Population Movements and the Threat of HIV/AIDS Virus at the Bangladesh-India Border

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Mohammad Jalal Uddin Sikder

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Mohammad Jalal Uddin Sikder

Research assistants
Zohra Akhter, Makfie Farah, Kaniz Fatema, S. M. Al-Amin

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ADB	Asian Development Bank
BBS	Bangladesh Statistic Bureau
BDR	Bangladesh Riffle
BDT	Bangladeshi Taka
BSF	Border Security Force of India
CARE	CARE Bangladesh
CIDA	Canadian International Development Agency
CHE	Commission for Human Security
CBO	Community-based organization
DGHS	Directorate General Health Services
DFID	UK Department for International Development
DB	Detective branch
FSW	Female sex worker
FGD	Focus group discussion
FHI	Family Health International
GoB	Government of Bangladesh
GOI	Government of India
HIV	Human Immune Virus
NTP	National TB Control Programmes
CNG	Compressed natural gas
HASAB	HIV/AIDS and STD Alliance Bangladesh
HIV	Human Immunodeficiency Virus (HIV)
ICDDRB	International Centre for Diarrhoeal Diseases Research, Bangladesh
IOM	International Organisation for Migration
IEC	Information, education, and communication
IDU	Injecting drug users
INGO	International non-governmental organization
MSM	Men who have sex with men
NAC	National AIDs Committee
NACO	National AIDs Control Organisation
NACP	National AIDs Control Programme
NASP	National AIDs/STD Programme
NGO	Non-governmental organization

NIC	National Intelligence Council's
PRSP	Poverty Reduction Strategy Paper (PRSP)
PLHIV	People living with HIV/AIDs
MSW	Male sex workers
MOHFW	Ministry of Health and Family Welfare
STC	SAARC Tuberculosis and HIV/AIDs Centre
SAARC	South Asian Association for Regional Cooperation
STI	Sexual Transmission Infections
SARS	Severe Acute Respiratory Syndrome
SMC	Social Marketing Ltd.
SIDA	Swiss International Development Agency
TB	Tuberculosis
UNDP	United Nation Development Programme
UNFEM	United Nation Development Fund for Women
UNPF	United Nation Population Fund
UNAIDS	United Nations Programme on HIV/AIDS (UNAIDS)
USAID	United States Agency for International Development
UP	Union Parishad
UNO	Upazila Nibahi (Executive) Officer
WHO	World Health Organisation
VCT	Vocational Training

1

INTRODUCTION

Bangladesh shares its border with India and Myanmar. The total length of the land border is about 4,246 km, of which 93.9 per cent is shared with India and the rest—about six per cent—with Myanmar.[1] Out of 64 administrative districts of Bangladesh, 31 share international land borders with India and Myanmar (29 and 2 respectively). However, the Bangladesh-India border possesses many interesting features; in fact, 51 Bangladeshi enclaves are located in the Indian territory, covering an area of 7,110 acres. Similarly, India has 111 enclaves in the Bangladeshi territory, covering an area of 17,158 acres.[2]

Although the authorized transit points for transportation of goods and the movement of people are limited along the borders, people from both India and Bangladesh continue to cross the porous borders through many unofficial transit points with relative ease. The ethno-cultural similarity of the populations living on both sides of the border, the absence of physical obstruction and resource constraints for effective border regulation all assist such movements.

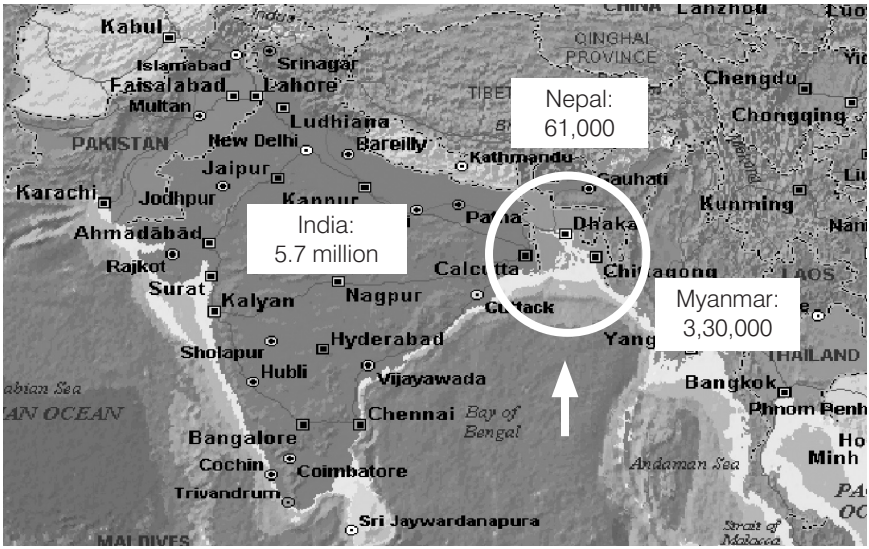
Both regular and irregular migration[3] takes place between India and Bangladesh. Although no reliable information is available on Bangladeshi migrants, it is well documented that both men and women migrate from Bangladesh to India (Sikder, 2005). Some migrate as families while others migrate independently. In 2003, the Intelligence Bureau of the Central Government of India, among other agencies, estimated that the number of Bangladeshis in India to be 16 million.[4] However, this data remains controversial as its collection was not based on any formal method or research. Due to the expansion of opportunities in the service sectors and trade, the short-term migration of professional and skilled Bangladeshis from India to Bangladesh have developed in recent years, along with

traditional migration through marriage and seasonal agricultural employment. According to newspaper reports and information received from the Bangladesh immigration department, Indians are often temporarily employed in a wide range of low-skilled and seasonal jobs. However, little research currently exists on this phenomenon. According to estimates from the Ministry of Foreign Affairs of Bangladesh, based on immigration clearance, the number of skilled and professional Indian workers hovers at around 0.1 million. Newspapers also report on seasonal migration from India to Bangladesh along their borders (Siddiqui, 2006: 1–3). Again, systematic work is not available to clarify the extent of such movements. A study conducted by Sikder (2005) shows that irregular cross-border population movement takes place from the Northeast state of Tripura, India, to the Comilla district of Bangladesh. Everyday, many Indians cross the border and engage in agricultural labour, as well as work in local hotels and the restaurant businesses, local barber and grocery shops. A decline in remuneration in agricultural labour was found to be one of the reasons for migration to Bangladesh. Interestingly, this decline in wages coincides with a decline in wage in Bangladesh due to the growing availability of cheap labour with the in-migration of Indians during the harvesting season. In the process, it encourages easy cross-border movement of people between these areas (ibid.: 443).

It is a matter of great concern that the neighbouring countries of Bangladesh, namely India, Myanmar and Nepal, are considered major sources of Human Immunodeficiency Virus (HIV). The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2006) estimated that about 5.7 million people in India have been reported to be HIV-positive in 2005, of which 5.2 million were adult aged 15 to 29 years (Map 1.1). Studies have found that injected drug abuse in India's northeast has led to HIV infection in over 80 per cent of drug abusers. Although a relatively small proportion of the Indian population is infected with HIV, a report from the Central Intelligence Agency (CIA) projects that the number of people infected with HIV in India will rise to 20 to 25 million by 2010.[5]

While HIV prevalence in Bangladesh is still very low—well below one per cent—recent data show that it is rising significantly, with the number of HIV-positive individuals increasing from 216 in 2006 to 333 in 2007 (GoB, 2007). UNAIDS (2006) estimated that approximately 11,000 Bangladeshis could have been living with HIV at the end of 2005. The recent National Serological and Behaviour Surveillance for HIV in Bangladesh (conducted in 2004–2005) showed that the prevalence of sexual transmission infections (STIs) is quite high among

MAP 1.1
HIV/AIDS cases in India and its neighbouring countries



vulnerable and bridging populations—those who move between high-risk individuals, such as female sex workers and those at low risk, such as wives and children. Interestingly, the survey revealed that the low rate of HIV infection in Bangladesh is not due to a decrease in risk behaviour. Indeed, it was shown that large numbers of men, including truckers, rickshaw pullers and other migrant labourers, continue to buy sex and that the number employing the services of sex workers is proportionally higher in Bangladesh than in any other country in Asia.

An International Centre for Diarrhoeal Disease Research Bangladesh (ICDDR B: 2004) study shows that there are more than 100,000 known sex workers in Bangladesh, most of them have not received AIDS (Acquired Immune Deficiency Syndrome) education and do not use condoms. Brothels near the border areas, where most of the customers are the people engaged in cross-border population movement, are at high risk. Another study conducted by Sikder and Khan (2006) noted that when informal traders cross the border, they visit the red-light district of the West Bengal in India and most of them do not use condom. As a result, they are likely to be infected with the HIV/AIDS virus.

Another CARE B (2006) study estimated that 180,000 truckers, and an equal number of truckers' assistants, convey goods by road. At the six land-port borders between India and Bangladesh (Annex 1), approximately 15,000 land-port workers unload goods arriving from India. Regional truck routes that link India, Nepal and Bangladesh have truckers from all these countries moving from high prevalence HIV/AIDS areas such as Manipur in India and Benapole in Bangladesh (ibid., 2006). It is important to note that this category of people certainly differs from other people in terms of their mode of migration, time spent abroad, living standards and social behaviour, for example. Their lifestyle, leisure, recreation and personal time is mostly unknown; especially how and to what extend they are at risk of HIV. However, road and sea transport workers act as a bridge population, transmitting HIV and sexually transmitted infections (STIs) to their wives and sex workers (ibid., 2006). Although much micro- and macro-level research has been carried out into the situation of HIV/AIDS in Bangladesh, currently, there is no synthetic work that provides a credible idea of the level of threats the HIV/AIDS virus poses along the border areas.

Rationale of the research

In the absence of adequate research on the subject, the present study will research and discuss the following issues.

- Why is HIV/AIDS considered a global health disaster?
- How are cross-border issues and HIV/AIDS related?
- Why are cross-border truck drivers, truck driver assistants and sex workers more vulnerable to HIV/AIDS?
- Why is HIV/AIDS a gender issue?

The Commission for Human Security (CHS) report (2003) describes that the global impact of HIV/AIDS is predicted to become the greatest health catastrophe in human history, exacting a death toll greater than the two world wars in the twentieth century, the influenza epidemic of 1918 or the Black Death of the fourteenth century. The impact of HIV/AIDS is being superimposed on other crises', such as the ongoing drought and famine in Southern Africa. HIV/AIDS has spread to every continent and kills productive adults, impoverishes families, creates orphans, destroys communities and weakens fragile governments. In some heavily infected countries, HIV/AIDS is depleting skilled

workers—teachers, nurses, police officers, civil servants—with some countries losing as much as 40 per cent of healthy people. The U.S. National Intelligence Council recently released projections for the "next wave" of the HIV/AIDS epidemic in China, Ethiopia, India, Nigeria and Russia (ibid., 2003: 98–99). Under these circumstances, HIV/AIDS is a health security concern that requires more inclusive participation from a wider range of actors and necessitates various policy interventions.

Different studies show that HIV/AIDS and its cross-border transmission is a growing problem. Migrants and mobile populations often work and live in environments that can be seen to be breeding grounds for unsafe sexual practices, including engaging in commercial or transactional sex, alcoholism and sexual violence (PHAMSA, 2007: 4). In another study (Dreser et al., 2002) in ports, cities and border areas of Central America and the south of Mexico, a high percentage of sex workers are mobile. Working temporarily and looking for the best economic opportunities, they create circuits of local, regional and international mobility, depending on the characteristics of demand in different times of the year, for example associated with harvests and festivals, in specific communities. This study analyses the conditions and consequences of the mobility of sex workers in Central America—Belize, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica and Panama—and at the frontier with Mexico to find explanations for their social and HIV/AIDS vulnerability.

Kulis et al. (2004) conducted surveys at four border crossings in Poland and at a workstation in Vilnius in Lithuania. In the course of the surveys, 901 truck drivers were sequentially selected at the waiting lines and the interviews were conducted by trained interviewers. The Poland survey supported the strong link between long absences from home and high-risk behaviour. Virtually all the truckers questioned travelled abroad regularly; 72.8 per cent travelled at least two or three times a month and 80 per cent reported spending four months or more per year away from home. Over 95 per cent reported spending their nights at parking places while on the road. Of the 42.3 per cent of drivers who admitted engaging in casual sex while travelling, 18.4 per cent stated that they never used condoms, while 15 per cent claimed to sometimes use condoms. Almost 62 per cent of all those surveyed reported that they never used condoms at home. A clear majority of the respondents—72 per cent—did not feel that they were in any danger of contracting HIV/AIDS. Only 16 per cent of all respondents felt they were at risk, the remaining 12 per cent being uncertain (Agenda Magazine, 2007).[6]

Sexual relationships are significant factors in the sexual transmission of HIV/AIDS. Physiologically, women have a greater vulnerability to HIV as the soft tissue in the female reproductive tract tears easily during intercourse. Women are also more likely to have other untreated sexually transmitted infections, which may not have noticeable symptoms (International Alert, 2007: 2).[7] In many societies, a culture of silence surrounds sex, with women often ignorant about and passive in sexual interactions. Moreover, unmarried girls are often expected to remain virgins (ibid., 2007: 3). In places where it is believed that sex with a virgin "cleanses" or "cures" men of HIV/AIDS, young girls are at particular risk of rape and sexual coercion. A women's economic dependence on a man may result in her giving priority to his decision on matters of sexual relations. The threat of violence, actual physical violence and the fear of abandonment act as significant barriers for women who have to negotiates the use of condom, discuss fidelity with their partners or leave a risky relationship. Additionally, women's differential access to medical care, counselling and information means that they are less likely than men to receive an accurate diagnosis, care and treatment once they have contracted HIV/AIDS. The risk of men contracting HIV can increase as a result of cultural attitudes to masculinity, fatherhood and the stigma of homosexuality. There is also the practice of late age marriage in some societies, where men do not marry until they have built up economic resources. Meanwhile, they may have no legitimate access to sex with women and so may engage in sex with other, often younger, men, thereby increasing their vulnerability. Such situation can prevent them from seeking information or admitting their lack of knowledge about sex or protection (ibid., 2007: 4–6).

Considering the above issues, the rationale of the present study is as follows.

- In general, lifestyle patterns of people who are involved in cross-border movements are completely unknown, particularly how and to what extent they are at risk of transmitting sexually transmitted diseases including HIV.
- It is not known what types of high-risk behaviours cross-border migrants are involved in.
- It is not known at which point people who are living in border areas of Bangladesh and involved in cross-border movements become vulnerable to HIV infection.
- It is not yet clear what kinds of gaps exist in the contemporary knowledge structure about the threat of HIV in the border areas of Bangladesh.

- There is no clear strategic policy direction for increased coverage of prevention and awareness packages for people of the border areas who are extensively involved in cross-border movements.

Objectives of the present study

This research project endeavours to empirically explore the socio-economic status of the people living near the borders. Apart from ascertaining the precise conditions that compel these people to engage in cross-border migration and sexual activity, it also seeks to examine whether their involvement in such activities contributes to ensuring their survival in terms of an improvement in status. Finally, the research will examine the role of the state in the process of such dynamics.

The specific objectives of the present study are to do the following.

- Identify the general lifestyle patterns of people who are involved in cross-border movements and how and to what extent they are at risk of the transmitting sexually transmitted diseases including HIV
- Identify at what stage and at what point do people, who are living in the border areas of Bangladesh and who are involved in cross-border movements, become vulnerable to HIV infection
- Increase understanding among stakeholders as to what gaps exists in contemporary knowledge structures in addressing the threat of HIV in the border areas of Bangladesh

Research methodology

Since this study focuses on individuals, it adopts a primarily qualitative approach. However, attempts were made to quantify the data and reach conclusions based on all the key findings. The methodology applied in this study is described below in detail.

Since this study forms part of the research project on Non-Traditional Security (NTS) Research Fellowship Programme of the Consortium of Non-Traditional Security Studies in Asia (NTS-Asia),[8] it requires a theoretical uniformity. Therefore, this paper extends the notion of securitization in exploring and framing the concerns over the spread of HIV/AIDS.

Brainstorming meeting

Before developing the conceptual framework and beginning the fieldwork, a brainstorming meeting was organized by the Refugee and Migratory Movements Research Unit (RMMRU), University of Dhaka, on 15 July 2007. Concerned scholars and experts took part to offer the researchers guidance in relation to the research questions, timetable, report writing and field work.

Secondary data

In the first stage of the study, information was compiled from various secondary sources. Secondary materials included books, database, statistical updates, terminology, booklets and campaign manuals useful for the study were collected from UNAIDS, UNDP, UNFEM, World Bank, ADB, IOM, CARE Bangladesh, USAID, Save the Children, FHI, ICDDRB, Bangladesh Statistic Bureau (Government of Bangladesh), HASAB and Social Marketing Ltd. Some secondary materials were also collected from journals, daily newspapers and electronically available resources.

Primary data

Given the paucity of information, a methodology was designed that relied more heavily on the generation of primary data. The data was collected from many primary sources including individual surveys, interviews with the local political leaders, teachers, journalists, government officials, medical doctors, NGOs officials and stakeholders. The three *upazilas* of the three districts near the Bangladesh-India border were brought within the study,[9] concentrating on the Benapole land port of the Sharsha Upazila of Jessore district, the Hili land port of Hakimpur Upazila of Dinajpur district and the Bhurmari land port of Patgram Upazila of Lalmonirhat district.[10]

Methodology for collecting data

It was necessary to generate primary data to understand at what stage and to what extent cross-border truck drivers and helpers and female sex workers are at risk of transmitting sexual diseases, considering the country context, the nature of their jobs and their living environment. The study also inquired about the mode of migration and the awareness level of the interviewees about HIV/AIDS. For this purpose, the study relied on individual interviews, focus group discussions as well as observational techniques.

For the study, 193 individuals, who engaged in cross-border migration and sexual activity, were randomly selected. Of these, 100 were male truck drivers and helpers and 93 were female sex workers. Of 100 truck drives and helpers, 50 were Indian and 50 were Bangladeshi. Among the sex workers, all of them were Bangladeshis. Additionally, three focus group discussions (FGDs) were conducted among the Indian female sex workers within border areas of the Bangladeshi territory. A focus group discussion was also conducted among the transgender in the Hilli land port of the Dinajpur district.

Due to the lack of adequate secondary materials, the following methodologies were adopted for collecting the qualitative and quantitative data.

Firstly, the research issues for the study were developed in line with a previous study on a cross-border migration for informal border trade conducted by RMMRU (Sikder, 2005; Sikder and Khan, 2006). Secondly, after scanning the news reports from different daily newspapers, the bordering areas of Jessore, Dinajpur and Lalmonirhat districts were selected. Thirdly, a 10-page preliminary questionnaire was prepared before being tested in the field. Before finalizing the questionnaire, it was revised several times on the basis of their responses.

Field visits that were undertaken in July 2007 continued until December 2007. Data was collected from a total of 193 individuals selected for the purpose of the study. For each district, the number of respondents was 75 in Jessore, 105 in Lalmonirhat and 20 in Dinajpur. However, the questionnaire underwent some changes in accordance with a newly emerging context.

Although an attempt was made to explore the socio-economic situation of the individuals engaged in cross-border migration and sexual activity, simple individual interviews were not always adequate. Therefore, in order to develop a deeper understanding of the issues under study, a FGD approach was also adopted. A total of nine FGD were conducted in the three districts. Among the eight FGDs, three FGDs of each district were conducted on Indian female sex workers in the Bangladesh territory. Each group consisted of five to six members. This helped us to understand the vulnerability of Indian female sex workers to HIV/AIDS. Such discussion meetings ensured not only the participation of the individuals engaged in cross-border migration and sexual activity, but also dealt with those who were not involved, with the objective of drawing a comparison between the two groups' perspectives.

Three FGDs were also conducted among journalists at the Press Clubs of three districts. The local elites residing in the areas under study were also

interviewed, including local journalists, the Union Parishad Chairmen, Union Parishad members, local politicians, local solicitors, local doctors, local teachers, government officials, NGO officials and the police.

Several in-depth case studies were conducted in order to highlight specific issues. The techniques of direct and participatory observation were also employed by researchers in the field in order to help gather insights into relevant issues. However, the participatory observation method was also helpful in exploring some security-sensitive issues that the subjects of the study were not comfortable discussing during the interview.

The data collected from the interviews at different levels were analysed using SPSS software. Before analysing the data, the questionnaires were examined thoroughly.

