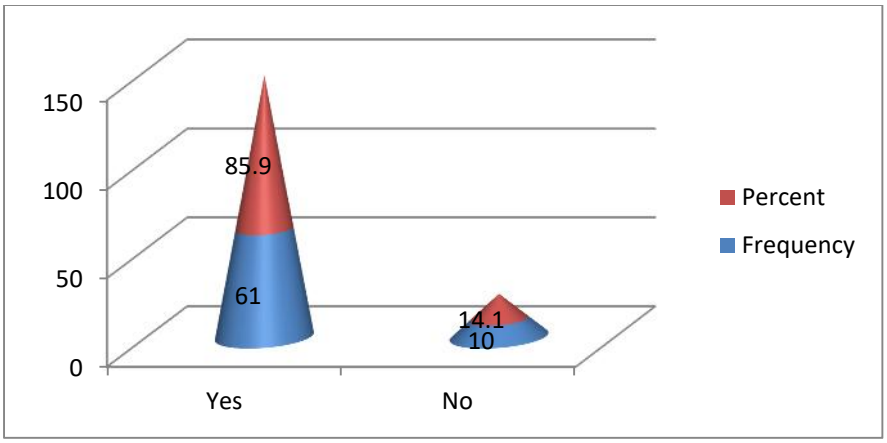
Source: Field Survey 2016

The respondents were also asked how often they consumed drugs in a week. In response, half of the respondents (50%) replied that they had drugs 3 to 5 days in a week. Interestingly, no TGs reported that they used a needle/syringe to inject any illegal drug into their bodies. Moreover, only 25.0% of them told that they took blood from anybody, and the majority of them reported that the blood was tested for HIV.

The following figure depicts the results on whether the respondents had ever tested HIV to see if they had HIV. The results of the current study display that a considerable number of them (85.60%) replied that they tested HIV to see if they had HIV while nearly 14.10% of them told in the negative manner. An overwhelming proportion of the participants (94.40%) claimed that they wanted to test HIV.

The findings of the study reveal that an overwhelming number of the TGs (98.60%) stated that they did sex with TGs, MSWs, FSWs, etc. while a few of them reported in the negative manner. It has been observed that, 82.90% of the TGs reported that they used condoms while they were having sex with their partners.

Figure 5.76: Distribution of TGs by ever tested HIV



Source: Field Survey 2016

Table 5.42: Distribution of TGs by attitudes and behaviors

Do you consume any kinds of drug?		
Yes	16	22.5
No	55	77.5
Do you ever use a needle/syringe to inject any illegal drug into your body?		
Yes	4	5.6
no	67	94.4
How often do you use drug in a week?		
3-5 Days in a week	2	50.0
Once a week	2	50.0
Did you ever share the needle/syringe with others?		
Yes	0	0.0
No	4	100.0
Did you ever take any blood?		
Yes	1	25.0
No	3	75.0
Was the blood tested for HIV?		
Yes	7	77.8
Don't know	2	22.2
Would you want to be tested for HIV/AIDS?		
Yes	67	94.4
No	4	5.6
Have you donated/sold blood to any other person?		
Yes	24	33.8
No	47	66.2

Source: Field Survey 2016

Table 5.43: Distribution of TGs by sexual behavior

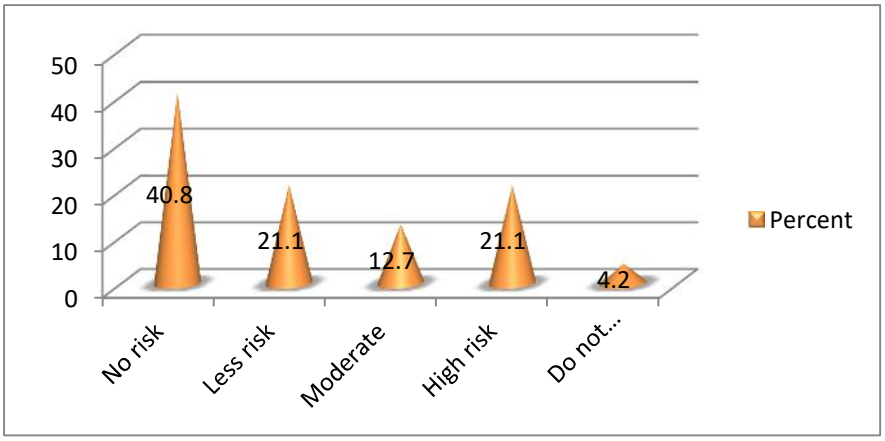
Have you ever had sex with anyone?		
Yes	70	98.6
No	1	1.4
If yes, with whom did you do sex?		
Hizra/TG	2	2.9
SW	2	2.9
MSM	57	81.4
Multiple responses	9	12.9
Did you use condom while you were performing sexual intercourse?		
Yes	58	82.9
No	12	17.1

Source: Field Survey 2016

5.25 Prevention and treatment of diseases of TGs

The TGs were asked that how much they felt the risk of being affected by HIV/AIDS. The results of the study demonstrate that approximately two-fifths of the respondents informed (40.80%) that they felt no risk to be affected by HIV/AIDS while 21.10% of them felt high risk. Nearly one-fifth of the TGs (21.10%) stated that they felt moderate risk. They were also asked whether they had any sexual disorder or not. In response, more than three-fourths of the respondents (76.1%) stated that they did not feel any symptom of sexual disorder. Among them who stated in the affirmative manner also reported that they sought treatment (88.20%) from DIC doctors, religious leaders etc.

Figure 5.77: Distribution of TGs by whether they feel the risk of being infected by HIV/AIDS



Source: Field Survey 2016

Table 5.44: Distribution of TGs by sexual disorder

Do you have any of these symptoms of sexual disorder?		
Pain when urinating	2	2.8
Pain at intercourse	1	1.4
Pus/blood from anus	3	4.2
Pain in lower abdomen	2	2.8
Others	1	1.4
No	54	76.1
Multiple response	8	11.3

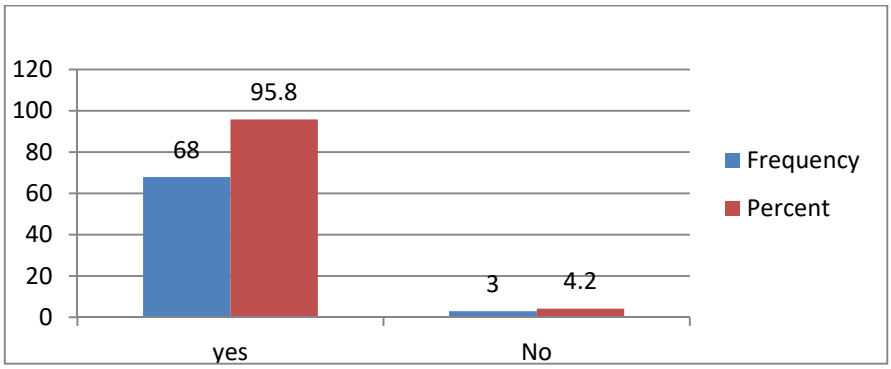
Source: Field Survey 2016

5.26 Services provided by DIC for TG

The DICs provide various facilities for the TGs also. This study further evaluates the services available by DICs for wellbeing of the TGs. They were asked whether they knew the kinds of services given by the DICs for them. The findings of the study unveil that a significant number of respondents (91.50%) informed that they knew about the services provided by the DICs for their wellbeing.

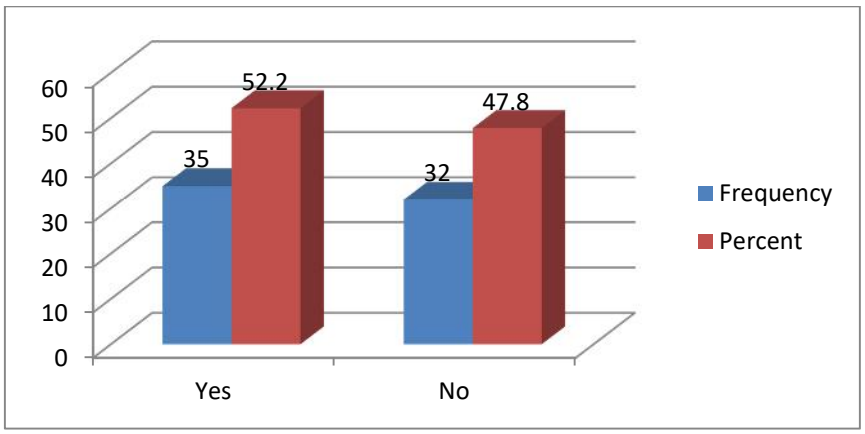
The respondents included in the study were asked if they got any kind of treatment from the DICs. In response, a significant number of them, 95.80% informed that they received free treatment from the DICs. Moreover, a great number of them (98.50%) stated that doctors did routine check-ups for them. Similarly, 94.40% informed that they received free medicine from the DICs. But the medicine was not sufficient as stated by 47.80% of them. In addition, 54.90% and 94.4% of them reported that they got condoms and lubricants from the DICs, respectively. The DICs also taught the TGs the techniques of using condoms as stated by 93.0% of them. This study also finds out that a significant number of them (91.5%) informed that the DICs provided free counseling for them.

Figure 5.78: Distribution of TGs by whether they get any type of treatment from DIC doctors



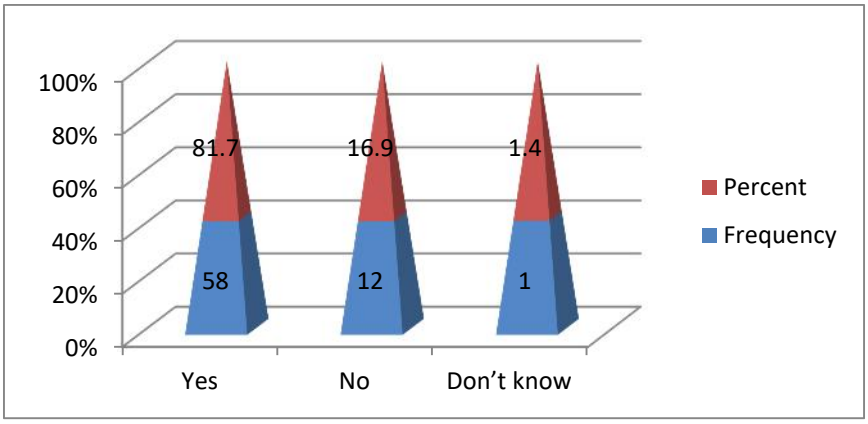
Source: Field Survey 2016

Figure 5.79: Distribution of TGs by medicine provided by DICs is sufficient



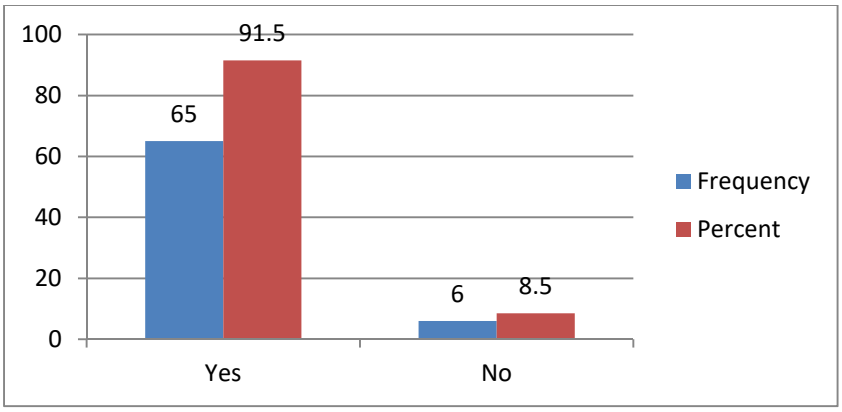
Source: Field Survey 2016

Figure 5.80: Distribution of TGs by whether they get any kind of treatment of STDs



Source: Field Survey 2016

Figure 5.81: Distribution of TGs by whether the DICs provide counseling or not



Source: Field Survey 2016

Table 5.45: Distribution of TGs by services provided by DICs

Do you know what kinds of services are provided by DICs?		
Yes	65	91.5
No	6	8.5
Does the doctor do routine check-up?		
Yes	67	98.5
No	0	0.0
Don't know	1	1.5
Do you get free medicine from there?		
Yes	67	94.4
No	3	4.2
Don't know	1	1.4
Did they teach techniques of using condoms?		
Yes	66	93.0
No	2	2.8
Don't know	3	4.2

Source: Field Survey 2016

5.27 Bivariate results of the study

This chapter mainly deals with statistical analysis of different variables used in the study. All the quantitative findings are presented by using bivariate techniques. In the case of bivariate analysis, cross tables are formed by using the SPSS and the statistical relations between the variables are tested by using a number of appropriate measures of association. In this regard, nature of the variables (e.g., level of measurement), size of the cross-table (e.g. number of rows and columns) and the distribution of cell frequency determine the choice of appropriate test statistics. Chi-square test is applied for nominal

level variables. When variables are nominal in nature and the table is larger than 2x2 formats with having any cell frequency less than 5 then V is applied (Bryman, 2004).

5.27.1 Association between socio-demographic characteristics of FSWs and some selected dependent variables

The following Table shows the association between some independent variables and some selected dependent variables. The results of the study demonstrate that most of the independent variables of the study are not associated with the dependent variables. For example, religion, ever-attended school, literacy, whether they read newspaper, having child, monthly income, source of income, religiosity are not associated with the dependent variable-using female condom while having sex. Only three variables, such as, age, whether they watch television, and marital status are found related to using female condom while having sex. The results indicate that the FSWs with older age, the respondents who did not watch television and divorced FSWs are less likely to use female condoms while having sex with the male counterparts.

Table 5.46: Summary Table of Chi-square and Cramer's V on some dependent variables by socio-demographic variables of FSWs

Socio-demographic variables	Whether they knew how to do safe sex	Whether they use female condom	Whether they make sexual relation with female
	Chi-square and Cramer's V values		
Age	V=0.130	V=0.56*	V=0.62**
Religion	V=0.009	V=0.05	V=0.03
Ever attended school	V=0.078	V=0.15	V=0.09
Literacy	V=0.130	V=0.15	V=0.07
Whether they read newspaper	V=0.19	χ^2 =4.24** df=1	V=0.04
Whether they watch television	V=0.52	V=0.32***	V=0.05
Marital status	V=0.12	V=0.21*	V=0.12
Having child	V=0.09	V=0.23	V=0.17
Monthly income	V=0.23	V=0.29	V=0.45
Source of income	V=0.04	V=0.06	V=0.11
Religiosity	V=0.27	V=0.06	V=0.08

***p=0.001 **p=0.01 *p=0.05 Source: Field survey 2016

5.27.2 Socio-demographic characteristics of IDUs and some selected dependent variables

Associations between some independent and dependent variables have been shown in the following Table. The results of the study display that there are no significant associations between the socio-demographic factors and the dependent variable - ever had sex. In the other vein, it is found that reading newspaper is robustly related to using condom while having sex. Similarly, there are no significant associations between age, religion, ever attended school, whether they watch television, marital status, having child, source of income and feeling risk of being affected by HIV/AIDS. Nevertheless, reading newspaper, monthly income and religiosity are found significantly related to feeling risk of being affected by HIV/AIDS. The findings of the study indicates that the IDUs with less exposure to newspaper, and those with high income are more likely to say that they feel the high risk of contracting HIV infection. On the contrary, it is found in the same vein that IDUs who offer prayer everyday are more likely to say that they do not feel risk of contracting HIV. Interestingly, no significant associations are found between the independent variables and the dependent variable- sharing of needles. Another dependent variable, ever taken blood, is only robustly associated with the monthly household income, that is, the IDUs with less income are likely to take blood from others.

Table 5.47: Summary Table of Cramer's V on some dependent variables by socio-demographic variables of IDUs

Socio-demographic variables	Ever had sex	Using condom while having sex	Feeling risk to be affected by HIV/AIDS	Sharing needles/syringes	Ever taken blood
	Cramer's V values				
Sex	V=0.15	V=0.11	V=0.14	V=0.06	V=0.13
Age	V=0.61	V=0.48	V=0.53	V=0.43	V=0.58
Religion	V=0.6	V=0.02	V=0.19	V=0.08	V=0.30
Ever attended school	V=0.32	V=0.15	V=0.16	V=0.12	V=0.05
Literacy	V=0.18	V=0.16	V=0.24	V=0.12	V=0.04
Whether they read newspaper	V=0.16	V=0.31*	V=0.42**	V=0.15	V=0.10

Whether they watch television	V=0.09	V=0.11	V=0.35**	V=0.09	V=0.05
Marital status	V=0.15	V=0.23	V=0.15	V=0.18	V=0.21
Having child	V=0.17	V=0.18	V=0.21	V=0.17	V=0.09
Monthly income	V=0.50	V=0.44	V=0.55**	V=0.44	V=0.60**
Source of income	V=0.31	V=0.32	V=0.29	V=0.25	V=0.29
Religiosity	V=0.19	V=0.10	V=0.26*	V=0.12	V=0.17

***p=0.001 **p=0.01 *p=0.05 Source: Field survey 2016

5.27.3 Socio-demographic characteristics of MSWs and some selected dependent variables

Two dependent variables like using condoms and feeling the risk of contracting HIV are significantly associated with monthly income and religiosity successively. The results of the study show that the MSWs with more income and those who never offer prayer are more likely to say that they use condoms while having sex with the female counterparts. However, no robust relationship are found between age, religion, ever attended school, literacy, whether they read newspaper, whether they watch television, marital status, having child, monthly income, source of income, religiosity and ever used needles/syringes, ever taken blood, ever had sex, using condom while having sex and feeling the risk of contracting HIV.

Table 5.48: Summary Table of Cramer's V on some dependent variables by socio-demographic factors of MSWs

Socio-demographic variables	**Ever used needles/syringes**	**Ever taken blood**	**Ever had sex**	**Using condom while having sex**	**Feeling the risk of contracting HIV**
	Chi-square and Cramer's V values				
Age	V=0.44	V=0.36	V=0.49	V=0.46	V=0.51
Religion	V=0.24	V=0.06	V=0.04	V=0.05	V=0.09
Ever attended school	V=0.24	V=0.07	V=0.15	V=0.08	V=0.25
Literacy	V=0.15	V=0.10	V=0.09	V=0.25	V=0.30

Whether they read newspaper	V=0.04	V=0.08	V=0.05	V=0.12	V=0.15
Whether they watch television	V=0.24	V=0.02	V=0.02	V=0.18	V=0.14
Marital status	V=0.07	V=0.04	V=0.17	V=0.16	V=0.19
Having child	V=0.24	V=0.13	V=0.18	V=0.19	V=0.31
Monthly income	V=0.38	V=0.52	V=0.35	V=0.56	V=0.54**
Source of income	V=0.26	V=0.18	V=0.41	V=0.21	V=0.28
Religiosity	V=0.19	V=0.14	V=0.28	V=0.29	V=0.33***

***p=0.001 **p=0.01 *p=0.05 Source: Field survey 2016

5.27.4 Socio-demographic characteristics of TGs and some selected dependent variables

Only one dependent variable as shown in the following Table is significantly associated with watching television. The findings of the study reveal that the respondent who watch television show greater tendency to report that they have intercourse with each other. However, no significant associations are found between age, religion, ever attended school, literacy, whether they read newspaper, whether they watch television, marital status, having child, monthly income, source of income, religiosity and using condoms and feeling the risk of contracting HIV.

Table 5.49: Summary Table of Cramer's V on some dependent variables by socio-demographic factors of TGs

Socio-demographic variables	Ever had sex	Whether they used condom	Feeling the risk of contracting HIV
	Chi-square and Cramer's V values		
Age	V=0.70	V=0.59	V=0.62
Religion	V=0.02	V=0.08	V=0.32
Ever attended school	V=0.05	V=0.16	V=0.29
Literacy	V=0.06	V=0.17	V=0.16
Whether they read newspaper	V=0.07	V=0.26	V=0.31
Whether they watch television	V=0.10***	V=0.32	V=0.14
Marital status	V=0.06	V=0.27	V=0.23
Having child	V=0.15	V=0.24	V=0.67
Monthly income	V=0.10	V=0.40	V=0.43
Source of income	V=0.24	V=0.37	V=0.29
Religiosity	V=0.49	V=0.09	V=0.21

***p=0.001 **p=0.01 *p=0.05 Source: Field survey 2016

CHAPTER SIX

CHAPTER SIX

QUALITATIVE FINDINGS OF THE STUDY

6.1 Findings of the case study

Case study 1: FSW, Mirpur DIC, name: MONI, age: 22

Moni, a FSW, is 22 years old. She is from Gaibandha now she permanently lives in the Dhaka City to carry on her occupation. She narrated how she entered this profession abruptly. She informed that her family was large in size. She has siblings along with step siblings. Her mother used to torture her mercilessly. She pressurized to earn money by herself. Then she decided to come to Dhaka and tried to get a job in a garments factory. When she arrived in the Dhaka City at Gabtoli bus terminal, it was 8 pm. After her arrival there she felt helpless. Then one person appeared with a knife and asked her to follow with him. That time she was wearing a gold necklace and ear ring. That is why that person took her in a dark place where other goons were waiting. Afterwards they took her to the roadside hotel and raped her over the whole night. She disclosed that the bed fully flooded with my blood and I became senseless. In the morning the hotel super brought another person and he raped her again. That person then saved her life from that hotel and married her at the Mazar. But after 4 months, her husband left her and sold her to another person. She came to understand that her husband had cheated her. Following that, she started commercial sex working. Later one of the street sex workers told her about the drop-in-center. So, she came at the DIC and became a regular beneficiary. Now, she knows about HIV/AIDS and other sexual diseases. She tells that as she had been in this profession for 9 years so she understood the situation. Because of her bad relationship with her family, she does not want to go back to them.

