

MALE MIGRANTS AS A HIGH-RISK GROUP: HARM REDUCTION AND HIV/AIDS IN BANGLADESH

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SINCE ITS EMERGENCE AS AN INDEPENDENT NATION IN 1971 Bangladesh has struggled to alleviate the overwhelming poverty and correlated misery that have plagued its people. Particular initiatives to improve the quality of life, such as fertility reduction through family planning and mortality reduction through better delivery of health care, particularly to women and children, have been highly successful. Programmes designed to reform the Bangladeshi economy have, however, been far more limited in their results, particularly with respect to providing employment for the country's large labour force (Shand and Alauddin, 1997:3). Reported figures on unemployment in Bangladesh are difficult to evaluate, ranging from a government estimate of 2.5% in 1995-96¹ (Bangladesh Bureau of Statistics, 1999:167) to 35.2% (Asia Source, 2001). Whatever the actual unemployment rate, the response to unemployment by large numbers of the labour force has been to seek better opportunities through both rural to urban internal migration and international migration (Chaudhury, 1978; Mahbub, 1985-86; Matin, 1986; Osmani, 1986; Hossain and Roopnarine, 1992). The current magnitude of labour migration is indicated by its economic importance; in 2003 remittances from overseas migrants were second only to the Bangladeshi garment industry as a source of foreign exchange (Dr. Anwarul Hoque, personal communication).

Although some women migrate, the overwhelming majority of migrants are male, many of them married men whose wives remain at home, a population known to be particularly likely to engage in

commercial sex (Caldwell, Anarfi & Caldwell, 1997). This paper deals with both the vulnerability of these migrants to HIV/AIDS while they are away from home and the vulnerability of their wives when they return, because cultural constraints prevent them from protecting themselves against sexually transmitted diseases their husbands may have contracted. I propose that both Bangladesh's peripheral position in a global economy and women's peripheral position within Bangladeshi society contribute to this problem, and I suggest that migrant men be considered a high risk population toward whom harm reduction policy initiatives be directed in attempts to work toward the problem's alleviation.

Bangladeshi Migration

Migration is not a new phenomenon in the area that now constitutes Bangladesh. During the 19th century, migrants, largely from the Sylhet area, moved to western nations, particularly to the United Kingdom. Migration destinations changed radically in the 1970s, however, when Great Britain enacted stricter immigration legislation and, at the same time, the oil-rich countries of the Middle East found themselves with a need for cheap and primarily low-skilled labour (Osmani, 1986:24-26). While Sylhet continues to send migrants, men from other areas of the former East Bengal have become more involved and Bangladeshi migrants have been recorded in "...South Korea, Japan, Taiwan, Hong Kong, Thailand, Malaysia, Singapore, Brunei...the U.K., Germany, Sweden, Italy...and in the U.S. and Canada," (Mahmood, 1995:700). However, the primary destination of Bangladeshi international labour migration is now the Middle East. Between 1980 and 1990 almost 297,000 Bangladeshis were recorded as entering the Gulf States as migrants; by the early 1990s, the figure had risen to almost 508,000 (Massey, Arango, Hugo, Kouaouci, Pellegrino & Taylor, 1998:139). Bangladeshi migrants in these countries are viewed not as future citizens, but primarily as temporary workers in low paying jobs that require little in the way of already formally acquired skills. Most Bangladeshi international migrants consequently contract for one or two years, with a much smaller number employed on three or four year contracts. The official number of Bangladeshis employed abroad in 1994 was a bit over 186,000; in 1998 it was almost

268,000, an increase over 4 years of about 44% (Bangladesh Bureau of Statistics, 1999:179). Official figures, however, "significantly understate total labour outflows" (Athukorala and Wickramasekara, 1996:555). Moreover, they do not include students, migrants who are not employed and migrants who are illegally resident in foreign countries.