The primary findings of the study were also presented at RMMRU's in-house seminar. RMMRU's researchers and members of the Young Researchers' Forum (YRF) also attended and their suggestions and comments are also included.

Limitations of the study

The present study has several limitations. First, the time available with which to conduct the fieldwork was relatively short. When the study was undertaken, the border areas of the three districts were caught up in the severe tensions that existed between Bangladesh and India. As a result, in a few cases, the interviews were shortened. Since the issue is particularly sensitive, many of the interviewees were reluctant to give information.

Second, the scope of the research is limited, as the study was undertaken covering only three bordering districts. It, therefore, does not claim to provide a general scenario of cross-border movements and the vulnerability of HIV/AIDS among truck drivers and helpers and sex workers because the nature and characteristics of each border area vary. It should also be mentioned here that Bangladesh shares a 151-kilometre long unfenced border with Myanmar. The district of Bandarban accounts for 102 km of this international border while the districts of Chittagong and Cox's Bazaar share the remaining 49 km. However, no micro-level research into the issue is available from these areas.

Third, due to time constraint, this study could not conduct fieldwork or interviews in the border areas of the Indian ports. There is a lack of information on the perception of HIV/AIDS along the Indian borders.

Fourth, the fieldwork was conducted during a period of stricter border control. According to immigration authorities in the Benapole land port of the Jessore district of Bangladesh, in November 2007, only 150 to 450 trucks per day were crossing the immigration post, while normally it was 650 to 900 per day. In the Bhurimari land port of Lalmonirhat district, 25 to 50 could cross the immigration post while previously it was 80 to 100 per day. After the state emergency, 80 to 100 trucks crossed the immigration post in the Hilli land port of the Dinajpur district while, previously, it was 250 to 300 per day. The impact of this situation was that other districts drivers and assistants were absent. Most of them were mainly from the nearest districts. As many drivers and assistants were absent, Bangladeshi sex workers from other districts were also not available. Therefore, there was a lack of variation.

Fifth, although there were many Indian truck drivers and helpers from different states of India, we interviewed those who could speak Bangla and so the study is restricted to Bangla respondents only.

Sixth, natural calamities like floods caused the field work to be postponed several times. It was seen that, due to flood, many sex workers at the border areas moved to other places. Therefore, we did not find them and failed to understand their livelihood disruption. However, many trucks also did not come to the border areas as roads were totally destroyed.

Notes

1. The Indian state of West Bengal shares 2,216.7 km; the state of Meghalaya, 443 km; the state of Mizoram, 318 km; the state of Assam, 262 km; the state of Tripura, 856 km and 151 km with Myanmar.
2. Enclaves are small and scattered pieces of landmass belonging to one country located in or surrounded by another.
3. Irregular migrants are defined as individuals who cross international boundaries illegally without any clearance and visa from the government of their country of origin or destination and returning to their country using the same method. Regular cross-border migrants are defined as individual who cross the international boundary for employment and other purposes with proper clearance and visa from the government of the home and host country and return to their country using the same method after work and other purposes.
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6. *Agenda Magazine* (2007), Challenging HIV/AIDS in transport, retrieved on 9 December 2007 from www.itfglobal.org/HIV-Aids/agenda1-wakeup.cfm.
7. International Alert, Meeting report: Panel discussion. inclusive of security, sustainable peace – Tools for action, retrieved on 15 July 2007 from www.international-alert.org/pdfs/TK17_HIV_AIDSAIDS.pdf.
8. NTS-Asia is network of research institutes and think tanks dealing with Non-Traditional Security (NTS) issues. Its secretariat is based in the Centre for NTS Studies at the S. Rajaratnam School of International Studies, Nanyang Technological University, Singapore. For more information, visit www.rsis-ntsasia.org.
9. For the convenience of administration, Bangladesh is divided into six administrative divisions. Each division is further sub-divided into 64 *zilas*. The *zila* is divided into a number of *upazilas*, each headed by a Upazila Nirbahi Officer. Currently, there are 496 *upazilas*, of which 36 are in metropolitan cities.
10. The land port, known as a border station, is the facility that provides controlled entry or departure for person and materials.

2

THEORETICAL FRAMEWORK

This section discusses the theoretical framework of this study on the risk of HIV/AIDS at the Bangladesh-India border. It claims that concerns over the spread of HIV/AIDS at the border regions constitute a security threat that demand urgency and sustained policy attention. Such a security threat is broadly captured from a perspective of human security or non-traditional security (NTS), which puts primacy on the people, instead of the state, as a unitary actor. For analytical rigor, this paper extends the notion of securitization by exploring and framing the concerns over the spread of HIV/AIDS.

Four major points supplement our discussion of the theoretical framework. First, the evolving notion of non-traditional security (NTS) sets the debate. Second, a global concern over the HIV/AIDS incidence is discussed to indicate the urgency of the policy problem. Third, the impact of HIV/AIDS is discussed from a livelihood perspective. Fourth and most importantly, the complex linkages between cross-border population movements and the spread of HIV/AIDS are discussed.

Understanding non-traditional security

Since the end of the cold war and the disintegration of the former Soviet Union, the study of international relations and its sub-field security studies have attempted to redefine and reconceptualize the notion of security. Such a reconceptualization became a necessity, as the traditional notion of state-centric military security appeared to be obsolete to some scholars and policymakers. In contrast, advocates of human security began to claim a paradigm shift in security studies—a disciplinary and policy shift from traditional to non-traditional security.

Proponents of the paradigm shift and NTS advocates claim that in many parts of the world, non-military challenges are perceived as being more threatening than the military power of some prospective enemy states. Thus, the NTS discourse[1] calls for a deepening and broadening of the field of security studies by including the economic, environmental, health and social problems.

It is interesting to note that non-traditionalists are often divided into two groups: the "wideners" and the "deepeners". The wideners argue that a predominantly military definition of security does not acknowledge that the greatest threats to state survival may not be military in nature, but environmental, social and economic. The deepeners, on the other hand, ask the question of whose security is being threatened and support the construction of a definition that allows the individual or system to be its focus, i.e. its referent object, rather than isolating the state (Terry, 1998: 1).

Many security issues which currently preoccupy policymakers and analysts, such as nationalism and ethnic conflict, the proliferation of weapons of mass destruction and regional political and military instability, are relatively consistent with the conventional national security concerns and practices. Non-traditional challenges, however, are now commanding increased attention.

Among the various policy issues framed by the NTS perspective as the most important are unchecked environmental degradation; the spread of infectious diseases, particularly HIV/AIDS and SARS; cross-border migration; translational organized crime, such as arms and drugs smuggling and human trafficking, and natural disasters.

Conceptualizing HIV/AIDS as a non-traditional security issue raises intriguing questions about security. The UN Security Council Resolution 1308 states: "HIV/AIDS is exacerbated by conditions of violence that increases the risks of exposure to the disease through large movements of people, widespread uncertainty over condition and reduced access to medical care. If unchecked, the HIV/AIDS may pose a risk to stability and security".[2] Individuals infected with HIV and their advocates have been labelled as threats to the state (Garret, 2005: 10).

States still consider the impact of HIV/AIDS to be of less concern than military threats so that the latter commands greater resources and attention. However, HIV/AIDS is increasingly being incorporated into the government security policy agendas. As a non-traditional security threat, the concern over HIV/AIDS is also receiving increasing attention from the scholarly community.

The Copenhagen School and securitization

The Copenhagen school of thought, championed by Barry Buzan and his associates, has popularized the notion of securitization. The Copenhagen school has argued that security can be understood as a result of speech acts through which perceived problems become a national security threat.[3] Analysts including Barry Buzan and Ole Wæver have employed this approach, arguing that security is a socially constructed concept and proposing to study the processes through which specific issues become illocutionary constructed as security issues (van Munster, 2005: 3). They argue

> Security is thus a self-referential practice, because it is in this practice that the issue becomes a security issue-not necessarily because a real existential threat exists but because the issue is presented as such threat ... The process of security is what in language theory is called a speech act. It is not interesting as a song referring to something more real: it is the utterance itself that is the act. By saying the words, something is done (Buzan et al., 1998: 24, 26).

The proponents of securitization argue that security is a speech act. The securitization process is initiated by the securitizing actors who "speak" security on behalf of particular referent object/objects. Securitization, thus, essentially offers a systematic framework for determining the existential threats to the survival of some kind of referent object that requires exceptional measures to protect the threatened referent object (Buzan et al., 1998: 21).

The Copenhagen school considers that there are no finite criteria regarding who can (or cannot) speak security. No actor conclusively holds the power of securitization. Nevertheless, in a hierarchical society, some actors occupy positions of power and are more likely to be accepted as voices of security. Typical examples of securitization actors include the political leaders, the bureaucrats, the governments, the media, the lobbyists and the various pressure groups. In theory, any securitization actor can potentially securitize any threat to any referent object. In reality, however, when such an actor presents something as threatening, the "securitizing move" will only be successful if the audience accepts that there is an existential threat to a shared value (Buzan et al., 1998: 6). While the government has the responsibility of speaking "security" on behalf of the state, Wæver (1995) argues that the government is usually also the orator of security for society. However, he admits that the relative success of societal

elites who speak "security" can only be determined in hindsight, as one considers whether the speaker had a significant amount of popular support among the society.

> Securitization can thus be seen as a more extreme version of politicization. It is the intersubjective establishment of an existential threat with a saliency sufficient to have substantial political effects. In theory, any public issue can be located on the spectrum ranging from non-politicized ... to securitized (meaning that the issue is presented as an existential threat requiring emergency measures, and justifying actions outside the normal bounds of political procedure). In principle, the placement of issues on this spectrum is open; depending on circumstances, any issue can end up on any part of the spectrum (Buzan, 1997: 14).

The securitization of HIV/AIDS

The following discussion attempts to show how concerns over the spread of HIV/AIDS are securitized by the speech acts of the various domestic and international actors, such as domestic policymakers, and international organizations.

Certain health issues have long been a source of international concern. By the end of the Second World War, the focus on risks from certain epidemic diseases crossing national borders was overtaken by a growing emphasis on the attainment of health by all people as a basic human right (Caballero-Anthony, 2006: 106). By extension, international health co-operation became a concern of international development efforts.

Over the past decade, infectious diseases such as HIV/AIDS, SARS and new drug-resistant strains of tuberculosis (TB) have drawn considerable policy attention. This has led to a growing interest among scholars in international relations and security studies to securitize infectious diseases to protect state and human security.

As a result, studies on the broad issue of public health and security are no longer confined to the scientific and medical community. However, given the rapid changes in the global environment and the complex interplay of risks associated with pandemics, it may well be that securitization of infectious diseases is no longer sufficient to generate a more effective approach when responding to these threats.

As other studies have also shown, the threats of emerging and re-emerging pandemics cut across related issues including poverty, natural disasters, migration and drug trafficking. In turn, these pandemics require the involvement of a wide range of actors. Hence, while securitizing infectious diseases can be a decisive approach to responding to such grave threats, it has to be complemented with other approaches to allow for a comprehensive and integrated method for addressing such complex problems (ibid.: 107).

The recurrent theme in the "securitization of HIV/AIDS" is that the pandemic is viewed as a threat to human security. Human security, often regarded a synonym for non-traditional security, primarily concerns threats to the survival of individuals, rather than to the state and society.

A major statement concerning human security appeared in the 1994 Human Development Report, an annual publication of the United Nations Development Programme (UNDP). The statement outlined a concept of human security as offering an innovative approach to addressing holistically the sources of insecurity affecting people worldwide. From a human security standpoint, the security of the individual is no longer defined exclusively within the realm of states and as a consequence of national security.

The origins of today's insecurities are diverse and can be found inter alia in social, economical, environmental and health factors. These insecurities are increasingly transcending state borders and having global repercussions. For humans to be secure, their lives must be free from pervasive threats, violent or otherwise, and their fundamental rights and safety must be protected.

The human security approach addresses non-traditional threats to people's security. This includes economic, food, health and environmental factors, as well as issues such as drugs, terrorism, organized crime, landmines and gender-based violence.

It does not offer only one definition of the content of human security, but aims instead to take a more diversified view of security interests. Human security is about recognizing the importance of the people's security needs side by side with those of states, minimizing risks, adopting preventive measures to reduce human vulnerabilities and taking remedial action when preventive measures fail (Bruderlein, 2001: 358). Human security concerns are, therefore, of interest to a wide range of actors, not only including states, but also international organizations, international non-governmental organizations (INGOs), domestic organizations and the individual.

The spread of HIV/AIDS across the world

According to UNAIDS and WHO, in 2006, there were 2.9 million deaths worldwide from AIDS and more than 39.5 million people were living with HIV, an increase of 2.6 million people from 2004 (Annex 2, 3 and 4). This figure includes the estimated 4.3 million adults and children who were newly infected with HIV in 2006, representing approximately 400,000 more new infections than in 2004 (Map 2).

The sub-Saharan Africa continues to bear the brunt of the global epidemic. Two thirds (63%) of all adults and children with HIV globally live in this region (sub-Saharan Africa), with its epicentre in southern Africa. One third (32%) of all people with HIV globally live in southern Africa and 34 per cent of all deaths due to AIDS in 2006 occur there.

Data on HIV/AIDS suggest that, in 2006, globally there were 2.9 million deaths from AIDS, with nearly three quarters of these deaths, or 2.1 million people, occurring in sub-Saharan Africa. Sub-Saharan Africa has, in total, an estimated 24.7 million adults and children infected with HIV, an increase of 1.1 million new infections from 2004.

In recent years, the rapid increase in HIV/AIDS prevalence is observed in three regions—East Asia, Eastern Europe and Central Asia—where the number of people living with HIV in 2006 was over one fifth (21%) higher than the figure in 2004.

In 2006, Eastern Europe and Central Asia had 270,000 adults and children newly infected with HIV, an increase in new infections of almost 70 per cent over the 160,000 people who acquired HIV in 2004. In South and South-East Asia, the number of new HIV infections rose by 15 per cent between 2004 and 2006, while in the Middle East and North Africa, the number of new infections increased by 12 per cent.

In Latin America, the Caribbean and North America, the number of people newly infected with HIV in 2006 remained approximately the same as in 2004. Table 2 illustrates that globally, and in every region, the number of adult women, defined as being 15 years or older, living with HIV is currently higher than at any time previously. The 17.7 million women living globally with HIV in 2006 represented an increase of over one million compared with 2004 (see Annex 4). In sub-Saharan Africa, for every 10 adult males living with HIV, there are approximately 14 adult females who are infected with the virus. Across all age groups, 59 per cent of the total population living with HIV in sub-Saharan Africa in 2006 were women. In the Caribbean, the Middle East, North Africa and Oceania, close to one in every two adults with HIV are female. Meanwhile,

in many countries of Asia, Eastern Europe and Latin America, the proportion of women living with HIV continues to grow.

UNAIDS and WHO (2006) also state that the centrality of high-risk behaviour, such as injecting drug use, unprotected paid sex and unprotected sex between men, is especially evident in the HIV epidemics of Asia, Eastern Europe and Latin America. In Eastern Europe and Central Asia, for example in 2005, two in three (67%) new HIV infections were due to the use of non-sterile drug-injecting equipment while sex workers and their clients accounted for approximately 12 per cent of new HIV infections.

Paid sex and injecting drug use accounted for a similar overall proportion of HIV infections in South and South-East Asia. Excluding India, almost one in two (49%) new HIV infections in 2005 were accounted for by sex workers and their clients, and more than one in five (22%) infections were among injecting drug users. A small but significant proportion of infections (5%) were in men who have sex with men. In Latin America, in contrast, one in four (26%) new HIV infections in 2005 were in men who have sex with men, while 19 per cent were injecting drug users. Although HIV prevalence in sex workers is relatively low in Latin America, they and their clients accounted for one in six (17%) HIV infections. Although HIV/AIDS extends into the general populations of countries in those regions, they remain highly concentrated around specific population groups.

The impact of HIV/AIDS from a livelihood perspective

The impact of HIV/AIDS from an NTS perspective can be discussed from two levels: the micro and the macro.

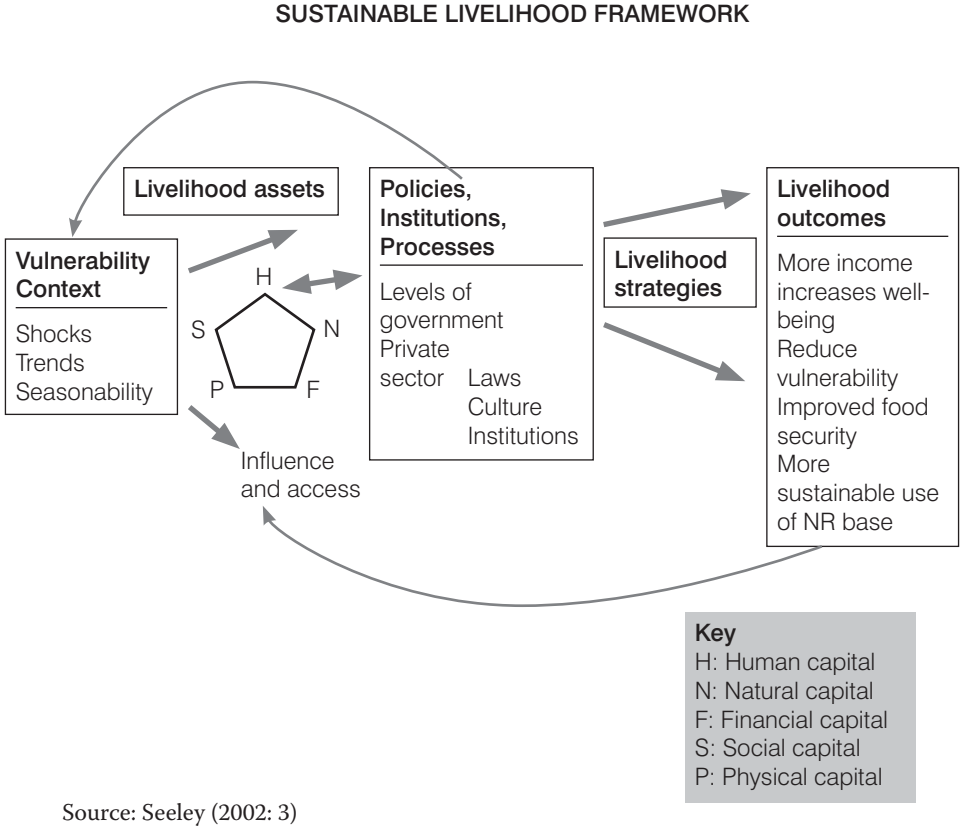
At the micro level, a livelihood framework can help us to understand the impact of the disease. The concept of livelihood has gained wide acceptance as a valuable means of understanding the factors that influence people's lives and well-being, particularly those of the poor in the developing world (Carney, 1998; Rennie and Singh; 1996). Chambers and Conway (1998: 4) define a sustainable rural livelihood as

> [a] livelihood that comprises the capabilities, assets (including both material and social resources) and activities required for a means of living. That a livelihood is sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities and assets both now and in the future, while not undermining the natural resource base.

Sustainable livelihood approaches place people at the centre of development and the life of the household, community or region. In the case of HIV/AIDS, this involves searching for strategies that do not focus solely on clinical conditions or medical solutions. According to Seeley (2002: 2),

> HIV/AIDS is not only a health issue that demands prevention and care for the sick; it is also a livelihoods issue, since, if AIDS-depleted households are not the target of particular support, the precarious livelihoods of survivors are likely to collapse under the impact of the epidemic.

FIGURE 2.1
Graphical presentation of the sustainable livelihood framework



Source: Seeley (2002: 3)

Utilizing a livelihood perspective, Seeley (2002: 3–5) describes how HIV/AIDS affects human, natural, financial, physical and social capital. Human capital includes health and well-being, and it is in that part of the assets pentagon that most emphasis has been put in thinking about the impact of the epidemic on livelihoods. For those with HIV/AIDS, good nutrition and access to affordable, effective healthcare is crucial. Studies have found that families and friends who are hard-pressed to pay for the care stop providing more than the bare minimum for someone who will "die anyway". Seeley (ibid.) also emphasizes the impact of HIV/AIDS on caregivers: anxiety about providing care; concern about paying bills; anxiety about the stigma of someone infected with HIV in the family; and concerns about coping with the death of a loved one. With the death of persons, knowledge of crops or medicines or of the history of the family and the community is lost; part of shared "capital" that enriches lives.