Case study 2: MSW, Maghbazar DIC, name: Shajid, age: 25

Shajid, a MSW is 25 years old. He lives in the Dhaka City with his family. He first started to come to the drop-in-center before 2 years. He narrated how he became a professional male sex worker. He told that he was first abused by his uncle. Then he was 6 years old; and day by day he was being abused by his uncle. In such a way he became used to it and started to like. Later he had sexual intercourse with one of his neighbors. He told that he had been in love affair for 7 years. He was seriously attracted to that senior neighbor. They did sex regularly. He further told that his life was going and with lots of fun. Then suddenly his partner stopped talking to him and got married to a girl. At then, he was very shocked. Then he started to communicate with other boys who were especially interested about boys only. He told that he made sexual relationship with other boys without knowing them. He became arrogant and prepared himself as a male sex worker. He did not know about HIV/AIDS clearly. He had only heard of it. He said, "Men do not need to use condom" he. He also did not know about sexual diseases. So, he had sexual intercourse freely. But when he became sick and came to know that he got some sexual disease, and then one of his friends told him about a DIC. Afterwards he started to come to the drop-in-center and knew about HIV/AIDS. He mentioned that as his boyfriend cheated him, so he started sex working with other males.

Case study 3: MSW, Mirpur 1, Name: Dulal, age. 27.

Dulal considers him as a transgender. He has changed his real name, and renamed himself as Tisha. His family lives in Barisal. His parents and two brothers form his family. His two brothers are married. Now his parents are offering him to marry a girl who is living beside his home. But he cannot marry her, because he only feels sexually attracted to a male. He is professionally a male sex worker. Now, he lives in the Dhaka City and does commercial sex working in the Mirpur 1 area. He told that he did not want to go to his village, because if he went there his family member would force him to marry, and he did not want to tell the truth to his parents. He thinks that they will be so shocked after hearing the reality. He now lives at the Mazar Road area. He has two rooms extra beside his room. He rent out those rooms for male sex working. He reported that there

were two little kids who regularly did sexual intercourse with each other. He does not want to stop them because he understands this kind of attractiveness. He said, A the female sex worker can openly express their identity and the hijra as well. But people mock at him or their community. That is why he likes to see the situation spread widely. He does not want to stop it. Every night, he wears girls' costumes and looks for customers at the Mazar Road area. He observes that all most all types of professionals come to him for sex work. Now, he is leading his life by doing so. He said, "I become a transgender. It is not my fault. So why people should mock at my physical changes. I can deeply feel what my family feels about me. But nobody wants to understand me. So, it really hurts me. I want to lead my life how it is formed basically, and no one, even me cannot change it. So this is my reality".

Case study 4: TG, near Mazar Road, name: Muhammad Ali, age: 35.

Muhammad Ali, aged 35, is a married man with two kids. He also does male sex working. He is currently living in the Dhaka City but his family lives at a village in Narshingdi. He has been married for 15 years. The reason he got married was his mother. His mother was old and weak. Because of his mother's sickness he got married. After every two months, he goes to visit his family and sometimes after 5 months. He sends money to his family to look after his children. He is known to his family as a dancer but actually he is a male sex worker. Every night he attracts his customer acting like a girl. He has mentioned that he becomes conscious about his profession. He is regularly using condoms for protecting himself from sexual diseases. He has learnt all this from the drop-in-center. He knows the techniques to inspire his customers to use condoms. He told that he got anal problems for sexual activities. He also mentioned that most of the times customers did not want to use condoms during sexual intercourse. For the choice, the customers offer more money to them and then they do sexual intercourse for extra money. Because he said, "This is his profession, so sometimes, he needs to agree with his customers' choice. He also told that as his customers' were not thinking about his health, so why he should give good advice. He thinks that many people are now suffering from sexual diseases for these reckless sexual intercourses.

Case study: 5 FSW, Mohammadpur DIC, name. ASMA, age: 16

Asma has entered into a new profession called sex working. She is a 16 year old girl. Earlier she was a garments worker. Her family hails from Shirajgonj. She has two siblings. She had a good friend named Shahana who strongly let her come in this new profession. She told that her friend Shahana, every day after her duty, waited outside the factory. That was going as usual. One day, Shahana was waiting for her and then took her to her (Shahana's) aunt's house. When Asma did not want to go that house, then Shahana told her to go for a while. She had something very important thing at her aunt's house. She needed it badly. Asma went that house. After entering the house, she saw that three men were sitting on the floor and laughing at her. Then Shahana suddenly left the house, and one man locked the door. The three men raped her whole night. In the morning, they gave her Taka 1,000. She was very upset and decided not to get back home. Then she started sex working. She is in this profession for 2 months. Now, her family now lives in Dhaka. She is not allowed to go to her house. Her family knows about her rape. But she told that after that accident every family member hates her. They told her to forget about the family. Now, she is leading her life in this occupation where there is no respect. She told that her life had become worst after the rape.

Case study 6: TG, Maghbazar DIC, name. Titu, age: 30

Titu considers himself a transgender. She lives in the transgender colony just beside the Maghbazar Rail Crossing. Along with him, there are more than 50 transgender. They are professionally sex workers. They collect money from the market. He told that he had a leader who maintained all the financial matters among them. As they all live together, so they are strongly separated from their families. Titu only changes his costumes at night. But he also mentioned that he used to do sex work around his colony. He said that there was a local political club where young boys play keram, every day in the evening. Titu used to go there where he easily got Taka 200-300. If he does not want to go there then the boys force him to do sex with them. According to him, at this Maghbazar area lots of people used to have sex with his community people; and like them, lots of people were suffering from sexual diseases. As the local people always disrespect them, so he does not want to aware them about sexual intercourse. He told that at the very beginning he did not use condoms, during sex. But now he always carries condoms. This is because, he had anal bleeding problem for a long time. But now he is cured. So, now he understands about sexual diseases, and wants to protect him. But sometimes, it is not possible to protect him from this because many customers do not want to use condoms. Now Titu is facing skin problems, but he is still continuing his work. He said that he was getting treatment from the drop-in-center, but he was not getting medicines. Only they prescribe treatment. He feels that it would be helpful for the transgender community. When they go to a pharmacy, the pharmacist neglects them. People say bad words and make them angry. He said that everything became tolerable, but I have become an arrogant person.

Case study 7: IDU male, name: Mahabub Alam, age: 40

Mahabub Alam has been taking injective drugs for 20 years. He is a 40 year old man and living in the Dhaka City with his family. He is not married yet and do not want to get married because 20 years ago when he was engaged with her girlfriend. That time his lover got married to another person. Then he became reckless and hopeless. His friend told him to take drugs to forget her. Then he started to take drugs. Still he is taking injective drugs and maintaining his sexual relationship with floating sex workers. He does not want to fell in love again. That is why he used to have sex with sex workers on the streets. He also mentioned that sex workers also sold drugs to them. Sometimes, they are also injective drug users. He said that he used to have sex when he was drunk. That time, he often forgets to use condoms. As he is a labor now, many labors are known to him as drug addicted. At the beginning, he used to share the needles. When he got the right information from the drop-in-center then he started to use unused needles. He further said that in the drop-in-center they could get syringes, so he became conscious. He inspires his friends to use unused needles. His family does not want to recover him from addiction. His family members always treat him as a thief and bad person. They do not love him. So he mostly stays outside the house. He said, "I need love from my family, but they are mentally so much decided that I become a bad person. But they do not want to understand that why I have become like this. Instead of helping me, they are neglecting me. While staying with the family they insult me and treat me in a bad way. It is really painful".

Case study 8: IDU, female, name: Josna, age: 30

A female IDU, Josna is a mother of two children. Her husband is a small businessman. She is a field worker at the female IDUs drop-in-center. Her previous occupation was different; she was a brothel based sex worker. She was at the brothel near Sadarghat. She had been at the brothel for 20 years, but finally she got married to her babu (client). Now she leads a normal social life. She told that she could easily move from one place to another because of her husband's support. When she was a sex worker she did not know about HIV/AIDS, or sexual diseases. She only heard of it and did not understand the real meaning and the message behind the words. She also did not know that condom use was so much important for a sex worker, not only for controlling birth, but also for protecting her from sexual diseases. She said that all the customers wanted to have sex without condoms, and for this reason, they used to pay more money. So, she used to tell her customers to use condoms but when the customers did not want to use to those she demanded more money. Now she is a HIV-positive woman and believes that by doing unsafe sex she has become HIV-positive. Four years ago, she got to know that. Now, she maintains her health by having nutritious foods and relaxing her body and mind. She used to get counseling from the drop-in-center regularly. Her family members know that she is HIV-positive and they are supporting her. But her neighbors and society people do not know it. She thinks, if society comes to know about her disease then she will be separated from the society. That is why, she is hiding her diseases. She said that one of her friends who was sex worker also ad HIV-positive. But she is still having sex with her customers without protection. She also said that when she was a sex worker, she used to take injective drugs and shared needles. But now she is not taking any drugs in a risky way. She mentioned that when she became frustrated, she used to go to the drop-in-center and take counseling.

6.2 Findings of the Focus Group Discussions

Focus Group Discussion (FGD)-01, Group: FSW DIC: Mirpur 1

Among all the respondents almost all female sex workers reported that they had been in sex working profession for over 6 years. A few of them opined that they had been in this occupation for over 10 years. Most of them had been raped by people who used to stay at the Mazar, bus and launch terminal. A few sex workers mentioned that they came to the Dhaka City in search of jobs, and a few of them said that they came to the capital city for visiting friends' houses. They first started their job as domestic workers, 5 out of the 12 respondents said that they came here to work in the garments factory.

Some of the respondents opined that they were neglected by their family members, because they belonged to extended families. There were so many siblings also. Some of them mentioned that their step mothers unfairness and discrimination were the reason.

Two of the respondents reported that their lovers sold them to brothel and after that, they started sex working, but most of them were raped by unknown persons. Two of the respondents said that they had been taken to an unknown place and then they were trapped by the dalal who made themselves engaged in sex working.

Most of the sex worker complained that when they got any contracts they used to meet more than two clients with the same amount of money. If they protested against their clients, then they were bitten by their customers. They also said that the customers cut their hair, and without any money, they did group sex without condoms.

The types of their customers are police, mastans, young child aged 10-16, hujur, teachers, students as well as old people. So, they reported that they met almost all aged people and a few of their customers used condoms; and they agreed to give them 50 taka more to do sex without condoms. Sometimes, they also requested their customers to use condoms to avoid sexual diseases and HIV/AIDS. A few customers agreed to do sex with condoms. All the respondents told that they were often charged by the police in the case of drug selling. They informed that if the police did sex with them whole night, then next morning they sent them to the jail in drug selling case. This is because they do not want to pay us the money. Sometimes, they are being engaged in marijuana selling, phensidyl, human trafficking, baba selling, etc. They strongly mentioned that the dalal usually did this kind of work. The dalal usually plan to trap new poor homeless girls for engaging in sex working. After talking to the poor girls, they take them to the safe place and provide all important things like food, new cloths and the false hope to get a job in the garments factory. But in their foods dalal mixes up drugs; and sometimes they push injection to send them to new place where the customers usually wait, and they are 5 to 6 in numbers.

Table 6.1: List of respondents for FGD-1

Names of the respondents	**Age (years)**
Farida	22
Moni	22
Soniya	25
Hasina	27
Mitu	23
Sumi	25
Mala	35
Mariyam	40
Pervin	25
Alachi	23
Ayesha	24
Nazma	25

They rape the helpless girl; so after that they become bad girls. So, now there is no way to escape from there. At last they engage themselves in sex working at the brothel or on street.

Focus Group Discussion (FGD)-02 groups: FSWs Mohammadpur DIC

Table 6.2: List of the respondents for FGD-2

Names of the respondents	Age (years)
Brishty	24
Kohinur	35
Asma	16
Roushon	35
Rani	30
Moni	30
Rekha	30
Renu	45

It is observed that most of the respondents know about the major four causes of HIV/AIDS infection. They mentioned that before starting commercial sex work they did not have any idea about HIV/AIDS and sexually transmitted diseases. When they came to this drop-in-center, they started to know about HIV/AIDS. They carry condoms and lubricants from the drop-in-center.

Here all the respondents are used to have drugs. They usually have cigarettes and some of the respondents take marijuana and yaba for addiction. They reported that they took drugs in day time for sleeping. They also mentioned that Gaza as marijuana helped to feel like flake and it helped to feel less tension. As they have been engaged in commercial sex working for more than 6 to 8 years, so they have also started to have drugs at the very beginning.

Regarding drugs, sometimes, they have to face legal problems. Police always look for their faults in cases of buying/selling drugs. Sometimes, they are also charged for human trafficking. All the respondents said that they were in this occupation because of their family violence and poverty. They all reported that they came to the Dhaka City in search for jobs, especially for working in the garments industry. But they were being trapped by the pimps from launch/boat/bus terminals. Some of the respondents said that they were being raped first; then they were forced to take drugs. Some of the respondents usually work on the streets and at the terminals as well as park areas. A few respondents reported that they were at brothel. But now, they are doing sex work in a contractual manner. All the respondents opined that they did not take needles or share needles.

They said that their life became meaningless, so they did not find it as fun anymore. They treat their life as the worst one. As a result, they become stubborn. Now, they can undermine to see a helpless girl in the city alone. They said that every day many poor girls come to this city for jobs or with their boyfriends on the basis of false promises. But they are ultimately sold at brothel and forced to become sex slaves for whole life. Sometimes, they try to save new girls from this kind of trap, but those girls do not trust them, and then get trapped by the dalal. For this reason, now they do not want to help the girls, and they simply do not care about those girls.

Focus Group Discussion (FGD) 03 group: MSW Maghbazar DIC

Table 6.3: List of the respondents for FGD-3

Names of the respondents	Age (years)
Noyon	23
Saddam	21
Shirajul	26
Shuvo	23
Sohan	23
Sagor	27
Jakir	30
Shaon	26
Shajid	25

The respondents opined that they naturally felt attraction for boys. They said that they liked to feel/treat themselves as girls. Among all the respondents, three MSMs do sex in exchange of money. All of them are physically vulnerable from their childhood. They said that they were physically abused by their uncles and private tutors, as well as by their neighbors as their elder brothers. They also mentioned their cousins as their sexual partners.

All three respondents said that they were acting as normal human beings. They used to talk to other boys, and their families thought that they were talking to girls. Some respondents reported that they were being cheated by their boyfriends and after that they started to do sex with others, most of the time unsafe sex. They think that it is because of their negligence from their lover. Mostly they cannot share this feeling with their families because of shame; they know that they are different from others. In this way, they get attached to other gays, or men who are used to have sex with men. Then they come to the new community where they can share their own views and feelings, because they believe that only their community people can understand their feelings, not others like family and society. This is because society people treat them as *'Miggya'*.

When they started to come to the Bandhu, they knew about sexual diseases and HIV/AIDS. But before that, they only heard of those words. Now, they understand the reasons of spreading sexual diseases and HIV/AIDS. They know about safe sex, and they also inspire other people to do safe sex. They mentioned that there were side prompters from Bandhu who provides condoms in the field to make them aware about safe sex. Most of them thought that condoms were only meant for birth control, but now they know that condom is not only for birth control, but it is also for safe sexual interaction.

On the other hand, they feel that from the drop-in-center they want more care, besides sexual diseases, they need general health care services. They also reported that, sometimes, doctors prescribed some medicines regarding sexual diseases; in that case, they needed to buy those medicines from outside pharmacy. They are not getting those medicines from the drop-in-center. As a result, when they seek for it, the pharmacy owner can understand the issue that what the medicine is for. They said that they wanted their privacy regarding this. They argued that the pharmacy owner disrespected them and

teased them and in that case, they could not say anything. So they demand supply of all secret medicines from the DIC.

At the field level, they usually go to parks in the evening and seek their customers. Sometimes, police also become their customers. They also mentioned their customers as students, hujurs, mullahs, rickshaw pullers, CNG drivers, bus drivers etc. Sometimes, they do not get their actual payments from their customers, especially from the police.

Focus Group Discussion (FGD) 04, group: MSW Mirpur DIC, near Mazar

Table 6.4: List of the respondents for FGD-4

Names of the respondents	Age (Years)
Fahim	20
Atikur	28
Sohel	18
Dulal	27
Bablu	19
Sohag	22
Nadim	18
Yousuf	22

All the respondents know about HIV/AIDS. They said that it is a virus, and it weakens human body's immunity. Unsafe sex, untested blood, from mother-to-child, sperm-these are the four main causes for spreading HIV/AIDS.

Most of them had their first sexual experience at early age. They did sex with their playmates, neighbors, hujurs, private tutors, best friends and family members. They observed that they were sexually attracted by men and started to search for their own community. When they were sexually abused and cheated by their lovers then they became arrogant and started to do unsafe sex with other people without using condoms. All the respondents treat themselves as sex workers. In their family, they call them a dancer. In the morning, they act as boy.

They reported that, bus drivers, CNG drivers, street children, security guards, rickshaw pullers, hujurs, students and police were their customers. They used to dress themselves as girls; they usually wear girls' costumes at night. Some of them go outside for sex working after p.m. and some of them like to do their jobs after 11 pm.

The places where they wait for their customers are bus and launch terminals, majar, Ramna Park, and some streets. Sometimes police, do not want to pay money. Instead of giving money, the police beat them, and sometimes, make false cases or charge sheets after doing sex.

About the DIC center, all the respondents reported that they could get all their important medicines from the DICs. There they can easily discuss their health complications. On the other hand, they said that sometimes they need to buy some extra medicines from a pharmacy. They also opined that they liked to get the general health facilities from the DICs. So that, they do not need to go to outside medicine shops.

Focus Group Discussion (FGD) 05 group: Transgender, Maghbazar DIC

Table 6.5: List of the respondents for FGD-5

Names of the respondents	Age (years)
Jhumur	32
Kajol	28
Titu	30
Tisha	21
Chompa	18
Rupa	19
Depeeka	26
Shajib	24

The respondents do not go to the drop-in-center regularly unless they get sick. Among all of the respondents, only two of them know about HIV/AIDS and the main factors behind spreading HIV/AIDS. All the respondents are used to take drugs, like Gaza, alcohol, yaba, etc. On the other hand, 3 of them are already infected by the sexually transmitted diseases. After their infection they got the treatment from the drop-in-center. Now they are recovering from those diseases. As a result, they think that they are not safe from HIV/AIDS and are in high risk of spreading it.

From their family life, they expressed that they were neglected by their family members. Then they started to live with this community treating as their family. They reported that because of the society they could not communicate with their family. They hardly visit their family, and especially when it becomes dark, when no one can see them they leave their homes early in the morning or at night.

Thus, they got gradually engaged in sex work for their survival. Besides, they mentioned that they did not know about HIV/AIDS as well as sexually transmitted diseases. But, later they came to know about this dangerous disease and sexually transmitted diseases. As a result, now they are using condoms and inspire their customers to use condoms. They get free condoms from the drop-in-center, and sometimes, they also buy it from shops. One respondent said that when she came to know about HIV/AIDS, she tried to avoid it, and did sexual intercourse. Now she has got sexually transmitted diseases, and is receiving treatment from the drop-in-center. (Jhumur) is scared of spreading HIV/AIDS because she knows that there is no cure for HIV/AIDS. They mentioned that they did blood test at the drop-in-center. They hardly go to the drop-in-center willingly, but when they get scared and the DIC workers strongly request them to do blood the test then they go there.

They also reported that they helped all the transgender and made them involved in their community, because according to them only a transgender can understand others problems. They opined that when they were born they were their parents' children. When they had hormonal change and became transgender then they are the transgender children. Real parents become unknown persons.

Focus Group Discussion (FGD) 06 group: Transgender DIC Mirpur -1, Darus Salam

Table 6.6: List of the respondents for FGD-6

Names of the respondents	Age (years)
Shuvo	25
Tanni	25
Sumon	27
Rani	28
Ashraf	35
Mousumi	35
Delowar	40
Sumi	22
Saidur	20
Mahbuba	47
Raz	30

All the respondents are working as male sex workers. According to them, they were not aware of HIV/AIDS before. But now they know about HIV/AIDS and sexually transmitted diseases. They know the major four causes of transmitting HIV/AIDS, and how sexually transmitted diseases can be spread. They reported that they were at high risk group.

As they identified out as a high risk group, they said that when they started to do sex work or physical intimacy with unknown people while they did not use condoms, they thought that condom was only for birth control. Now they know the real importance of using condoms. They reported that condom was not only for controlling births but it was also for safe guarding from sexually transmitted diseases.

All the respondents said that they wished to make their own families and they loved to treat themselves as girls. They usually go outside for sex working after 9 pm at night. They refer their spots as Parbat Cinema Hall, High Court Mazar, Gabtoli Bus Terminal and Ramna Park. They also go to their customers' houses. Sometimes they go to the roadside hotels. They move around all their surroundings and seek for customers. They confessed that their customers, most of the time, hammered them regarding their payments/wages. Sometimes, they get more than two customers at the same time with the same amount of money.

The respondents informed that at the very beginning, they used olive oil, Vaseline, shampoo for sexual intercourse. But now they can get free lubricant from the DIC. They get the solutions for sexual diseases and other complications. But they still demand that they want to get general health care from the DIC. They said that they could have breakfast here. They also opined that they could watch television, play and sing songs. They can dance as like as a girl. They can meet their community here and can share their sorrows and happy moments with their friends, as if they all are living with their family. They cannot move freely. They need to act in their family. Some of the respondents sleep at the DIC, and they also influence other TGs in the field or their surroundings to come at the DIC.