While determining the actual number of Bangladeshi international migrants is extremely difficult, an accurate assessment of the number of people who have migrated internally is virtually impossible, since people move freely about the country. The most important type of internal migration involves movement from rural to urban areas and the contribution of migration to increases in urban populations can provide some rough guide to its magnitude. Dhaka, the national capital is a primary target area for rural migrants. Between 1961 and 1981 the city's population increased from 557,000 to 3,454,000 (United Nations, 1987:5). Migration was responsible for 62.8 per cent of that growth between 1961 and 1974 and for 70.5 per cent between 1974 and 1981. Approximately 60 per cent of the city's growth between 1981 and 2000 was expected to be the result of migration (United Nations, 1987:6). In the past the "most important contributor to increased urban population has been rural-urban migration" (Mahmood, 1995:710) and, although the rate of migration may slow because of alternative destinations, this will probably continue to be the case. In a 2003 study in a Dhaka squatter settlement virtually all adult men living there had migrated from rural areas because of their inability to support a family and the hope of finding employment in the capital (Johnson n.d.).

Because records are not kept on the return flow of either internal or international migrants, it is impossible to provide data on this important phenomenon. In many cases internal migrants return quite regularly as visitors to their home areas although they continue to live and work elsewhere. With respect to international migrants, the brevity of labour contracts suggests a considerable return flow and Osmani (1986:34) has calculated, for a three-year period, return flows ranging between 43 and 69 percent. Although

this is not a recent study, there is little reason to expect that these flows have decreased, given the increases in labour migration. I can provide some information on return flow from my own experience in Matlab, a rural area, where I conducted fieldwork for a year in 1998. Although my work had no direct connection with migration, one criterion for inclusion in my sample of married couples was that husband and wife be cohabiting. In the three largest villages of the six from which the research sample was drawn, there were 1751 married women who met the other criteria for inclusion. However, 38% of these women had non-resident husbands who had migrated, either internally or internationally, to pursue labour opportunities. Once the sample was selected from those couples who met all the criteria, including a resident husband, the situation became more complicated, but also more informative. Over the next six months, a number of women who had not been included in the sample asked to be included because their husbands had since returned. Conversely, many women who had been included in the sample had to be replaced because, between the drawing of the sample and the actual interview, their husbands had left. Women assured me that this was not an unusual situation, that they are accustomed to their husbands' movements. There was in fact a good deal of banter about the oddity of my having "migrated" to Bangladesh for my work while my husband stayed at home. Male migration has become widespread and expected, and, even more importantly, the status of "migrant" has become quite fluid.

Migration, Commercial Sex, and Sexually Transmitted Diseases

A number of researchers have established the link between migration and sexually transmitted diseases, including HIV/AIDS². Writing of the AIDS epidemic in Africa, Caldwell et al. (1997:51-52) note:

AIDS probably has a closer relationship to migration than any other infectious disease...for migration is a primary cause of behaviour which facilitates the transmission from one person to another.

They go on to make further links between migration, AIDS, commercial sex and its high risk factors:

Migrant men are more likely to seek new sexual partners and more likely to find them in commercial sex than when at home ... commercial sex is more dangerous because the women involved in it usually have a large number of partners and because some of these partners live particularly high-risk lives.

Other studies have indeed connected transmission of the human immunodeficiency virus to commercial sex (Carael, 1997; Herdt, 1997; Singhanetra-Renard, 1997), a common behaviour throughout the world for migrant men who are unaccompanied by their wives. It may be an even more common behaviour, however, in countries like Bangladesh and the Muslim countries of the Middle East, where families ideally seclude their female members and often the most easily available extramarital heterosexual partners are sex workers. In the Asia/Pacific region, according to Monitoring the AIDS Pandemic (MAP, 1999:16) :

...sex workers are particularly vulnerable to HIV...and represent the most significant core group for transmission to the rest of the population through their clients. The critical factors influencing the rate of spread from sex workers include the number of clients per day and the proportion of men in a society who regularly visit sex workers. In nations with high levels of both of these factors and where sex is not protected by condoms, HIV epidemics spread very rapidly.

Bangladeshi women are not unaware of the possibility that their husbands may indulge in extramarital sexual relations while away from home. However, when I spoke with migrants' wives about their husbands' absences and their sexual fidelity while away, there tended to be a difference in attitude depending on the age of the wife and the length of the marriage. Younger, more recently married women objected primarily to having no husband available to soften the move from a father's house to a husband's. These women complained that they were ill-treated by their husbands' parents, particularly by their mothers-in-law. A woman who had been married only six months when her husband left for Saudi Arabia asked "Why did I

leave my mother and father? To be a servant in my mother-in-law's house? In my father's house even a maid is treated better than I am here" (Farzana, aged 20, married 6 months). When I brought up the question of how men might behave sexually when they are away from home, most young wives claimed that while they had heard of the sexual escapades of some migrants, their husbands would be faithful to them, offering as reasons for this fidelity either Muslim proscriptions or the love their husbands had for them. Older women who had been married longer and were less likely to be under a mother-in-law's scrutiny spoke quite differently, some emphasizing that they enjoyed the freedom and responsibility they were experiencing, while others commented on the burden that single parenthood involved. But the greatest difference was in their attitudes toward extramarital sex on their husbands' part. There was a greater assumption among these women that their husbands would engage in sex while they were away from home.