Natural capital is affected by the HIV/AIDS epidemic as land may not be tilled and certain crops may not be grown because of a lack of labour. Land may be sold to pay for medical fees, funeral costs or everyday household expenses. Forests may not be managed, with some areas being over-harvested because they are close to home for labour-starved households. Depleted water sources may be over-exploited as a household with a sick person who requires frequent washing will require more than their usual share of water.

Financial capital includes difficulties with accessing credit for people with HIV/AIDS and also their family members. Access to credit has never been easy for the poorest sections of the communities, especially for women. Those with HIV/AIDS can experience high interest rates to cushion the risk for the lender; thus, making loans prohibitive and undermining even modest agricultural or business development.

Physical capital is impacted upon by HIV/AIDS in a variety of ways. For example, the sick and the caregiver cannot repair a leaking roof or join in community efforts to clear clogged drains in the road. Infrastructure deteriorates if people have no time, energy or the necessary numbers to maintain it. Small tasks that are neglected become larger, requiring more labour intensive work, which, if left undone, can have profound implications for the maintenance of natural resources as well as infrastructure. Physical capital, like some forms of natural capital, can be convertible. For example, a house or a bicycle may be sold to pay bills relating to HIV/AIDS.

Social capital is affected by HIV/AIDS, as death and sickness erode social

networks. Friends and families are lost, making the maintenance of kinship groups more difficult. Cultural events are reduced, except for funerals. Some cultural and social events may change because of a perception of risk among some afraid that social activity may spread the HIV virus. In the absence of formal credit, the loss of family and friends may spell the end of access to informal, affordable credit as well as the loss of a trusted caregiver for a child or old person.

Within a livelihood framework, it is important to consider the impact of HIV/AIDS on food security at the household level. In Bangladesh, as in many other developing countries, agriculture is a key employer and food security is a major issue. At the household level, food security means the ability of all individuals to access an adequate supply of food in a stable and sustainable way. In developing countries, food security may depend upon subsistence agricultural production.

The ability of households to produce food depends upon a wide range of factors, depending on whether production is agricultural livestock, or horticulture, and other factors, such as access to available fertile land, the availability of labour and appropriate seeds and tools and climate conditions (Young, 2001 in Devereux and Maxwell, 2001: 239). Nevertheless, household food insecurity occurs in situations where people lose their entitlement command over food. Sen (1981) argues that entitlement failure can be the result of a direct loss of access to production-based entitlement.

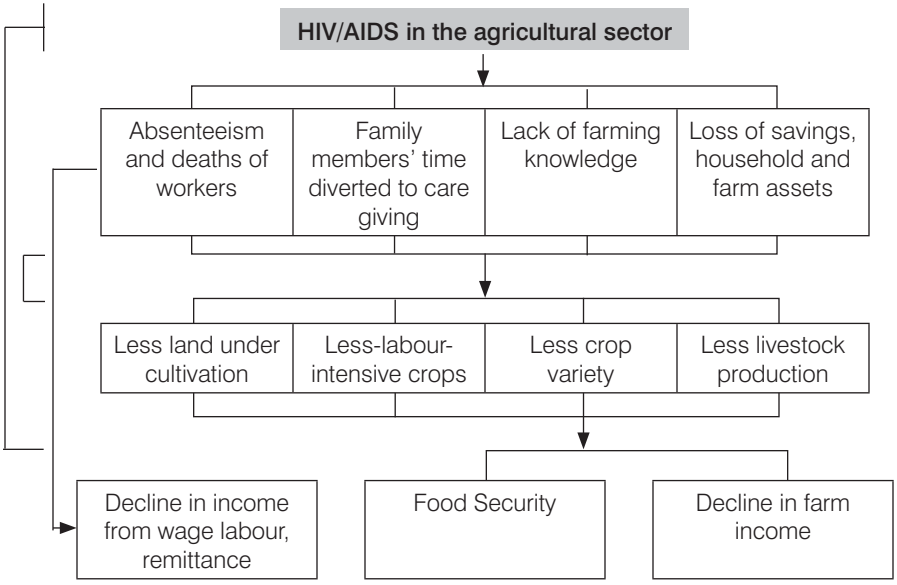
For instance, Sen explains that a peasant possesses his land, labour power and a few other resources, which together make up his endowment. The peasant, by selling his labour power, can receive a wage and with that buy commodities, including food. Or, alternatively, he can grow some cash crops and sell them to buy food and other commodities.

The foregoing discussion suggests that the prevalence of HIV/AIDS has a tremendous impact on the food availability for households because it reduces the labour available at the household level. Due to sickness, adults cannot spend time for agricultural production and there is a loss of his labour. Hence, agricultural production declines and households may not be able to harvest any crops.

When a household is affected by HIV/AIDS, it also affects coping strategies during food crises. Generally, households are able to achieve food security when they can produce a sufficient amount of nutritious food, or earn sufficient cash income to purchase food, or alternatively sell or barter assets for food in hard

times. The HIV/AIDS epidemic erodes each of these coping methods. It reduces a household's capacity to produce and purchase food, reduces their assets and exhausts social safety nets.

FIGURE 2.2
Impact of HIV/AIDS on agricultural food security caused by the reduction of production and loss of income of household members affected by illness (UN, 2004: 62)



The effects of HIV/AIDS will be felt by individuals and their families, and then ripple outwards to the macro economy. The aggregate deaths of adults from HIV/AIDS results in reductions in the available labour force. Less experienced labourers replace experienced workers, resulting in reduced worker productivity. These reductions in the labour force and worker productivity can result in a decline in overall output and economic growth. This can lead to a decline in national food supplies and a rise in food prices, including those in urban areas.

Additionally, increased morbidity and mortality levels affect national economies by reducing the volume of savings available and changing the ways

savings are used, ultimately affecting the GNP growth rate. The breakdown of commercial enterprises may undermine the country's capacity to export and generate foreign exchange (FAO, 2001: 15). However, as the direct cost of AIDS include major expenditure on medical care and funeral expenses, it results in a significant reduction in savings and accumulated capital. Government expenditure on health care is increased, with less spending on sectors such as education and agriculture, which are very important for the growth of the national economy.

Cross-border migration and the risks of HIV/AIDS prevalence and transmission

The relationship between HIV/AIDS and cross-border movements are complex. Unprotected sex, sex with multiple partners and the sharing of drug paraphernalia are key factors contributing to the spread of HIV. Human mobility can lead to the virus moving from one population to another (Skeldon, 2000). There is a perception that mobile populations, including cross-border migrants, bring HIV with them when entering any countries or communities. IOM (2002), in a position paper on "HIV/AIDS and Migration", observes that linkages between population mobility and HIV/AIDS are related to the conditions and structures of the migration process, including in communities of origin, during transit, at destinations and upon return. Factors linking population mobility and increased vulnerability to HIV include poverty, a lack of legal protection, discrimination and exploitation.

At transit and destination areas, there is an inadequate supportive infrastructure. Given their wholesale denial of basic rights, migrants do not have the opportunity or power to negotiate or bargain collectively for basic services and rights. Cultural and language barriers prevent them from accessing services. Each of these factors may increase the likelihood that people encounter HIV, and the same factors also reduce an individual's ability to protect himself or herself from the virus. In the absence of adequate services and information, migrants not only become vulnerable to HIV but also unknowingly become a link in the transmission of the virus to others, including their spouses to whom they return at periodic intervals. Population mobility may also affect the HIV vulnerability of people who do not migrate at all, such as people in communities along major transit corridors (UNDP, 2004: 15).

Other potential risk factors for migrants include separation from families and partners, and separation from the socio-cultural norms that guide behaviour in more stable communities. In such a context, migrants become vulnerable to HIV largely because of their human need for recreational options, companionship, intimacy and sex. The social and economic conditions in which migrants live and work, with uncertainty about future employment prospects and even their legal status, only add to this vulnerability (IOM, 2002).

The transient nature of migrants' lives puts them at risk. Preoccupied by more immediate challenges of physical survival and financial need, many people on the move regard HIV as a distant risk. The longer they spend away from home, the more likely it is that some will indulge in casual, high-risk sex. Other factors increasing the chances of HIV infection include lengthy delays at border crossings, which can turn these areas into hotspots for high-risk sexual activities. The overcrowded shacks of farm workers, the isolation of migrant worker hostels or the anonymity of refugee camps beckons companionship and the possibility of risky sexual conduct. In addition, the absence of social networks and norms that usually form and shape human behaviour heightens their risks. Faced with these situations and in search of emotional, physical or sexual gratification, many migrants slip into alcoholism, drug use and multi-partner sex.

Migrants infected with HIV/AIDS experience additional difficulties in accessing healthcare due to the high costs, especially if they are outside their country of nationality. Migrants at risk of HIV/AIDS often have limited access to voluntary counselling and testing, and to care and support. Migrants with HIV/AIDS risk potential unemployment while the stigma and discrimination associated with the illness can wreck their lives. Because of the multitude of factors that affect HIV vulnerability, multi-sectoral approaches that bring together actors from source, transit and destination communities are required (UNDP, 2004: 16).

Global responses to the HIV/AIDS epidemic

In 2000, the U.S. National Intelligence Council (NIC) identified a range of risks from the spread of infectious disease, including increased social fragmentation, economic decline, political polarization and tension leading to the risk of instability. By the mid to late 1990s, amid evidence of failure to stem the spread of the disease, HIV/AIDS began to attract the keen attention of the security policy

community, prompting U.S. Secretary of State Colin Powell to declare that it "now represents so great a threat to stability in Africa, Asia and Latin America that it needs to be regarded as a national security issue" (Gow, 2002 in Mcinnes and Lee, 2006: 10). Similarly, Richard Holbrooke, former U.S. ambassador to the UN and Director of the Global Business Council on HIV/AIDS, described the disease as "a direct threat to social, political and economic stability" (Lobe, 2002:.).

While HIV/AIDS has received particular focus, other acute infections of potentially epidemic proportions have also received attention. At the 54th World Health Assembly in May 2001, WHO urged member states to participate actively in improving epidemic alert and response measures to ensure "global health security". A number of countries have already sought to strengthen disease surveillance and monitoring systems at the national and regional levels. For example, in 2000, the EU published an evaluation of arrangements for managing epidemiological emergencies involving more than one EU member state. In the U.K., the Department of Health commissioned an internal study of the public health implications of increased population mobility including infectious disease control (Mcinnes and Lee, 2006: 10–11).

UNAIDS introduced a new lexicon to the health and development world with new jargon such as "multi-sectoral approaches" and "mainstreaming HIV/AIDS" in order to push governments to involve all segments of society in the fight against the pandemic (Ndinga-Muvumba, 2006 : 4).

Despite these alarming statements, many HIV/AIDS-affected countries do not take the issue seriously. The lack of funds allocated to combating HIV/AIDS, the social stigma that has come to be associated with the disease has been a significant obstacle in getting political actors to put forth a case for aggressively responding to it. Moreover, despite the advocacy on fighting HIV/AIDS carried out by NGOs and international organizations, this agenda has yet to be mainstreamed into the security agenda of states in many regions.

Conclusion

As a non-traditional security threat, the prevalence and transmission of HIV/AIDS is also receiving increasing attention as a legitimate topic for academic study. The recurrent theme in the "securitization of HIV/AIDS" considers the pandemic as a threat to human security.

Human security primarily concerns threats to the survival of individuals, rather than to the state and society. Given the widespread impact of HIV/AIDS on the lives of people, a micro- and macro-level impact needs to be investigated.

This paper claims that a micro-level livelihood framework can help us understand the micro-level impact of the disease. The concept of livelihood has gained wide acceptance as a valuable means of understanding the factors that influence people's lives and well-being, particularly those of the poor in the developing world. Within a livelihood framework, it is also important to consider the impact of HIV/AIDS on food security at the household level. The relationship between HIV/AIDS and cross-border movements is complex.

As the preceding discussion suggests, the linkages between population mobility and HIV/AIDS are related to the conditions and structures of the migration process, including in communities of origin, at spaces of transit, at points of destination and upon return to the places of origin. Factors linking population mobility and increased vulnerability to HIV include poverty, a lack of legal protection, discrimination and exploitation. As incidences of HIV/AIDS have increased dramatically, this has met with responses at all levels from the local to the global. In the next chapter, we will describe the magnitude, nature of and national responses to HIV/AIDS in Bangladesh and India.

Notes

1. Among the NTS scholars, the most prominent are Mohammad Ayoob (1997), Ken Booth (1991), Barry Buzan (1997) and Ole Wæver (1995).
2. UN Security Council Resolution 1308, 17 July 2000.
3. The concept of speech-acts was originally formulated by J. L Austin, who identified the existence of what he called performative speech acts, whereby saying something is being done, like betting, giving a promise, naming a ship. www.gmu.edu/academic/ijps/vol3_1/Neuman.htm.

3

SCENARIO OF HIV/AIDS IN INDIA AND BANGLADESH

In this section, the scale and nature of HIV/AIDS in India and Bangladesh will be presented. Responses from the Government of India (GoI), the Government of Bangladesh (GoB), international organizations, NGOs and civil society will also be outlined.

HIV/AIDS prevalence and national responses in India

Scale

About 5.7 million Indians were living with HIV in 2005, which indicated that there were more people with HIV in India than in any other country in the world (UNAIDS, 2006). However, the National AIDS Control Organization (NACO), which was established in 1992 in India, claims that the actual figure is lower. NACO conducted the HIV Sentinel Surveillance together with the support of two national institutes: the National Institute of Health and Family Welfare and the National Institute of Medical Statistics, ICMR, New Delhi. Over the years, the numbers of sentinel sites were increased from 180 in 1998 to 703 in 2005. This was expanded greatly for the 2006 surveillance, round to a total of 1,122 sites, to cover all the districts of the country. Based on the revised estimates, the total people living with HIV/AIDS (PLHIV) in the country are estimated to be 2.5 million. Out of these, 0.97 million (39.3%) are women and 0.09 million (3.8%) are children. The estimated adult prevalence in the country is 0.36 per cent (0.27%–0.47%). Among them, 88.7 per cent are adults (15–49 years), 7.5 per cent are aged 50 and above, while 3.8 per cent are children (<15 years). The

proportion of infections among children and adults above 50 years of age has been increasing during the last five years (NACO, 2006).

According to the NACO (2006), India's highly heterogeneous epidemic is largely concentrated in six states in the industrialized south and west, and in the northeastern tip (Map 3). The highest number of PLHIV is in Andhra Pradesh and Maharashtra, with nearly 0.5 million PLHIV each. Along with Tamil Nadu and Karntaka, the four south Indian states contributed 63 per cent of all the PLHIV in the country. Though Manipur and Nagaland have the highest HIV prevalence in the country, due to their small population size, the estimated number of PLHIV in these two states is around 25,000. Of the six high prevalence states, West Bengal, Gujarat and Uttar Pradesh have greater burden of the epidemic with more than 0.1 million PLHIV in each of these states. Similarly, the states of Kerala, Bihar, Rajasthan, Orissa, Chhattisgarh, Madhya Pradesh and Haryana have around 50,000 PLHIV each though HIV prevalence in these states is low.

Nature of HIV

The Indian epidemic continues to be concentrated in populations with high-risk behaviour characterized by unprotected paid sex, anal sex and injecting drug use with contaminated injecting equipment. Several high-risk groups have high HIV prevalence, and sexual networks are wide and inter-digitizing. According to India's National AIDS Control Organization (NACO), several factors put India in danger of experiencing the rapid spread of HIV. Sexual transmission is responsible for 84 per cent of reported HIV cases and HIV prevalence is high among sex workers (both male and female) and their clients. A large proportion of women with HIV appear to have acquired the virus from regular partners who were infected during paid sex. Condom usage is particularly limited when commercial encounters take place in "risky" locations with low police tolerance for this activity. Surveys in 2005 revealed that 42 per cent of sex workers in Haryana thought they could tell whether a client had HIV based on his physical appearance. At the same time, another study in Mysore revealed that only 14 per cent of sex workers used condoms consistently with clients and that 91 per cent of them never used condoms during sex with their regular partners (NACO, 2006).

No reliable information is available about the role of sex between men in India's HIV epidemic, but the few studies that have examined this subject have found that a significant proportion of men in India have sex with other men. Among men who have sex with other men, a high prevalence of HIV is recorded

in the states of Karnataka (19.2%), Maharashtra (15.6%), Manipur (12.4%), Delhi (12.3%), Gujarat (11.2%) and Andhra Pradesh (10.3%). Overall, eight states have shown more than five per cent HIV prevalence among men who have sex with other men , while four states have HIV prevalence between one per cent and five per cent. The remaining states recorded less than one per cent prevalence among men who have sex with other men. Moreover, urban areas of the country such as Delhi, Pune, Bangalore, Surat, Vadodara, Rajkot and Kolkata recorded very high HIV prevalence among men who have sex with other men (NACO, 2006).

Injecting drug use is the main risk factor for HIV infection in the north-east, especially in the states of Manipur, Mizoram and Nagaland), and features increasingly in the epidemics of major cities elsewhere including Chennai, Mumbai and New Delhi. Using shared injecting drug equipment is the main risk factor for HIV infection in northeast India and features increasingly in the epidemics of cities in other states.

Migration for work takes people away from the social environment of their families and community. This can lead to an increased likelihood to engage in risky behaviour. Infection rates have been on the increase among women and infants in some states as the epidemic spreads through bridging population groups. As in many other countries, unequal power relations and the low status of women, as expressed by limited access to human, financial and economic assets, weakens the ability of women to protect themselves and negotiate for safer sex both within and outside of marriage, thereby increasing their vulnerability (NACO, 2006).

National responses

Government

Shortly after reporting the first AIDS case in 1986, the government of India established a National AIDS Control Programme (NACP), which was managed by a small unit within the Ministry of Health and Family Welfare. The programme's principal activity was then limited to monitoring HIV infection rates among risk populations in select urban areas.

In 1991, the scope of NACP was expanded to focus on blood safety, prevention among high-risk populations, raising awareness in the general population and improving surveillance. A semi-autonomous body, the National AIDS Control Organization (NACO), was established under the Ministry of Health and

Family Welfare to implement this programme. This "first phase" of the National AIDS Control Programme lasted from 1992 to 1999. Screening of donated blood became almost universal by the end of this phase. However, performance across states remained variable.

The Indian government has said that, in the future, it would build further on partnerships with civil society organizations and also work towards greater active involvement of the target groups themselves as part of its AIDS programme. There will be greater integration of the medical response to the epidemic, for example, through provision of ART, STI services, and treatment of opportunistic infections through the National Rural Health Mission. The surveillance system of the NACP was also greatly improved over the course of the first and second phase and will be further enhanced under the third phase (NACO, 2006 and World Bank, 2006).

NGOs and CBOs

There are numerous NGOs and CBOs working on HIV/AIDS issues in India at the local, state and national levels. Projects include targeted interventions with high-risk groups; direct care of people living with HIV; general awareness campaigns; and care for children orphaned by AIDS. In some states that are supported by bilateral projects, NGOs receive capacity building and supportive supervision to implement targeted and tailored interventions. In other states without such support, the state AIDS control societies assume the responsibility, but most have only one staff member (the NGO adviser) to manage all NGOs implementing not only targeted prevention interventions but also care and support activities. Although all targeted interventions should include STI services as a component, NGOs generally face challenges in implementing and promoting high-quality STI services, including functional referral, as part of their projects. As a result, many members of high-risk groups, for example, female sex workers and their clients, men who have sex with other men and IDUs, do not have access to adequate STI services (World Bank, 2006 and YouthAIDS, 2006).

Development partners

India receives technical assistance and funding from a variety of UN partners and bilateral donors. Bilateral donors such as USAID, CIDA, and DFID have been involved since the early 1990s at the state level in a number of states.

USAID has committed more than US$70 million since 1992, CIDA US$11 million and DFID close to US$200 million. The number of major financers and the amount of funding available has increased significantly in the last year. Since 2004, the Bill and Melinda Gates Foundation has pledged US$200 million and the Global Fund has approved US$54 million for HIV/AIDS. DFID (GBP107 million) is providing pooled financing together with the World Bank (US$250 million) in overall support to India's HIV/AIDS programme NACP. Other donors include the Clinton Foundation, various UN agencies, DANIDA, SIDA and the European Union (NACO, 2006; USAID, 2006; YouthAIDS, 2006; World Bank, 2006).

Major challenges

According to the World Bank (2006) and USAID (2006), the major challenges in India for combating against HIV/AIDS are the following.