Focus Group Discussion (FGD) 07 DIC: Nayabazar, Gulisthan Group: IDUs Male

Table 6.7: List of respondents for FGD-7

Names of the respondents	Age (years)
Rahim	50
Kamal	40
Babul	32
Mahabub alam	40
Md. Reza Hossain	43
Md. Rabu	47
Md. Mahabub Islam	37

All the respondents reported that they had been taking drugs through syringes for nearly 15 years. Among all of them, 3 respondents opined that they had been taking drugs for 20 years. As a benefit, they mentioned that when they took drugs through syringes they feel relaxed. It removes body pain, make the mind fresh and they can enjoy sex.

The respondents informed that they had been coming to this drop-in-center for 3 years. They are professionally day-labors and small businessmen. They also mentioned that they were taking drugs because they were not happy with their life. Most of the injective drug users are living apart from their families. They said that their family members did not

help them to abandon injection. But they neglect them, and sometimes, treat them as mad. So, they feel that their family members do not trust them. As a result, when they are not addicted, still their family members claim that they are addicted. That is why, they are not living with their family anymore. When they stay home, they stay alone.

About the DIC, they said that after every 3 months they did some medical tests at the center. For an example, they do tests for sexually transmitted diseases and HIV/AIDS. All of the respondents regularly take injective drugs and they keep it secret. They reported that at the beginning this life they shared needles with others. But now they are getting new syringes from the DIC. Now they do not share needles. Rather they request other injective drug users not to share needles.

They demanded that they needed socio-psychological support from their families, they needed love. They informed that when their family members misbehaved with them then became arrogant and started to take more injective drugs. They opined that as they were addicted, so if someone misbehaved with them then they became stubborn. They argued that if they got love, then maybe, they could stay away from that bold way. They said that they all came to this path through their friends, co-workers. Some of the respondents said that they were cheated. They also mentioned that they often did sex with street sex workers. They also said that injective drug was better than Gaza, because ganja destroy brain.

Almost all the respondents got arrested by the police. They said that the police tortured them most. But sometimes, the police also sell drugs to them and demand money. They thought that the police was not for help, rather for bad torture. They reported that 1 syringe could be used for 3 months. The police sell drugs through the local politicians because they maintain good relationship with the police as well as with the lawyers.

They reported that there were many people who shared needles, were HIV-positive. They said that HIV-positive person walks like a robot because of their less weight; they got fever. According to them, in the old Dhaka City 10% of the drug users are HIV-positive.

Focus Group Discussion (FGD) 08, DIC: Nayabazar, group : IDUs female

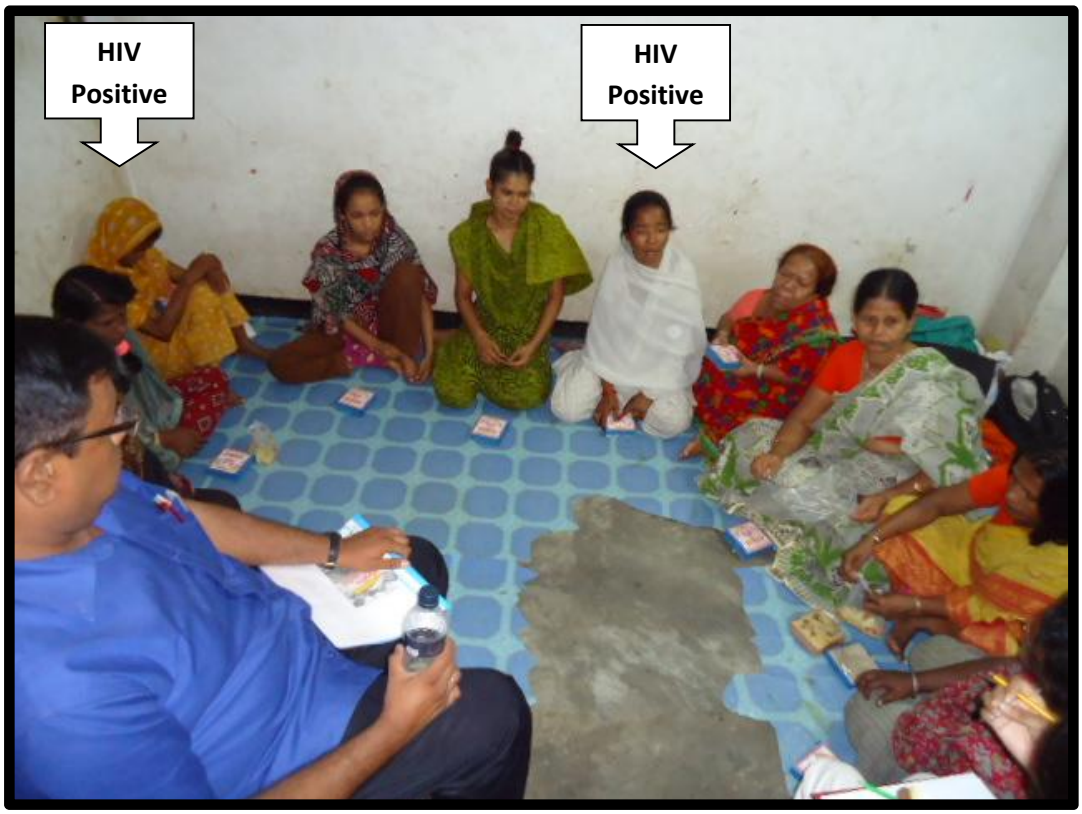


Table 6.8: List of the respondents for FGD-8

Names of the respondents	Age (years)
Pervin	30
Fariya	30
Firoza	50
Hajera Begum	47
Beauty	35
Rina	30
Josna	30
Sumi	18
Hasina	52

Among all of the respondents two of them were HIV-positive. Here, 3 of them do not know the details about HIV/AIDS, but they are concerned about sexually transmitted diseases. Among them four respondents regularly take injective drugs; and others, beside injective drugs, they take alcohol, yaba, etc.

All of the respondents reported that they were engaged in brothel based sex working. Now they are doing mobile as well as street sex working. Among them a few of the respondents are married. Some got divorced. Because of this, they do not lead normal life. They mentioned that drugs helped to forget pains and feel relaxed. They said that they

took drugs at night or in the early morning, then they sleep at the DI. They can watch television there and take baths. They opined that they could spend their leisure time freely.

Two of the respondents who were HIV-positive reported that they did not know that they would be infected by this fatal disease. One respondent said that she just came to know about it 2 months ago. She agreed that as she did street based sex work and many types of people used to come to her and had sex without any protection; as a result, she was infected by the virus. Now she is doing sex work with condoms. But many customers do not want to use condoms and they think she is lying. As a result, she thinks that many people could be infected by her.

Another woman said that from sex working she became infected. Now she thinks that from the customers she has got infected by this virus. She is married, now she has two children. Everybody knows and supports her. She maintains consulting with the DIC personnel. She said that only her family members knew it. She hides this from society, because the society would raise a lot of questions and discriminate her. For the sake of living her short life in peace, she does not want to spread this news.

CHAPTER SEVEN

CHAPTER SEVEN

DISCUSSION AND CONCLUSION

7.1 Introduction

DIC is one of the interventions for HIV/AIDS prevention in Bangladesh where various services are provided for HIV/AIDS high-risk groups namely FSWs, IDUs, MSWs and TGs. This chapter is a general summary of the findings about HIV/AIDS related risk practices of the users of DIC in Dhaka city.

7.2 Socio-economic background of DIC users

FSWs, IDUs, MSWs and TGs' socio-economic characteristics have their own contribution to the understanding of their HIV/AIDS related risk practices. This study found that three-fifths of the FSWs' ages were between 16 to 31 years whereas one-third of the respondents fall in the category of 14-16 years. Again, more than two-fifths of the IDUs' ages were less than 30 years whereas a little less than one-third of the respondents fall in the category of 31-40 years. Similarly, a little more than three-fifths of the MSWs' ages were between 16 to 30 years whereas around one-third of the respondents fell in the category of 31-40 years. Likewise, around one-third (66.20%) of the TGs' ages were between 16 to 30 years.

Education is a key constituent of the respondents. It affects many aspects of them. Studies have shown that educational attainment has strong influence on HIV/AIDS related risk practices of participants such FSWs, IDUs, MSWs, and TGs.

Survey findings revealed that a little less than half of the FSWs (44.30%) have completed primary level of education whereas for IDUs it was 38.10 percent. In terms of MSWs, the percentage of MSWs who completed constituted only 22.9 percent of the total. Again, the percentage of TGs who completed the same grade was almost double- the figure was 39.40. This study also demonstrated that significant number of FSWs, 53.7 percent, had one child only while for IDUs, this percentage sharply reduced to 28.8 percent. Approximately 40 percent of the MSWs reported that they had two children. However, an overwhelming number of TGs said that they did have any child; the figure was 84.60.

In terms of marital status, a good number of FSWs, 40.0 percent, were married whereas around half of the IDUs were married. The findings of the study also indicated that

around 46 percent and only 8.6 percent of the MSWs and TGs were married accordingly. The findings of the also displayed that a considerable number of FSWs', 27 percent, monthly income was more than 30,000 taka and their main source of income was sex working whereas almost the same number of IDUs', 30.60 percent, monthly income was less than 10,000 taka and their main source of income was daily labor. Again, 42.7 percent of the MSWs and 46.50 percent of the TGs said that their incomes were same-less than 10,000 taka monthly. Job with SWs and sex working were the main sources of income of MSWs and TGs, accordingly. This study also indicated that an overwhelming proportion of FSWs, IDUs, MSWs and TGs were Muslim; the figures were 99.10%, 98.5%, 94.80%, 97.20% successively. In addition, most of the respondents including FSWs, IDUs, MSWs and TGs performed religious activities sometimes. The results of the study suggested that Bangladesh is a predominantly Muslim country.

7.3 Exposure to mass media

Respondents such as FSWs, IDUs, MSWs and TGs had exposure to various mass media such as television newspaper and so on. These mass media have enhanced their level of knowledge about HIV/AIDS, STDs, sexual behavior and risk practices. The findings of the study revealed that all respondents had exposure to newspaper and there was little variation in terms of exposure to newspaper. For example, 65.5 percent and 78.8 percent of the FSWs and IDUs reported that they had exposure to newspaper whereas an overwhelming number of MSWs, 92.70 percent, said that they read newspaper. Again, around three-fourths of the TGs had exposure to newspaper. However, there was some variation with regard to frequency of reading newspaper - 59.50 percent of the MSWs read newspaper daily whereas 30.60, 38.50, 29.50 percent of the FSWs, IDUs and TGs reported that they had exposure to newspaper respectively.

In terms of exposure to television, this study also found that an overwhelming number of the IDUs, MSWs, and TGs had exposure to television; the figures were 99.30, 99.0, and 98.60, respectively. However, 64.30 of the FSWs reported that they had exposure to television with regard to frequency of watching television, 30.6 percent of the FSWs watched television daily where for IDUs, MSWs, and TGs these figures were 62.40, 81.10, 74.30 percent accordingly.

7.4 HIV/AIDS-related awareness and knowledge

Knowledge and awareness about HIV/AIDS and STDs have significant influence on sexual behavior and risk practices of FSWs, IDUs, MSWs and TGs. One of the important objectives of this study was to assess the knowledge and awareness of HIV/AIDS.

7.4.1 HIV/AIDS-related awareness and knowledge of FSWs

This study examined the knowledge and awareness about HIV/AIDS of FSWs. The results of the study demonstrated that almost all respondents (99.1%) had heard of HIV. They were also asked whether HIV was a virus or not. In response, a good number of them (61.40%) also provided correct answer-HIV is virus. They also mentioned DIC (95.60%) as their main source of HIV information followed by television (57%), seminar/workshop (55.3%), NGO worker (35.1%), and poster/billboard (17.5%). The findings of the study also demonstrated that 95.3 percent respondents reported that HIV infection spread through unsafe physical relation (95.3%) followed by sharing of infected needles/syringes (77.6%), blood transfusion (72.9%), mother to child (56.1%), kissing (19.6%) etc. They also suggested some ways such as through safe sexual relation (96.30%), using germfree needles/syringes (82.20%), receiving germ free blood (62.6%), taking the advice of doctors (53.30%), creating mass awareness (4.70%), following religious norms (2.80%) of HIV prevention.

FSWs were also asked whether they heard of AIDS or not. The results of the study displayed that an overwhelming number of them (99.10%) said that they heard of AIDS and more than four-fifths of the FSWs said that AIDS is a disease. The main sources of information about AIDS were the seminar/workshop (96.5%), television (53.5%), doctor/health worker (44.70%), DIC (34.2%), poster/billboard (13.2%), newspaper (6.10%), NGO workers (7.90%), the study revealed.

They also mentioned some main sign/symptoms, including recurring fever for more than 2/3 months (62.2%), rapid weight loss (43.2%), dry cough for more than 2/3 months (42.3%), profound and unexplained fatigue (43.2%), diarrhea lasting more than a week (27.9%), white spots or unusual blemishes on the tongue, in the mouth, or in the throat (27%), Memory loss, depression, and other neurological disorders (15.30%) of HIV infection. Then, FSWs were asked whether they know any HIV infected person or not.

Approximately three-fifths of the respondents (60.4%) reported that they knew HIV infected person.

The pooled knowledge about HIV/AIDS of the FSWs showed that only 46.80 percent of the FSWs had moderate knowledge about HIV/AIDS while 44.10 percent of them displayed low knowledge about the subject. Again, 9 percent of the FSWs (36.7%) were found with high knowledge.

7.4.2 HIV/AIDS-related awareness and knowledge of IDUs

IDUs' HIV/AIDS-related awareness and knowledge was also examined in this study. The results of the study displayed that almost all IDUs (97.8%) had heard of HIV while a considerable number of participants (51.9%) reported HIV as a virus. They mentioned DIC (92.4%) as their main source of HIV information followed by television (66.4%), NGO worker (40.5%), newspaper (21.4%) seminar/workshop (19.8%), poster/billboard (11.5%) and doctor/health worker (6.1%) etc.

Also, IDUs were asked about how HIV infection spreads. Approximately 90 percent respondents reported that HIV infection spread through unsafe physical relation. Female respondents were more likely to report that HIV infection spread through unsafe physical relation. The study also indicated that the second important ways of spreading HIV infection was sharing of infected needles/syringes (73.1%) followed by blood transfusion (54.6%), mother to child (32.8%), having sex with HIV infected people (11.8%), mosquito/insect bites (8.4%) etc. They also said that HIV infection could be protected by using germfree needles/syringes (79.8%), protected sexual relation (79.0%), by receiving germ free blood (47.1%), taking the advice of doctors in terms of having child (10.1%), creating mass awareness (3.4%) etc.

IDUs were also asked whether they heard of AIDS or not. In response, an overwhelming number of them (97.8%) said that they heard of AIDS. The findings of the study again displayed that 82.4 of them said that AIDS is a disease while around one-tenth of the participants (7.6%) stated that AIDS is a virus. In terms of source of information, they mentioned seminar/workshop (92.4%) as their main sources of information about AIDS. The second important source of AIDS information was television (64.9%) followed by DIC (37.4%), poster/billboard (15.3%), newspaper (10.70%), NGO workers (3.1%) etc.

IDUs stated some sign/symptoms including rapid weight loss (42.1%) followed by recurring fever for more than 2/3 months (24.0%), memory loss, depression, and other neurological disorders (21.5%), profound and unexplained fatigue (17.4%), white spots or unusual blemishes on the tongue, in the mouth, or in the throat (14.0%), diarrhea lasting more than a week (13.20%), etc. of HIV infection. Moreover, a significant number of them said that they did not know about the sign and symptoms of the disease.

The results of the study demonstrated that approximately three-fifths of the respondents (62.0%) reported that they knew HIV infected person. Again, more than two-fifths of the respondents (43.8%) said that they would keep it secret if they knew HIV infected people. In addition, a considerable proportion of the participants (65.3%) said that they are in great risk of contracting HIV. They mentioned several causes of behind this perception, including using needles and syringes (35.4%), not using condoms (2.50%), multiple sex partners (2.50%) etc.

The pooled knowledge of respondents about HIV/AIDS and STDs demonstrated that about half, 49.60 percent, of the IDUs had moderate knowledge about HIV/AIDS while 28.80 percent of them showed high knowledge about the subject. Again, 21.50 percent of the IDUs were found with low knowledge.

7.4.3 HIV/AIDS-related awareness and knowledge of MSWs

This study also evaluated MSWs' knowledge about HIV. The findings of the study showed that an overwhelming number of respondents (89.60 percent) said that they had heard of HIV**.** Again, a considerable number of respondents (69.80 percent) provided correct response- HIV is a virus. This study also found multiple sources of HIV/AIDS information of the MSWs. The results of the study displayed that a significant number of respondents mentioned DIC (87.2%) as their main source of HIV information. Other sources of HIV/AIDS information were television (74.4%), NGO worker (37.2%), newspaper (31.40%), poster/billboard (12.8%), seminar/workshop (10.5%), radio (8.1%) etc.

MSWs reported some causes of HIV infection. These were unsafe physical relation (97.6%) followed by sharing of infected needles/syringes (69.5%), blood transfusion (61.0%), mother to child (39.0%), Male Sex with Male (9.8%), sex with FSWs (8.5%) etc. This study also revealed that said that HIV infection could be protected through safe

sexual relation as stated by 95.10 percent of the MSWs. They also said some other ways such as using germfree needles/syringes (63.40%), receiving germ free blood (52.40%), taking the advice of doctors (17.10%), following religious norms (7.30%), creating mass awareness (2.40%) etc.

To evaluate the knowledge of the MSWs, they were asked whether they heard of AIDS or not. The findings of the study demonstrated that an overwhelming number of them (95.80%) said that they heard of AIDS. Again, a significant proportion of MSWs (72.80 percent) said that AIDS is a disease while around 15 percent of the participants stated that AIDS is the final stage of HIV infection.

The main sources of information about AIDS were the DIC as stated by 79.30 percent of the respondents, the findings of the study indicated. Other sources of AIDS information stated by them were television (73.90%), NGO workers (38.0%), newspaper (25.0%), radio (12.0%), seminar/workshop (10.90%), poster/billboard (7.60%), cinema/drama (6.50) etc.

The main sign/symptoms of HIV infection, this study found, reported by participants were rapid weight loss (71.9%), recurring fever for more than 2/3 months (47.2%), diarrhea lasting more than a week (38.20%), dry cough for more than 2/3 months (30.30%), memory loss, depression, and other neurological disorders (14.6%), profound and unexplained fatigue (12.40%), white spots or unusual blemishes on the tongue, in the mouth, or in the throat (9.0%), etc.

The pooled knowledge of the respondents about HIV/AIDS and STDs demonstrated that only 54.0 percent of the MSWs had moderate knowledge about HIV/AIDS while 33.80 percent of them showed high knowledge about the subject. Again, 12.30 percent of the MSWs were found with low knowledge.

7.4.4 HIV/AIDS-related awareness and knowledge of MSWs

This study examined the awareness and knowledge of TGs. The findings of the study showed that almost all TGs (98.60 percent) had heard of HIV. This study also evaluated the sources of HIV/AIDS information. The results of the study displayed that a significant number of respondents mentioned DIC (97.10 percent) as their main source of HIV information. Other sources of information about HIV were television (75.70%), NGO

worker (38.60%), and poster/billboard (18.60%), seminar/workshop (17.10%), newspaper (15.70%) etc.

In this study, TGs were asked about how HIV infection spreads. The findings of the study revealed that 95.40 percent respondents reported that HIV infection spread through unsafe physical relation followed by sharing of infected needles/syringes (67.70%), blood transfusion (55.40%), mother to child (29.20%), male sex with male (9.20%) etc. They also reported that HIV infection can be protected through safe sexual relation, receiving germ free blood (64.60%), using germfree needles/syringes (52.30%), taking the advice of doctors (30.80%), creating mass awareness (4.60%), following religious norms (1.50%) etc.

TGs were also asked whether they heard of AIDS or not. In response, an overwhelming number of them (95.80%) said that they heard of AIDS. They also stated some sources such as DIC (95.60%), television (77.90%), NGO workers (39.70%), DIC (34.2%), poster/billboard (19.10%), seminar/workshop (16.20%), newspaper (11.80%) etc. of HIV/AIDS information.

This study also examined the signs and symptoms of HIV/AIDS. The findings of the study demonstrated that a significant proportion of respondents (61.20%) reported recurring fever for more than 2/3 months as one of the main symptoms followed by rapid weight loss (58.20%), dry cough for more than 2/3 months (40.30%), memory loss, depression, and other neurological disorders (14.90%), profound and unexplained fatigue (6%) etc.

The pooled knowledge of the respondents about HIV/AIDS and STDs showed that only 47.80 percent of the TGs had moderate knowledge about HIV/AIDS while 37.20 percent of them showed high knowledge about the subject. Again, 15 percent of the TGs were found with low knowledge.

7.5 Sexual behavior and risk practices

This study assesses FSWs' sexual behavior and risk practices. They were asked whether they knew how to have safe sex or not. The result of the study demonstrated that a whopping 99.1 percent FSWs reported that they knew how to conduct safe sexual intercourse with their customers. This finding of this study is not in accord with that the study conducted by UNAIDS (2008) in China. The findings of the study revealed that

nearly 30% did not know how to use condoms. The number of customers FSWs encountered in this study ranges from 1 to7 per day. This study also showed that more than half, 54.8 percent, of the respondents said that they had 1-3 clients every day. Majority of the respondents (74.0 percent) said that their clients used condom while having sex with them whereas a little more than one-fourth of them reported in the negative manner about this issue. This finding of the current study did not match with those of the study conducted by Maharaj and Cleland (2005). According to them, only 8% of married contraceptive users report condom use, and this rate has shown no increase over the last 20 years. However, all respondents in this study stated that they requested their customers to use condom while having sex with them for several reasons namely avoiding the infection of STIs/STDs and HIV.