You've lived long enough; you aren't a child. You know that sex is important. For men and for women, too. But women have less time to think about it. There are children to feed, work to do, always. And we are watched, always. But some men think about nothing else. If they are with their wives they have sex with their wives, but if their wives aren't there, well, someone else will do. That's the way men are. They can't help themselves when they want a woman" (Rehana, aged 42, married 26 years).

Significantly, none of these women, even those who assumed their husbands would engage in extramarital sexual relations, discussed the possibility of their husbands contracting an STD.

Data on commercial sex within Bangladesh are scanty, but in a study done in a brothel in Tangail, about 60 miles north of Dhaka, sex workers were found to have, on an average, three clients per day and only 3 per cent reported using condoms. Twenty per cent had an active STD while 60 per cent reported having had an STD (AIDSfocus Newsletter 1997:1). Family Health International (2003) reports greater condom use among female sex workers (31.2% to 34.5%), but also larger numbers of clients for some segments of the

sex worker population, 44 per week for hotel-based workers. Given the high risk behaviour of sex workers and the connection between commercial sex and migration it may be crucial to consider migrant males themselves a high risk population and to target specific prevention and treatment programmes directly toward them.

A relevant question about risks to migrant men is the prevalence of HIV/AIDS in Bangladesh and in the Middle Eastern countries to which many migrants travel. Within Bangladesh, data are again few and pertain to small samples. Officially, Bangladesh is listed as a country with low HIV prevalence and with projections over the next 3-5 years of a slow increase in prevalence. Family Health International (2003) cites 13,000 known cases of HIV/AIDS in 2001 and 650 deaths from the disease. This is almost inevitably an underestimate since diagnosis and reporting of the disease are affected by the serious social stigma it bears. It is worth noting that West Bengal, the contiguous Indian state and one with which there is considerable border crossing, has an adult HIV prevalence among high risk populations of over 5% (MAP, 1999, Annex 1:13). Moreover, projections for the future of India as a whole are dire: "with a population approaching one billion...3 million to 5 million of its people are infected, and the number of new infections will double every 14 months" (Satcher, 1999:1479). With the exception of the small area of the country that borders on Burma, one of the "most affected areas" of South Asia with respect to AIDS (Caldwell, Indrani, Barkat-e-Khuda, Caldwell & Caldwell, 2000:79), Bangladesh is literally surrounded by India. Figures from the World Health Organization (20002) on North Africa and the Middle East are, like Bangladesh's, low, citing a total of 550,000 persons living with AIDS. The same document, however, notes that "Less is known about HIV infection in North Africa or the Middle East than in other parts of the world."³ In both Bangladesh and the countries to which men predominantly migrate, it appears, on the basis of limited sampling and sometimes problematic figures, that there is not yet an HIV/AIDS epidemic. Consequently, in Bangladesh, aggressive action taken at this point may well be able to avert the effects of a predicted Asian pandemic. Indeed, a World Bank news release (No. 99/2268/SAS) speaks of Bangladesh's "unique opportunity...to act

early and decisively."⁴ This is clearly the time for Bangladesh to forcefully pursue a policy designed to reduce high-risk sexual behaviour and thereby minimize the potential for a devastating disease among its citizens. Returning male migrants present an important population focus for such policy.