- There are institutional constraints, both structural and managerial, to scale up at the national and state levels. It is critical that these factors be addressed as the programme expands its response to the epidemic.
- NACO will need to change its role and responsibilities to provide the leadership and direction for a stronger multi-sector response for the next phase in India's fight against HIV/AIDS while the states will need to provide implementation capacity to put a robust programme into place.
- The capacity to mount a strong programme is weakest in some of the poorest and most populated states.
- There is a need for tailored capacity-building activities and for more attention to be paid to performance-based financing approaches. In addition, the programme also experiences high turnover of state-level project directors, resulting in limited continuity and variability in performance across states.
- There are over 32 large donor agencies working with NACO in different states and on different programmes, apart from many more that support NGOs in states. Each donor comes with its own mandate and requirements, as well as areas of focus. The transaction costs to the Indian government are huge. There is a need for better coordinating mechanisms among the donors and clear leadership by the government to reduce the transaction costs.

- There remains a need for greater use of data for decision-making, including programme data and epidemiological data. A lot of data that is being generated is not adequately used for managing the programme or in policy formulation and priority setting. Results-based management and linking incentives to the use of data should be explored.
- Stigma and discrimination against people living with HIV/AIDS and those considered to be at high risk remain entrenched. Stigma and denial undermine efforts to increase the coverage of effective interventions among high-risk groups, such as men who have sex with other men , sex workers and injecting drug users. Harassment by police and ostracism by family and community drives the epidemic underground and decreases the reach and effectiveness of prevention efforts.
- New approaches need to be tried to reach rural communities with information about HIV/AIDS, safe sex and how to prevent and treat HIV and AIDS.

HIV/AIDS prevalence and national responses in Bangladesh

Scale

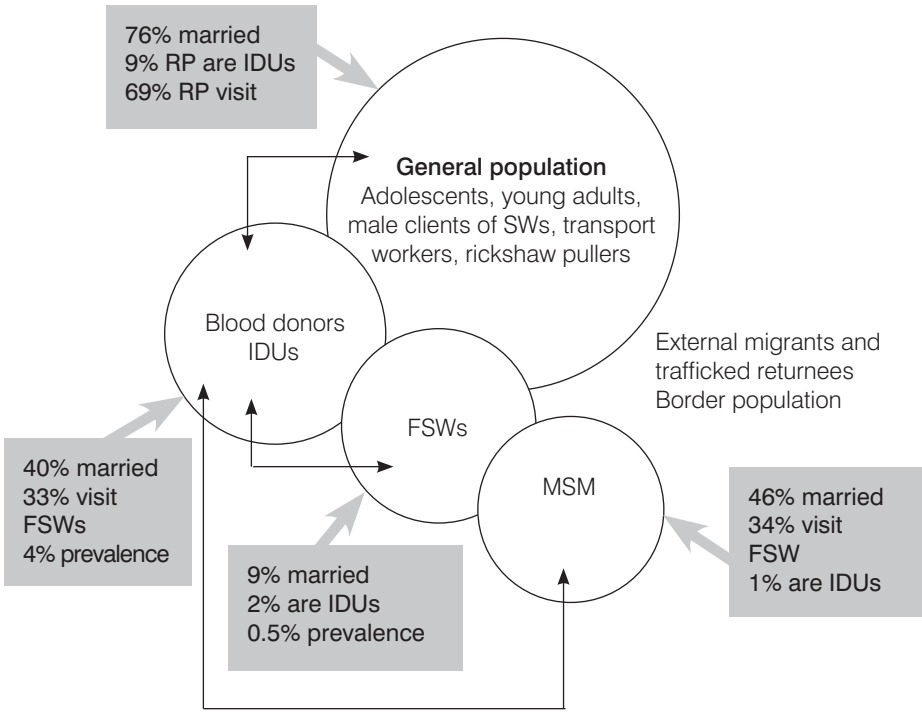
With a prevalence rate of less than one per cent, HIV/AIDS in Bangladesh may initially not look like a major threat. However, as the Bangladeshi population exceeds 140 million, a mere one per cent rise would mean the addition of more than one million infected sufferers. The first patient with AIDS was diagnosed in Bangladesh in 1989. However, until December 2007, only 1,207 new HIV positive cases were reported officially. Of these, 365 have developed AIDS and 123 have died (Table 3.1). According to the National AIDS/STD

TABLE 3.1
Total reported HIV and AIDS cases in Bangladesh

Cases	Number, end 2005	Number in 2006	Number in 2007	Total
New HIV cases	658	216	333	1,207
AIDS cases	134	106	125	365
AIDS deaths	74	35	14	123

Source: NASP, Director General of Health Services, GoB, 2005

FIGURE 3.1
Risk situation in Bangladesh



Programme (NASP) of GoB in 2006, out of 216 new HIV positive cases, 142 were male, 73 were female and one was unknown. Of the new cases of HIV, 68.06 per cent were aged above 25 years and 31 per cent were migrants. The educational status of the new HIV positive cases was very low; only 28 per cent of new cases were literate, 23.61 per cent had studied up to primary level and 26.85 per cent had studied to secondary level.

UNAIDS estimated that approximately 11,000 Bangladeshis could have been living with HIV at the end of 2005. Bangladesh's sixth round of sentinel surveillance (2004–2005) showed an overall prevalence rate of 0.6 per cent (Table 3.2). The sixth round was carried out in five groups: injecting drug users (IDUs), female sex workers (FSW), men who have sex with other men (MSM), male sex workers (MSW) and bridge population groups (mobile men including rickshaw drivers, truckers and dockworkers).

TABLE 3.2
HIV prevalence rates over the rounds

Surveillance round	Numbers tested	HIV (%)
First round	3,886	<1% (0.4)
Second round	4,634	<1% (0.2)
Third round	7,063	<1% (0.2)
Fourth round	7,877	<1% (0.3)
Fifth round	10,445	<1% (0.3)
Sixth round	11,029	<1% (0.6)

Source: NASP, Director General of Health Services, GoB, 2005

Nature of HIV

Bangladesh is still considered as a country of low HIV/AIDS prevalence. However, the bordering countries of India, Myanmar, Nepal and Thailand—where the movement of people between these countries is easy and constant—have seen fast transmission rates of HIV/AIDS. Moreover, the behavioural patterns and extensive risk factors that facilitate the rapid spread of the infection are prevalent, making Bangladesh highly vulnerable to an HIV/AIDS epidemic. These risk factors include poverty, gender discrimination, a large commercial sex worker and brothel sex worker population, a large number of hidden and resident sex workers, lack of basic sexual knowledge and a lack of proper knowledge of sexually transmitted diseases (STDs/STI). Another major risk is that drug use increases the risk of HIV and can start at a young age; the danger of becoming infected with HIV by sharing needles is well documented and real.

In Bangladesh, IDUs are most likely to be potential carriers of HIV/AIDS among the vulnerable groups in the country. The sixth round of the national HIV and behavioural surveillance report (2004–2005) showed that the HIV infection rate among IDUs in central Bangladesh—mainly in Dhaka city—is now 4.9 per cent. This represents an increase from 1.4 per cent in 2000 to 1.7 per cent in 2001 and four per cent in 2002. These IDUs are not an isolated population, but are often married and are sometimes involved with prostitution. Data found that 44 per cent of female IDUs are also sex workers and had a higher prevalence rate of syphilis (9.2% prevalence rate compared with 2.9% of male IDUs). The population of IDUs who are most at risk often face homelessness, unemployment and

incarceration and they sell their blood professionally. Therefore, the illegal sale of blood by IDUs increases the threat of tainting the national blood supply (GoB, 2005).

There are over 100,000 sex workers in Bangladesh, including both men and women. Brothel-based female sex workers reportedly see around 18 clients per week, while street-based and hotel-based workers see an average of 17 and 44 clients per week respectively. There is a significant prevalence of sexually transmitted diseases (STDs) among sex workers in central Bangladesh, with approximately 43 per cent of female sex workers and 18.2 per cent of male sex workers having syphilis (UNAIDS, 2005).

The lack of knowledge of HIV/AIDS may be creating the potential for a future epidemic in Bangladesh. While knowledge of HIV is nearly universal among sex workers and their clients, awareness remains extremely low among the general population. Research has indicated that only 17 per cent of the populations most at risk are informed about HIV prevention, while misconceptions about HIV/AIDS range from 3.7 per cent among transgender (Hijra) to 36.6 per cent among brothel-based female sex workers (GoB, 2005).

Further, the high-risk behaviour of having unprotected sex is evidenced by the low use of condoms among FSWs and MSWs. Data shows that the overall condom use rate among all FSWs is 30.9 per cent, while the rate is only 24.1 per cent among street-based sex workers (ibid., 2005). Among transgenders, the condom use rate is much lower at 15.6 per cent. Brothel-based sex workers reported having unprotected sex with their clients on a regular basis. Among client groups, such as rickshaw pullers and truck drivers, roughly 83 per cent have never used condoms when buying sex. Data on condom use among MSMs during anal sex indicates that in non-commercial sex, the rate of condom use is 37 per cent, while in commercial sex, the rate is 49.2 per cent (ibid., 2005).

Gender violence and inequality exist in largely male-dominated Bangladeshi society, thereby placing women and girls at additional risk of HIV. A large number of the clients of sex workers are married men who put their wives at risk of HIV.

National responses

Government

In view of the pandemic that started in the early 1980s, the government of Bangladesh formed a National AIDS Committee in October 1985 for the pre-

vention and control of HIV/AIDS. The country's National Policy on HIV/AIDS and STD-related issues was drafted in 1996 and adopted in 1997. The national response has included the establishment of a National AIDS Committee (NAC) and Technical and Co-ordination Committees at the central level and committees at various peripheral levels. A number of activities have been implemented by the NAC, the Ministry of Health and Family Welfare (MOHFW) as well as by the Directorate General Health Services (DGHS).

Despite substantial work having already been undertaken, the government's response has been neither adequate nor satisfactory. The GoB's expression of commitment to AIDS prevention has yet to be translated into action at the ground level. The government has issued a plan of action to address HIV/AIDS within the framework of the Health and Population Sector Programme. The Strategic Plan (1997–2002) envisaged the involvement of community and religious leaders as well as student and youth leaders in HIV/AIDS prevention advocacy programmes.

While early commitment was limited and implementation of HIV control activities slow, Bangladesh has strengthened its programmes to improve its response. The government's 2005 Poverty Reduction Strategy Paper highlighted HIV/AIDS. The Government of Bangladesh also prepared a National Strategic Plan for HIV/AIDS for the period 2004 to 2010 under the guidance of NAC and with the involvement and support of different stakeholders. Efforts to mainstream HIV/AIDS in the public sector outside of the Ministry of Health and Family Welfare were initiated through the designation and training of focal points on HIV/AIDS in 16 government ministries (GoB, 2005 and 2006; World Bank, 2006; USAID, 2005). The priority strategies include the following.

- Preventing transmission of HIV through the expansion of interventions targeted among individuals with high-risk behaviours including sex workers and their clients, truck drivers and injecting drug users
- Strengthening STD case management to include a syndromic approach
- Increasing the availability, accessibility and use of quality condoms
- Providing information, education and communication activities targeted at policymakers and the general population
- Enabling legislation and the use of the media, and creating an enabling environment for people in general
- Rational use of blood/blood products and a thorough screening of donated blood for HIV and other pathogens

- Provision of counselling and other support including the expansion of voluntary testing facilities targeted at pregnant women or women contemplating pregnancy and breastfeeding mothers
- Implementing activities to include legal amendments to counter discrimination against people living with HIV/AIDS and towards improving community acceptance
- Establishing HIV/AIDS and STD surveillance to determine the present and future magnitude of the problem and to monitor HIV/AIDS and STD programmatic interventions and their effects
- Strengthening the capacity for diagnosing STD/HIV/AIDS

Development partners

Currently, U.K. Department for International Development (DfID), USAID, SIDA and GTZ are financing a number of HIV/AIDS-related programmes in Bangladesh. These include a social marketing programme; peer education and condom promotion activities; information, education and communication efforts; STI treatment; surveillance and operational research; and capacity building for NGOs. Three UN agencies are also assisting the government of Bangladesh in the implementation of three project components. UNICEF is managing the NGO service-delivery component; WHO is managing the blood safety activities; and UNFPA is managing the capacity-building component. A Global Fund grant for $40 million (Round 6) to promote prevention of HIV among adolescents and young people brings together the government and Save the Children, USA and is being implemented through NGOs. The FHI/USAID supported project ($13 million, 2005–2008) is also focusing on selected interventions for some high-risk groups, including expansion of VCT services (World Bank, 2006; UNAIDS, 2006).

Non-governmental organizations (NGOs)

More than 380 NGOs and AIDS service organizations have been implementing programmes/projects in different parts of Bangladesh. These initiatives focus on the prevention of sexually transmitted diseases among high-risk groups involving mostly female sex workers, MSM, IDUs, rickshaw pullers and truckers. NGOs are often in a better position than the public sector to reach high-risk groups, such as sex workers and their clients and injecting drug users. Building the capacity of NGOs, especially smaller organizations, and combining their reach with the resources and strategic programmes of the government is an effective

way to change the behaviour of high-risk groups and prevent the spread of the virus to the general public (World Bank, 2006; UNAIDS, 2006).

Major challenges

Although progress has been made in the above areas, the government of Bangladesh, World Bank, UNAIDS, USAID, WHO, UNICEF and UNFPA have identified several challenges to prevent the further spread of HIV in Bangladesh. These challenges include the following.

- The issue of mainstreaming HIV/AIDS into the Bangladeshi Poverty Reduction Strategy Paper (PRSP) and other frameworks and sectors has not been adequately addressed, as HIV/AIDS has been largely considered as a problem to be dealt with through the health sector.
- Sentinel surveillance remains key to following trends of HIV infection and behavioural changes, as well as for monitoring the outcome and impact of responses to HIV/AIDS. There is a need to increase the scale of behavioural change activities and health promotion interventions for high-risk behaviours and vulnerable groups, particularly IDUs and sex workers.
- Sensitize national and local leaders to the importance of addressing HIV/AIDS and to conduct advocacy to help leaders from all sectors understand their role as opinion leaders.
- To ensure the safety of blood transfusions, the government has established 98 centres throughout the country to screen blood for HIV, syphilis, malaria, Hepatitis B and Hepatitis C. In addition, efforts have been made to promote voluntary blood donation, as opposed to professional blood donation. To further support this, legislation for blood transfusions was put in place in 2002; currently, its enforcement and implementation remains a challenge.
- Only seven facilities have been established for the purpose of voluntary counselling and testing voluntary counselling and testing. However, efforts for expansion are underway through government collaboration with NGOs and development partners.
- To expand advocacy and awareness among the general population through multi-sectoral agencies; to promote the social acceptability of condom use; and to ensure the adequate supply and access to condoms.

- Reduce discrimination against those infected with HIV or groups engaging in high-risk behaviours through appropriate advocacy, policies and related measures.
- Strengthen the government's capacity for programme implementation, management and monitoring of programme activities.
- Promote NGO capacity for programme planning, implementation and supervision of interventions.
- Strengthen mechanisms for collaboration and coordination within and between the government, the non-governmental sector, development partners and other stakeholders.
- More effective mechanisms should be established for sharing strategic information necessary for policy and programming purposes on HIV/AIDS and these new mechanisms should be applied accordingly. Further, documentation and sharing of best practice should be an integral part of the national response.

Collaboration between India and Bangladesh

It was very difficult to find any ongoing partnership projects between India and Bangladesh for fighting against HIV/AIDS. Both the governments of Bangladesh and India have individually taken measures to prevent HIV/AIDS. A comprehensive national policy and a plan of action has been formulated in both India and Bangladesh, emphasizing targeted interventions and strengthening of STI management. However, not enough attention has been given by both countries to the implementation of interventions in the border areas.

However, at the regional level, SAARC Tuberculosis and HIV/AIDS Centre (STC) has been working for prevention and control of TB and HIV/AIDs in the region since 1992 by coordinating the efforts of the National TB Control Programmes (NTPs) and National AIDs Control Programmes (NACPs) of member countries. The objective of STC is to work for prevention and control of TB and HIV-related TB in the region by coordinating the efforts of the National Tuberculosis Control Programmes of the member countries. The following programmes were undertaken by STC in 2006.

- Public awareness and advocacy programmes on TB and HIV/AIDS
- Participation in international/regional meetings, seminars and conferences in the field of TB and HIV/AIDS and NTP Review in member countries

- Production and distribution of STC publications
- Strengthening of STC Library and strengthening and updating of their website
- Carry out situation analysis of TB and HIV/AIDS Control Programme Activities in India and Nepal
- SAARC Regional Meeting of Managers of National TB Control Programmes from SAARC member states
- SAARC regional training on leadership and strategic management in TB and HIV/AIDS Control
- SAARC regional training on data management applications for TB and HIV/AIDS managers
- Strengthening SAARC Regional Epidemiological Networking by developing software (Epi. Centre for TB and other for HIV/AIDS data management)

Conclusion

This section has attempted to highlight the scale, nature and national responses to HIV/AIDS in Bangladesh and India. It is seen that approximately 5.7 million Indians were living with HIV in 2005, of which 88.7 per cent are adults (15–49 years), 7.5 per cent are aged 50 and above, while 3.8 per cent are children (<15 years). Although the HIV prevalence rate is less than one per cent, approximately 11,000 Bangladeshis could have been living with HIV at the end of 2005. Nevertheless, the bordering countries of India, Myanmar, Nepal and Thailand have seen fast transmission rates of HIV/AIDS while the movement of people between these countries is easy and constant. Moreover, the behavioural patterns and extensive risk factors that facilitate the rapid spread of the infection are prevalent, making Bangladesh and India highly vulnerable to an HIV/AIDS epidemic. Both the governments of Bangladesh and India have taken measure to prevent an epidemic of HIV/AIDS but not enough attention has been given to the border areas between these countries.

4

THE INTERVIEWEES

Any social science study demands a profile of the target population. The main objective of this section is to provide basic information on the study areas, respondent's age, educational status, household situation, livelihood options, income opportunities and land ownership pattern.

Description of the study areas

This study was conducted in the Benapole land port of the Sharsha upazila, Jessore district, Hili land port of Hakimpur upazila, Dinajpur district, and Bhurmari land port of Patgram upazila, Lalmonirhat district (Map 4). One of the reasons for the selection of these areas was that they were considered to be the most cross-border migration-prone areas in Bangladesh. Scanning of the national and local daily newspapers confirmed this. Another reason is that this study aims to draw a comparison between cross-border migration and the risk of HIV/AIDS spreading in three different border areas of Bangladesh. Finally, easy access to these areas also motivated the researcher during the selection process.

It is essential to understand the socio-economic situation of the study areas in order to understand cross-border population movements and the vulnerability to HIV/AIDS. In this section, the information was collected from different government agency offices in Sharsha, Hakimpur and Patgram Upazila, as well as from local and national NGOs.

Geographical and socio-economic characteristics of the areas under study

GoB (2002) statistics show that Sharsha Upazila (Jessore district)—with an area of 336.34 sq km—is bounded by West Bengal of India and Chaugachha Upazila

on the north, Kalaroa Upazila on the south, Jhikargachha Upazila on the east, West Bengal of India on the west. It consists of 11 union parishads, 135 *mouzas* and 172 villages. As the Benapol border crossing of the Sharsha Upazila is the largest and busiest crossing point between India and Bangladesh, business people, smugglers and truck drivers come from all parts of the country, cross in and out of Bangladesh this way, and stay overnight in Jessore town. On the other hand, the bulk of Indian exports to Bangladesh takes place through the Petrapole land border point in West Bengal, India.

Hakimpur Upazila (Dinajpur district) with an area of 99.92 sq km, is bounded by Nawabganj (Dinajpur) and Birampur Upazila on the north, Panchbibi Upazila on the south, Ghoraghat Upazila on the east, West Bengal of India and Birampur Upazila on the west. The main river is Little Jamuna and Tulsi Ganga. The *upazila* consists of four union parishads, 69 *mouzas* and 91 villages. The Hilli land port of Hakimpur Upazila of Bangladesh is the second largest land ports in Bangladesh. Major import and exports activities take place in this port. The Hilli land port in the Malda district of West Bengal is also located right on the border and a row of houses in this town have their front doors in India and their rear doors opening on to the railway platform of Hilli in Bangladesh (ibid., 2002).