The results of the study also revealed that the use of female condom was significantly lower than that of male condom- only 22.6 percent FSWs said that they used female condom while they were having sex with their clients. Again, an overwhelming number of respondents (93.9%) said they had checked the expiry date of condoms before they used those. Vaginal sex was the most performed form of sex as stated by 84.3 percent of the respondents. Interestingly, almost all respondents (99.10%) they knew how to have sex with them. With respect to having sex with females, this study found that only 7.0 percent participants said they had sex with females. In terms of MSWs, this study showed that 28.10 percent of the respondents said that they had intercourse with somebody. The results of the study also revealed that they had sex with various persons including MSWs (72.0%) followed by SWs (9.7%), transgender (5.40%) etc. Also, majority of the participants reported (72.0%) that they used condoms while they were having intercourse.

This study evaluated the consumption of drugs of the IDUs and their risk practices. The findings of the study revealed that majority of the respondents (97.7 percent) said that they had drugs daily. This study also found that IDUs used a needle/syringe to inject any illegal drug into their body as reported by an overwhelming percent of the respondents (97.8 percent). Not only they injected drugs into their body through the use of needle/syringe but also they shared those with others as stated by a significant number of participants (65.6 percent). However, no TGs reported that they used a needle/syringe to inject any illegal drug into their body. Again, only 25.0 percent said that they took blood from anybody and majority of them reported that the blood was tested for HIV.

7.6 Attitudes and behaviors of the respondents

7.6.1 Attitudes and behaviors of the FSWs

In this study, it was found that a substantial number of FSWs (68.70 percent) had been working as sex workers for 1-10 years. This study also evaluated a good number of factors that motivated respondents to become involved in this profession. The findings of the current study displayed that 38.3 percent of them reported that they got trapped by dalal to be engaged in this profession followed by economics necessity (13.0%), family disorder (11.3%), easy way of earning (11.3%), forced by someone (11.3%), convinced by someone (7.8%) etc. Though FSWs require legal document/license to carry out sex working, an overwhelming proportion of them (98.30 percent) said that they did not have any legal document to conduct sex working, this study showed.

Though clients of different ages come to FSWs, they permitted young clients aged between 20 to 30 years most, as reported by 60.9 percent of the respondents. Moreover, the second preference of them to have sex was adolescents (21.7%) whose ages were less than 20 years whereas middle-aged customers (31-50 years) constituted 17.4 percent of the total respondents in terms of preference of them to carry out intercourse. The professions of their clients were service holders (59.1%), student (56.5%) rickshaw puller (50.4%), businessmen (44.3%) bus/truck driver (40%), factory worker (34.3%), police (25.2%) etc.

FSWs receive some amount of money at the exchange of intercourse with the customers and their charge ranges from TK 50 to 1000. The results of the study demonstrated that a significant number of FSWs (35.7%) reported that the range of money they received from customers was 50 to 199 taka. Similarly, their per day income vary from person to person. This study also found that 34.8 percent FSWs' per day income was more than 800 taka whereas for those who reported that their daily income was 301-500 taka made up 31.3 percent of the total participants. Most importantly, an overwhelming proportion of FSWs (84.3%) reported that if they were unwilling to maintain sexual relationship, their clients forced them to do intercourse with them. Likewise, a significant number of respondents (73.0%) said that their clients took decision in terms of beginning sex with them.

7.6.2 Attitudes and behaviors of the IDUs

The results of the study suggest that IDUs' consumption of drugs is higher than that of MSWs. . The findings of the study demonstrated that an overwhelming number of IDUs (99.30%) stated that they consumed drugs while 76 percent said that they had drugs. IDUs consumed various types of drugs including injecting drugs (94.7%). The second important drugs which were consumed by IDUs were Ganja (61.70%), Tablet (53.40%) Yaba (38.3%), Heroine (31.6%), Phensidyl (28.60%), Alcohol (19.50%) etc. The results of the study also showed that they got these drugs from various sources including markets (19.50%), other IDUs (5.30%), multiple sources (51.90%) etc. Moreover, the results of the current study displayed that a considerable number of them (83.60 percent) replied that they tested HIV to see if they had HIV. Again, an overwhelming proportion of the participants (95.5%) claimed that they wanted to test HIV.

Regarding the sexual behavior of the IDUs, this study found that a little more than four-fifths, 81.30% percent, of the IDUs stated that they had sex with someone in their life. This finding of the study is moderately consistent with that of the study carried out by Schneider et al. (2009) on truck drivers in Andhra Pradesh, India. The findings of their study demonstrated that 29.1% of truck drivers reported having sex with a commercial sex worker in their lifetime. The sexual partners of IDUs in this study were CSWs (40.40%), MSM (6.40%), multiple partners (63.20%) etc. While they were having sex, they used condom as reported by 54.10 percent of the respondents. In addition, 44.0 percent of the IDUs said that they did not use condom while they were doing sexual intercourse with their partners.

This study also evaluated MSWs' pattern of drug consumption. In contrast to the drug consumption of IDUs, the findings of the study demonstrated that an overwhelming number of respondents (76.0%) stated that they did not consume drugs. They had various types of drugs including injecting drugs (94.7%). The second important drugs, which were consumed by IDUs, were alcohol (87.0%), Ganja (34.8%), Yaba (8.7%), Tablet (4.3%) etc. They got these drugs from various sources including friends (73.9%), markets (17.4%) etc. Again, majority of the respondents (66.70%) said that they had drugs 3-5 days in a week. Moreover, 87.50 percent of the respondents said that they did not use a needle/syringe to inject any illegal drug into your body.

Respondents were also asked whether they tested HIV or not. The results of the study revealed that a significant number of the participants (75.0%) said that they had tested HIV to see whether they had HIV or not. Similarly, majority of the participants (89.6 percent) said that they wanted to test HIV.

7.6.3 Attitudes and behaviors of the TGs

This study suggests that consumption of drugs is lower among TGs than IDUs. The findings of the study also demonstrated that a significant number of respondents (77.50 percent) stated that they did not consume drugs while around one-fourth of the respondents said that they had drugs. They mentioned various types of drugs including ganja (87.50 percent). The second important drugs, which were consumed by TGs, were Yaba (81.30 percent), Tablet (12.50 percent), Phensidyl (12.50 percent) etc. The findings of the study also displayed that TGs got these drugs from various sources including friends (50 percent), markets (37.50 percent), IDUs (6.30 percent) etc.

Again, the results of the study demonstrated that 50 percent TGs said that they had drugs 3 to 5 days in a week. However, no TGs reported that they used a needle/syringe to inject any illegal drug into their body. Moreover, only 25.0 percent said that they took blood from somebody and majority of them reported that the blood was tested for HIV while 85.60 percent claimed that they tested HIV to see if they had HIV. Again, an overwhelming number of the TGs (98.60 percent) stated that they did sex with TG, MSWs, FSWs etc. while 94.40 percent IDUs said that they wanted to test HIV. In addition, 82.90 percent of the TGs reported that they used condoms while they were having intercourse with their partners, the study found.

7.7 Prevention and treatment of diseases

7.7.1 FSWs' prevention and treatment of diseases

Nowadays HIV/AIDS and STDs are serious infectious diseases around the world. The results of the study indicated that majority of the respondents, 80 percent, said that they did not have any curative measure/treatment for this infectious disease from DIC. T Again, 89.30 percent of the TGs said that they received treatment from DIC doctor and DIC doctor provided free treatment for them as reported by 99.10 of the FSWs.

DIC provided with free counseling for FSWs. The findings of the study revealed that a whopping 93.70 respondents said that they are satisfied with the counseling provided by

DIC. Again, 97.40 percent of the FSWs said that DIC authority taught them the techniques of using condoms. Just 87 percent of the total respondents said that they got training on various subjects namely HIV/AIDS, STDs, beauty parlor, human rights, knitting etc.

7.7.2 IDUs' prevention and treatment of diseases

This study also examined the prevention and treatment of HIV/AIDS of the IDUs since they are high risks groups. Respondents were asked if there is any curative measure for HIV/AIDS or not. The findings of the study depicted that just half of the respondents said that there is no a curative measure for HIV/AIDS whereas for those who said that there is curative measure for HIV/AIDS represented 37.30 percent of the total respondents.

IDUs were asked that how much they felt the risk to be affected by HIV/AIDS. The results of the study demonstrated that approximately three-fourths of the respondents said that they felt moderate risk to be affected by HIV/AIDS while 20.90 percent of them felt high risk. The percentages of female respondents who did not feel any risk at all were slightly bigger than that of their male counterparts.

At the time of carrying out survey, respondents were asked whether they felt illness or not. In response, a little more than half of the respondents, 51.5 percent, said that they felt illness. They were also asked if they had any symptom of sexual disorder. The results of the study displayed that they mentioned some symptoms namely pain when urinating (9.7%), discharge of fluids (2.20%), itching/ rash on genital (1.5%) etc. They sought treatment for these diseases as stated by 66.70 percent of the participants. The results of the present study revealed that a good number of the respondents, 52.50 percent, sought treatment from DIC doctors.

7.7.3 MSWs' prevention and treatment of diseases

One of the important objectives of this study was to assess MSWs' prevention and treatment of HIV/AIDS. They were asked if there is any curative measure for HIV/AIDS or not. The findings of the study depicted that more than half of the respondents (52.1%) said that there is no a curative measure for HIV/AIDS. Again, the results of the study demonstrated that approximately one-third of the respondents (36.5%) said that they felt no risk to be affected by HIV/AIDS while 34.4 percent of them felt less risk. The results

of the study also demonstrated that a good number of respondents (74.0%) stated that they did not feel any kind of illness during the time of survey.

They were also asked if they had any symptom of sexual disorder. The findings of the study displayed that majority of the participants (64.6%) reported that they did not have any symptom of sexual disorder. Those who reported that they had some symptoms of sexual disorder mentioned some symptoms namely pain when urinating (7.3%), blood from anus (7.3%), discharge of fluids (4.2%), pain at intercourse (2.1%) etc. They sought treatment for these diseases as stated by 67.6 percent of the participants. Nearly three-fifths of the MSWs reported that they sought treatment from DIC doctors.

7.7.4 TGs' prevention and treatment of diseases

Approximately two-fifths of the TGs (40.80%) reported that they felt no risk to be affected by HIV/AIDS while 21.10 percent of them felt high risk. Again, around one-fifth of the TGs (21.10%) stated that they felt moderate risk. TGs were also asked whether they had any sexual disorder or not. The results of the present study demonstrated that they did not feel any symptom of sexual disorder as stated by 76.10 percent of the TGs. Respondents who stated in the affirmative manner also reported that they sought treatment (88.20%) from DIC doctor, religious leader etc.

7.8 Services provided by DIC

7.8.1 Services provided by DIC for FSWs

This study also evaluated the services provided by DIC for the welfare of FSWs, IDUs, MSWs, and TGs. The findings of the study revealed that a significant number of FSWs said that DIC provides various facilities for doing well to them. For example, 100 percent of them said that DIC provided sleeping facility for them while 90.40 percent of the FSWs reported that DIC provided free blood test for them. Moreover, 42.6 percent of the FSWs said that DIC provides free food for them. However, this food is not sufficient for them as stated by 83.70 of the FSWs. DIC provide not only food, doctor, treatment facility but also access to newspaper, television etc. The results of the study also displayed that around three-fourths of the respondents said that it provided newspaper/ magazine facility for them while a whopping 98.3 percent stated that it also provided the opportunity of watching television. Overall, the perception of them towards DIC facilities was good reported by around three-fourths of the study subjects (70.4%).

7.8.2 Services provided by DIC for IDUs

DIC provides various facilities for IDUs as well. The findings of the study indicated that a significant of respondents (93.30%) said that a significant of respondents (93.30%) said that they knew about the kinds of services provided by DIC for the wellbeing of the IDUs. Again, a significant number of respondents, 86.60 percent, said that they received treatment from DIC and the doctors from DIC provided free treatment from DIC as reported by most of the respondents (94.80%). Moreover, a great of the respondents (84.50%) stated that doctors did routine checkup for them. Similarly, 72.40 percent of the IDUs said that they received free medicine from DIC. But this medicine was not sufficient for them as stated by 47.4 percent of the IDUs. In addition, 78.4 percent of the IDUs said that they received lubricants and needle/syringe respectively. Not only they were given condom for free but also they were taught the techniques of using those condoms as said by 72.40 and 74.60 percent of the respondents respectively.

IDUs are generally suffering from various STDs due to their unsafe sexual behavior. The results of the present study demonstrated that a little more than half of the participants said that DIC provided treatment of STDs. Again, a significant number of respondents (81.30) said that they DIC provided counseling for them. Moreover, 87.20 percent of the respondents said that they were satisfied with free counseling provided by DIC. However, around half, 49.30 percent, of the respondents said that they did not receive any training from DIC. DIC provided training for the respondents on various subjects including counseling (23.20%), rehabilitation (7.10%), education (3.60%) etc. DICs provided various facilities such as free blood test facility, HIV/STIs preventive service, free food, watching TV, opportunity for sleeping, free newspaper/magazine etc. However, a good number of respondents (54.50%) replied that they did not get food from DIC while 63.6 percent of the respondents said that the food provided by DIC was not sufficient for them. As expected, 63.40 percent of the IDUs' perception towards the services of DIC was good.

7.8.3 Services provided by DIC for MSWs

This study also evaluated the services provided by DIC for the welfare of MSWs. The findings of the study revealed that a significant of respondents (87.50%) said that they knew about services provided by DIC for the wellbeing of the IDUs. For example, 90.60 of the MSWs said that they received treatment from the doctors while 98.90 percent of them stated that this treatment was provided free for them. Similarly, a whopping 97.70 of the participants reported that doctors gave routine checkup for them regularly. As expected, as many as 86.50 of the MSWs said that they got free medicine from DIC. The findings of the study also demonstrated that a little more than four-fifths of the (84%) of the respondents reported that they got lubricants from DIC. 72.90 percent of the respondents reported that they were given required condom from DIC. Again, same number of respondents said that they received treatment of STDs (81.20%) and counseling on various issues (81.20%).

Training is another important service provided by DIC for making MSWs well equipped with essential knowledge in daily life. The results of the study demonstrated that 68.80 of the MSWs reported that they received training while an overwhelming proportion of participants (97.0%) stated that they understood the subjects of training. Again, 82.3 and 71.9 percent of the respondents said that DIC provided facility of free blood test and food for them, respectively. However, majority of the respondents (79.7%) said that this food was not sufficient for them. In addition to this, 70.8 percent of the MSWs said that DIC provided with the opportunity for sleeping for them. Similarly, DIC provided newspaper/magazine for MSWs as said by 84.40 percent of them. The results of the study also displayed that around three-fourths of the respondents' (76.0%) attitudes were good towards DIC.

7.8.4 Services provided by DIC for TGs

DIC provides various facilities not only for FSWs, IDUs and MSWs but also for TGs. This study also evaluated the services, which are provided by DIC for the welfare of TGs. The findings of the study revealed that a significant of respondents (91.50%) said that they knew about the kinds of services provided by DIC for the wellbeing of the TGs. Moreover, 95.80 of the respondents reported that they received treatment from the DIC doctors for free. In addition, a great of the respondents (98.50%) stated that doctors did routine checkup for them. Similarly, 94.40 percent of the TGs said that they received free

medicine from DIC. However, this medicine was not sufficient for them as stated by 47.80 percent of the TGs. In addition, 54.90 and 94.4 percent of the respondents reported that they got condoms and lubricants from DIC, respectively. This study also found that a significant number of the respondents (91.5%) said that they DIC provided free counseling for them.

7.9 Conclusion

Acquired Immunodeficiency Syndrome (AIDS) has become one of the most serious health problems in the world. In many parts of the world, young people in this age-group are at particularly high risk of HIV infection from unprotected sex, sex between men and IV drug-use because of the very high prevalence rates often found amongst people who engage in these behaviors (Maimaiti et al. 2010). Despite the current low prevalence of HIV/AIDS in Bangladesh, HIV/AIDS is increasingly being viewed as a major threat for the development of Bangladesh since it can weaken economic growth, educational institutions, governance, and social stability etc. (Huda and Amanullah, 2013). This study, therefore, evaluated the HIV/AIDS related risk practices among the users of selected drop in centers of Dhaka city. Drop in centers is one of the interventions for HIV/AIDS prevention in Bangladesh where health services are provided for HIV/AIDS high risk group (Bhuyain, 2000). The results of the study demonstrated that 99.1 percent FSWs reported that they knew how to conduct safe sexual intercourse with their customers. The number of customers they encountered ranges from 1 to7 per day. Again, more than half, 54.8 percent, of the respondents said that they had 1-3 clients everyday whereas approximately one-fifth of them stated that they found 3-5 customers per day. Majority of the FSWs (74.0%) said that their clients used condom while having sex with them whereas a little more than one-fourth of them reported in the negative manner about this issue. All respondents said that they requested their customers to use condom while having sex with them for several reasons namely avoiding the infection of STIs/STDs and HIV.

Consumption of drugs is higher among IDUs. The findings of the study demonstrated that an overwhelming number of respondents (99.30%) stated that they consumed drugs while only 0.70 percent said that they did not have drugs. They mentioned various types of drugs including injecting drugs (94.7%). The second important drugs which were consumed by IDUs were Ganja (61.70%), Tablet (53.40%) Yaba (38.3%), Heroine

(31.6%), Phensidyl (28.60%), Alcohol (19.50%) etc. They got these drugs from various sources including markets (19.50%), other IDUs (5.30%), multiple sources (51.90%) etc. Not only they injected drugs into their body through the use of needle/syringe but also they shared those with others as stated by a significant number of participants (65.6%). This study also evaluated the sexual behavior of the respondents. The results of the study demonstrated that a little more than four-fifths, 81.30% percent, of the respondents stated that they had sex with someone in their life. The sexual partners of IDUs were CSWs (40.40%), MSM (6.40%), multiple partners (63.20%) etc. While they were having sex they used condom as reported by 54.10 percent of the respondents.

This study also evaluated MSWs' pattern of drug consumption. The findings of the study demonstrated that an overwhelming number of respondents (76.0%) stated that they did not consume drugs. They mentioned various types of drugs including injecting drugs (94.7%). The second important drugs, which were consumed by IDUs, were alcohol (87.0%), Ganja (34.8%), Yaba (8.7%), Tablet (4.3%) etc. They got these drugs from various sources including friends (73.9%), markets (17.4%) etc. Again, 87.50 percent of the respondents said that they did not use a needle/syringe to inject any illegal drug into your body. Moreover, majority of the respondents (66.70%) said that they had drugs 3-5 days in a week. Regarding their sexual behavior, this study found that around three-fifths of the study subjects reported that they did not have sex with anybody. The results of the study also revealed that they had sex with various persons including MSWs (72.0%) followed by SWs (9.7%), transgender (5.40%) etc. Also, majority of the participants reported (72.0%) that they used condoms while they were having intercourse.

In terms of TGs, the findings of the study demonstrated that a significant number of respondents (77.50%) stated that they did not consume drugs while around one-fourth of the respondents said that they had drugs. They had various types of drugs including ganja (87.50%). The second important drugs, which were consumed by TGs, were Yaba (81.30%), Tablet (12.50%), Phensidyl (12.50%) etc. The findings of the study also displayed that TGs got these drugs from various sources including friends (50%), markets (37.50%), IDUs (6.30%) etc. Moreover, half of the respondents (50%) said that they had drugs 3 to 5 days in a week. Interestingly, no TGs reported that they used a needle/syringe to inject any illegal drug into their body. Bivariate results indicate that FSWs with older age, respondents who did not watch television, those read newspaper and divorced FSWs are less likely to use female condoms while having sex with the male counterparts. Again,

IDUs with less exposure to newspaper, and those with high income are more likely to say that they feel the high risk of contracting HIV infection. The results of the study also show that MSWs with more income and those who never offer prayer are more likely to say that they use condom while having sex with the female counterparts. This study suggested that DIC provided various facilities such as free treatment, free routine check-up, free medicine, free lubricants, training, counseling, free access to television radio and so on for the FSWs, IDUs, MSWs, and TGs. DIC is also used for providing training to FSWs, IDUs, MSWs and TGs on HIV, STIs and other issues.

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ANNEXURE

Annexure 1

Interview Schedule

On

HIV/AIDS RELATED RISK PRACTICES AMONG THE USERS OF SELECTED DROP IN CENTERS OF DHAKA: A CULTURAL STUDY

Questionnaire ID **(Female Sex Worker- FSW)** .... | | | |

Personal Information:
Address of Drop in Centre: .....
.....