Harm Reduction and High Risk Sexual Practices

Any policy approach to HIV/AIDS will, of necessity, be complex and multifaceted but a primary objective should be the reduction of high risk sexual behaviour among migrant males. A useful paradigm for the development of such policy is what has been termed "harm reduction," an approach that has been used in a number of countries, including Holland, the United Kingdom, Australia, Canada and the United States (Erickson, Riley, Cheung & O'Hare, 1997; Marlatt, 1998; Inciardi and Harrison, 2000) to reduce high-risk behaviours. Although the primary focus of harm reduction strategies has been addiction, it can also provide a model for dealing with other high risk behaviours (Shell-Duncan, 2001), including high risk sexual behaviours. An important assumption of harm reduction programmes is that although the elimination of high risk behaviour is an ideal, the reality is that most individuals will not practice abstinence. Consequently, harm reduction attempts to minimize the deleterious effects of ongoing high risk behaviour through education and the provision of safer alternatives. It is important to note that, contrary to some criticisms, harm reduction policies are not opposed to abstinence, nor do they advocate high risk behaviour. Their efficacy comes from the recognition that even if humans strive toward perfection they are fallible, and from their attempts to ameliorate the outcomes of such fallibility for both those engaging in high risk behaviour and the other people upon whom those behaviours have an effect.

[H]arm reduction is much more than a humane approach to those at highest risk and already suffering the consequences of their behaviours, it can apply to the whole population, stretching along a continuum of risk from high to low. The broadest way that harm reduction can be conceptualized is in relation to prevention in populations who are not yet afflicted by the problem in question. A great

number of individuals in a society fall into those low- and moderate-risk groups, making the potential benefit of harm reduction large (Marlatt, 1998:ix).

Marlatt's category of "populations who are not yet afflicted" would seem currently to fit most of Bangladesh and the potential for keeping those populations protected through harm reduction procedures is great. But the country is at a critical point that requires that such policies be supported, implemented and targeted to appropriate populations soon if they are to be effective in averting a potential cataclysm.

There are proven effective measures to limit the transmission of HIV/AIDS and successful programmes stress the importance of these preventive measures, focusing on education and behavioural change. With respect to education, research concerning knowledge of HIV/AIDS in Bangladesh provides some depressing data. Mitra et al.(1997:181) found that only 19% of ever-married women and 33% of currently married men had ever heard of AIDS, and that knowledge was greatly skewed toward the educated and the urban in a country where most people have low levels of education and are rural. Of those few who had heard of AIDS, 41% of the women and 27% of the men believed there is no way to avoid HIV infection, and of those who believed there is a way to avoid the disease, 69% of women and 51% of men had no idea of how that might be done. In a survey of girls and boys aged 15 to 19, approximately 95% of the girls and just under 90% of the boys did not know how to protect themselves against HIV (UNAIDS 2000:43). These studies suggest that HIV/AIDS education within Bangladesh will require a major commitment and will have to start early in life. While it may be discomfoting to some to consider the discussion of sexuality as part of the educational system, it is possible to conduct such programmes without offending sensibilities since they can be designed around questions of health, informing students of the possible fatal outcomes of unprotected sexual intercourse and can offer abstinence as a possible strategy. Once educational systems impart basic information about HIV/AIDS, those who choose not to pursue abstinence can obtain further information from more

general programmes designed to meet the needs of all individuals and to emphasize the special risks associated with migration and with commercial sex.. The harm reduction paradigm has shown that such programmes work best as local level programmes, conducted by local people, often those who have themselves been members of high risk groups. Returning migrants would seem to be an ideal group for recruitment of such educators; they have gone through the migration experience themselves and are able to speak with authority to future migrants. Such migrant educators would themselves need education designed to deal with the etiology, prevention and treatment of HIV/AIDS before they could, in turn, act as resources for local people. The costs of training such peer educators to work locally with people who know and trust them would be considerably less than initiating a top-down programme to address the problem, and miniscule when compared to the financial and social costs incurred by increases in HIV/AIDS.

Migrant men can provide information for local males, whether they intend to migrate or not, but they will probably not be able to discuss the subject with females because of the sexual separation that pervades much of Bangladeshi life. It is crucial that both males and females have access to information that can save their lives and the lives of their children. In terms of reaching women, Bangladesh has a great advantage in that the government has already established a system of female family health workers whose principal responsibilities include providing family planning information and these workers are a natural local level source of information about HIV/AIDS for those women who need information both about HIV/AIDS in general and about the increased risk that migration entails. At the same time, a more general public information programme needs to be mounted, using the same kinds of media coverage utilized in family planning campaigns. India has recently begun airing HIV/AIDS information on television, a medium that, along with radio, would be of particular importance in reaching a large illiterate population. Even in rural areas and in the slums of Dhaka, people have access to radio and television and often get important information through them. Some education programmes are being implemented in Bangladesh by both

government and non-governmental agencies, but they have not discussed migrants as a possible high risk or vulnerable population.