Patgram Upazila (Lalmonirhat district), with an area of 261.51 sq km, is surrounded by India on the north, east and west and Hatibandha Upazila and part of India on the south. Noted rivers of the *upazila* are Dharala, Saniajan, Singimari and Tista. The *upazila* is made up of one municipality, seven union parishads, 74 *mouzas*, 56 villages and 27 enclaves. Dahagram is the largest enclave of the country. The Bhurimari land port of Patgram Upazila is used for carrying truck-load goods and tourists who go to Darjeeling in India or to Nepal and Bhutan via India. The name of the land port of the other side of the border is Changrabandha (ibid., 2002). The main socio-economic characteristics of three *upazilas* are described in Annex 5.

Number of respondents

Table 4.1 shows that the total number of Bangladeshi male respondents was 50. Among them, 24 were truck drivers and 26 helpers. Out of 50 Indian male respondents, 39 were truck drivers and 11 were helpers. Among the sex workers, 100 were Bangladeshis. However, Indian female sex workers from the focus group discussions (FGDs) have also been included.

TABLE 4.1
Total number of respondents

	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Truck driver	24	—	24	39	39
Truck helper	26	—	26	11	11
Sex worker	—	93	93	—	—
Total	50	93	143	50	50

Gender and area distribution

The field survey was carried out in Sharsha Upazila of Jessore district, Partgram Upazila of Lalmonirhat district and Hakimpur Upazila of Dinajpur District. The number of interviewees was not evenly distributed in these three areas. Interviews were taken on the basis of availability of land port and villages in the vicinity. Table 4.2 shows that highest number of interviews, 49.7 per cent, took place in the Lalmonirhat district. The second highest is 34 per cent in Jessore district and the lowest is 16.3 per cent in the Dinajpur district. Male-female ratio with respect to the study sites was also not even. The highest number of female (56) interviewees came from the Lalmonirhat district and 21 were from the Dinajpur district. Only 16 female interviewees were from the Jessore district. In contrast, the highest number of male interviewees in both Bangladesh and India (50) was from the Jessore district: 40 were from the Lalmonirhat district and 10 from the Dinajpur district. To understand the nature of cross-border migratory movements and the vulnerability of Indian female sex workers to HIV/AIDS, a number of FGDs were

TABLE 4.2
Distribution by sex and area

Area (District)	Bangladeshi		Indian	Total
	Male	Female	Male	
Jessore	25	16	25	66
Lalmonirhat	25	56	15	96
Dinajpur	—	21	10	31
Total	50	93	50	193

conducted in the Jessore, Lalmonirhat and Dinajpur districts. The total number of participants in the FGDs was between four and six. It should be noted that the duration of FGDs was very short. Researchers talked to them when they have just crossed the border and/or were planning to move quickly to some place safe.

Location of district of origin

Although the interviews took place in the districts of Lalmonirhat, Dinajpur and Jessore, out of total 64 districts in Bangladesh, 20 districts were identified as the

TABLE 4.3
Location of the respondents' districts of origin

Bangladeshi				Indian		
Home district	**Male**	**Female**	**Total**	**Home district**	**Male**	**Total**
Lalmonirhat	11	56	67	Calcutta	4	4
Jessore	21	11	32	Coochbehar	1	1
Manikgong	2		2	Jalpaiguri	14	14
Tangail	2		2	Malda	1	1
Dhaka	2	2	4	Nadia	4	4
Sathkhira	0	2	2	North 24 Parganas	19	19
Khulna	1	2	3	North Dinajpur	7	7
Narail	0	1	1			
Pabna	4	1	5			
Bogura	3	0	3			
Kurigram	1	0	1			
Ranjpur	3	1	4			
Nilphamari	0	3	3			
Comilla	0	1	1			
Dinajpur	0	8	8			
Gaibandha	0	1	1			
Kushtia	0	1	1			
Joypur	0	1	1			
Nawabgonj	0	1	1			
Natore	0	1	1			
Total	50	93	143		50	50

source of district of origin of the Bangladeshi respondents (Map 1). 65.73 per cent of respondents' origin was the Northwest districts of Bangladesh. These districts were Lalmonirhat, Bagura, Kurigram, Ranjpur, Nilphamari, Dinajpur, Gaibandha, Joypur and Natore. 27.27 per cent of respondents were from the Southwest districts include Jessore, Sathkhira, Khulna, Narail and Kushtia. 6.29 per cent of respondents were from greater Dhaka division. These districts were Manikgonj, Tangail, Dhaka, and Nawabgonj. The remaining district was Comilla, in the southeast of Bangladesh. On the other hand, the location of districts of origin of all Indian respondents was only under the state of West Bengal. The highest 19 were from the district of North 24 Parganas and the second highest was 14 from Jalpaiguri.

Age composition

Table 4.4 outlines the age of the interviewees. This table considers the current age as well as the age of the respondents when they crossed the border for the first time in their life.

As many as 51 Bangladeshi females were under the age of 15 when they first crossed the border, while five of the 100 Bangladeshi male were less than 15 years old when they first got involved in cross-border migration. The second largest group for both male and female was within the age range of 16 to 20 years.

Twenty-four of the Bangladeshi male currently belonged to the age group of 16–25 years. The second and third largest groups were of 26–35 and 36–45 years' brackets respectively. Of the 93 Bangladeshi sex workers, the current age of 44 of them were 26 to 35 years, and 29 of them were 36–45 years old. The 16 youngest female interviewees belonged to the age group of 16–25 years.

Thirty-two of the 50 Indian males were below 20 years of age when they became involved in cross-border migration. Among them, 19 interviewees were aged 10–15. Fourteen of the respondents became involved in cross-border migration when they were 21–30 and two respondents when they were 31–35. On the other hand, the second and third current age groups of Indians were the 21–30 and 31–40 respectively.

Overall, the average age during the first migration move for female sex workers was 17 years old while for the Bangladeshi males, it was 20.5 years old. From both the categories, a large number of respondents had been involved in cross-border migration at a very young age. The current average ages of the Bangladeshi male and female are 26.50 and 34 years, respectively, and 32 years old for the Indian males.

TABLE 4.4
The difference in age

Age group	Bangladeshi						Indian	
	Current age			Age when interviewees first crossed the border			Current age	Age when interviewees first crossed the border
	Male	Female	Total	Male	Female	Total	Total	Total
0–10				1	15	16		1
11–15				4	36	40		12
16–20	11	4	15	25	25	50	2	19
21–25	13	12	25	11	7	18	10	9
26–30	15	20	35	8	5	13	11	5
31–35	6	24	30		3	3	12	2
36–40	3	16	19	1	1	2	5	1
41–45	1	13	14		1	1	7	
46–50	1	4	5				2	1
51–55							1	
Total	50	93	143	50	93	143	50	50

TABLE 4.5
Current average age

	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Average	26.50	34	30.25	32	32
Minimum	17	18	17	18	18
Maximum	50	50	50	55	55

TABLE 4.6
Average age when interviewees first crossed the border

	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Average	20.5	17	18.75	20	20
Minimum	8	7	7.5	10	10
Maximum	36	42	39	49	49

According to Table 4.7, the average duration of involvement in cross-border migration for Bangladeshi male and female was 17 and six years, respectively, and for the Indian truck drivers, it was 11 years. The average duration of involvement in cross-border migration of two groups from both India and Bangladesh does not vary much.

TABLE 4.7
Total years of involvement in cross-border migration

	Bangladeshi			Indian	
	Male	**Female**	**Total**	**Male**	**Total**
Average	6	17	11.5	11	11
Minimum	1	1	1	1	1
Maximum	28	35	31.5	31	31

The participants of the FGDs who were Indian female sex workers became involved in cross-border migration at a very young age. They crossed the international border illegally to meet their relatives who used to live in Bangladesh. Better income was another reason for them to cross the border. In FGDs in the Lalmonirhat district, it was found that the Indian authority raised fences on their side. As fences did not cover the river, they could easily cross over the border by swimming. In the FGDs, it was also noted that most participants were very young and their ages were between 25 and 30 years.

Religious affiliation

Table 4.8 reveals that 161 of the 193 respondents were Muslims and 32 of them belonged to the Hindu community. The representation of the minority community in this study is not proportionate to the ratio of the population.[1] Among those of the Hindu faith, 30 were males and only two were females.[2] There were more Hindu females who were directly involved in cross-border migration but were unwilling to be interviewed, thus limiting our understanding of the socio-economic conditions of the Hindu community. In the case of Indian truck drivers, 29 were Hindus and 21 were Muslims.

TABLE 4.8
Number of people involved in cross-border migration by religion

Religion	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Islam	49	91	140	21	21
Hindu	1	2	3	29	29
Total	50	93	143	50	50

Martial status

Table 4.9 shows the marital status of two groups under the study. It is interesting to see that in the case of Bangladeshi sex workers, their marital status before and after migration changed significantly. Before migration, 44 of them were unmarried. After migration, only one remained unmarried. While 63 Bangladeshi sex workers were living with their spouses, 13 respondents were deserted, seven were separated, eight were widowed and one was divorced. The woman divorcee was 40 years of age. She stated that her divorce was not done through any paper work; her husband divorced her verbally and it was accepted by the local society. Conversely, in the case of Bangladeshi males, 41 of them were unmarried before migration; at the time of the FGDs, only 20 remained unmarried. On the other

TABLE 4.9
Marital status by sex and country

Status	Bangladeshi						Indian	
	Current			Before migration			Current	Before migration
	Male	Female	Total	Male	Female	Total	Male	Male
Unmarried	20	1	21	41	44	85	12	39
Married	30	63	93	9	40	49	38	11
Separated	0	7	7	0	2	2		
Divorced	0	1	1	0	0	0		
Widower	0	8	8	0	2	2		
Deserted	0	13	13	0	5	5		
Total	50	93	143	50	93	143	50	50

hand, 11 Indian males were married before migration; at the time of the FGDs, 38 respondents are married. No case of separation, divorce and widowing was found among the male interviewees in both the countries.

Case studies revealed that some Bangladeshi female sex workers, who were staying with their families, said that their husbands knew about their profession. In most cases, their husbands forced them into this work. Others said their husbands could abandon them any time. But, for better livelihood and social security, these women were forced to marry again. In the FGDs, the community leaders such as local teachers and local government officials reported that the rate of separation, desertion and divorce was high among the sex workers. Secondly, a large number of young sex workers (below 25 years) faced a higher likelihood of desertion, divorce and separation and re-marriage. 20 of 93 sex workers married twice and five married thrice in their lifetime. Not a single male except one Indian male married twice. It should be noted that researchers did not find out the actual number of marriage of each male respondents. As the interview was conducted at the border areas and not at their home, it was hard to tell if they were married before. On the other hand, most interviews of female respondents were conducted at their home. Six of 13 deserted women also reported that they lived with a male partner like a married couple although they did not get married. Due to social insecurity, they need a male member in their family to look after their children and also to help them pass the time. In this case, they have to cover the daily expenses of their male partner.

Educational background

The rate of literacy of the Bangladeshi sex workers was very low. Lack of access to schooling was not the reason for this; respondents or their families had to think about their livelihoods. The rate of early dropouts from school was very high. Table 4.10 shows that 35 out of 93 Bangladeshi sex workers were not literate. Thirty-two of them could sign their names and 16 could read and write. Six respondents attended class I to V and three attended up to class X. None of the female respondents passed HSC level of education. But one female passed SSC. A section of female respondents attended primary school for a few years to obtain food and other facilities including free schooling for girls provided by the government.

A good number of Bangladeshi and Indian males had some level of literacy. Of the 50 Bangladeshi male, 10 knew how to sign their names. Nineteen respond-

ents attended class I to V and 13 attended up to X. A few of them studied up to HSC level; six of them were not literate. Sixteen of the Indian male respondents could sign their names and five respondents were illiterate. Among the interviewees, a good number had studied up to SSC and HSC.

The number of female belonging to the "not literate" and "can sign" categories is higher than that of the male. Therefore, the data above indicates generally a low level of education among the target population; hence, there is little access to the print media.

TABLE 4.10
Educational profiles by sex and country

Status	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Can sign	10	32	42	16	16
Can read and write	0	16	16		
Can not read and write	6	35	41	5	5
Studied up to class V	19	6	25	11	11
Studied up to Class X	13	3	16	13	13
Studied up to SSC	0	1	1	3	3
Studied up to HSC	2	0	2	2	2
Total	50	93	143	50	50

In the FGDs, the local community pointed out that the disinclination of the families of the Bangladeshi respondents to send them to schools was one of the reasons for the high rate of illiteracy. Fifty-four of the respondents have sent their children to schools whereas 25 did not. Among the 25 respondents, 19 were female and six were male. The rest of them neither have children nor are married. However, most of the female respondents admitted that they have sent their daughters to school only to obtain the government scholarship for their enrolment. They also revealed that if their children were engaged in work, their earnings would have been higher compared to what they have got from the scholarship fund.

During the FGDs with local community leaders and during individual interviews, it was widely stated that engagement in informal border trade has been the principal livelihood strategy for many of the residents in the region, both Bangladeshi as well as Indian. Children were also engaged in informal border

trade. They were often employed as carriers; thus, saving their employers money on the transportation of goods. They were used mainly by female respondents, not only because children get sympathy from border security forces but also because they offer very cheap labour. For work as a day's carrier, a child could earn BDT50–80. It also came out that most of the female respondents rent out their children to act as carriers in order to earn extra money. As a result, they put their children at risk of being trafficked, physically injured or caught in crossfire. The Indian respondents were in a better situation, considering the fact that only two respondents did not send their children to school because they wanted their children to help in their family. However, 21 of the Indian respondents sent their children to school and the rest of them neither had children nor are married.

Household size and composition

Interviews were done mostly on two types of families, namely nuclear and joint. Living with one or two friends was also considered a different type of household. However, most of these were nuclear families.[3] The study found that out of 93 Bangladeshi sex workers, 78 were nuclear family units and 11 were joint family units. Among the nuclear units, seven were staying alone. They were mainly deserted and widowed. Although these women had children, they lived separately from their children. It is interesting to note that four sex workers in Jessore district lived with their friends. They were mainly separated and their age was within the range of 22–25 years. Jessore was not their main home district. They were born in another district. They had no contact with their home district or their families. In contrast, the Bangladeshi and Indian male respondents had a more balanced distribution of nuclear and joint families.

TABLE 4.11
Current type of household of the interviewees

Status	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Nuclear	22	78	100	27	27
Joint	28	11	39	23	23
Live with one or more friends	0	4	4		
Total	50	93	143	50	50

It was also noted that some of the respondents with joint families stated that they stayed together as they felt that the collective income helped them to better manage their family expenses. A section of them also felt that it was their responsibility to look after their parents and extended family members. It may be explored that the joint family can provide financial assistance to other members within the family. Nevertheless, it was seen that most Bangladeshi sex workers, including those who lived alone, had a nuclear family unit. In such a situation, getting any help from their family is quite difficult. This is not only because of the fewer number of earning members in their families but also because their occupation is not recognized by the state or society in any formal or legal manner. Thus, the society does not provide them any support at any stage. It is not certain whether the state considers them a vulnerable group. Hence, we are also uncertain if state may or can put them under any programme of "social safety net".[4]

The average household size[5] of Bangladeshi male and female respondents was 4.85, according to Table 4.11, the national average being 4.88 (GoB, 2001).[6] Among them, the average household size of the female respondents was 3.97 and male respondents 5.74. The following table also shows that the household size of Indian male respondents was 5.26, whereas the national average was 5.3 (Census of India, 2001).[7] The bigger family size was found to be 14 among the Indian male respondents and the smallest one among Bangladeshi respondents.

TABLE 4.12
Total family size of the respondents

Status	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Average	5.74	3.97	4.85	5.26	5.26
Minimum	2	1	1	1	1
Maximum	14	10	14	11	11

Household income

Analysing household income is a complex and difficult task, particularly in rural areas where very often a family has two or more sources of income both in cash and in kind, and seldom keeps any detailed record of payments and receipt. The number of income earners of a household is also very important in trying to

understand the earning patterns in the local and outskirt areas. This is significant in terms of the economic security of the family, as other members in the household help to keep track of daily livelihood expenses.[8] According to Table 4.13, 60.3 per cent of the Bangladeshi sex workers and 32 per cent of Bangladeshi males had more than one earner in their families. However, 39.8 per cent of the Bangladeshi sex workers and 18 per cent of the Bangladeshi male respondents were the only income earner in their family. On the other hand, 42 per cent of Indian male respondents had more than one income earners in their families and the rest (58 per cent) of them were the only income earner.

TABLE 4.13
Total number of current earning members of family

No. of earners	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
1	18 (36%)	37 (39.8%)	55 (37.9%)	29 (58%)	29 (58%)
2	17 (34%)	46 (49.5%)	63 (31.5%)	15 (30%)	15 (30%)
3	14 (28%)	10 (10.8)	24 (12%)	5 (10%)	5 (10%)
4	1 (2%)		1 (2%)		
5				1 (2%)	1 (2%)
Total	50 (100%)	93 (100%)	93 (100%)	50 (100%)	50 (100%)

It has been found that, comparatively, Bangladeshi male respondents had more income earners in their family than the Bangladeshi female respondents, with many male respondents helping other members in their family to find jobs. However, among the Bangladesh female sex workers, it was mainly married sex workers, who had more than one income earners of their family. The study found that 52 of 63 married Bangladeshi sex workers had more than one earner in their family. Among them, one widower and three who were deserted by their husbands had more than one earning member as well.

The table 4.14 describes the total monthly income of the household.[9] The current average monthly family income among the Bangladeshi female respondents was BDT6,994 and among the male respondents, it was BDT10,517. The family with the highest monthly earnings among the male respondents had three earning members. Of these three, the respondent had income from truck driv-

ing and cultivable land, his brother had a cottage business and his father had a business selling livestock. One Bangladeshi female had three earning members in her family. Besides her own income from the sex trade and informal border trade,[10] the income of her husband who worked as a van driver and a son who worked as an informal trader in the border areas has also been included. It was observed that, besides their work in the sex trade, female respondents were also engaged in other occupations in order to generate extra income. The other sources of income included, for example, money from micro-credit or petty businesses.

Table 4.14 also reveals that the average family income of the Indian male respondents was BDT7,259. The highest family income of a respondent was BDT19,600 and the lowest was BDT1,800. Two respondents were earning monthly BDT19,600; both of them were the only income earner in their family. They had their own truck and this meant higher income.

TABLE 4.14
Total current monthly income of the household

	Bangladeshi (Taka)			Indian (Taka)[11]	
	Male	**Female**	**Total**	**Male**	**Total**
Average	10,517	6,994	8,755.5	7,259	7,259
Minimum	1,500	1,500	1,500	1,800	1,800
Maximum	43,000	24,000	43,000	19,600	19,600

Occupational pattern

The study found different types of occupational patterns among the respondents' families. The general trend in the respondents' families had been to work in the transportation sector as, for example, daily wage labourer, agro farmer, van/rickshaw puller or petty trading businessman. Table 4.15 shows that 26 of the Bangladeshi respondent's family members worked as day labourers. Eleven of them worked as truck drivers or helpers. However, nine of them worked as farmers; this means they had their own cultivable land. Eight respondent's family members were involved in petty trading. A total of eight respondents' family members were involved in informal border trade. It is interesting to note that a few also worked in the technical and formal sectors. Two worked as car

TABLE 4.15
Occupations of the respondent's family members

Occupational pattern	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Informal border trader	—	8	8	—	—
Truck driver/helper	9	2	11	10	10
International migrant	1	—	1	1	1
Agro labourer	3	5	8	—	—
Agro farmer	9	—	9	8	8
Sharecropping	1	—	1	1	1
Fishing business	—	1	1	1	1
House painter	—	—	—	1	1
Mosque imam	—	—	—	1	1
Shopkeepers	5	2	7	4	4
Tailoring	1	1	2	1	1
Mason	1	—	1	2	2
Petty trader	5	3	8	4	4
Press and printing	1	—	1	—	—
Construction workers	2	1	3	—	—
Livestock's trader	2	—	2	—	—
Local union parishad member	1	—	1	—	—
Domestic worker	—	1	1	—	—
Daily labourer	1	25	26	—	—
Rickshaw pullers	1	—	1	—	—
Van puller	—	8	8	—	—
Taxi driver	2	—	2	—	—
Factory garage worker	2	—	2	—	—
Butcher	1	—	1	—	—
Sweeper	—	1	1	—	—
Cobblers	—	1	1	—	—
Hotel boy	—	1	1	—	—
Local government nurse	1	—	1	—	—
Unemployed	—	2	2	—	—

drivers or in a job related to CNGs (compressed natural gas), while one worked in the government sector and another as an elected member of the local union parishad (UP).