সম্মতি পত্র

আসছালামু আলাইকুম/ আদাব,

আমার নাম মোঃ মনজুর। আমি ঢাকা বিশ্ববিদ্যালয়ে PhD গবেষণা করছি। আমার গবেষণার বিষয় হল "ঢাকা শহরের নির্দিষ্ট Drop in Centre এর সেবা গ্রহীতাদের মধ্যে HIV/ AIDS এর আশঙ্কা: একটি সাংস্কৃতিক সমীক্ষা" আমি ঢাকা শহরের নির্দিষ্ট Drop in Centre এর সেবা গ্রহীতাদের সাথে কথা বলব। এই তথ্যগুলো HIV/ AIDS এর আশঙ্কা নির্ণয় ও সেবা প্রদানে ভূমিকা রাখবে। এই জরীপে অংশ নিলে আমি HIV/ AIDS বিষয়ে আপনার ধারনা/ জ্ঞান ও সচেতনতা নিয়ে কিছু প্রশ্ন জিজ্ঞাসা করব যা আপনার স্বাস্থ্যের উপর প্রভাব ফেলে। এর ভিতর আপনার যৌন আচরণও থাকবে। যদি আপনি সাক্ষাৎকার দিতে ইচ্ছুক হন, এটা অত্যন্ড় জর"রী যে আপনি স্বেচ্ছায় সঠিক এবং সত্য উত্তর দিচ্ছেন। আমি এই ব্যাপারে আপনার সক্রিয় সহযোগিতা কামনা করছি। যদি আপনার কাছে কোন প্রশ্ন অতিরিক্ত ব্যক্তিগত মনে হয় আপনি তা এড়িয়ে/ বাদ দিতে পারবেন অথবা যে কোন সময় সাক্ষাতকার বন্ধ করে দিতে পারবেন।

অন্য কেউ যাতে আপনার কথাবার্তা শুনতে না পারে সেরকম স্থানে আমরা আপনার সাক্ষাতকার নিতে চাচ্ছি। আপনার প্রদানকৃত তথ্য এ কাজে নিয়োজিত ব্যক্তি ছাড়া অন্য কেউ জানতে পারবে না, সম্পূর্ণ গোপন রাখা হবে।

আমি কি আপনার সাক্ষাতকার শুর" করতে পারি? হ্যাঁ..... ☐ না..... ☐

সাক্ষাতকারীর স্কাক্ষর..... তারিখ:.....

সাক্ষাতকারীর স্কাক্ষর..... তারিখ:.....

সাক্ষাতকার শুর" করার সময়ঃ..... সাক্ষাতকার শেষ করার সময়ঃ.....

SECTION- A BACKGROUND INFORMATION

No.	Question	Coding Categories	Skip
101	Sex of the Respondent?	Male----------1 Female----------2 TG----------3	
102	Age of the Respondent?		
103	Religion of the respondent?	Islam----------1 Hindu----------2 Others----------3	
104	Have you ever attended any school?	Yes----------1 No----------2	→104B
104A	If yes, which class have you passed?		
104B	Can you read now?	Yes----------1 No----------2	→106
105	Do you read newspaper/ Magazine?	Yes----------1 No----------2	→106
105A	If yes, how often do you read newspaper/ Magazine?	Daily----------1 3-5 days in a week----------2 Weekly----------3 Monthly----------4	
106	Do you watch TV?	Yes----------1 No----------2	→107
106A	If yes, how often do you watch TV?	Daily----------1 3-5 days in a week----------2 Weekly----------3 Monthly----------4	
107	Marital Status	Married----------1 Unmarried----------2 Divorced----------3 Widowed----------4 Living with partner----------5 Separated----------6 Abandoned----------7 Others (Specify)----------8	→109
108	Do you have any child?	No----------1 One ----------2 Two----------3 More----------4	
109	How much is your monthly income?		
110	What is your source of your income?		
111	How often do you offer religious activities?	Everyday----------1 Sometimes----------2 Never----------3	

SECTION- B : AWARENESS AND KNOWLEDGE ON HIV/ AIDS

No.	Question	Coding Categories			Skip
201	Have you ever heard about HIV?	Yes----------1 No----------2 →			202
201A	If yes, what is the source of your information about HIV? (More than one answer Possible)	Source	Yes	No	
		TV	1	2	
		Radio	1	2	
		Newspaper	1	2	
		Poster/ Billboard	1	2	
		Doctor/Health Worker	1	2	
		Seminar/ Workshop	1	2	
		DIC	1	2	
		NGOs Worker	1	2	
		Cinema/ Drama	1	2	
		Clients	1	2	
		Others	1	2	
201B	What is HIV?	A Disease----------1 A Virus ----------2 A Myth ----------3 A Curse from God----------4 Don't know----------5 → Others (pleas specify) ----------6			202
201C	What is the main source of HIV infection? (More than one answer possible)	Unsafe physical relation	1	2	
		Sharing of infected needles/ syringes	1	2	
		Mosquito/ Insect bites	1	2	
		Blood transfusion	1	2	
		Mother to Child	1	2	
		Male sex with Male	1	2	
		Sex with CSWs	1	2	
		Kiss/ Handshake	1	2	
		Sex with HIV infected people	1	2	
		Don't know	1	2	
201D	How can HIV infection be protected? (More than one answer possible)	Protected sexual relation	1	2	
		By using germfree Needles/ Syringes	1	2	
		By receiving germ free blood	1	2	
		By following religious norms	1	2	
		Creating mass awareness	1	2	
		Taking the advice of doctors in terms of having child	1	2	
		Others	1	2	
		Don't know	1	2	
202	Have you ever heard about AIDS?	Yes----------1 → No----------2			301

202A	What is the source of your information about AIDS?	Source	Yes	No	
		TV	1	2	

	(More than one answer Possible)	Radio	1	2	
		Newspaper	1	2	
		Poster/ Billboard	1	2	
		Seminar/ Workshop	1	2	
		DIC	1	2	
		NGOs Worker	1	2	
		Cinema/ Drama	1	2	
		Don't know	1	2	
		Others	1	2	
202B	What is AIDS?	A Disease----------1 A Virus ----------2 A Myth ----------3 A Curse from God----------4 Final stage of HIV infection-----5 Don't know----------6 → 301 Others (pleas specify) ----------7			
202C	What are the signs and symptoms of people living with HIV/ AIDS? (More than one answer possible)	Rapid weight loss	1	2	
		Dry cough for more than 2/3 months	1	2	
		Recurring fever for more than 2/3 months	1	2	
		Profound and unexplained fatigue	1	2	
		Swollen lymph glands in the armpits, groin, or neck	1	2	
		Diarrhea lasting more than a week	1	2	
		White spots or unusual blemishes on the tongue, in the mouth, or in the throat	1	2	
		Memory loss, depression and other neurological disorders	1	2	
		Don't know	1	2	
		Others	1	2	
203	Do you know any HIV/ AIDS infected people?	Yes----------1 No----------2			
204	If you know any HIV/ AIDS infected people, will you keep it secret?	Yes----------1 No----------2			

205	After I read each statement, please tell me whether you don't agree with it, you disagree with it or you don't know about it.			
	Statement	Yes	No	Don't know
205A	AIDS is a myth	1	2	3
205B	Teachers who have AIDS or are infected with HIV should not be allowed to teach in schools	1	2	3
205C	Students who have AIDS or are infected with HIV should not be allowed to study in schools	1	2	3
205D	People with AIDs should be isolated from healthy people to avoid spreading the disease.	1	2	3
205E	There is no cure for AIDS	1	2	3
205F	Most people with HIV/ AIDS could have avoided it	1	2	3
205G	HIV transmits through sneezing, coughing, kissing, hugging, mosquito bites.	1	2	3
205H	HIV can be passed only from women to men.	1	2	3

205I	HIV can be passed through one single unsafe sexual contact.	1	2	3
205J	Only men who have sex with men are at most risk of contracting HIV.	1	2	3
205K	You can tell if a person has AIDS by looking at him/her	1	2	3
205L	HIV/AIDS is a serious threat to Bangladesh	1	2	3
205M	AIDS is a curse from GOD.	1	2	3
205N	Herbal remedies and religious healing are successful in killing HIV	1	2	3
205O	AIDS is an alien illness	1	2	3
205P	AIDs is an illness of those who commit adultery.	1	2	3
205|Q	A person can get HIV by sharing a meal with someone who is infected?	1	2	3
206	Do you think that you are in risk of contracting HIV?	Yes ----------1 No----------2 → 207 Don't know/ Not sure-------99		
206A	If yes, do you think your own chances of getting HIV are small, moderate, high?	Small----------1 Moderate----------2 High----------3 Don't know----------99		
207	If yes or no/ don't know in to Q 206, why do you think so, justly (Record all response)	**IF YES** Multiple sex partners----------1 Not using condoms----------2 Intercourse with sex-worker------3 Homo-sexuality or sex with transgender----------4 Using needles and syringe of others----------5 Blood transfusion without testing blood----------6 Other (specify)----------77 **IF NO** Avoiding sex----------1 Using condoms----------2 One sex partner only/ Faithful sex partner----------3 Avoiding sex with sex-worker---4 No homo-sexuality or sex with transgender----------5 Not using needles and syringes of others----------6 Never having sex----------7 No blood transfusion without testing blood----------8 Other (specify)----------77		

SECTION- C : CLIENTS ATTITUDE AND BEHAVIOR

No.	Question	Coding Categories	Skip
301	How long have you been working as sex workder?		
302	Do you have a legal document?	Yes ----------1 No----------2 Applied for license----------3	
303	What factors that motivated you to enter into this profession?	Economics Necessity----------1 Family Disorder----------2 Easy Earning----------3 Forced by someone----------4 Trapped by dalal----------5 Sexual abused by house owned-6 Taken by husband----------7 Convinced by someone----------8 Others (please specify)----------9	
304	What was your previous profession?	Housewife----------1 Housemaid----------2 Unemployed----------3 Employee----------4 Student----------5 Others (please specify)----------6	
305	What type of clients did you permit most to have sex?	Adolescent (Below 20)----------1 Young aged (20-30y)----------2 Middle aged(31-50y)----------3 Old age (50y+)----------4	
306	What is the profession of your clients?	Factory worker----------1 Rickshaw puller----------2 Bus/ Truck Driver----------3 Police----------4 Muscleman----------5 Businessman----------6 Student----------7 Teacher----------8 Service holders----------9 Others (please specify)----------10	
307	How much do you charge for encounter?		
308	How much do you earn per day?	Tk----------	
309	If you are unwilling to maintain sexual relationship, do your clients force to do so?	Yes ----------1 No----------2	
310	Who take decision in the case of beginning sex?	Your clients----------1 You----------2 Both----------3 Others----------4	
311	Do your clients pay you properly?	Yes ----------1 No----------2	
311A	If No, why?	----------	401

SECTION- D : SEXUAL BEHAVIOR AND RISK PRACTICES

No.	Question	Coding Categories	Skip
401	Do you know how to make safe sex?	Yes----------1 No----------2	
402	How many clients do you have per day?	1----------1 1-3----------2 3-5----------3 5+----------4	
403	Do your clients use condom while having sex?	Yes----------1 No----------2	→ 403B
403A	Do all your clients use condom while having sex?	Yes----------1	→ 404
		No----------2	
403B	If no, do you request your clients to use condom?	Yes----------1 No----------2	→ 404
403C	If yes, why?		
404	Do you use female condom?	Yes----------1 No----------2 Don't know----------3	
405	What form of sex do you usually have with your clients?	Vaginal----------1 Anal.----------2 Oral----------3 Others(please specify)-------4	
406	Do you know how to use condom properly?	Yes----------1 No----------2	
407	Do you make sexual intercourse with female? (Suppose Lesbian)	Yes----------1 No----------2 Don't know----------3	
408	Can a condom be re-used?	Yes----------1 No----------2 Don't know----------3	
409	Do you check the expiry date of condom?	Yes----------1 No----------2 Don't know----------3	
410	From where, Do you get condoms?	Clients----------1 Peer workers----------2 DIC Authority----------3 Health workers----------4 NGOs workers----------5 Shops----------6 Dispensary----------7 Others(please specify)--------8	

SECTION- E : PREVENTION AND TREATMENT

No.	Question	Coding Categories	Skip
501	Is there any curative measure for HIV/ AIDS/	Yes----------1 No----------2 Don't know----------3	
502	Now Do you feel any kind of illness?	Yes----------1 No----------2	
503	Do you have any of these symptoms of sexual disorder?	Discharge of fluids----------1 Pain when urinating---------2 Pain in valve----------3 Itchy/rash on genital--------4 Pain at intercourse----------5 Pus/Blood from anus-------6 Pain in lower abdomen-----7 Others(please specify)------8 No----------9	→601
503A	If yes, did you seek treatment?	Yes----------1 No----------2	
503B	If yes, what type of treatment have you taken?	No measure taken----------1 Traditional Medicine-------2 Govt. Hospitals Dr.---------3 Private clinics Dr.----------4 Medicine shop----------5 Peer worker----------6 DIC Dr.----------7 NGOs provided facilities--8 Others (please specify)-----9	

SECTION- F : SERVICE PROVIDED BY DIC

No.	Question	Coding Categories	Skip
601	Do you know what kinds of service are provided by DIC?	Yes----------1 No----------2	
602	Do you get any type of treatment from the doctors?	Yes----------1 No----------2 Don't know----------3	→603
602A	If yes, does the doctor provide free treatment?	Yes----------1 No----------2 Don't know----------3	
602B	Does the doctor do routine checkup?	Yes----------1 No----------2 Don't know----------3	
603	Do you get free medicine from here?	Yes----------1 No----------2 Don't know----------3	→604
603A	Is the medicine provided by DIC sufficient?	Yes----------1 No----------2	
604	Do you get the required condom from DIC?	Yes----------1 No----------2 Don't know----------3	

605	Do you get lubricants DIC?	Yes----------1	

		No----------2 Don't know----------3	
606	Did they teach techniques of using condom?	Yes----------1 No----------2 Don't know----------3	
607	Do you get any kinds of treatment of STDs from here?	Yes----------1 No----------2 Don't know----------3	
608	Does DIC provide you any kind of counseling?	Yes----------1 No----------2 Don't know----------3	→609
608A	Are you satisfied with the counseling?	Yes----------1 No----------2	
609	Have you received any kind of training from DIC?	Yes----------1 No----------2 Don't know----------3	→610
609A	Did you understand the subject of training?	Yes----------1 No----------2	
609B	If yes, what kind of training?		
610	Does DIC provide the facility of free blood test?	Yes----------1 No----------2 Don't know----------3	
611	Does DIC send for blood test elsewhere? If yes, do they provide any convenience bill?	Yes----------1 No----------2 Don't know----------3	
612	In the last 12 months, did you receive any HIV/ STI preventive service from DIC?	Yes----------1 No----------2 Don't know----------3	
613	Do you get any food from here?	Yes----------1 No----------2 Don't know----------3	→614
613A	If yes, is the food provided by DIC sufficient?	Yes----------1 No----------2	
614	Do you get the opportunity to watch TV from here?	Yes----------1 No----------2 Don't know----------3	
615	Do you get the opportunity to sleep/ rest here?	Yes----------1 No----------2 Don't know----------3	
616	Do you get any Magazine/ Newspaper/ Advertisement?	Yes----------1 No----------2 Don't know----------3	
617	Last of all, What's your remark about the service of DIC?	Good----------1 Bad----------2 Moderate----------3	
618	Last of all, Do you want to say something about DIC service? Please say----		

Thank you for your participation

Annexure 2

Interview Schedule

On

HIV/AIDS RELATED RISK PRACTICES AMONG THE USERS OF SELECTED DROP IN CENTERS OF DHAKA: A CULTURAL STUDY

Questionnaire ID **(IDUs)** ....

Personal Information:

Address of Drop in Centre: .....

.....

সম্মতি পত্র

আসছালামু আলাইকুম/ আদাব,

আমার নাম মোঃ মনজুর। আমি ঢাকা বিশ্ববিদ্যালয়ে PhD গবেষণা করছি। আমার গবেষণার বিষয় হল ÒXvKv kn‡ii wbw`ó **Drop in Centre** Gi †mev MnxZv‡`i g‡a¨ **HIV/ AIDS** Gi Avk¼v: GKwU mvs¯wZK mgx¶vÓ আমি ঢাকা শহরের নির্দিষ্ট Drop in Centre এর সেবা গ্রহীতাদের সাথে কথা বলব। এ তথ্যগুলো HIV/ AIDS এর আশঙ্কা নির্ণয় ও সেবা প্রদানে ভূমিকা রাখবে। এই জরীপে অংশ নিলে আমি HIV/ AIDS বিষয়ে আপনার ধারনা/ জ্ঞান ও সচেতনতা নিয়ে কিছু প্রশ্ন জিজ্ঞাসা করব যা আপনার স্বাস্থ্যের উপর প্রভাব ফেলে। এর ভিতর আপনার যৌন আচরণও থাকবে। যদি আপনি সাক্ষাৎকার দিতে ইচ্ছুক হন, এটা অত্যন্ড় জর"রী যে আপনি স্বেচ্ছায় সঠিক এবং সত্য উত্তর দিচ্ছেন। আমি এই ব্যাপারে আপনার সক্রিয় সহযোগিতা কামনা করছি। যদি আপনার কাছে কোন প্রশ্ন অতিরিক্ত ব্যক্তিগত মনে হয় আপনি তা এড়িয়ে/ বাদ দিতে পারবেন অথবা যে কোন সময় সাক্ষাতকার বন্ধ করে দিতে পারবেন।

অন্য কেউ যাতে আপনার কথাবার্তা শুনতে না পারে সেরকম স্থানে আমরা আপনার সাক্ষাতকার নিতে চাচ্ছি। আপনার প্রদানকৃত তথ্য এ কাজে নিয়োজিত ব্যক্তি ছাড়া অন্য কেউ জানতে পারবে না, সম্পূর্ণ গোপন রাখা হবে।

আমি কি আপনার সাক্ষাতকার শুর" করতে পারি? হ্যাঁ..... ☐ না..... ☐

সাক্ষাতকারীর স্কাক্ষর.....

তারিখ:.....

সাক্ষাতকারীর স্কাক্ষর..... তারিখ:.....

সাক্ষাতকার শুর" করার সময়ঃ..... সাক্ষাতকার শেষ করার সময়ঃ.....

SECTION- A BACKGROUND INFORMATION

No.	Question	Coding Categories	Skip
101	Sex of the Respondent?	Male----------1 Female----------2 TG----------3	
102	Age of the Respondent?		
103	Religion of the respondent?	Islam----------1 Hindu----------2 Others----------3	
104	Have you ever attended any school?	Yes----------1 No----------2	→104B
104A	If yes, which class have you passed?		
104B	Can you read now?	Yes----------1 No----------2	→106
105	Do you read newspaper/ Magazine?	Yes----------1 No----------2	→106
105A	If yes, how often do you read newspaper/ Magazine?	Daily----------1 3-5 days in a week----------2 Weekly----------3 Monthly----------4	
106	Do you watch TV?	Yes----------1 No----------2	→107
106A	If yes, how often do you watch TV?	Daily----------1 3-5 days in a week----------2 Weekly----------3 Monthly----------4	
107	Marital Status	Married----------1 Unmarried----------2 Divorced----------3 Widowed----------4 Living with partner----------5 Separated----------6 Abandoned----------7 Others (Specify)----------8	→109
108	Do you have any child?	No----------1 One ----------2 Two----------3 More----------4	
109	How much is your monthly income?		
110	What is your source of your income?		
111	How often do you after religious activities?	Everyday----------1 Sometimes----------2 Never----------3	

SECTION- B : AWARENESS AND KNOWLEDGE ON HIV/ AIDS

No.	Question	Coding Categories			Skip
201	Have you ever heard about HIV?	Yes----------1 No----------2 →			202
201A	If yes, what is the source of your information about HIV? (More than one answer Possible)	Source	Yes	No	
		TV	1	2	
		Radio	1	2	
		Newspaper	1	2	
		Poster/ Billboard	1	2	
		Doctor/Health Worker	1	2	
		Seminar/ Workshop	1	2	
		DIC	1	2	
		NGOs Worker	1	2	
		Cinema/ Drama	1	2	
		Clients	1	2	
		Others	1	2	
201B	What is HIV?	A Disease----------1 A Virus ----------2 A Myth ----------3 A Curse from God----------4 Don't know----------5 → Others (pleas specify) ----------6			202
201C	What is the main source of HIV infection? (More than one answer possible)	Unsafe physical relation	1	2	
		Sharing of infected needles/ syringes	1	2	
		Mosquito/ Insect bites	1	2	
		Blood transfusion	1	2	
		Mother to Child	1	2	
		Male sex with Male	1	2	
		Sex with CSWs	1	2	
		Kiss/ Handshake	1	2	
		Sex with HIV infected people	1	2	
		Don't know	1	2	
201D	How can HIV infection be protected? (More than one answer possible)	Protected sexual relation	1	2	
		By using germfree Needles/ Syringes	1	2	
		By receiving germ free blood	1	2	
		By following religious norms	1	2	
		Creating mass awareness	1	2	
		Taking the advice of doctors in terms of having child	1	2	
		Others	1	2	
		Don't know	1	2	
202	Have you ever heard about AIDS?	Yes----------1 No----------2 →			301

202A	What is the source of your information about AIDS?	Source	Yes	No	
		TV	1	2	

	(More than one answer Possible)	Radio	1	2	
		Newspaper	1	2	
		Poster/ Billboard	1	2	
		Seminar/ Workshop	1	2	
		DIC	1	2	
		NGOs Worker	1	2	
		Cinema/ Drama	1	2	
		Don't know	1	2	
		Others	1	2	
202B	What is AIDS?	A Disease----------1 A Virus ----------2 A Myth ----------3 A Curse from God----------4 Final stage of HIV infection-----5 Don't know----------6 → 301 Others (pleas specify) ----------7			
202C	What are the signs and symptoms of people living with HIV/ AIDS? (More than one answer possible)	Rapid weight loss	1	2	
		Dry cough of more than 2/3 months	1	2	
		Recurring fever for more than 2/3 months	1	2	
		Profound and unexplained fatigue	1	2	
		Swollen lymph glands in the armpits, groin, or neck	1	2	
		Diarrhea lasting more than a week	1	2	
		White spots or unusual blemishes on the tongue, in the mouth, or in the throat	1	2	
		Memory loss, depression and other neurological disorders	1	2	
		Don't know	1	2	
		Others	1	2	
203	Do you know any HIV/ AIDS infected people?	Yes----------1 No----------2			
204	If you know any HIV/ AIDS infected people, will you keep it secret?	Yes----------1 No----------2			