Beyond education, the means to engage in safe sex need to be available, since presumably some percentage of the population will continue to engage in potentially high risk sexual practices. Information about AIDS transmission without the ability to prevent that transmission will not deter the spread of the disease. Harm reduction programmes have offered deterrence measures in other areas of behaviour. In the case of intravenous drug use, for example, the provision of safer alternatives has included strategies such as medicalization of addictive drugs, substitution of less harmful substances (such as methadone), and needle exchanges. If migrant men choose not to forego commercial sex, safer alternatives to current practice will be needed. Since condoms have been proven as effective prophylaxis, they would seem to be an obvious choice for those who will not or cannot choose abstinence as a strategy⁵. In the words of a UNAIDS Report (2000:59-60), "All the scientific evidence points in the same direction: correct and consistent use of condoms of good quality vastly reduces the likelihood of HIV transmission." There has been no dearth of condoms in Bangladesh and social marketing has made them an affordable means of contraception. For those for whom the minimal costs are still too high, further subsidies could be provided. Again the costs of these subsidies are inconsequential when compared to the costs of epidemic AIDS. More importantly, the protection from STDs provided by condoms has not been emphasized in campaigns designed to foster their use, which have focused on their contraceptive effects. Responsibility for family planning has largely been delegated to women and men have been minimally involved, with the result that female contraceptives have been emphasized. It is understandable that family planning has focused on women, who have a greater interest in controlling fertility because the physical costs of pregnancy fall disproportionately on them. But it is possible to make men active participants in promoting condom use, both for family planning and prophylactic purposes. During my own research on family planning men continually told me that they

appreciated being included and consulted, since they felt that family planning had become exclusively a female domain. Because men do not bear the greatest physical burden of pregnancy does not mean that they are oblivious to or uncaring about the welfare of their wives, and presumably harm reduction programmes could benefit from their desire to be included in what might more inclusively be called "family health."

While high rates of marital condom use (at least 20%) have been reported for some countries (Knodel and Pramualratana 1996:101), there are also reports that suggest problems in promoting such use (ibid). The experience of Thailand is instructive since that country has been recognized as vigorously addressing its AIDS epidemic. According to Knodel and Pramualratana (1996), Thai men are willing to use condoms in commercial sex encounters because they recognize the dangers of contracting HIV/AIDS. In marital sexual relations, however, men are reluctant to use condoms because they are felt to decrease men's pleasure and to create questions as to spousal fidelity. While men are willing to forego some pleasure in non-marital sex for the sake of safety, only 2% of marital contraception involves condom use. Condoms in Thailand are seen as an effective prophylactic, but not as a desirable or particularly effective contraceptive, while in Bangladesh they are associated primarily with family planning and even in that arena-their use is low. It is important to remember that Bangladeshis are not Thais and that different initial environments, different approaches to the problem and different views of sexuality may well create different outcomes. In Thailand, for example, "both commercial sex patronage and noncommercial sexual contacts are common for married...men" (Knodel 1996:97). Although Bangladeshi men may engage in such behaviour (see Caldwell, 2001), it is not positively sanctioned and probably much less common when at home. The men most at risk for such behaviours are migrants when they are apart from their wives. Clearly, education and promotion of safe sexual practices for men before they migrate would be the ideal, and would protect both sex workers and these clients. However, if migrants have not had the benefit of such programmes, the best harm reduction strategy for such men and their wives may be one that emphasizes

the use of condoms upon return for a period during which men could undergo voluntary testing for STDs of all types. For couples who wish to limit family size this period would also have the advantage of providing protection while a couple decides on a contraceptive regime, the most popular of which, oral contraceptives and contraceptive injections, require previous planning.

Testing cannot, of course, stand alone and needs to be accompanied by adequate counseling for those found to be HIV positive. That counseling would presumably include providing methods for safe marital sex. Such a strategy would meet the needs of harm reduction for both partners. Suggesting voluntary testing and counseling in Bangladesh may seem unrealistic, given the costs of such programmes, but AIDS is a development issue as well as a public health issue and development funds would be well used to support such programmes. "Redirecting to AIDS existing project resources already programmed for social funds, education and health projects, infrastructure and rural development is fully justified, as the AIDS epidemic ...undermin[es] the very goals of these other investments" (UNAIDS 2000:114).