On the other hand, 10 family members of the Indian male respondents worked in the transport sector. Nine worked in the agriculture sector. Among them, eight worked as agro farmers and one as an agro sharecropper. Family members of four interviewees worked as shopkeepers and four as petty traders. Two of them also worked as masons and one as a tailor.

Bangladeshi female respondents' families are mainly from the Jessore and Dinajpur districts and they reported their engagement in informal border trade. It was further reported that following the promulgation of the emergency and with stricter border control, the incidence of such illegal cross-border trading has somewhat waned. The officer of a local police station pointed to the flip side of this. He linked the increase in crime rate in recent times to the inability of the local people to engage in irregular trade and thereby generate income. It may be noted that the extent of involvement of poor people in irregular trade is limited to a few kilograms of rice, cosmetics and household items such as bed sheets, spreads and towels.

FIGURE 4.1
Female and children internal migrants breaking stone at the Bhurimari land port

TABLE 4.16
Occupations of the respondents

Occupation	Bangladeshi					Indian		
	Male		Female		Total	Male		Total
	First	Second	First	Second		First	Second	
Informal border trade			15	9				
Sex worker			56	40				
Truck driver/|helper	50					45		
Agro farmer							5	
Domestic work			4	2				
Work in a car garage		1						
Restaurant worker			3	1				
Petty trading			1	1				
Breaking stones			13	20				
Sweeper			1					
N/A (They had no second occupation)				20				

It was also revealed during interviews in Lalmonirhat district that most female respondents' families also work as day labourers—they crush stones. Lalmonirhat district is the place to discover stones. The nearby Dharala River originates from India. Stones come rolling down with the river stream, providing livelihood for many people. People from other districts temporarily come and work here. During the FGDs with local community and local businessmen, they stated that the present caretaker government imposed a new law. Every businessman who runs the business for crushing stones or collecting/extracting stones from the river-bed should have a licence from the government. With the introduction of this new law, only two businessmen, who had the licence, could run their businesses. In the long run, many local people and migrants, both male and female became unemployed. Due to the lack of jobs, many local women also got engaged in sex work. It was further noted that many local female sex workers stated that due to the lack of jobs, they were also thinking of migrating temporarily to other districts. They also mentioned that their friends already

migrated to other districts and they had come to know that they were also engaged in sexual activity in the destination areas.

The study found that in most cases, respondents were engaged in more than one occupation which helped in increasing their household income. Table 4.16 demonstrates the occupational status of the respondents. Here, the occupational status is divided into two groups: primary and secondary.

It was found that the primary occupation of the 56 Bangladeshi female respondents was work in the sex trade while it was a secondary occupation for 40 respondents, who were also engaged in domestic work, stone crushing and work in the restaurants. Crushing stones was the primary occupation for 13 of them. Of the total 50 Bangladeshi male respondents, truck driving or helping was the primary occupation for 49 of them while one was engaged in work in a garage as his secondary occupation.

For all the 50 Indian respondents, being a truck driver or helper was the primary occupation for 45 respondents, while working in the agriculture sector was a secondary occupation for five respondents.

Land ownership

As far as this study is concerned, it is important to know the land ownership pattern of the respondents. Scarcity of land, landlessness and unequal land distribution are common features in villages where poverty is rampant. Table 4.17 shows that out of 93 Bangladeshi female sex workers, only 28 owned land. Among them, 26 had only homestead land and the other two had homestead land, arable land and a pond. Out of 50 Bangladeshi males, 41 owned land. Among them, 36 had homestead and arable land and five had only homestead. Forty-three of 50 Indian males had both homestead and arable land. A few of them also had a pond.

TABLE 4.17
Respondents' ownership of land

Land ownership	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Yes	41	28	69	43	43
No	9	65	74	7	7
Total	50	93	143	50	50

It should be noted that the respondents used to live in joint families, but the families split up when they started working and got married. As they had many family members and had very little land, the land was distributed among the family members. As a result, the amount of arable land decreased significantly.

Conclusion

This section has attempted to describe the area where this research was conducted and of the people residing there. The study revealed that the people in the border areas became engaged in cross-border migration at a very early age, considering it to be natural, obvious and even thinking of it as legal. Although cross-border migration involved substantial risk, it at least helped them to survive. It was also seen that most males were married and many female respondents were widowed, separated or divorced. Therefore, the burden of family responsibility also forced them to become involved in occupations peculiar to the area or, for that matter, in any occupation. As a result, it was not only these respondents alone but often also other family members who took part in such income-generating activities. However, respondents also stated that truck driving and work in the sex trade was often not their first occupation; many also worked as, for example, agro farmers, agro labourers, petty traders, day labourer and rickshaw pullers. It is interesting to note, however, that besides housework, most female respondents had only one occupation and this involved informal border trade. The following chapter will discuss the nature and process of cross-border migration.

Notes

1. The distribution of Bangladesh population by religion is 88.3 per cent Muslims, 10.5 per cent Hindus, 0.6 per cent Buddhists and 0.3 per cent Christians (GoB, 2001).
2. The religion composition of India is 80.5 per cent Hindus, 13.4 per cent Muslims, 2.3 per cent Christians, 1.9 per cent Sikhs, 0.8 per cent Buddhist, 0.4 per cent Jains, 0.6 per cent other religions and persuasions and 0.1 per cent religion not stated (GoI, 2001). Retrieved on 1 December 2007 from www.censusindia.gov.in/Census_Data_2001/India_at_glance/religion.aspx.
3. The nuclear family is defined as one where a couple lives with or without their unmarried children. Usually, joint families are two to three generations compris-

ing aging parents or in-laws living with their sons or daughters and grandchildren. In other instances, parents or male siblings gave shelter to their widowed or separated female children or siblings.

4. The social safety net is a term used to describe a collection of services provided by the state, such as welfare, unemployment benefit, universal healthcare, homeless shelters and minimum wage and sometimes subsidized services like public transport, which prevent individuals from falling into poverty beyond a certain level. Retrieved on 28 November 2007 from en.wikipedia.org/wiki/Social_safety_net.
5. Here, household size was calculated as the number sharing meals from the same kitchen.
6. Bangladesh has about 25.3 million households, while 98.2 per cent are dwelling household. Male-headed households are 89.6 per cent and female-headed ones are 10.4 per cent (GoB, 2001).
7. Census of India (2001), Office of the Registrar General & Census Commissioner, Ministry of Home Affairs, India. Retrieved on 1 December 2007 from www.censusindia.gov.in/Census_Data_2001/Census_data_finder/H_Series/Household_Size.htm.
8. It should be noted here that the family income of the interviewees not only included personal income from truck driving and the sex trade but also income from other sources.
9. The income includes respondent's own income and the income of other members in their family. If the respondent's family had any cultivable land, the price of the crops obtained yearly was converted into Taka. Then, it was divided by 12 months and added the price of one month into total monthly income of the family.
10. The term "informal border trade" is more commonly known as smuggling, regardless of the individuals engaged in the trade, their traded goods and the process of undertaking the activity.
11. 1 BD Taka = 1.60 Indian Rupee (This figure was found out during the field work). It converted the current monthly income of the Indian respondents to Bangladeshi Taka.

5

NATURE OF HUMAN MOVEMENT ACROSS THE BORDER

Population movement within different parts of the undivided India for business or family reunification was common practice throughout the history of the subcontinent. When the Bengal Border Commission in 1947 drew the borders between India and former East Pakistan (currently Bangladesh) along a Hindu-Muslim divide, it did not consider the ground realities. The territorial partition cut across the lifeline of Bengal. As a result, the new reality of "nationhood", as it had been politically constructed, endangered the livelihood of the inhabitants living in the border areas—inhabitants that faced adjustment to a new reality at both state and individual levels. For the individuals living on the border areas, far away from the administrative centre of the "nation-state", a livelihood that was previously fortified by the integrated ethnic and social networks, now confronted dislocation. Ensuring a minimal livelihood became a desperate activity, and many were forced to continue crossing the border in order to find work or trade goods through the kith and kinship networks that remained. In continuing to cross the border, however, these people often became trapped in grey areas of legality. Their only means to ensuring a secure livelihood posed a threat not only to the states they crossed to but also to themselves as they become vulnerable to illegal activities such as drug, arms and human trafficking. As a result, in the case of Bangladesh and India, the cross-border population movements have become an increasingly salient issue. It forms part of the controversial debate between "national security" and "human security" that has emerged within the security discourse since the end of the Cold War. In other words, the greater the securitization that takes place on the part of states, the greater the insecurity felt by the individuals involved in such activities (Sikder and Khan, 2006: 14).

A Sikder (2005) study shows people from both countries regularly cross the border without legal documents. The socio-economic condition of the bordering districts of Bangladesh is comparatively less developed than any other districts in Bangladesh (Annex 6). Informal border trade is the main livelihood for many people in the border areas of Bangladesh. The most harmful commodities that are illegally imported across the borders to Bangladesh are various types of narcotics. Among these are Phensidyl, wine, beer, cannabis and addictive tablets.

The study also reveals that the border disputes and cross-border firing for land is a common phenomenon in border areas. When ordinary Bangladeshi people work on the farmland along the Bangladesh border, they are often killed by the Indian Border Security Forces (BSF) (Annex 7). It also emerged that the number of crimes increases when the informal border trade ceases due to a re-emergence of border conflict. Border conflict also takes place for several incidents such as cattle theft or the seizure of contraband goods which can lead to clashes between the people living near the borders of the two countries, quite often leading to conflicts between the countries' security forces (Annex 8). At such times, the movement of goods across the borders ceases, causing a sharp decline in the daily earnings of a large number of people involved in the trade. In such a situation, females, in particular, are severely affected because most poor women of the border areas engage in informal border trade. People involved in informal border trade play a role in border conflicts. In order to restore peace at the borders, people become involved in informal border trade to ensure that the clashes are resolved between the border security forces of the two countries with the help of the linemen of both countries.[1] These measures ensure that people involved in informal border trade resume their activity upon resolution of the conflict (ibid.).

Beyond the informal border trade and others, some districts of Bangladesh are also used as a route for human trafficking. Human trafficking has recently become important in Bangladesh, with the victims being mainly women and children. However, no accurate statistics have yet been produced in the country. Bangladesh National Women Lawyers' Association (BNWLA), an organization involved in the rescue of trafficking victims reports that 10,000 women and children are trafficked to India every year and 30,000 Bangladeshi children have been supplied to Indian brothels (BNWLA, 1999). However, these statistics remain controversial as they are also not based on any formal research. Traffickers take women and children from different areas of the country, and any woman or child

is at risk of being targeted. Since it is economically beneficial, many people living in the border areas have taken to this activity. As a result, a connection has been found between informal border trade and human trafficking (ibid.).

Given these scenarios of the border areas, this section deals with the different aspects of cross-border migration of truck drivers and helpers and sex workers, including routes, modes and destination, companion during migration, problems faced during border crossings and cross-border frequency and periods.

Information about cross-border jobs

The study attempted to understand how Bangladeshi sex workers and Bangladeshis and Indian truck drivers and helpers received job information where crossing the border was a necessity. It was seen that Bangladeshi female respondents utilized their social networks to get their job information. Table 5.1 shows 32 of Bangladeshi sex workers stated that neighbours or "known persons who were involved in cross-border migration and worked in India" were the prime source of information for cross-border jobs. Eighteen interviewees mentioned their relatives who worked in India, including mothers and sisters. Twenty-one respondents got their job information from the *dalals* (middlemen). Twenty-two interviewees stated their friends, including Bangladeshi and Indian who used to work in India, and they took necessary measures before bringing them along. It was noted that two cross-border jobs were identified for Bangladeshis: work in the sex trade and informal border trade.

TABLE 5.1
Source of job information

Sources	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Dalal (middlemen)		21	21		
Neighbour/known person		32	32		
Relatives		18	10		
Colleagues	25		25	11	11
Friends	5	22	27	14	14
Own	20		20	25	25
Total	50	93	143	50	50

Bangladeshi and Indian truck drivers and helpers obtained cross-border job information of employment in the transport industry from their own work place. Twenty-five Bangladeshi and 11 Indian truck drivers and helpers received information from their colleagues who were also working in the transport industry. Nineteen respondents got information from their friends and 45 got the information themselves. So, the data indicates that social network of female sex workers provided a very strong source of information regarding migration to the neighbouring countries.

Bangladeshi female respondents in the Lalmonirhat district stated that they did not need to cross the border or go to India to find work in the sex industry. Sometimes their Indian friends, who were working in the sex industry and lived near the border areas in India, requested them to join them in their place of work. In the FGDs with Indian female sex workers in Lalmonirhat and Dinajpur districts, they also stated that they came to Bangladesh as per request of their Bangladeshi friends. It was known that sometimes both sides faced a shortage of sex workers. In that situation, sex workers of both countries requested each other to fill in the gap.

Most Bangladeshi sex workers in the Jessore district stated that their prime source of information for cross-border job was their neighbours and middlemen. They went to Calcutta, Mumbai or Delhi with them to earn more money. They worked there as dancers and sex workers in the brothels. It has been found from various sources that a large number of Bangladeshi women work in Mumbai in the informal sector. FGDs with the local community leaders and individual interviews revealed that most of the cross-border females from Jessore migrate to Mumbai as their social connection is very strong in Mumbai. Bangladeshi sex workers from the Lalmonirhat district and the Dinajpur district concentrated their movement in the greater West Bengal in India. However, a few of them also migrated to Delhi, Bihar and Mumbai.

It was further observed that a total of 40 respondents also had family members who were involved in cross-border jobs. Altogether, 45 members of their families were also involved in cross-border jobs. Three Bangladeshi sex workers and one Indian and one Bangladeshi truck driver and helper had more than two members of their families doing such jobs. Table 5.2 details the involvement of the family members, which included fathers, mothers, husbands, wives, brothers, daughters and sisters. It is interesting note that the family members of Bangladeshi and Indian truck drivers and helpers were involved in the trans-

port industry. On the other hand, 18 members of the Bangladeshi sex workers' families were engaged in informal border trade, seven were in the sex industry, one worked as a van puller and another in the restaurant.

TABLE 5.2
Members of the family involved in cross-border jobs

	Bangladeshi			Indian	
	Male	**Female**	**Total**	**Male**	**Total**
Husband		13	13		
Father	1		1		
Mother		1	1		
Son		6	6	2	2
Daughter					
Brother	6	1	7	6	6
Sister		5	5		
Brother-in-Law				2	2
Sister-in-law		1	1		
Nephew/Nice				1	1
Total	7	27	34	11	11

Routes and transportation of cross-border migration

Interviewees of Bangladeshi sex workers used mostly the land route for crossing the border. In the Dharla River of the Lalmonirhat district, the river route was the most easily accessible. It is noted that the point of crossing the border is known as *Ghat.* In the border areas, the route through which human and goods are transported is locally called *Ghat*. This *Ghat* is controlled by local influential informal border traders, political leaders and others; no one is able to pass without their help. People who cross the border *Ghat* pay a fee to the *Ghat* owner through the middleman. A nexus between *the Ghat* owner, border security forces and the middleman make it possible to cross the border. All Bangladeshi female interviewees stated that they had to follow these *Ghats to* cross the border.

Annex 9 shows that Bangladeshi sex workers used mostly the nearest border of their villages to cross the border. Interviewees of the Jessore district identified

Benapole as their main transit point in Bangladesh. Through this point, they went to Petrapole, Bangaon, Calcutta, Howra and Mumbai in India as their last destination. Those who were from the Dinajpur district used Hilli point as their main route. Through Hilli's, they went to Malda, Calcutta, and Delhi in India. Respondents of the Lalmonirhat district also mostly used Bhurimari as their route for crossing the border. They also went to their last destination in Calcutta, Delhi and other places of India and Bhutan as well. It is seen that each respondent used several points for crossing the border. It depended on the situation of the border areas. On the other hand, both Bangladeshi and Indian truck drivers and helpers used several points to cross the border with their trucks. It was observed that most of them touched all land ports in both countries.

The study also found that the means of transportation of Bangladeshi and Indian truck drivers for crossing the border was their trucks. On the other hand, Bangladeshi sex workers go to the bordering areas on foot or by van. A few interviewees of the Lalmonirhat district either swam across or used boats for the river crossing. Those Bangladeshi sex workers who went to Calcutta-Mumbai and Calcutta-Delhi used the train as their main means of transport. Others used the bus for common transport when they moved in the West Bengal of India.

Companion during migration

Bangladeshi female respondents were found to be accompanied by different people including family members, neighbours, middlemen, relatives and known persons during cross-border migration. Seventy-six per cent of interviewees stated that they went to India with their neighbours or known persons. Those who were crossing the border for the first time moved with neighbours or known persons who had the experience of crossing the border many times over a long period of time. Thirteen per cent of the interviewees were accompanied by their relatives including brother/sisters, husbands, parents and other relatives. Eleven per cent of the interviewees were also accompanied by their friends. So, it was seen that women were less likely to cross the border alone.

Problems during cross-border migration

The study found that Bangladeshi female sex workers possess little idea of where they were going. Their idea about the work place were developed based

on the stories told to them by their neighbours, friends, middlemen or relatives who were experienced in crossing the border. After crossing the border, 68 of Bangladeshi female interviewees temporarily waited near the slum areas of the Indian border. Twelve stated that they waited in the bus, truck and railway stations, seven in the local rent mess and six in the local hotels.

Bangladeshi female respondents pointed out that the transit was full of risk emanating from various quarters. Twenty-five respondents stated that border security forces halted them when they attempted to cross the border. Five respondents said that they were held by the India police while crossing the border. Some of the interviewees identified the existence of local *Mastans,* dacoits and snatches who very often take away money and valuables from people migrating to India. Seven interviewees mentioned two or more sources of problem described below while migrating. It was noted that middlemen or brokers sometimes demanded additional money over and above their fees. Nevertheless, 50 of the interviewees said that they never faced any problem when crossing the border.

Bangladeshi and Indian truck drivers and helpers criticized the immigration system of both the countries. They stated that, sometimes, it takes long time to pass the immigration point. On some days, they have to face a local strike, which will result in them staying at the border area for a longer time. They cannot go back home in due time. They also lose the contacts who help them

TABLE 5.3
Sources of problems faced during migration

Source	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Border guard		25	25		
Police		5	5		
Middlemen		6	6		
More than once source of problem including border guard/police/middleman/ local muscleman		7	7		
No problem	50	50	50	50	50
Total	50	93	93	50	50

carry goods. Moreover, the immigration system of both the countries are not up-to-date, resulting in immigration authorities taking a long time to release their papers. Due to these unavoidable circumstances, they spend more time at the border area than necessary. They often had to resort to sleeping inside the trucks for security reasons and due to the lack of accommodation facilities for them. They also pointed out that it was physically not comfortable to sleep in the trucks for long hours.

Frequency and timing of cross-border movement

Of the total of 93 Bangladeshi female respondents, the average frequency of movement was 11.36 times per month, the highest number of crossings was 30 per month and the lowest was once. The average crossing frequency of the Bangladeshi male respondents and the Indian male respondents were 2.43 and 6.26 times per month respectively. It was seen that females tended to cross the border more than males. The reason for this was their engagement in sexual activity and informal border trade. On the other hand, the frequency of cross-border movement of Bangladeshi male respondents was lower. It was pointed out that Bangladesh mainly imports commodities from India. And there are very few exporting items to India. Therefore, they were not as busy carrying and realizing goods as Indian drivers.

TABLE 5.4
Frequency of cross-border movement per month

	Bangladeshi			Indian	
	Male	**Female**	**Total**	**Male**	**Total**
Average	2.43	11.36	6.9	6.26	6.26
Minimum	1	1	1	2	2
Maximum	8	30	30	15	15

On an average, Bangladeshi female respondents stayed in India for two days. Those who went to Calcutta, Delhi, Bihar and Mumbai stayed there for more than six months. Female respondents were also found to stay for six to eight hours in India. It was noted that most Bangladeshi female respondents crossed

the border between midnight and early morning in order to avoid the border security forces.

Bangladeshi male respondents stayed mostly in India for five to six hours. They just crossed the border in their trucks and unloaded the goods. A few of them stayed 15 to 20 days depending on their work. A different scenario was found in Indian male respondents. Respondents from the Jessore district stayed three to 15 days or, in some cases, a month. In the Lalmonirhat district, they stayed one to two days and three to seven days in the Dinajpur district.