205	After I read each statement, please tell me whether you don't agree with it, you disagree with it or you don't know about it.			
	Statement	Yes	No	Don't know
205A	AIDS is a myth	1	2	3
205B	Teachers who have AIDS or are infected with HIV should not be allowed to teach in schools	1	2	3
205C	Students who have AIDS or are infected with HIV should not be allowed to study in schools	1	2	3
205D	People with AIDs should be isolated from healthy people to avoid spreading the disease.	1	2	3
205E	There is no cure for AIDS	1	2	3
205F	Most people with HIV/ AIDS could have avoided it	1	2	3
205G	HIV transmits through sneezing, coughing, kissing, hugging, mosquito bites, inset's bites.	1	2	3
205H	HIV can be passed only from women to men.	1	2	3

205I	HIV can be passed through one single unsafe sexual contact.	1	2	3
205J	Only men who have sex with men are at most risk of contracting HIV.	1	2	3
205K	You can tell if a person has AIDS by looking at him/her	1	2	3
205L	HIV/AIDS is a serious threat to Bangladesh	1	2	3
205M	AIDS is a curse from GOD.	1	2	3
205N	Herbal remedies and religious healing are successful in killing HIV	1	2	3
205O	AIDS is an alien illness	1	2	3
205P	AIDs is an illness of those who commit adultery.	1	2	3
205|Q	A person can get HIV by sharing a meal with someone who is infected?	1	2	3
206	Do you think that you are in risk of contracting HIV?	Yes ----------1 No----------2 → 207 Don't know/ Not sure---------3		
206A	If yes, do you think your own chances of getting HIV are small, moderate, high?	Small----------1 Moderate----------2 High----------3 Don't know----------99		
207	If yes or no/ don't know in to Q 206, why do you think so, justly (Record all response)	**IF YES** Multiple sex partners----------1 Not using condoms----------2 Intercourse with sex-worker------3 Homo-sexuality or sex with transgender----------4 Using needles and syringe of others----------5 Blood transfusion without testing blood----------6 Other (specify)----------77 **IF NO** Avoiding sex----------1 Using condoms----------2 One sex partner only/ Faithful sex partner----------3 Avoiding sex with sex-worker---4 No homo-sexuality or sex with transgender----------5 Not using needles and syringes of others----------6 Never having sex----------7 No blood transfusion without testing blood----------8 Other (specify)----------77		

SECTION- C : SEXUAL/ DRUG BEHAVIOR AND RISK PRACTICES

No.	Question	Coding Categories	Skip
301	Do you consume any kind of drug?	Yes----------1 No----------2 →	303
301A	If yes, what kind of drugs?	Phensidyl----------1 Heroin----------2 Alchohol----------3 Ganja----------4 Yaba----------5 Tablet----------6 Injection----------7 Others----------8	
302	From where, Do you get the Drugs?	From others IDUs----------1 Buy from Market----------2 Friends----------3 DIC----------4 Others (please specify)-------5	
303	Do you ever use a needle/ syringe to inject any illegal drug into your body?	Yes----------1 No----------2 → Refused to answer----------3 Don't know----------99	305
304	How often do you used drug in a week?	Daily----------1 3-5 days in a week----------2 Once a week----------3	
305	Did you ever share the needle/ syringe with others?	Yes----------1 No----------2 Refused to answer----------3 Don't know----------4	
306	Did you ever taken any blood?	Yes ----------1 No----------2 →	308
307	Was the blood tested for HIV?	Yes----------1 No----------2 Don't know----------3	
308	Have you ever been tested to see if you have HIV?	Yes ----------1 No----------2	
309	Would you want to be tested for HIV/ AIDS?	Yes----------1 No----------2 Don't know/ Not sure---------3	
310	Have you donate/sell blood to any other person?	Yes ----------1 No----------2	
311	Have you ever had sex with anyone?	Yes ----------1 No----------2 →	401
311A	If yes, with whom did you do sex?	Hizra/ TG----------1 SWs----------2 MSM----------3 Others----------4	
311B	Did you use condom while you were performing sexual intercourse?	Yes----------1 No----------2 Don't know----------3	

SECTION- D : PREVENTION AND TREATMENT

No.	Question	Coding Categories	Skip
401	Is there any curative measure for HIV/ AIDS	Yes----------1 No----------2 Don't know----------3	
402	How much do you feel the risk to be affected by HIV/ AIDS	No risk----------1 Less risk----------2 Moderate----------3 High risk----------4 Don't know----------5	
403	Now do you have felt any kinds of illness?	Yes----------1 No----------2	
404	Do you have any of these symptoms of sexual disorder?	Discharge of fluids----------1 Pain when urinating----------2 Pain in valve----------3 Itchy/ rash on genital----------4 Pain at intercourse----------5 Pus/ Blood from anus----------6 Pain in lower abdomen---------7 Others (please specify)-------8 No----------9 →	501
404A	If yes, did you seek treatment?	Yes----------1 No----------2 →	501
404B	What type of treatment have you taken?	Traditional Medicine----------1 Govt. Hospitals Dr.----------2 Private clinics Dr.----------3 Medicine shop----------4 Peer worker----------5 Religious leader----------6 DIC Dr.----------7 NGOs provided facilities----8 Others (please specify)--------9	

SECTION- E : SERVICE PROVIDED BY DIC

No.	Question	Coding Categories	Skip
501	Do you know what kinds of service are provided by DIC?	Yes----------1 No----------2	
502	Do you get any type of treatment from the doctors?	Yes----------1 No----------2 → Don't know----------3	503
502A	If yes, does the doctor provide free treatment?	Yes----------1 No----------2 Don't know----------3	
502B	Does the doctor do routine checkup?	Yes----------1 No----------2 Don't know----------3	
503	Do you get free medicine from here?	Yes----------1 No----------2 → Don't know----------3	504
503A	Is the medicine provided by DIC sufficient?	Yes----------1 No----------2	
504	Do you get the required condom from DIC?	Yes----------1 No----------2	

		Don't know----------3	
505	Do you get lubricants from DIC?	Yes----------1 No----------2 Don't know----------3	
506	Do you get needle/ syringes from DIC?	Yes----------1 No----------2 Don't know----------3	
507	Did they teach techniques of using condoms?	Yes----------1 No----------2 Don't know----------3	
508	Do you get any kinds of treatment of STDs from here?	Yes----------1 No----------2 Don't know----------3	
509	Does DIC provide you any kind of counseling?	Yes----------1 No----------2→	509
		Don't know----------3	
509A	Are you satisfied with the counseling?	Yes----------1 No----------2	
510	Have you received any kind of training from DIC?	Yes----------1 No----------2→	510
		Don't know----------3	
510A	Did you understand the subject of training?	Yes----------1 No----------2	
510B	If yes, what kind of training?		
511	Does DIC provide the facility of free blood test?	Yes----------1 No----------2 Don't know----------3	
512	Does DIC send for blood test elsewhere? If yes, do they provide any convenience bill?	Yes----------1 No----------2 Don't know----------3	
513	In the last 12 months, did you receive any HIV/ STI preventive service from DIC?	Yes----------1 No----------2 Don't know----------3	
514	Do you get any food from here?	Yes----------1 No----------2→	514
		Don't know----------3	
514A	If yes, is the food provided by DIC sufficient?	Yes----------1 No----------2	
515	Do you get the opportunity to watch TV from here?	Yes----------1 No----------2 Don't know----------3	
516	Do you get the opportunity to sleep/ rest here?	Yes----------1 No----------2 Don't know----------3	
517	Do you get any Magazine/ Newspaper/ Advertisement?	Yes----------1 No----------2 Don't know----------3	
518	Last of all, What's your remark about the service of DIC?	Good----------1 Bad----------2 Moderate----------3	
519	Last of all, do you want to say something about DIC service? Please say----		

Thank you for your participation

Annexure 3

Interview Schedule

On

HIV/AIDS RELATED RISK PRACTICES AMONG THE USERS OF SELECTED DROP IN CENTERS OF DHAKA: A CULTURAL STUDY

Questionnaire ID **(MSW/TG)** ....

Personal Information:

Address of Drop in Centre: .....

.....

সম্মতি পত্র

আসছালামু আলাইকুম/ আদাব,

আমার নাম মোঃ মনজুর। আমি ঢাকা বিশ্ববিদ্যালয়ে PhD গবেষণা করছি। আমার গবেষণার বিষয় হল "ঢাকা শহরের নির্দিষ্ট Drop in Centre এর সেবা গ্রহীতাদের মধ্যে HIV/ AIDS এর আশঙ্কা: একটি সাংস্কৃতিক সমীক্ষা" আমি ঢাকা শহরের নির্দিষ্ট Drop in Centre এর সেবা গ্রহীতাদের সাথে কথা বলব। এই তথ্যগুলো HIV/ AIDS এর আশঙ্কা নির্ণয় ও সেবা প্রদানে ভূমিকা রাখবে। এই জরীপে অংশ নিলে আমি HIV/ AIDS বিষয়ে আপনার ধারনা/ জ্ঞান ও সচেতনতা নিয়ে কিছু প্রশ্ন জিজ্ঞাসা করব যা আপনার স্বাস্থ্যের উপর প্রভাব ফেলে। এর ভিতর আপনার যৌন আচরণও থাকবে। যদি আপনি সাক্ষাৎকার দিতে ইচ্ছুক হন, এটা অত্যন্ড় জর"রী যে আপনি স্বেচ্ছায় সঠিক এবং সত্য উত্তর দিচ্ছেন। আমি এই ব্যাপারে আপনার সক্রিয় সহযোগিতা কামনা করছি। যদি আপনার কাছে কোন প্রশ্ন অতিরিক্ত ব্যক্তিগত মনে হয় আপনি তা এড়িয়ে/বাদ দিতে পারবেন অথবা যে কোন সময় সাক্ষাতকার বন্ধ করে দিতে পারবেন।

অন্য কেউ যাতে আপনার কথাবার্তা শুনতে না পারে সেরকম স্থানে আমরা আপনার সাক্ষাতকার নিতে চাচ্ছি। আপনার প্রদানকৃত তথ্য এ কাজে নিয়োজিত ব্যক্তি ছাড়া অন্য কেউ জানতে পারবে না, সম্পূর্ণ গোপন রাখা হবে।

আমি কি আপনার সাক্ষাতকার শুর" করতে পারি? হ্যাঁ..... ☐ না..... ☐

সাক্ষাতকারীর স্কাক্ষর..... তারিখ:.....

সাক্ষাতকারীর স্কাক্ষর..... তারিখ:.....

সাক্ষাতকার শুর" করার সময়ঃ..... সাক্ষাতকার শেষ করার সময়ঃ.....

SECTION- A: BACKGROUND INFORMATION

No.	Question	Coding Categories	Skip
101	Sex of the Respondent?	Male----------1 Female----------2 TG----------3	
102	Age of the Respondent?		
103	Religion of the respondent?	Islam----------1 Hindu----------2 Others----------3	
104	Have you ever attended any school?	Yes----------1 No----------2	→106
104A	If yes, which class have you passed?		
104B	Can you read now?	Yes----------1 No----------2	→104B
105	Do you read newspaper/ Magazine?	Yes----------1 No----------2	→106
105A	If yes, how often do you read newspaper/ Magazine?	Daily----------1 3-5 days in a week----------2 Weekly----------3 Monthly----------4	
106	Do you watch TV?	Yes----------1 No----------2	→107
106A	If yes, how often do you watch TV?	Daily----------1 3-5 days in a week----------2 Weekly----------3 Monthly----------4	
107	Marital Status	Married----------1 Unmarried----------2 Divorced----------3 Widowed----------4 Living with partner----------5 Separated----------6 Abandoned----------7 Others (Specify)----------8	→109
108	Do you have any child?	No----------1 One ----------2 Two----------3 More----------4	
109	How much is your monthly income?		
110	What is your source of your income?		
111	How often do you after religious activities?	Everyday----------1 Sometimes----------2 Never----------3	

SECTION- B : AWARENESS AND KNOWLEDGE ON HIV/ AIDS

No.	Question	Coding Categories			Skip
201	Have you ever heard about HIV?	Yes----------1 No----------2 →			202
201A	If yes, what is the source of your information about HIV? (More than one answer Possible)	Source	Yes	No	
		TV	1	2	
		Radio	1	2	
		Newspaper	1	2	
		Poster/ Billboard	1	2	
		Doctor/Health Worker	1	2	
		Seminar/ Workshop	1	2	
		DIC	1	2	
		NGOs Worker	1	2	
		Cinema/ Drama	1	2	
		Clients	1	2	
		Others	1	2	
201B	What is HIV?	A Disease----------1 A Virus ----------2 A Myth ----------3 A Curse from God----------4 Don't know----------5 → Others (pleas specify) ----------6			202
201C	What is the main source of HIV infection? (More than one answer possible)	Unsafe physical relation	1	2	
		Sharing of infected needles/ syringes	1	2	
		Mosquito/ Insect bites	1	2	
		Blood transfusion	1	2	
		Mother to Child	1	2	
		Male sex with Male	1	2	
		Sex with CSWs	1	2	
		Kiss/ Handshake	1	2	
		Sex with HIV infected people	1	2	
		Don't know	1	2	
201D	How can HIV infection be protected? (More than one answer possible)	Protected sexual relation	1	2	
		By using germfree Needles/ Syringes	1	2	
		By receiving germ free blood	1	2	
		By following religious norms	1	2	
		Creating mass awareness	1	2	
		Taking the advice of doctors in terms of having child	1	2	
		Others	1	2	
		Don't know	1	2	
202	Have you ever heard about AIDS?	Yes----------1 No----------2 →			301

202A	What is the source of your information about AIDS?	Source	Yes	No	
		TV	1	2	

	(More than one answer Possible)	Radio	1	2	
		Newspaper	1	2	
		Poster/ Billboard	1	2	
		Seminar/ Workshop	1	2	
		DIC	1	2	
		NGOs Worker	1	2	
		Cinema/ Drama	1	2	
		Don't know	1	2	
		Others	1	2	
202B	What is AIDS?	A Disease----------1 A Virus ----------2 A Myth ----------3 A Curse from God----------4 Final stage of HIV infection-----5 Don't know----------6 → 301 Others (pleas specify) ----------7			
202C	What are the signs and symptoms of people living with HIV/ AIDS? (More than one answer possible)	Rapid weight loss	1	2	
		Dry cough of more than 2/3 months	1	2	
		Recurring fever for more than 2/3 months	1	2	
		Profound and unexplained fatigue	1	2	
		Swollen lymph glands in the armpits, groin, or neck	1	2	
		Diarrhea lasting more than a week	1	2	
		White spots or unusual blemishes on the tongue, in the mouth, or in the throat	1	2	
		Memory loss, depression and other neurological disorders	1	2	
		Don't know	1	2	
		Others	1	2	
203	Do you know any HIV/ AIDS infected people?	Yes----------1 No----------2			
204	If you know any HIV/ AIDS infected people, will you keep it secret?	Yes----------1 No----------2			

205	After I read each statement, please tell me whether you don't agree with it, you disagree with it or you don't know about it.			
	Statement	Yes	No	Don't know
205A	AIDS is a myth	1	2	3
205B	Teachers who have AIDS or are infected with HIV should not be allowed to teach in schools	1	2	3
205C	Students who have AIDS or are infected with HIV should not be allowed to study in schools	1	2	3
205D	People with AIDs should be isolated from healthy people to avoid spreading the disease.	1	2	3
205E	There is no cure for AIDS	1	2	3
205F	Most people with HIV/ AIDS could have avoided it	1	2	3
205G	HIV transmits through sneezing, coughing, kissing, hugging, mosquito bites, insects bites.	1	2	3
205H	HIV can be passed only from women to men.	1	2	3

205I	HIV can be passed through one single unsafe sexual contact.	1	2	3
205J	Only men who have sex with men are at most risk of contracting HIV.	1	2	3
205K	You can tell if a person has AIDS by looking at him/her	1	2	3
205L	HIV/AIDS is a serious threat to Bangladesh	1	2	3
205M	AIDS is a curse from GOD.	1	2	3
205N	Herbal remedies and religious healing are successful in killing HIV	1	2	3
205O	AIDS is an alien illness	1	2	3
205P	AIDs is an illness of those who commit adultery.	1	2	3
205|Q	A person can get HIV by sharing a meal with someone who is infected?	1	2	3
206	Do you think that you are in risk of contracting HIV?	Yes ----------1 No----------2 → 207 Don't know/ Not sure---------3		
206A	If yes, do you think your own chances of getting HIV are small, moderate, high?	Small----------1 Moderate----------2 High----------3 Don't know----------99		
207	If yes or no/ don't know in to Q 206, why do you think so, justly (Record all response)	**IF YES** Multiple sex partners----------1 Not using condoms----------2 Intercourse with sex-worker------3 Homo-sexuality or sex with transgender----------4 Using needles and syringe of others----------5 Blood transfusion without testing blood----------6 Other (specify)----------77 **IF NO** Avoiding sex----------1 Using condoms----------2 One sex partner only/ Faithful sex partner----------3 Avoiding sex with sex-worker---4 No homo-sexuality or sex with transgender----------5 Not using needles and syringes of others----------6 Never having sex----------7 No blood transfusion without testing blood----------8 Other (specify)----------77		

SECTION- C : SEXUAL/ DRUG BEHAVIOR AND RISK PRACTICES

No.	Question	Coding Categories	Skip
301	Do you consume any kind of drug?	Yes----------1 No----------2	 303
301A	If yes, what kind of drugs?	Phensidyl----------1 Heroin----------2 Alchohol----------3 Ganja----------4 Yaba----------5 Tablet----------6 Injection----------7 Others----------8	
302	From where, Do you get the Drugs?	From others IDUs----------1 Buy from Market----------2 Friends----------3 DIC----------4 Others (please specify)-------5	
303	Do you ever use a needle/ syringe to inject any illegal drug into your body?	Yes----------1 No----------2 Refused to answer----------3 Don't know----------99	 → 306
304	How often do you used drug in a week?	Daily----------1 3-5 days in a week----------2 Once a week----------3	
305	Did you ever share the needle/ syringe with others?	Yes----------1 No----------2 Refused to answer----------3 Don't know----------4	
306	Did you ever taken any blood?	Yes ----------1 No----------2	 → 308
307	Was the blood tested for HIV?	Yes----------1 No----------2 Don't know----------3	
308	Have you ever been tested to see if you have HIV?	Yes ----------1 No----------2	
309	Would you want to be tested for HIV/ AIDS?	Yes----------1 No----------2 Don't know----------3	
310	Have you donate/sell blood to any other person?	Yes ----------1 No----------2	
311	Have you ever had sex with anyone?	Yes ----------1 No----------2	 → 401
311A	If yes, with whom did you do sex?	Hizra/ TG----------1 SWs----------2 MSM----------3 Others----------4	
311B	Did you use condom while you were performing sexual intercourse?	Yes----------1 No----------2 Don't know----------3	

SECTION- D : PREVENTION AND TREATMENT

No.	Question	Coding Categories	Skip
401	Is there any curative measure for HIV/ AIDS	Yes----------1 No----------2 Don't know----------3	
402	How much do you feel the risk to be affected by HIV/ AIDS	No risk----------1 Less risk----------2 Moderate----------3 High risk----------4 Don't know----------5	
403	Now do you have felt any kinds of illness?	Yes----------1 No----------2	
404	Do you have any of these symptoms of sexual disorder?	Discharge of fluids----------1 Pain when urinating----------2 Pain in valve----------3 Itchy/ rash on genital---------4 Pain at intercourse----------5 Pus/ Blood from anus---------6 Pain in lower abdomen--------7 Others (please specify)-------8 No----------9 →	501
404A	If yes, did you seek treatment?	Yes----------1 No----------2 →	501
404B	What type of treatment have you taken?	Traditional Medicine----------1 Govt. Hospitals Dr.----------2 Private clinics Dr.----------3 Medicine shop----------4 Peer worker----------5 Religious leader----------6 DIC Dr.----------7 NGOs provided facilities----8 Others (please specify)--------9	

SECTION- E : SERVICE PROVIDED BY DIC

No.	Question	Coding Categories	Skip
501	Do you know what kinds of service are provided by DIC?	Yes----------1 No----------2	
502	Do you get any type of treatment from the doctors?	Yes----------1 No----------2 → Don't know----------3	503
502A	If yes, does the doctor provide free treatment?	Yes----------1 No----------2 Don't know----------3	
502B	Does the doctor do routine checkup?	Yes----------1 No----------2 Don't know----------3	
503	Do you get free medicine from here?	Yes----------1 No----------2 → Don't know----------3	504
503A	Is the medicine provided by DIC sufficient?	Yes----------1 No----------2	
504	Do you get the required condom from DIC?	Yes----------1 No----------2	