Personal Agency and Condom Use

There are two major potential objections to implementing a harm reduction policy that encourages condom use as an effective measure for the protection of migrants and their wives. The first is a practical objection based on the assumption that Bangladeshi men will not use condoms. Indeed, based on past usage, this is not an irrational argument. Condom use has increased in Bangladesh, but condoms have never constituted a large percentage of total contraceptive methods, rising from 0.7% in 1975 to only 3.9% in 1996-97 (Mitra et al.1997: 50).⁶ This argument is clearly based on the assumption that because Bangladeshi men have not used condoms, they will not use condoms. Perhaps the best counter to that argument is the history of family planning in Bangladesh. When family planning programmes began in the early 1950s in what was then East Pakistan, no one could have predicted their eventual success. It was assumed that, for a number of reasons, people would not use contraceptives to limit family size. Among those

reasons were high infant and childhood mortality; a cultural preference for large families and especially for sons; the economic dependence of the elderly, especially women, on their children and, again, especially on sons; and the labour value of children. Nonetheless, these programmes enjoyed enormous success and a reasonable question concerns what created that success.

Some important supply side factors helped. In the early 1970s the newly independent government of Bangladesh widened contraceptive options while simultaneously providing greater access through what has since been termed "doorstep delivery," in which contraceptives were delivered to women by health or family planning workers. But there have been important changes on the demand side as well. Infant and childhood mortality have declined dramatically. The number of infant deaths per 1,000 live births was 117 in 1979-83, 87 in 1989-93 (Mitra et al. 1995: 14) and 72.8 in 1998 (Development Data Group, 2001). A similar decline has taken place in under-five mortality, from 180 deaths per 1,000 live births in 1979-83 (Mitra et al. 1995:14) to 96 in 1998 (Development Data Group, 2001). People now expect that a greater percentage of their offspring will survive; they no longer have to produce "excess" children in the expectation that some will be lost. The decline in mortality is, of course, welcome, but there are other factors contributing to lower fertility that are not such boons to Bangladesh.

Between 1960 and 1985, landlessness increased dramatically, from a total of 1.5 to 7.75 million landless households, and the percentage of families considered functionally landless, i.e., with 0.5 acres or less, grew from 35 in 1960 to 50 in 1978 (Hossain, 1987:25). In 1998, 56% of all land holdings qualified as functionally landless (Bangladesh Bureau of Statistics, 1999:196). Increasing landlessness has resulted from a combination of population growth with partible inheritance, land loss through natural disaster, and land transfers that have sharply distinguished the landless poor from what have been termed "middle peasants" and large landholders (Hossain 1987:24). Because large landholders opt to specialize in land dealing, even they do not provide agricultural opportunities for the landless poor. Consequently, the

increase in landlessness has not been offset by increases in reliable agricultural employment, and landless farmers are forced into service or artisanal employment. At the same time, as income for rural farming declines it limits markets for such goods and services, and people thus employed are seriously underemployed (Hossain 1987: 22:24). Landless households cannot benefit from the labour of children on family farms, and the saturation of the agricultural labour market and the underemployment of non-agricultural workers in rural areas suggest that adults, not children, will benefit from the limited available employment opportunities.

Children's value as old-age support has also become more problematic. Duza and Nag (1993:73) discuss reasons why parents in focus groups now see sons as a less reliable source of support, citing conditions of economic deterioration in which adult children are seen as incapable of supporting themselves because of scarcity of land or employment, and therefore incapable of supporting parents, either because of their limited income or their need to migrate for employment. At the same time that children's survival became more certain and their economic value declined, means were made available for couples to limit their family size and people seized upon those means.

There are two points to be made here: conditions change, and people have agency, so that when conditions change, they are capable of adapting to new situations with new behaviour. This has certainly been the case with respect to willingness to use certain contraceptive technologies. As people become more aware of the dangers of STDs, particularly of the potentially fatal danger of HIV/AIDS, and of how that danger can be avoided, sexual practices can change as well. But motive, that demand element, will only follow education, and even the best motives will not be sufficient to effect the necessary change if programmes do not emphasize the supply element and advocate the use of condoms.