Conclusion

It appears that cross-border migration is occurring in the marginal sections of society. Female respondents migrate to India on foot, by boat, bus or train and the male respondents in their trucks. Some of the common destinations of the female respondents are Mumbai, Delhi and Calcutta, where they work mostly as dancers and sex workers in brothels. During their journey, they were accompanied by their neighbours, relatives or friends, or middlemen, as they were crossing the border for the first time and did not know the way. Sometimes, border security forces, local muscleman, middlemen and police created problems in their movement.

Note

1. A lower ranking lineman works as a medium of communication between the two border forces.

6

SOCIAL BEHAVIOUR OF THE RESPONDENTS

Separation from spouse, family and socio-cultural norms, together with isolation and loneliness and a sense of anonymity can lead to social practices that make migrants more susceptible to exposure to HIV (UNDP, 2001). In an effort to understand the social behaviour of cross-border migrants, this section deals with findings regarding the respondents' leisure and entertainment, use of injectable drugs, access to health and job opportunities in the destination country.

Leisure and entertainment

In the South Asian context, family and friends play an important role in people's life. In connection to this, cross-border migrants living in the host country without family members identify themselves outside their common and regular periphery of entertainment. Within such limited opportunities, they very often avail themselves to entertainment activities that may throw them into dangerous situations in their life. Severe alcoholism, watching pornographic movies and establishing extramarital physical relations may lead to frequent and unsafe sexual relationship with unknown persons and ultimately increase the possibility of HIV infection.

Table 6.1 makes a comparison of how people spend their leisure time when they live in their home country. The highest number of respondents mentioned that they used to pass their leisure time with friends. It was followed by interviewees who used to watch movies in VCD or VCR and on television. Some of them mentioned their visits to the cinema halls. It is interesting to note that among other activities, drinking alcohol, phensidyl[1] and using injectable drugs are

worth mentioning. The case studies and personal interviews of Bangladeshi and Indian male respondents show that many people who worked in the transport industry drank alcohol. Four Bangladeshi sex workers mentioned that they used to drink alcohol frequently in their leisure time. They noted that other female sex workers also used to have this habit. During personal interviews with them, it was revealed that when they were engaged in sex with customers, they were forced to drink alcohol to give their customers more pleasure. Therefore, some of them could not avoid the effects of alcoholism. Moreover, it was noted during the time of interviews that most female respondents in the Jessore district had their own VCD/VCR and television in their home. Female respondents stated that they bought these not only for their own entertainment but also for their customers as they usually go to those houses where these entertainment items are available.

There were 15 male interviewees who mentioned gambling. Interestingly, six female interviewees were found to indulge in gambling. Thirty-one male and

TABLE 6.1
Leisure and entertainment of the interviewees in their home country

Leisure	Bangladeshi						Indian		
	Male			Female			Male		
	Yes	No	Total	Yes	No	Total	Yes	No	Total
Spend time with family	11	39	50	76	17	93	6	44	50
Spend time with lovers	3	47	50	47	46	93	1	49	50
Spend time with friends	45	5	50	30	63	93	45	5	50
Watch VCD/VCR/TV	42	8	50	51	42	93	30	20	50
Going to cinema hall	7	43	50	20	73	93	16	34	50
Visiting relatives/ neighbours		50	50	31	62	93	1	49	50
Sex	16	34	50	26	67	93	15	35	50
Gambling	9	41	50	6	87	93	6	44	50
Drinking alcohol	20	30	50	24	69	93	26	24	50
Drinking phensidyl	5	45	50	7	86	93		50	50
Use of injectable drug	1	49	50	25	68	93	1	49	50
Smoking *ganja* (cannabis)	2	48	50	3	93	93	9	41	50
Resting	4	46	50	11	82	93	1	49	50

26 female interviewees also identified work in the sex industry as a source of entertainment. Female respondents stated that they would use their time to get as many as customers as they could so they could earn more money. Bangladeshi male respondents also stated that they did not want to occupy their spare time with unnecessary activities. As they are poor, ensuring livelihood is their main task. They are also responsible for their family.

On the other hand, Indian male respondents said that their trucks are always used to carry goods from state to state and from country to country. Both Bangladeshi and Indian male respondents also stated that those who do not have a truck of their own can rent one from truck owners. They also have to deposit a fixed amount with the owner. As there are always many drivers looking for work, they do not want to miss a single day of work. If they do, other drivers will take the job.

The study also attempted to identify the extent to which the influence from friends in illicit activities would increase the likelihood of one in adopting such a behaviour. Thirty-four male and 22 female respondents said that they had friends who had sex for entertainment. Eight male and six female respondents said that their friends took part in gambling. Fifty-four male and 40 female respondents said that their friends drank alcohol regularly. Twenty-six male and 35 female respondents also said that their friends watched movies in VCD/VCR.[2] It is interesting to note that 42 female respondents stated that their friends used injectable drugs.

TABLE 6.2
Entertainment activities of respondents' friends

Type of entertainment that friends engage in	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Sex	12	14	26	22	22
Gambling	7	6	13	1	1
Drinking (wine and beer)	22	40	62	32	32
Drinking phensidyl		18	18		
Use of injectable drugs		42	42		
Watch VCD/VCR	14	35	49	12	12
Visit cinema hall	10	14	24	13	13

When asked if the respondents join their friends in these entertainment activities, five male and 17 female respondents said that they regularly joined their friends. Fourteen male and three female respondents said that they often go out with friends. There were very few respondents who did not participate in their friends' entertainment activities. It appears that as far as cross-border migrants' social behaviour is concerned, peer pressure has significant impact and hence social awareness campaigns of HIV/AIDS should target them.

The study also attempted to identify how respondents spent their leisure time when they were in another country. Table 6.3 gives a comparative picture. Men (87) were mostly found spending their free time with their friends. It should be noted that friends mean colleagues and other truck drivers and helpers who live in the same environment. Few of them mentioned that they had old friends in other country. Thirty-three of them went to cinema halls and watched VCDs/VCRs and television. During field work, satellite TV channels were seen in every tea stall and restaurant in the border areas of Bangladesh. On the Indian side, there were a few cinema halls in the border area, and drivers and helpers are the main viewers. Twenty-four male interviewees also identified sex as a source of entertainment. There were 11 male interviewees who mentioned smoking ganja for leisure. Twenty-one male respondents said that they used to drink in their leisure time.

Bangladeshi female respondents, on the other hand, said that they hardly had any free time in the country of destination. However, a large number of them (60) engaged in sex in their leisure time. Interestingly, 30 of the female respondents had boyfriends in India. They pass their leisure time with them when they go to India. It should be mentioned that Indian films are famous in this sub-continent. Sixty-seven female respondents went to cinema halls to watch Indian movies when they were in India. Moreover, Indian films are available in video-cassette format in most areas of Bangladesh so it is easy for anybody to watch Indian movies in Bangladesh. Fifty-three of the respondents watched VCDs/VCRs/TV regularly, which shows the availability of Indian movies. The study surprisingly found that many female interviewees were found to indulge in drinking, injectable drug use and gambling. A small number of female respondents were found to be free from these vices. They spent time gossiping with their friends and exchanging visits. This may lead one to argue that women are more vulnerable than men when abroad due their high-risk behaviour.

TABLE 6.3
Leisure and entertainment of the interviewees when abroad

Leisure	Bangladeshi						Indian		
	Male			Female			Male		
	Yes	No	Total	Yes	No	Total	Yes	No	Total
Spend time with lover			50	30	63	93			50
Spend time with friends	47	3	50	25	68	93	40	10	50
Watch VCD/VCR/TV	13	37	50	53	40	93	15	35	50
Go to cinema hall		50	50	26	67	93	5	45	50
Visiting relatives			50	4	89	93		50	50
Sex	9	41	50	33	60	93	15	35	50
Gambling		50	50	4	69	93		50	50
Drinking alcohol	8	42	50	30	63	93	21	29	50
Drinking phensidyl		50	50	13	80	93		50	50
Use of injectable drug		50	50	19	74	93		50	50
Smoking *ganja* (cannabis)	10	40	50	9	84	93	1	49	50
Resting	9	41	50	4	89	93	7	43	50

Use of injectable drugs

Various studies consider injectable drug users a high-risk group for HIV/AIDS. This study tried to look into the likelihood of injectable drugs use among cross-border migrants. Nineteen female and only 2 male respondents were found to be IDUs in the study. Among the male respondents, one was Bangladeshi and the other was Indian. It was revealed from the informal discussions with people in the study sites that the Lalmonirhat district was known to be the source for injectable drugs. These injectable drugs are produced in India and made available in the local market. Fifteen of the female respondents reported that they shared the needles and syringes for injecting drugs with others and cleaned the needles with water. Two male respondents reported using heroin. Female respondents could not remember the name; but, they mentioned that it might be either heroin or opium. They only asked the shopkeepers in the local market or smugglers to sell them drugs without asking for the name of the drug.

Access to health service

The study tried to determine the respondents' access to health services and what they did at home and abroad when they suffered from severe illness. Table 6.4 reveals that during the time of their stay at home, most of them went to local doctor's chambers when they felt ill. Out of 193 respondents, 61 Bangladeshi respondents and 34 Indian respondents went to local doctor's chambers in this regard. It should be noted that in the vicinity of the interviews sites in Bangladesh—with the exception of the Jessore and Dinajpur districts—only two local MBBS doctors were found in the Bhurimari land port of the Lalmonirhat district. The *upazila* local hospital is located far from the interview site so the local medical diploma holders played the significant role of doctors. There were also 48 respondents who took their own decisions to buy medicine from the local pharmacy without any consultation with the doctors. Notably, only 27 female respondents were found visiting the NGO's health clinics. It was widely seen that there were a few NGOs in the interview sites providing special health services for women. These services encourage many female respondents to visit these clinics. However, three respondents did not take any measures during the time of their illness at home.

When sick while abroad, 179 respondents did not take any measures to seek medical treatment. They cited various reasons for this. Bangladeshi and Indian male respondents mentioned that as they had to stay abroad for some days, they did not feel the need for any assistance from doctors. They also added that if they had to stay aboard for a longer period of time, they would perhaps go to the local pharmacy and buy medicine. However, Indian respondents in the Jessore and Lalmonirhat districts stated that they got free health assistance from an NGO—whose name they could not recall—a few years back. This NGO's office was based in the truck stations. But, the NGO stopped their activities subsequently. It was also revealed that there was no government clinic in the truck stations. Bangladeshi female respondents stated that they avoided seeking medical assistance while staying abroad. In most cases when they felt ill, they self-medicated with medicines bought from the pharmacy. They also mentioned that it would be risky for them to go for a check-up in the doctor's chamber or hospital as they entered Indian territory illegally; they were afraid of police harassment.

TABLE 6.4
Measures taken during illness

Measures	Bangladeshi				Indian	
	At home		Abroad		At home	Abroad
	Male	Female	Male	Female	Male	Male
Go to the local doctor's chamber	13	48		9	34	1
Buy medicine from pharmacy without doctor's consultation	27	7		1	14	3
Go to the local hospital	8	4		1		
Go to local Kabiraj and homeopathic		7			1	
Go to NGO's health clinic		27				
Do not seek medical assistance or take any measure	2		50	82	1	47
Total	50	93	50	93	50	50

Condition of the working place

The working conditions of both groups abroad were poor. Although Bangladesh and India set up several terminals in the land ports, they did not provide accommodation facilities for truck drivers and helpers. Most of the truck drivers and helpers had to stay or sleep inside the trucks. The land ports authority also did not provide any cooking facilities for them, thereby forcing them to cook by the roadside, which raises concern over the lack of food hygiene. Those who had better income stayed in the local mess where they had to pay approximately Taka 20–30 per night. Few respondents stayed in the nearby slum, commonly known as *jhopra patti.* In the FGDs with the local community and individual interviews, it was revealed that these *jhopra potties* were controlled by local *mastans* and ran by the sex workers.

The work condition of Bangladeshi sex workers both at home and abroad was found to be poor and unhygienic. Some of them used their own houses for

work. Nevertheless, most of them said that their work places were in the *jhopra patti* or local mess. Respondents in the Dinajpur district stated that they rented a house on a monthly basis and paid Taka 450 per month. Those who worked in Mumbai and Delhi lived in brothels. It was known that respondents who lived in slum areas were more vulnerable than those who lived in rented or their own houses. There is a sense of independence in the latter group as opposed to those living in the slums, where there was very little privacy. Men and women living in the slums are more susceptible to various kinds of risks. They are tempted or motivated or forced by others to indulge in illicit emotional involvement and sexual activities. One female interviewee told that the living environment in the self-built houses was better than in the *jhopra patti*. Female respondents who lived in their own houses found it safer and more secure, and hence were less vulnerable than those living in the slums or mess.

Conclusion

This chapter has demonstrated interesting findings about the social behaviour of respondents including their state of socialization, their leisure and entertainment and the conditions of their working place. As far as leisure and entertainment are concerned, male and female interviewees stated that they used to spend time with family, neighbours and friends. Watching movie in the VCRs and going to the cinema halls were popular modes of entertainment. Many of them also engaged in sexual activities, alcohol drinking, injectable drugs use. The study has also found that those who stayed in the slums were more vulnerable to behaviours that put them at risk to contracting HIV/AIDS than those who lived in their own or rented houses. Their attachment to a different socio-economic environment may expose them more to high-risk behaviour that, in many ways, is reflected in his or her sexual behaviour.

Notes

1. Phensidyl is a cough syrup that has been banned under the Drugs Policy of Bangladesh as an inessential drug. Initially, it entered the drug market as a cough syrup, but it was soon found to have particularly high alcohol content. Subsequently, Phensidyl has become a generic name for a cocktail of drugs, the basis of which may be the cough syrup.
2. VCDs are commonly used for watching pornographic films.

7

SEXUAL BEHAVIOUR OF THE RESPONDENTS

Individual sexual behavioural pattern is often an important indicator in the understanding of a person's vulnerability to HIV/AIDS. It has also become commonplace that vulnerability to HIV is greater when people are living and working in conditions of poverty, powerlessness and social instability. Separation from family and socio-cultural norms, isolation/loneliness, a sense of anonymity that offers more sexual freedom and inadequate financial resources make migrants more susceptible to adopting high-risk sexual behaviour (UNAIDS and IOM, 1998).

This section highlights the sexual behaviour of cross-border truck drivers and helpers and sex workers from Bangladesh and India. It concentrates on the type of sex practised by the interviewees including partnership in sex, sex acts at different stages of migration and the usage of condom during sex.

Type of sex

Among the cross-border interviewee migrants, 186, including 93 Bangladeshi female respondents, were found to be heterosexuals and seven to be homosexuals. Out of 93 females, five were married and two were deserted by their husbands. The study also found that 168 respondents were used to vaginal sex. Although male interviewees said that they had little idea about anal sex, 25 female respondents were used to having anal sex. These female respondents also said that as they were sex workers, they were used to having all kinds of sex, depending on their clients' preference.

TABLE 7.1
Type of sex

Marital status	Bangladeshi				Indian	
	Male		Female		Male	
	Heterosexual	Homosexual	Heterosexual	Homosexual	Heterosexual	Homosexual
Unmarried	20		1		12	
Married	30		58	5	38	
Separate			7			
Divorced			1			
Widower			8			
Deserted			11	2		
Total	50		86	7	50	

It is interesting to note that one FGD was conducted on a transgender[1] group of six members in the Dinajpur district. Their customers were both Bangladeshi and Indian truck drivers and helpers. Every day, they would cross the border to find their customers. During the FGDs, the local community observed that, for some reason, Indian border security force respects or bears with these transgender. When this group crosses the border, border security forces do not ask for any legal document. As a result, it turns out to be a more mobile group with easier access to either sides of the border and more heavily involved in the sex industry on both sides of the border. Thus, it appears that as far as cross-border migrants' social behaviour is concerned, a HIV/AIDS social awareness programme targeting only this group should be launched. In personal interviews with local community leaders in the Lalmonirhat and Jessore districts, they also reported that transgenders in their localities engaged in work in the sex industry. But, the research team did not find any transgender during its field visits to these districts.

First sexual experience

The study inquired about the age at which interviewees had their first experience of sex.[2] Table 7.2 shows that female respondents had their first experience of sex between the age of nine and 15. Most women had their first experience of sex from as early as 15 years of age. All except six females respondents had their first experience of sex before they were 15 years old. For all the female

respondents, the average age of their first sexual experience was 12.26 years old, with the oldest being 24 years old and the youngest, nine years old.

For the male respondents, however, the age of their first experience with sex ranged between 12 and 20 years old. The average age at which Bangladeshi men first had sex was 16.90 years old; for Indian men, it was 17.96 years old. One hundred men, comprising more than half of the total respondents, stated that they had their first experience of sex below the age of 20. It implies that men and women begin to experience sex at an age when they have little information about HIV/AIDS and other STIs. This invariably increases their vulnerability to HIV/AIDS.

TABLE 7.2
Distribution of the interviewees' ages when sex was first experienced

Age group	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
0–10		27	27		
11–15	13	60	73	10	10
16–20	34	5	39	35	35
21–25	3	1	4	5	5
Total	50	93	143	50	50

TABLE 7.3
Interviewees' ages when sex was first experienced

Age	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Average	16.90	12.27	14.59	17.96	17.96
Minimum	12	9	9	14	14
Maximum	24	24	24	25	25

First sex partner

Thirty-four women said that they first experienced sex with their husbands. Given the fact that they had their first experience of sex at an early age, it can only imply that female respondents were married at an early age. Extra-marital sexual relationship has been identified by researchers as one of the main sources

of HIV/AID infection. There were 33 women who said they had their first experience of sex with lovers. It was difficult for the research team to analyse the role of extramarital relationship on sexual behaviour because of the non-disclosure of facts by the respondents on this sensitive matter. However, female respondents stated that they first had sex with their boyfriends and thought of getting married in future. But, in the end, they were cheated by their boyfriends and consequently did not marry them. Nine female respondents first had sex with neighbours and three with relatives. Ten female respondents said that their first had sex with their clients. One female respondent stated that she was born and brought up in an Indian brothel. Naturally, her clients had been her first and main sex partners. It is interesting to note that there were four women who said they first had sex with border security personnel. In personal interviews with them, they said that their first occupation was in informal border trade. One day, their goods were seized by the border security forces. The border security forces offered release of their goods in exchange for sex with them. They agreed to this proposition because they had not only invested their own money in the purchase of the goods but had also borrowed capital from NGOs, as well as from local and non-local *mohajons*.[3] If their goods were seized, they would have to bear the loss for the entire year.

In contrast, most male respondents first had sex with persons who were not their legitimate partners. Their sex partners included relatives, lovers, neighbours and sex workers. A total of 52 male respondents first had sex with sex workers. Among them, 28 were Bangladeshi and 24 were Indian. The age of Bangladeshi male who first had sex with sex workers was between 16 and 30

TABLE 7.4
Distribution of interviewees' first sex partner

First sex partner	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Relatives	5	3	8	4	4
Lovers	5	33	38	9	9
Neighbours	11	9	20	10	10
Husband/Wife	1	34	35	3	3
Sex worker/Client	28	10	38	24	24
Border security forces		4	4		
Total	50	93	143	50	50

and for the Indian male, it was mostly between 21 and 35. Only four of the male interviewees said that it was their wives with whom they first had sex.

The study tried to find out from the respondents the motivations for having sex the first time. Seventy-one per cent of the interviewees comprising 75 female and 62 male said that they participated in it willingly. Sexual relations between husband and wife is normal and a legitimate phenomenon. It is interesting note that 16 women reported that it was their lovers or border security forces who forcibly made them first had sex. Male and female interviewees who first had sex with sex workers and clients were encouraged to do so by their friends. This indicated that peer pressure was the reason for the cross-border migrants' initiation into sex.

TABLE 7.5
Distribution of first sex experience

First had sex	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Willingly	29	75	104	33	33
Forcibly		16	16		
Encouraged by others	21	2	23	17	17
Total	50	23	143	50	

Sex experience abroad

Cross-border migrants are considered as being in the high-risk group for contracting HIV/AIDS. The extent of participation in sex with different people will therefore indicate increased vulnerability. It is interesting to note in connection to this that 65 per cent interviewees, comprising 69 per cent female and 31 per

TABLE 7.6
Opportunity for sex abroad

Having sex aboard	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Yes	9	88	97	30	30
No	41	5	46	20	20
Total	50	93	143	50	50

cent male, said that they had the opportunity to pay for sex aboard. Among 30 Indian male respondents, 20 had paid for sex in Bangladesh, seven in Nepal and three in Bhutan.