		Don't know----------3	
505	Do you get lubricants DIC?	Yes----------1 No----------2 Don't know----------3	
506	Did they teach techniques of using condom?	Yes----------1 No----------2 Don't know----------3	
507	Do you get any kinds of treatment of STDs from here?	Yes----------1 No----------2 Don't know----------3	
508	Does DIC provide you any kind of counseling?	Yes----------1 No----------2 → 509 Don't know----------3	
508A	Are you satisfied with the counseling?	Yes----------1 No----------2	
509	Have you received any kind of training from DIC?	Yes----------1 No----------2 → 510 Don't know----------3	
509A	Did you understand the subject of training?	Yes----------1 No----------2	
509B	If yes, what kind of training?		
510	Does DIC provide the facility of free blood test?	Yes----------1 No----------2 Don't know----------3	
511	Does DIC send for blood test elsewhere? If yes, do they provide any convenience bill?	Yes----------1 No----------2 Don't know----------3	
512	In the last 12 months, did you receive any HIV/ STI preventive service from DIC?	Yes----------1 No----------2 Don't know----------3	
513	Do you get any food from here?	Yes----------1 No----------2 → 514 Don't know----------3	
513A	If yes, is the food provided by DIC sufficient?	Yes----------1 No----------2	
514	Do you get the opportunity to watch TV from here?	Yes----------1 No----------2 Don't know----------3	
515	Do you get the opportunity to sleep/ rest here?	Yes----------1 No----------2 Don't know----------3	
516	Do you get any Magazine/ Newspaper/ Advertisement?	Yes----------1 No----------2 Don't know----------3	
517	Last of all, What's your remark about the service of DIC?	Good----------1 Bad----------2 Moderate----------3	
518	Last of all, Do you want to say something about DIC service? Please say----		

Thank you for your participation

Annexure 4

Checklist for case study

1.0 Personal Identity:

1.0 Age
1.1 Sex
1.2 Religion
1.3 Attending school
1.4 Marital status
1.5 Income
1.6 Source of income
1.7 Religiosity
1.8 Exposure to mass media

2.0 Knowledge on HIV/AIDS:

2.1 Ever heard of HIV/AIDS
2.2 Sources of your knowledge
2.3 Knowledge about HIV infection/spread
2.4 Knowledge about signs and symptoms of people living with HIV/AIDS

3.0 HIV/AIDS related Risk practices:

3.1 Having safe sex
3.2 Use of condom
3.3 Use of condom properly
3.4 Having drugs/needle sharing
3.5 Other risk practices

4.0 Prevention and Treatment:

4.1 Feeling illness
4.2 Symptoms of sexual disorder
4.3 Any curative measure
4.4 Type of treatment

5.0 Facilities Provided by DIC:

5.1 Types of services provided by DIC for free

Annexure 5

Checklist for FGD

1.0 Personal Identity:

1.1 Age
1.2 Sex
1.3 Religion
1.4 Attending school
1.5 Marital status
1.6 Income
1.7 Source of income
1.8 Religiosity
1.9 Exposure to mass media

2.0 Knowledge on HIV/AIDS

2.1 Ever heard of HIV/AIDS
2.2 Sources of your knowledge
2.3 Knowledge about HIV infection/spread
2.4 Knowledge about signs and symptoms of people living with HIV/AIDS

3.0 HIV/AIDS related Risk practices:

3.1 Having safe sex
3.2 Use of condom
3.3 Use of condom properly
3.4 Having drugs/needle sharing
3.5 Other risk practices

4.0 Prevention and Treatment:

4.1 Feeling illness
4.2 Symptoms of sexual disorder
4.3 Any curative measure
4.4 Type of treatment

5.0 Facilities Provided by DIC:

5.1 Types of services provided by DIC for free

Annexure – 6

Seminar Report

সমাজবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
ঢাকা–১০০০, বাংলাদেশ
ফোন : ৯৬৬১৯০০-৭৩/৬৫৭৫, ৬৫৭৬

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Fax : 880-2-9667222
E-mail : vcoffice@du.ac.bd

তারিখ..... ২০

Dated, the..... 20

২২/০৫/২০১৭

সেমিনার রিপোর্ট

৩ ফেব্রুয়ারী ২০১৪ এবং ১৫ মে ২০১৭ তারিখে অনুষ্ঠিত বিভাগীয় একাডেমিক কমিটিতে পি এইচ ডি গবেষক মোঃ মনজুর কর্তৃক রেজিষ্ট্রেশন নং-১৫৯-২০১৩/২০১৪ "HIV/AIDS Related Risk Practices among the Users of Selected Drop-in-Centers of Dhaka: A cultural Study" শিরোনামের উপর সেমিনার উপস্থাপিত হয়। বিভাগীয় একাডেমিক কমিটি কর্তৃক তা অনুমোদিত হয়।

এ বিষয়ে প্রয়োজনীয় ব্যবস্থা গ্রহণের জন্য বিভাগীয় একাডেমিক কমিটি কর্তৃক সুপারিশ করা হয়।

অধ্যাপক ড. নেহাল করিম
চেয়ারম্যান

অধ্যাপক ড. নেহাল করিম
চেয়ারম্যান
সমাজবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়

তত্ত্বাবধায়ক

অধ্যাপক
সমাজবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়

(ASM Amanullah)

Annexure – 7

Certificate of Supervisor

সমাজবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
ঢাকা–১০০০, বাংলাদেশ
ফোন : ৯৬৬১৯০০-৭৩/৬৫৭৫, ৬৫৭৬

DEPARTMENT OF SOCIOLOGY
University of Dhaka
Dhaka-1000, Bangladesh
Phone : 9661900-73/6575, 6576
Fax : 880-2-8615583
E-mail : duregstr@bangla.net

তারিখ ২৫/০৫/২০১৯

Dated, the.....20

তৃতীয় সেমিনার

মোঃ মনজুর, পিতা- মরহুম আমানউল্লাহ, সাং- ৬নং শরৎ চন্দ্র চক্রবর্তী রোড, মাহুতটুলী, ঢাকা- ১১০০। গত ১৫ মে ২০১৭ইং তারিখে অনুষ্ঠিত বিভাগীয় একাডেমিক কমিটিতে পি এইচ ডি গবেষক মোঃ মনজুর কর্তৃক রেজিষ্ট্রেশন নং- ১৫৯-২০১৩/২০১৪ "HIV/AIDS Related Risk Practices among the Users of Selected Drop in Centers of Dhaka: A Cultural Study" শিরোনামের উপর তৃতীয় সেমিনার উপস্থাপিত হয়। বিভাগীয় একাডেমিক কমিটি কর্তৃক তা অনুমোদিত হয়।

এ বিষয়ে প্রয়োজনীয় ব্যবস্থা গ্রহণের জন্য বিভাগীয় একাডেমিক কমিটি কর্তৃক সুপারিশ করা হয়।

আমি তাঁহার জীবনের সর্বাঙ্গীন উন্নতি ও মঙ্গল কামনা করছি।

ASM Amanullah

ড. এ.এস.এম আমানউল্লাহ
তত্ত্বাবধায়ক ও অধ্যাপক
সমাজবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়।

অধ্যাপক
সমাজবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়

Annexure – 8

Supervisor Concerning Letter about Data Collection from Bondhu Social Welfare Society (BSMS)

সমাজবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
ঢাকা-১০০০, বাংলাদেশ
ফোন : ৯৬৬১৯০০-৭৩/৬৫৭৫, ৬৫৭৬

তারিখ.....২০

DEPARTMENT OF SOCIOLOGY
University of Dhaka
Dhaka-1000, Bangladesh
Phone : 9661900-73/6575, 6576
Fax : 880-2-8615583
E-mail: duregstr@bangla.net

Dated, the.....20

03rd February, 2015

Mr. Shale Ahmad
Executive Director
Bondhu Social Welfare Society
Dhaka.

"To Whom It May Concern"

This is to certify that Md. Manzur, Lecturer and Head of the Department of Sociology, Siddheswari University College, Moghbazar Dhaka, Bangladesh, is currently working as a doctoral student under my supervision. His PhD research title is **'HIV/AIDS Related Risk Practices among the Users of Selected Drop in Centers of Dhaka: A Cultural Study".**

I have known Md. Manzur for last five years as he worked for me as a research assistant in several projects. He has excellent communication skills, extremely organized, reliable, sincere, have good knowledge on his research topic. In addition, he is extremely aware of maintaining confidentiality of the information collected and lastly respectful to the ethical issue regarding the topic.

For his research purpose he has to interview some **MSW & TG**. As your Organization is working with "High Risk Groups" such as **MSW & TG**, it would be highly appreciable if you help him to collect some information from your Drop in Centers. Md. Manzur can work independently and is able to follow and respect the organizational rules strictly.

In conclusion, it would be highly encouraging if you take necessary steps for helping him in all the possible way.

Yours Truly,

Prof. ASM . Amanullah, PhD
National Health Sociologist
Department of Sociology
University of Dhaka

If any questions,
Mr. Manzur-01757043039

Annexure – 9

Permission and Access for Data Collection form Selected DICs under BSWS

Bandhu Social Welfare Society
SUPPORTING SEXUAL HEALTH AND WELLBEING OF SEXUAL MINORITIES

Ref: BSWS/HIV/AIDS/2013/01

Date: 7 February, 2015

Md. Manzur
PhD Student
Department of Sociology
University of Dhaka, Dhaka.

Subject: Permission and access for data collection from selected DICs for a study on 'HIV/AIDS Related risk practices among the users of selected drop in centers of Dhaka : a cultural study'.

In response to your letter, recommended by Prof. ASM Amanullah, National Health Sociologist Department of Sociology University of Dhaka, dated February 03, 2015 Bandhu Social Welfare Society endorsed the data collection from the MSM and TG DICs at Dhaka city implemented by BSWS. In this connection, Program Officer, DIC Managers are requested to extend all kind of collaboration and support for data collection among the MSM and TG in the Drop in Centers.

Thanks

Shale Ahmed
Executive Director
Bondhu Social Welfare Society
99, Kakrial, Dhaka-1000, Bangladesh

CC:
PO, DIC Manager, HIV/AIDS Sector, BSWC
DIC Code No-3, 4, 5, and others, Dhaka, Bangladesh.

Head Office: 99 Kakrail, 2nd & 3rd Floor, Dhaka-1000, Bangladesh, Phone: 88 02 9339898, 9356868, 8356041, Fax: 88 02 9330148
E-mail: shale@bandhu-bd.org, Website: www.bandhu-bd.org

Annexure – 10

Permission and Access for Data Collection form Selected DICs under BSWS

Bandhu Social Welfare Society
SUPPORTING SEXUAL HEALTH AND WELLBEING OF SEXUAL MINORITIES

তারিখ: ৭ই ফেব্রুয়ারী, ২০১৫ ইং

প্রতি,
মোঃ মনজুর
পিএইচডি গবেষক
সমাজবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
ঢাকা।

বিষয় ঃ বন্ধু সোশ্যাল ওয়েলফেয়ার সোসাইটি (BSWS) পরিচালিত ঢাকায় অবস্থিত ডিআইসি সমূহে এইচআইভি/এইডস্ সম্পর্কে গবেষণাকর্মের তথ্য সংগ্রহে অনুমতি প্রদান প্রসঙ্গে।

জনাব,
গত ৩ই ফেব্রুয়ারী, ২০১৫ ইং তারিখে অধ্যাপক এএসএম আমানউল্লাহ পিএইচডি জাতীয় স্বাস্থ্য সমাজবিজ্ঞানী, সমাজ বিজ্ঞান বিভাগ, ঢাকা বিশ্ববিদ্যালয়, ঢাকা এর লেখা সম্মতি ও অনুরোধ পত্র বিবেচনা করে আপনাকে বন্ধু সোশ্যাল ওয়েলফেয়ার সোসাইটি (BSWS) পরিচালিত ঢাকা কেন্দ্রিক নির্বাচিত ডিআইসি সমূহে এইচআইভি/এইডস্ (HIV/AIDS) সম্পর্কে গবেষণার জন্য তথ্য সংগ্রহ করার নিমিত্তে সমুদয় কাজ করার অনুমতি প্রদান করা হল।

উল্লেখিত বিষয়ে আরো কোন সহযোগিতার প্রয়োজন হলে আমার সাথে সরাসরি অথবা এএসএম রহমত উল্লাহ ভূইঞার সাথে যোগাযোগ করার জন্য অনুরোধ করা হল।

ধন্যবাদান্তে

সালেহ আহমেদ
নির্বাহী পরিচালক
বন্ধু সোশ্যাল ওয়েলফেয়ার সোসাইটি
৯৯, কাকরাইল, ঢাকা-১০০০, বাংলাদেশ।

Head Office: 99 Kakrail, 2nd & 3rd Floor, Dhaka-1000, Bangladesh, Phone: 88 02 9339898, 9356868, 8356041, Fax: 88 02 9330148
E-mail: shale@bandhu-bd.org, Website: www.bandhu-bd.org

Annexure – 11

Picture of DIC Officer, Manager and respondent of BSWS

Md. Manzur with Mr. Rahmatullah, Global Fund Program Manager, GFATM Round 9 South Asia Regional Grant, Bondhu Social Welfare Society, Kakrail, Dhaka

Md. Manzur with Shymol Kumar Mondol, DIC Manager, Darus Salam

Md. Manzur Taking Information from Lalbag DIC-MSW

Before taking Information Shamim with Md. Manzur, Darus Salam DIC-TG

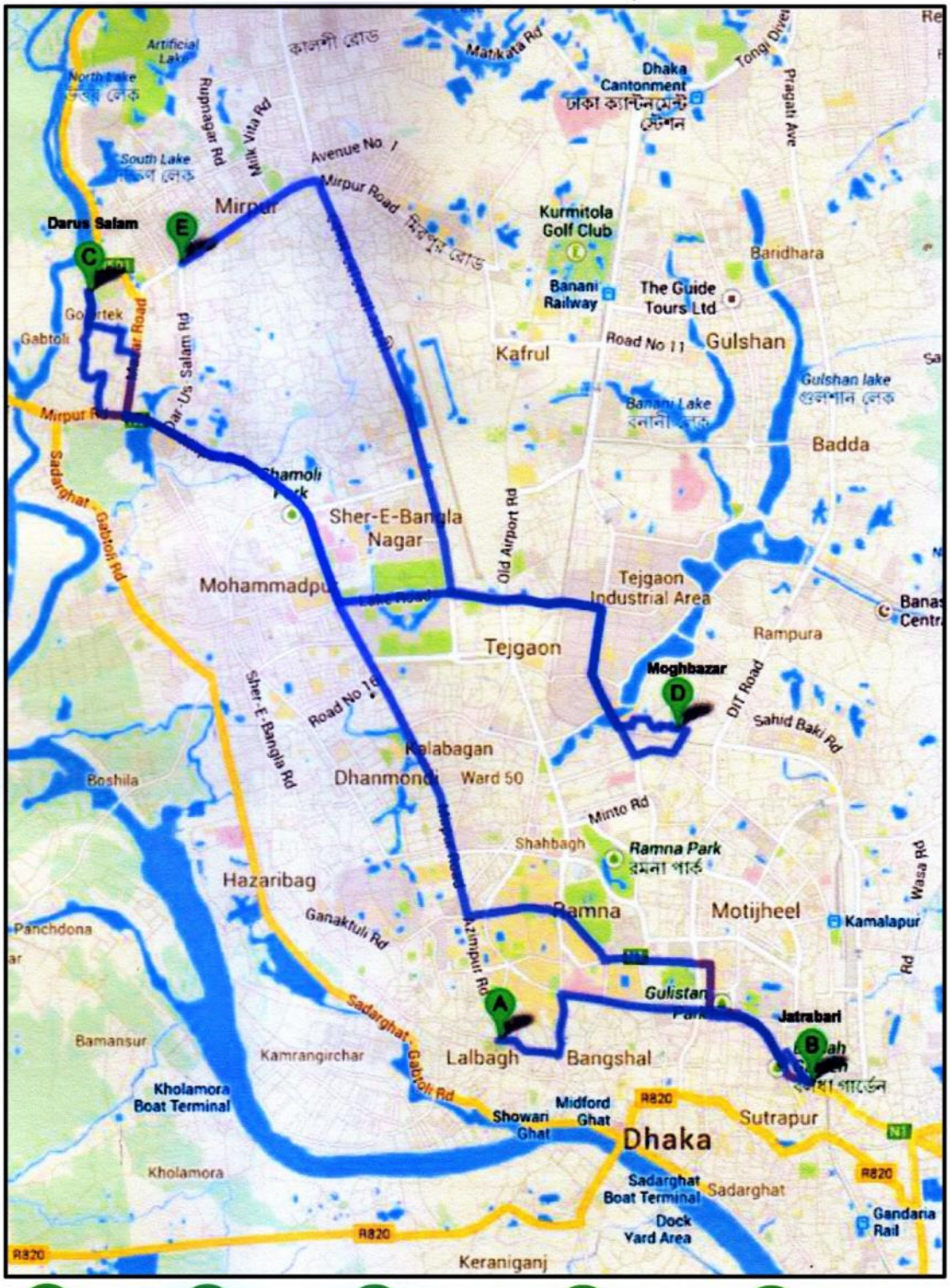
ANNEXURE – 12

Information of RCC DIC

Package # (# of DIC Established)	Division (# of DIC Established)	District (# of DIC Established)	Location (Modality, Population)	Modality	Address of the DIC	Name of the Focal person/DIC Incharge and Contact Number	Name and contact detail of second focal person	DIC ID		
								SR/SSR/ SP Code	DIC Code	DIC Operated by
			Uttara (365, MSM)	365	House: 2, 2nd Floor, Road-3/C, Secotr-9, Uttara, Dhaka-1230	Mr. Bhabendranath Mallik, DIC Manager, Mobile: 01716314473	Nurjahan yesmin, Counselor Mobile: 01721298040	03	02	
			Jatrabari (602, MSM)	602	M.P.C. Bhaban 91/1, Swamibagh, Dhaka-1100	AK Humayun Kabir, DIC Incharge, Mobile: 01711246065	Md. Mizanul Haque Mitu, Counselor, Mobile: 01724971118	01	03	BSWS
			Lalbagh (602, MSM)	602	House- 01, Road-02, East Rasulpur, Bara Mosjid Dhal, Kamrangir Char, Nababgonj, Dhaka.	Md. Yeasin Munshi, DIC Manager, Mobile: 01729844040	Abul Quasem George, Counselor Mobile: 01712642759	01	04	
			Darus Salam (602, MSM)	602	23A/A, First Colony, Majar Road, Gabtoli, Dhaka.	Shyamol Kumar Mondol, DIC Manager, Mobile: 01672521993	Gazi Shafique Ahmed, Counselor Mobile: 01925160055	01	05	
			Moghbazar		177, Nayatola, 1st Floor, Boro Moghbazar (Near RAB-3), Dhaka	Md. Harunur Rashid (PO), DIC Manager Mobile: 01714101016				
			Mirpur		61/KHA, Road-03, (3rd Floor), Uttar Bishil(Back Side of Mirpur Mazar), Mirpur-1, Dhaka-1216.	Md. Harunur Rashid PO), DIC Deputed Mobile: 01771255668				

Annexure – 13

Bondhu Social Welfare Society
DIC Location (MSM/TG)



Annexure – 14

Supervisor Concerning Letter about data collection from Durjoy Nari Shongho (DNS)

সমাজবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
ঢাকা-১০০০, বাংলাদেশ
ফোন : ৯৬৬১৯০০-৭৩/৬৫৭৫, ৬৫৭৬

তারিখ.....২০

DEPARTMENT OF SOCIOLOGY
University of Dhaka
Dhaka-1000, Bangladesh
Phone : 9661900-73/6575, 6576
Fax : 880-2-8615583
E-mail: duregstr@bangla.net

Dated, the.....20

14th February, 2015

President
Durjoy Nari Shongho
122 PC Culture Housing Society, Road # 1, Block # Ka
Mohammadpur, Dhaka-1207
Bangladesh.

"To Whom It May Concern"

This is to certify that Md. Manzur, Lecturer and Head of the Department of Sociology, Siddheswari University College, Moghbazar Dhaka, Bangladesh, is currently working as a doctoral student under my supervision. His PhD research title is **'HIV/AIDS Related Risk Practices among the Users of Selected Drop in Centers of Dhaka: A Cultural Study".**

I have known Md. Manzur for last five years as he worked for me as a research assistant in several projects. He has excellent communication skills, extremely organized, reliable, sincere, have good knowledge on his research topic. In addition, he is extremely aware of maintaining confidentiality of the information collected and lastly respectful to the ethical issue regarding the topic.

For his research purpose he has to interview some **FSWs**. As your Organization is working with "High Risk Groups" such as **FSWs**, it would be highly appreciable if you help him to collect some information from your Drop in Centers. Md. Manzur can work independently and is able to follow and respect the organizational rules strictly.

In conclusion, it would be highly encouraging if you take necessary steps for helping him in all the possible way.