Structural Reform and Condom Use

The second potential objection is somewhat more complex and argues that a policy of harm reduction ignores the underlying

issues, advocating temporary and expedient measures instead of radical solutions to underlying structural problems. There are two such major and encompassing problems that need to be addressed: Bangladesh's peripheralization in a global economy and women's peripheralization in Bangladeshi society. I want to be clear here that I am using "peripheral" not as a synonym for unimportant, but rather in the sense associated with underdevelopment theorists, as simultaneously necessary for the continued operation of a system, and without power within the system. Bangladesh has been peripheralized for a long time and with devastating effects. When the country was still East Bengal, the British consciously demolished a prosperous native textile industry in order to eliminate competition with British textiles and to provide a market for them. In destroying an industrial base, the policy also effected the relocation of urban textile workers and their greater direct reliance on an agricultural base, increasing the demands on those resources. At the same time, East Bengal's agricultural production was also manipulated to meet British needs. When the Crimean war closed the Russian hemp trade to Britain, colonial policy encouraged production of jute and it became East Bengal's primary export. This cash crop became so important that land was removed from rice cultivation to meet the demand. But jute processing took place far from the local source. Factories were located in West Bengal as part of an overall process that assigned West Bengal, and especially Calcutta (now Kolkata), to the position of internal core to East Bengal's internal periphery, a process that was to have further repercussions after the 1947 partition left Muslim East Bengal seriously lacking in industrial facilities and knowledge (Baxter 1997). After partition assigned East and West Bengal to Pakistan and India, respectively, factories for jute processing were finally established in East Pakistan, but the capital for those factories came from West Pakistan, the richer, more politically powerful, and more technologically skilled province. Management also came from West Pakistan and there was, consequently, little advancement or training in management for East Pakistanis, further constraining opportunities for Bengalis in what was now their own country.

It is important to remember that Bangladesh is one of the most densely populated countries in the world with a population of over 133 million in approximately 133,000 square kilometers, an area roughly the size of the state of Minnesota, slightly larger than Greece and somewhat smaller than Nepal. Almost 64% of the country's labour force is in the agricultural sector and there is simply not sufficient land to support this concentration. Industrialization has increased in Bangladesh, but is still a minor element in terms of the number of people it employs. Independence has not changed Bangladesh's peripheral position in a global economy. What has changed is that, now, instead of exporting agricultural raw goods, Bangladesh is exporting people, a migrant labour force, and so long as that labour force cannot be fully and gainfully employed at home, migration will continue and probably increase. Given the chance for employment elsewhere, people leave and will continue to do so.

Just as Bangladesh and other developing countries are crucial to developed countries' prosperity, so are women in Bangladesh crucial to the continuation of patriarchy and the associated privilege of being male. Hierarchy is a crucial concept in social relations in Bangladeshi society. An individual's access to power and material resources is largely determined by three attributes: class, age, and gender. Although there is room for individual variation, generally, rich supercedes poor, age supercedes youth, and male supercedes female. Kinship is based on patrilineal principles and postmarital residence is virilocal, with the result that wives produce members for, but are not themselves members of, the localized patrilineal group into which they marry. Male children are preferred over female and one of a woman's most important roles within the family is producing sons. The birth of sons, indeed, improves a woman's position within the kin group and sons provide her one of the few avenues through which she may be able to pursue her own interests. Sons are valued as perpetuators of the lineage, as repositories of social prestige, as financial and political supports for their parents. Sons are especially important for women, since, in consolidating their position within the family, they provide their mothers some security against divorce. Sons are also expected to provide support for their mothers in the event of divorce or

widowhood, the devastating effects of which arise from the institution that most seriously affects women's lives, their seclusion under the rules of purdah.

Purdah ("veil" or "curtain") enjoins the seclusion of women and the prohibition of their interaction with unrelated males⁷. Girls begin to be subject to rules of seclusion shortly before puberty. Although the degree to which women can be secluded varies, particularly by the wealth of a family, the ideal is for women to be confined to the bari (a homestead that encompasses a number of patrilineally related households) or to interconnecting homesteads, if they are joined by paths that enable women to travel without being seen by men. The degree to which a family is able to maintain its women in seclusion is an indicator of its respectability; a woman's chastity is directly associated with her family's honour. Seclusion seriously curtails women's access to local knowledge, to formal education, and to economic opportunities beyond the household level. Purdah creates and reinforces women's dependence on men, especially their economic dependence. Indeed, the ideal of men's and women's roles within the family reflects this dependence: men are responsible for supporting and protecting their families and can expect to receive in return deference and obedience from family members. The division of the world into male public space and female private space, and the division of behaviour into male initiative and female passivity both affect women's autonomy in ways that may influence women's sexuality. Women's economic dependence, a result of purdah, denies them power over most of Bangladeshi life, but perhaps most poignantly, denies them power over their own bodies. It is difficult, if not impossible, under this system for women to define the conditions of sexual intercourse, to insist, for example, on the use of condoms.