Yours Truly,

ASM Amanullah

Prof. ASM . Amanullah, PhD
National Health Sociologist
Department of Sociology
University of Dhaka

If any questions,
Mr. Manzur-01757043039

Annexure – 15

Letter of Permission and Access for Data Collection form selected DICs

দূর্জয় নারী সংঘ
Durjoy Nari Shangha
RCC Project-GFATM, Package-909
13-A/4-A Babar Road, Block-B, Mohammadpur,
Dhaka-1207, Phone : 88-02-9116292
E-mail : durjoy.hiv.program@gmail.com

Date: 17th February, 2015

To
Prof. ASM. Amanullah , PhD
National Health Sociologist
Department of Sociology
University of Dhaka

Subject: Permission and access for data collection from selected DICs

জনাব,
গত ১৪ই ফেব্রুয়ারী, ২০১৫ই তারিখে আপনার লেখা সম্মতি পত্রে মো: মনজুর সাহেবকে তার গবেষনার বিষয়ে ডিএনএস কনর্সোটিয়াম পরিচালিত ঢাকার ডিআইসি সমুহে HIV/AIDS সম্পর্কিত গবেষনার কাজে সহযোগিতার অনুরোধ কল্পে, তাকে ঢাকায় নির্বাচিত ডিআইসি সমুহে গবেষনার জন্য তথ্য সংগ্রহ করার সমুদ্বয় কাজ করার অনুমতি প্রদান করা হল।

উল্লেখিত বিষয়ে, আরো কোন সহযোগিতার প্রয়োজন হলে আমার সাথে সরাসরি অথবা ডিএনএস কনর্সোটিয়ামের, টিম লিডার কে,এম,নূরুল গনির সাথে যোগাযোগ করার জন্য অনুরোধ করা হইল।

ধন্যবাদ

রহিমা বেগম
প্রেসিডেন্ট দূর্জয় নারী সংঘ
এবং ফোকাল পারসন
দূর্জয় নারী সংঘ কনর্সোটিয়াম
ঢাকা।

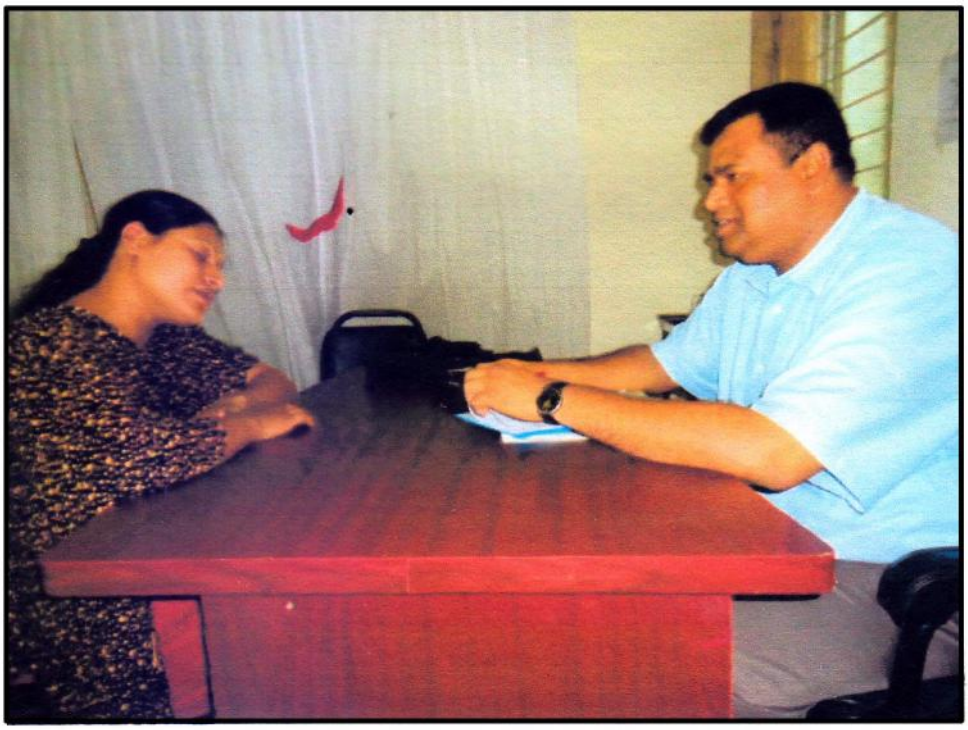
Annexure – 16

Pictures of Deputy Program Manager (NASP), President of DNS, Coordinator of DIC and Respondent of FSW

Md. Manzur with Dr. Anisur Rahman, Deputy Program Manager, National AIDS/STD Program (NASP), Directorate General of Health Services Ministry of Health & Family Welfare, Gulshan-1, Dhaka

Md.Manzur with Durjoy Nari Shangha (DNS) President Ms. Rahima Begum

Md. Manzur with Shanti Rani Nandi, Adabor FSW DIC Coordinator



Md. Manzur Taking Information from Mohammadpur DIC-FSW

Annexure – 17

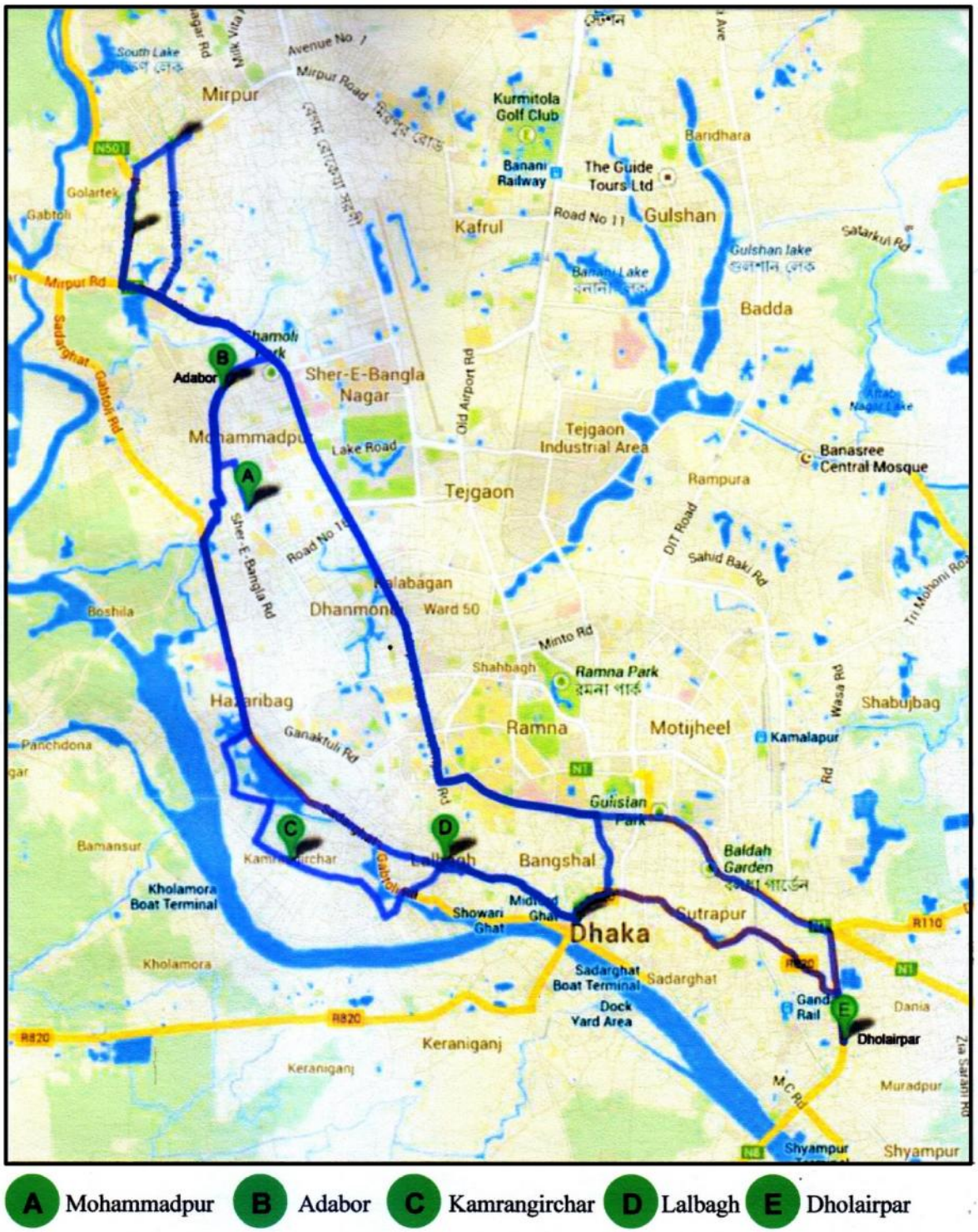
DIC Name and Address under Durjoy Nari Shangho

দূর্জয় নারী সংঘ
Durjoy Nari Shangha
RCC Project-GFATM, Package-909
13-A/4-A Babar Road, Block-B, Mohammadpur,
Dhaka-1207, Phone : 88-02-9116292
E-mail : durjoy.hiv.program@gmail.com

DIC Code	District Name	DIC Name & Address	Name of DIC Coordinator and Mobile #
18	Dhaka	Dolaipar DIC C/O, Md. Bellal Hossain 165, Muradpur Madrasha Road, Jurain, Dhaka.	Mr. Kazol 01760-591633
19		Lalbagh DIC C/O, S.K. Mahbub Hossain 38, B.C. Das Street (3rd Floor), Dhaka.	Biva Rani Saha 01911-251819 01745-109170
20		Kamrangirchar DIC C/O, Sharif Mofazzal, "Sharif Villa", 492, Rachulpur, Chamrangirchar, Dhaka.	Mr. Shaymol Halder 01718-045876
21		Keranijgonj DIC C/O, Mr. Nazrul Islam Nazu, Aganagor, Keranigonj, Dhaka.	Ms. Rozina Begum 01911-803700
46		Mohammadpur DIC C/O, Ireen Haque, N-7, Nurjahan Road, Mohammadpur, Dhaka.	Mr. Herok Chowdhury 01710-862737
47		Adabor DIC C/O, Md. Siddiqur Rahman 37, Jahangir Alam Lane, Sunibir Housing Society Ltd. Adabor, Mohammadpur-1207.	Shanti Rani Nandi 01712-969440

Annexure – 18

Durjoy Nari Shongo
DIC Location (FSWs)



Annexure – 19

Supervisor Concerning Letter for IDUs

সমাজবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
ঢাকা-১০০০, বাংলাদেশ
ফোন : ৯৬৬১৯০০-৭৩/৬৫৭৫, ৬৫৭৬

তারিখ.....২০

DEPARTMENT OF SOCIOLOGY
University of Dhaka
Dhaka-1000, Bangladesh
Phone : 9661900-73/6575, 6576
Fax : 880-2-8615583
E-mail: duregstr@bangla.net

Dated, the.....20

14th February, 2015

Program Manager
(Mr. Anup Kumar Basu)
Save The Children
House No. CWN (A) 35, Road No. 43
Gulshan-2, Dhaka-1212.

"To Whom It May Concern"

This is to certify that Md. Manzur, Lecturer and Head of the Department of Sociology, Siddheswari University College, Moghbazar Dhaka, Bangladesh, is currently working as a doctoral student under my supervision. His PhD research title is **'HIV/AIDS Related Risk Practices among the Users of Selected Drop in Centers of Dhaka: A Cultural Study".**

I have known Md. Manzur for last five years as he worked for me as a research assistant in several projects. He has excellent communication skills, extremely organized, reliable, sincere, have good knowledge on his research topic. In addition, he is extremely aware of maintaining confidentiality of the information collected and lastly respectful to the ethical issue regarding the topic.

For his research purpose he has to interview some **IDUs**. As your Organization is working with "High Risk Groups" such as **IDUs**, it would be highly appreciable if you help him to collect some information from your Drop in Centers. Md. Manzur can work independently and is able to follow and respect the organizational rules strictly.

In conclusion, it would be highly encouraging if you take necessary steps for helping him in all the possible way.

Yours Truly,

Prof. ASM. Amanullah, PhD
National Health Sociologist
Department of Sociology
University of Dhaka

If any questions,
Mr. Manzur-01757043039

Annexure – 20

Approval to Access data from IDUs Implemented by Care Consortium under Save the Children

Save the Children

Ref: BDCO/HIV/AIDS/2012/096

27 February, 2015

Md. Manzur
Head of Dept of Sociology
Siddheswari Degree College
Dhaka

Subject: Endorsement of data collection from the DICs for a study on 'HIV/AIDS RELATED RISK PRACTICES AMONG THE USERS OF SELECTED DROP IN CENTRES OF DHAKA: A CULTURAL STUDY'.

In response to your letter, dated February 14, 2015 Save the Children endorsed the data collection from the IDU DICs at Dhaka City implemented by CARE Consortium under the package GF 906. You are requested to maintain all ethical and confidentiality properly as IDUs are the marginalized and stigmatized population in the society.

Please note that Save the Children preserve all rights regarding access to data and to seek approval before publishing and or disseminating the report publicly.

In this connection, Team Leader of the 906 CARE IDU package is requested to extend all kind of collaboration and support for data collection among the IDUs in the Drop in Centers.

Thanks,

Dr. Lima Rahman
Program Director
HIV/AIDS Sector

CC:
Chief of Party, HIV/AIDS Sector, Save the Children
Sr. Project Manager. IDU, HIV/AIDS Sector, Save the Children
Team Leader, CARE Consortium, Package 906

Save the Children in Bangladesh
House CWN (A) 35 Road 43
Gulshan 2 Dhaka 1212
Bangladesh
www.savethechildren.net

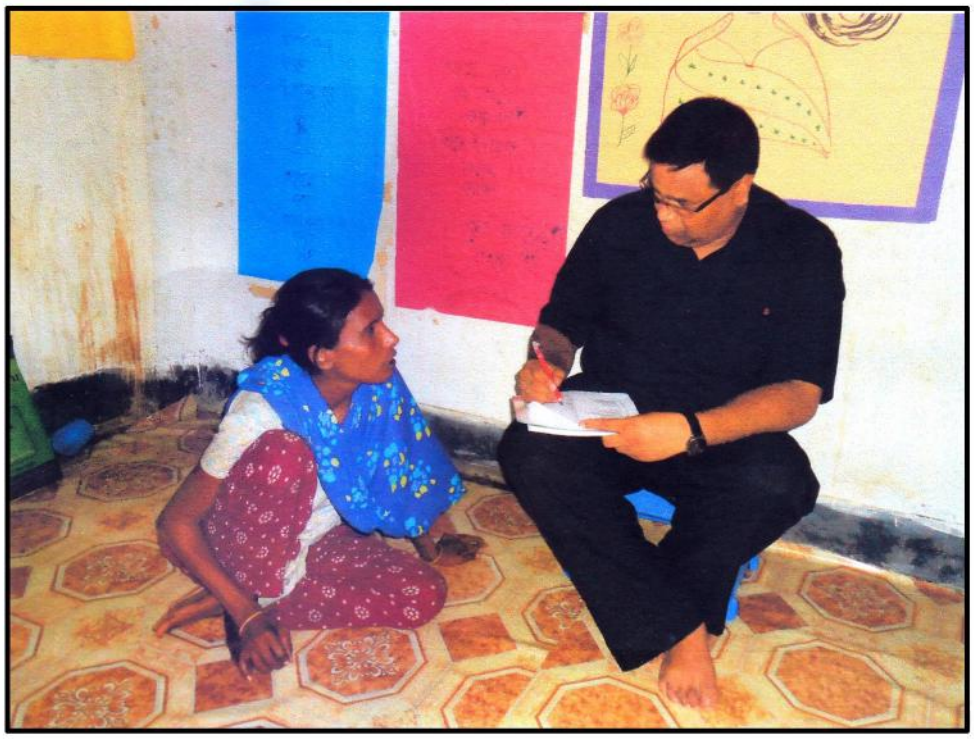
Save the Children International
St. Vincent House
30 Orange Street
London WC2H 7HH
United Kingdom

Annexure – 21

Pictures of Team Leader, Coordinator and IDUs Respondent

Md. Manzur With Dr. Rupali Sisir Banu, MBBS, MPH, Team Leader, GFATM-HIV Program Care Banglasdesh, Karwan Bazar, Dhaka

Md. Manzur with Shahna Akter Shimu, DIC Coordinator, Nayabazar, (Female) IDU

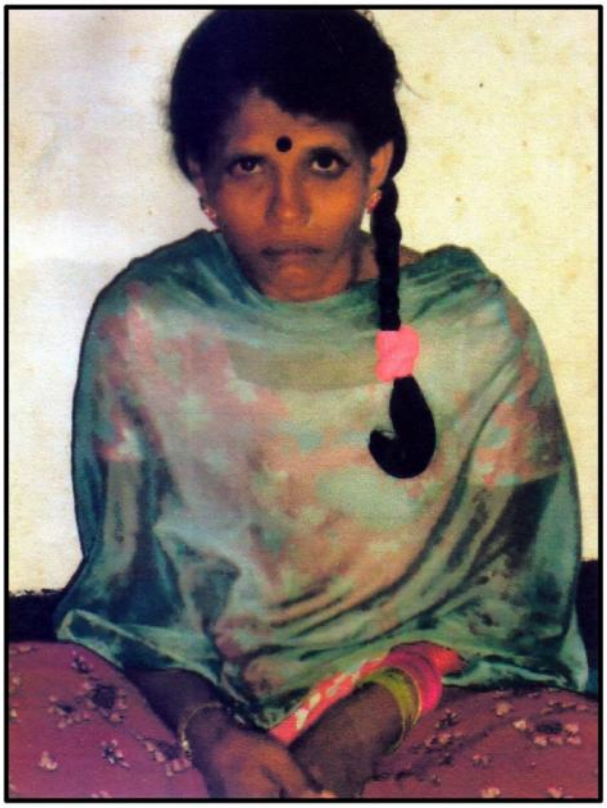


Md. Manzur taking Information from Nayabazar Female DIC-IDUs

Md. Manzur taking Information Sutrapur DIC-IDU

Annexure – 22

Picture of Female IDUs HIV+ve



HIV+ve-Nayabazar Female IDUs

HIV+ve-Nayabazar Female IDUs

Annexure – 23

List of DIC Address of IDUs under save the Children

Expanding HIV Prevention in Bangladesh (RCC)
Principal Recipient: Save the Children
Periodic Programmatic and Financial Report
Reporting Period: Period 11 (October 2012 to November 2012)
Implementing Organization (Sub-recipient): CARE Consortium
Package #:GF-IDU# 906

Division Name	District Name	DIC Number	DIC Address	DIC Coordinator Name & Contact #	No. of IDUs
1	2	4	5	6	7
Dhaka	Dhaka	Shongi-36	Sadarghat, Dhaka 8, Waizeghat Lane, Minar Plaza, Sadarghat, Dhaka.	Md. Anwar Hossain 01913-385181, 01711-016960	163
Dhaka	Dhaka	Shongi-36	Gulistan, Dhaka 130/1, Hai Osman Goni Road, Dhaka.	Md. Murad Ali 01928-457385	165
Dhaka	Dhaka	Shongi-37	Shahzadpur, Dhaka 1047, Khilbarir Tek, Shahjadpur, Gulshan, Dhaka-1212.	Runa Laila 01712-586388	159
Dhaka	Dhaka	Shongi-38	Islambag, Dhaka 43, Raj Narayan Road (1st Floor), Lalbagh, Dhaka.	Md. Sawar Uddin Shah Masud 01921-678996	188
Dhaka	Dhaka	Shongi-39	Chowdhuripara, Dhaka House# 258, West Rampura, Wapda Road, Dhaka.	Ruhul Amin Bhuiyan 01918-536881	309
Dhaka	Dhaka	Shongi-40	Modhubazar, Dhaka Road # 9/A, 156 West Dhanmondi, Dhaka.	Md. Tawaha Ruaim Haque 01712-544811	130
Dhaka	Dhaka	Shongi-41	SK Das, Dhaka House# 70/1, S.K. Das Road, Sutrapur, Dhaka.	Md. Anisur Rahman 01714-275298 Reza Hasan Sabbir 01675-433122	384
Dhaka	Dhaka	Shongi-42	Aganagar, Dhaka 18/1, Ground Floor, Islamabad, Immam Bari, Thana Road, Zinzira, Keranigonj, Dhaka.	Md. Masud Rana 01711-583756	292
Dhaka	Dhaka	Shongi-43	Kaligonj, Dhaka House-77, Road-3, Block-A, Kaligonj Bazar, Keranigonj, Dhaka.	Md. Faisal 01816-452060	286
Dhaka	Dhaka	Shongi-44	Mitford, Dhaka House- 2/A/1, Choto Katara, Chakbazar, Dhaka-1211.	Ms. Salma Yesmin 01914-486636	122
Dhaka	Dhaka	Shongi-45	Moulavibazar, Dhaka House-92/1, Nazimuddin Road, Dhaka.	Md. Sekandar Ali 01913-628874	284
Dhaka	Dhaka	Shongi-46	Bakshibazar, Dhaka 21, Nawabkatra Road, Khan Mansion, Bakshibazar, Dhaka.	Md. Abu Osman 01720-667516	131
Dhaka	Dhaka	Shongi-47	Hazaribag, Dhaka 42, Gonoktuly Lane, Hazaribagh, Dhaka.	Md. Farhad Ahmed 01914-574389	223
Dhaka	Dhaka	Shongi-48	Khilgaon, Dhaka Holding-108, Block-C, Khilgaon, Dhaka-1219	Md. Asaduzzaman 01710-487317 01918-066395	309

Additional Information of DICs_RCC P-12_GF#906_CARE

Division Name	District Name	DIC Number	DIC Address	DIC Coordinator Name & Contact #	No. of IDUs
1	2	4	5	6	7
Dhaka	Dhaka	Shongi-49	Jurain, Dhaka 722/1, Hazi Khorshed Ali Sarder Road, East Jurain, Dhaka.	Md. Habibullah 01915-349424	270
Dhaka	Dhaka	Shongi-50	Nayabazar-(Male), Dhaka, 41, KP Ghosh Street, Dhaka.	Mr. M.N. Huda 01716-202713 Md. Anwarul Islam 01734-511263	336
Dhaka	Dhaka	Shongi-51	Nayabazar-(Female), Dhaka, House- 24, Samsabad, Nayabazar, Dhaka.	Shahana Akter Shimu 01672-002040 01914-892434	75
Dhaka	Dhaka	Shongi-52	Citypolli-(Female), Dhaka, House- 6/4, North Dholpur, Jatrabari, Dhaka.	Ms. Jesmin Akhter 01743-831228	110

Annexure – 24

Care Consortium
DIC Location (IDUs)