Obviously, these internal and international inequities have to be addressed if Bangladesh's future is going to be better than its present, but the solutions that would create equity for Bangladesh in a world economy and for women in Bangladeshi society have not yet appeared and may be a long time in coming. While I alluded earlier to the importance of agency, it is important to note that that agency

was able to operate to change fertility patterns in Bangladesh only after the institutional commitment was made by the government and international funders to provide alternatives from which people could choose, a regime of natural fertility or one of reproductive control. Changing Bangladesh's position in the world economy and women's position within Bangladeshi society are not matters of isolated, individual choice and will not be effectively addressed until there is the possibility that individual choices can be effective as part of larger movements. The developed nations have a responsibility to recognize the importance of advocating and supporting reform on the policy level that will work to overcome the current conditions that drive Bangladeshi men to choose to leave and that require Bangladeshi women to relinquish control over the conditions of their own sexuality. But those reforms will require massive economic and cultural change, both of which move at a glacial pace when compared to the speed with which HIV/AIDS can devastate a population. Given the urgency of the predicted HIV/AIDS pandemic in Asia, the expedient nature of a forceful harm reduction policy among migrants should be considered as a virtue rather than a drawback.

Conclusion

Male labour migration continues to be an important demographic phenomenon in Bangladesh. When migrants are away from home without their spouses, the potential for commercial sexual encounters is high and these encounters are usually what can be termed high risk, because of the likelihood of unprotected sex and multiple partners, some of whom may engage in further high risk behaviours. I have suggested that male migrants, therefore, be considered a high risk group with respect to HIV/AIDS and that special efforts be made to reach these men and their wives through harm reduction programmes, emphasizing the use of condoms. I fully acknowledge that higher level, long-term reforms are crucial in changing two major structural problems, Bangladesh's peripheral

position in a global economy and women's peripheral position within Bangladesh society. I strongly advocate, however, more expedient measures designed to protect the Bangladeshi population from a potentially devastating epidemic and I urge that these measures begin as quickly as possible to take advantage of the country's current low rates of infection. Bangladesh has a unique opportunity at a critical moment and pursuing that opportunity may enable the country to save the lives of literally millions of Bangladeshi men, women and children.

HIV/AIDS IN BANGLADESH

Notes

1. The figures from the government of Bangladesh are undoubtedly an underestimate since they include as employed persons "working one or more hours for pay or profit or working without pay in a family farm or enterprise."
2. To describe HIV/AIDS as a sexually transmitted disease is, of course, to isolate and focus on one of several modes of transmission. However, preliminary data from Bangladesh (Caldwell et al., 2000:81) indicate that sexual transmission is, at this point, the most common mode of infection in that country.
3. The World Health Organization groups North Africa and the Middle East in the reporting of these statistics and it is not possible to separate the two regions. Some Bangladeshis do migrate to North Africa, particularly to Libya, but that migration is quite minor when compared to the Middle East. For this grouped region, the main modes of transmission are intravenous drug use and heterosexual intercourse; it is not possible to determine from WHO data which mode is more prominent in each area.
4. The government of Bangladesh, despite scarce resources, took a major step with the beginning of testing of high-risk groups in 1998.
5. In the latter category I would include sex workers who have no other means of earning a living. Prostitution, although legal in Bangladesh, with official registration, ostracizes women and makes their pursuing any other kind of remunerative work unlikely if not impossible.
6. Interestingly, husbands report a higher rate of use, 5.7%, than do their wives, 3.9%. The discrepancy may reflect "contraceptive use with non-marital partners, which is presumably higher among men than women" (Mitra et al.1997:56).
7. What follows is admittedly a generalized and somewhat monolithic description of purdah and there are certainly variations by region, age, class and religion. However, the ideal of purdah can always be invoked to evaluate women's behaviour; I have seen destitute women, breaking bricks to survive, admonished by men because they are "behaving immodestly" in working openly on the streets of Dhaka.

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