The study identified the frequency of sex for the interviewees when abroad. Of 88 female respondents, 79 said that they had sex abroad once or twice a week, five once or twice a month and three several times a month. Female respondents stated that the frequency of sex abroad depended on the availability of customers. The situation in the border areas is also important in increasing the chances of cross-border movement. They also reported that during festivals such as *Eid*[4] or *Durga Puja*[5] or local festivals, crossing the border becomes less of an obstacle. During these occasions, they can easily cross the border and get more customers. On the other hand, out of 14 male respondents, nine cross the border several times a month, eight once or twice a month and five once or twice a week.

TABLE 7.7
Frequency of sex abroad

Frequency of sex aboard	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Once a week		1	1	1	1
Once or twice a week		79	79	4	4
Once or twice a month	3	5	8	5	5
Several times a month	6	3	9	5	5
Never had sex	41	5	46	35	35
Total	50	93	143	50	50

The study identified a large number of individuals avoiding sex abroad. Table 7.8 reveals that different reasons had been given for not having sex abroad. Each respondent also had multiple answers. The first and foremost reason—fear—for not having sex outside the country was provided by 34 male respondents. The lack of opportunity and money, fear of losing their job, fear of law enforcement agencies and fear of contracting diseases were described as reasons for male interviewees not engaging in sexual activity

abroad. Twenty-four male respondents stated that they never had sex outside the country. On the other hand, five female respondents mentioned the lack of opportunity as the reason for not having sex abroad. They went to India to sell sex but did not find any customer.

TABLE 7.8
Reasons for not having sex abroad (multiple)

Reasons for not having sex abroad	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Faithfulness towards husband/wife	1		1	4	4
Lack of courage	21		21	13	13
Lack opportunity	9	5	13	6	6
Fear of law enforcement agencies	7		7	12	12
Fear of diseases	2		2	7	3
Fear of losing job	4		4	11	11
Lack of time	3		3		
Lack of money	4		4		
N/A	9	88	96	15	15

Sex partners at different stages of migration

Table 7.9 shows the comparison of sex partners of the respondents before, during and after migration. Each respondent had multiple sex partners before, during and after their migration. Before migration, 69 male respondents experienced sex with sex workers. Thirty-three male respondents experienced sex with their wives. However, 68 respondents said that they had multiple sex partners including neighbours, relatives and lovers and eight respondents stated that they did not have a sex partner before migration.

Compared to the men, 64 female respondents had sex with their husbands before migration. As most women worked in the sex industry before migration, they had multiple sex partners, including lovers, neighbours, relatives, clients, Bangladeshi and Indian truck drivers and helpers, before migration. It is interesting to note that 25 women were found to have sex with Bangladesh border security

forces, while five of them had sex with Bangladesh police. One female respondent also had a sex partner in her female friend and another had her house employer as her partner. It was also found that during the time of cross-border migration,

TABLE 7.9
Sex partners at different stages of migration (multiple)

Sex partner	Sex partners before migration			Sex partner after migration			Sex partner during migration		
	BD Male	BD Female	IN Male	BD Male	BD Female	IN Male	BD Male	BD Female	IN Male
Husband/ Wife	16	64	17	20	69	24			
Lover	9	42	18		57				
Neighbour	17	13	12	4	23	3			
Relative	8	6	4	2	7	3			
Sex worker/ Client	41	6	28	24	33	25			
House employer		1			2				
Friends		1			7				
Bangladesh border security force		25			32			9	
Indian border security force					33			14	
Bangladeshi police		5			25				
Indian police					21			8	
Local mastan								17	
Bangladeshi truck drivers/ helpers		58			62				
Indian truck driver/helper		56			59				
Never had sex	8	2							

* BD: Bangladesh; IN: India

23 female respondents were forced to have unpaid sex with border security forces and another eight female respondents with the Indian police. They also mentioned that if they did not comply, they could not cross the border. Seventeen female respondents said that local *mastans* in both the countries also forced them to sex with them for no payment. They had to agree for their own security.

The study also found some similarity between the sexual behaviour of both men and women after migration. It was seen that the number of male and female respondents having multiple sex partners has increased. One hundred and thirteen interviewees, including 69 female and 44 male, said that they had their spouse and others as their sex partners after migration. Data indicate a trend where men were more dependent on their wives for their sexual needs. This was also conditioned by social rules, norms and fears of stigma within the country. Nevertheless, 61 men practised sex with neighbours, relatives and sex workers. It was noted that some male respondents reported that they used to have sex with sex workers but they stopped after marriage. On the other hand, although 69 female respondents used to have sex with their husbands after migration, they also had sex with multiple partners. Incidences of female respondents having sex with boyfriends increased after migration from 42 to 57 respondents. The reason was that many female respondents were widowed, deserted or separated. They had boyfriends both at home and aboard. After migration, they experienced sex with border security forces, police, truck drivers and helpers. Clients in the sex industry had also increased. It is interesting to note that after migration, seven had experienced sex with their female friends whereas only one experienced it before migration. Female respondents stated that they were not used to have sex with another female before migration. But, their perspective changed after having sex with Indian females.

Sex experiences in different places

The study tried to identify the incidences of sex experienced by the respondents at different places in India and Bangladesh. As we mentioned earlier, nine Bangladeshi and 20 Indian truck drivers and helpers had experienced sex abroad. Bangladeshi males had sex mostly in the Calcutta district and Jalpaiguri district of West Bengal in India. In their own country, they had sex in almost all districts of Bangladesh. Transport stations and border areas of the districts were the main areas they had sex. Annex 10 shows the places in both the countries where the respondents had sex. Indian truck drivers and helpers also had sex in the border

towns, land ports in Bangladesh and India. Few of them had sex in the districts of Mymensingh and Chittagong. However, Indian truck drivers and helpers also had sex in the greater West Bengal of India, Mumbai, Bihar, Gujrat, Andhra Pradesh, Uttar Pradesh, Chattisgar of India. On the other hand, Bangladeshi female sex workers' concentration was in different border land ports in both India and Bangladesh. However, few of them had sex in Delhi and Mumbai.

Use of condom

The vulnerability of a person to HIV/AIDS is also dependent on his usage of condoms. Bangladesh has recently recorded a sharp reduction in birth rate. This signifies the success of family planning methods and campaigns. Although the use of condom has great importance as a birth control measure, it can gain popularity as a safeguard against HIV/AIDS. The successes of other family planning methods reflected less usage of the condom. In the study, 66 male and 56 female respondents were found to have used condoms during penetrated sex. The rest of them said that they did not use condom during sexual intercourse.

TABLE 7.10
Respondents' condom usage

Use of condom	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Yes	34	56	90	32	32
No	16	37	53	18	18
Total	50	93	143	50	50

Again among those who used condoms, only 47.5 per cent said they used condom on a regular basis. The rest of the 52.5 per cent stated that they did not use condoms regularly during sexual intercourse. The research found mixed answers from the respondents with regards to the reason for not using condom on a regular basis. Female respondents said that there was a shortage of condoms in the locality. Only one or two NGOs provided free condoms. But these NGOs were shut down a few years ago. One NGO was still providing condoms but

they were not sufficient. Condoms were not available in the local shops either. Sometimes, shopkeepers either charge a high price for one condom or do not sell them individually. The respondents, therefore, had to buy a full packet which was, at times, beyond their means. They also maintained that they cannot afford to lose time putting on a condom before making out with the customers. However, many customers do not want to use condoms even when the respondents pressed them to.

Female respondents stated that when they informed the customers about the risk of contracting HIV/AIDS, the latter were not concerned, and would sometimes even respond by saying "It is not your headache if I die". On the other hand, male respondents mentioned the shortage of condoms. They also said that they did not feel comfortable using a condom during sexual intercourse.

TABLE 7.11
Frequency of condom use

Frequency of condom use	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Regular	15	27	42	16	16
Often	3	7	10	3	3
Sometimes	16	22	38	13	13
Total	34	56	90	32	32

Conclusion

This chapter discussed sexual behavioural pattern as one of the easiest and most effective criteria for assessing a group's or community's vulnerability to HIV/AIDS. The study found that the interviewees were mostly heterosexuals although seven were homosexuals. The study also found that men and women were married and had sex at an age when they had very little knowledge of safe sex. This particular finding is true for the rural areas all over Bangladesh.

For many respondents, having one sex partner led to boredom and, ultimately, they ended up satisfying their sexual needs with persons other than their legitimate or regular partner. The study revealed that limited sources and opportunity for entertainment resulted in a section of men using sex as a form

of entertainment. Paying for sex has severe consequences in the detection of HIV/AIDS cases.

A comparative study of sexual behaviour during the time of migration and after the return from aboard indicates greater sexual activity and that too with multiple partners. The study also found low and irregular condom use—which posed a high HIV/AIDS risk factor—among cross-border labour migrants.

Practising safe sex depends in many ways on one's awareness and knowledge of STD and HIV/AIDS. In relation to this, it is pertinent to examine the cross-border migrants' awareness of HIV/AIDS and STDs.

Notes

1. Transgender is locally called *hijra, a* sexually handicapped person who is either a hermaphrodite or a eunuch or of equivocal malformation viewed as neither male nor female. Retrieved on 15 December 2007 from banglapedia.org/HT/T_0213.HTM.
2. Here, sex means penetrated sex.
3. *Mohajon* is a local word for a person who offers loans to people usually at a high interest rate.
4. Eid ul-Fitr is an Islamic festival that marks the end of Ramadan, the month of fasting. Retrieved from en.wikipedia.org/wiki/Eid_ul-Fitr. Eid ul-Adha takes place on the tenth day of the Islamic month of Dhul Hijja. It is one of two Eid festivals that Muslims celebrate. Retrieved from en.wikipedia.org/wiki/Eid-ul-Adha.
5. Pūjā is a religious ritual of the Hindu community where they pray or show respect to God (or godess). Retrieved from en.wikipedia.org/wiki/Puja.

8

KNOWLEDGE OF HIV/AIDS AT THE BORDER

It is generally assumed that there is a low level of understanding of the deadly disease HIV/AIDS among the people at the border. Several factors may contribute to this, including that the fact that HIV/AIDS may not be sufficiently prevalent to create a natural awareness among people. Those who are identified as being infected with the virus often hide their illness from others. Furthermore, the low literacy of the masses deters them from obtaining more information about HIV/AIDS. This section highlights the respondents' awareness of HIV/AIDS. The section will also focus on the respondents' knowledge of other sexually transmitted diseases and condom use.

Perception about AIDS

The interviewees were asked about the ways a person may become infected with HIV/AIDS. Thirty-five per cent were found to have no knowledge of the issue. The other interviewees were found to have an idea about HIV transmission, that it includes sex with a HIV-positive individual, having more than one sex partner, sharing needles, receiving infected blood, mothers infecting the foetus and breast feeding by an infected mother. Female respondents were found to be less informed about the modes of HIV transmission than male respondents.

When queried about the modes of HIV infection, sixty-two male respondents—the highest number of the male interviewees—identified it as not using a condom. The second highest number of male interviewees—59 males—said that injecting with an infected needle is a cause of HIV/AIDS; thirty-seven male interviewees mentioned receiving infected blood, 28 mentioned having sex with sex workers and 27 said sex with a HIV-infected individual. Three

men said that breastfeeding by an infected mother could spread the virus to a child's blood. Transmission of HIV/AIDS from an infected mother to a foetus was identified by four male interviewees and five male respondents mentioned using contaminated old blades for shaving. It is interesting to note that 10 male respondents incorrectly mentioned other "causes" of transmission. These respondents stated that HIV could be contracted by showering, eating or sharing water with or touching another HIV-infected person. Some respondents said that the virus could be transmitted through mosquito bites. A small number of respondents cited that used or old condoms could be a source of transmission.

This study found that, out of a total of 93 female interviewees, the largest proportion—43 females—identified not using a condom as a cause of transmission. Thirty-five female interviewees identified injecting with an infected syringe while 31 female respondents mentioned having sex with infected people as potential causes of spreading HIV. However, 12 female respondents identified having sex

TABLE 8.1
Interviewees' perception of HIV/AIDS transmission (multiple)

Modes of HIV/AIDS transmission	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Sex with HIV-infected individual	13	31	44	14	14
Receiving infected blood	21	19	40	16	16
Injecting with an infected syringe	31	35	66	28	28
From infected mother to foetus	3	14	17	1	1
Through breastfeeding	1	10	11	2	2
Not using condom	30	43	73	32	32
Having sex with sex worker/ clients	14	12	26	14	14
Using contaminated old blades for shaving	4		4	1	4
Others	1	11	12	9	9
Do not know	10	46	56	11	11

with an unknown customer as the prime cause of HIV infection. Nineteen said that receiving infected blood could cause AIDS. Transmission from an infected mother to her foetus or breastfeeding by an infected mother was mentioned by 24 women. The study notes that 46 respondents had no knowledge of this issue. Eleven respondents who mentioned "others" stated that they had previously heard of the virus' name but could not remember any details. However, they also mentioned that showering, eating or drinking water with or touching a HIV-infected person, or using an old condom could be potential causes of infection.

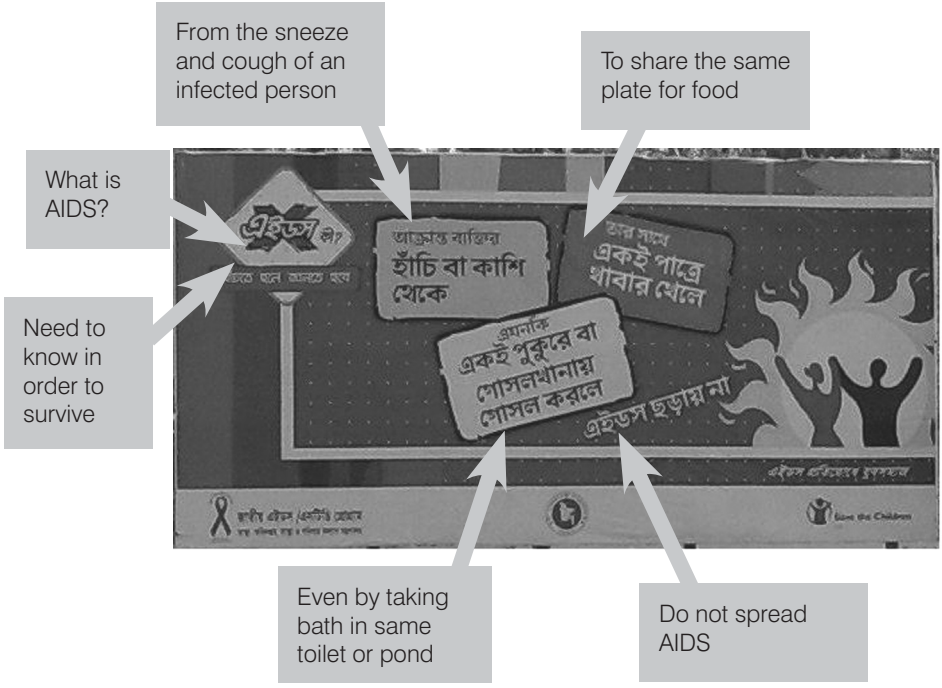
The researchers noted that during personal interviews with respondents, the majority tried to avoid saying that the virus could be transmitted by having sex with sex workers/customers. It seems that they avoided highlighting this issue as they were working in the sex industry. Researchers also noted that some interviewees initially showed awareness of the issue but were later found to have little knowledge of HIV/AIDS when it was discussed in depth. The study found that most respondents knew that a person could be infected by not using a condom. However, 30 per cent of total respondents did not use condoms regularly during sexual intercourse. Thus, it is important to consider the behaviour of individuals in addition to their awareness of the issue.

The research also sought to consider the respondents' knowledge of HIV/AIDS prevention. Most respondents (126) answered that using a condom is an effective way of preventing HIV infection. This was followed by the response from 85 respondents that using a sterilized syringe is another method of prevention. Fifty-three respondents identified blood screening before transfusion as a preventive measure to combat AIDS. Nineteen interviewees opined that prohibiting sex may be a way of preventing HIV amd 14 mentioned keeping sex confined between a married couple. Having only one sex partner was another reply given by only 16 interviewees. It is interesting to note that 18 respondents could not remember any preventive methods for combating AIDS. Altogether, 67 interviewees had no knowledge of HIV prevention. It was further noted that the educational level of interviewees suggests that those who had some knowledge of AIDS obtained it from doctors or counsellors. Respondents also stated that NGOs workers came and told them about the risks of HIV/AIDS. As most of the respondents were not literate, it was difficult for them to remember anything.

TABLE 8.2
Interviewees' awareness of HIV prevention

Ways to prevent AIDS infection	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Using condom	38	50	88	38	38
Having only one sex partner	1	12	13	3	3
Limit sex to married couple	2	11	13	1	1
Not having sex at all	3	13	16	3	3
Screening blood before transfusion	19	18	37	16	16
Using sterilized syringe	32	23	55	30	30
Others	1	17	18		
Do not know	10	46	56	11	11

FIGURE 8.1
The government- and Save the Children Fund-sponsored billboard on the AIDS awareness campaign



The research team tried to investigate why some respondents had said that showering, eating or drinking water with or touching a HIV-infected person could be potential causes of infection. It was found that the respondents knew or heard this information from the billboard at the Jessore Benapole border post. The research team took a photo of the billboard and found some anomaly. Although the intent of the messages on the billboard was alert the people about the risk of HIV/AIDS, it might have sent out the wrong messages. If you read the sentences in Figure 8.1, you can see that the last small sentence reads "Do not spread the AIDS", which many respondents could not read or understand properly. The study earlier also mentioned that most of the respondents were not literate; therefore, it was hard for them to understand the messages on the billboard. The message should be written such that it is understood by everyone, including people who are illiterate.

Sources of information

Any information to be disseminated needs to be communicated effectively through the media and this is also true for the awareness campaign against HIV/AIDS. When asked, interviewees said that they came to know about the disease from various sources, such as radio, television, newspapers, posters, local NGOs and other people.

Table 8.3 indicates that most of the respondents learnt about HIV/AIDS from local NGOs and health workers. Many interviewees have ranked television as the most effective means for disseminating information about HIV/AIDS. Posters, local NGOs and doctors were also identified as sources of information by the interviewees.

According to the study, although the impact of television is perceived to be very high, the interviewees' access to it seems limited. Limited economic resources, coupled with a low level of education, allow only a small percentage of people to access electronic and print media. It is interesting to note that few Indian male respondents stated that they received information on AIDS prevention from the FM radio in their trucks. Nevertheless, not every truck had an FM radio. However, some respondents said that many Bengali-speaking Indian drivers and helpers could not understand the messages as they are in Hindi. In addition to this, there were no FM radio facilities at the border areas in Bangladesh. Bangladeshi truck drivers and helpers reported that they did not receive

TABLE 8.3
Interviewees' source of information for HIV

Interviewees' source of information for HIV	Bangladeshi						Indian		
	Male			Female			Male		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
Radio		2	2		3	8		6	6
Television	19	9	6	9	35	12	22	11	2
Newspaper	1						1		
Other people		2	4		14	1		1	
Poster	3	6	8		7	12	1	5	5
Signboard/ billboard	5	11	9	2	6	6		8	12
Local NGOs and government health worker	14	9	6	59	13	2	23	4	6

any radio frequency in the border areas and, as a result, they did not receive any HIV/AIDS prevention messages from the radio.

Most respondents mentioned that very limited work relating to HIV/AIDS was done by NGOs. Though some materials written on the walls about AIDS and its prevention were evident at some study sites in the Jessore, Dinajpur and Lalmonirhat districts, these areas lacked concrete advocacy programmes on the prevention of AIDS. It should be noted that no other NGOs except Social Marketing Companies (SMCs) at the Benapole land port of the Jessore district and the Hili land port of the Dinajpur district had any activities on health issues, including advocacy programmes on the prevention of AIDS. Previously, there had been a few NGOs with activities on the prevention of AIDS at the border areas, but these have now closed down. National NGOs with programmes on HIV/AIDS were found to be based only in cities and not in the border areas. However, the lack of awareness about HIV/AIDS among respondents indicates only a limited involvement of NGOs in this areas. Interviewees made the comment that they leave for work in the morning and return home when it is nearly evening, thus any efforts by governmental or non-governmental bodies, if they exist, would not likely reach them.

The study also tried to determine whether respondents received any information on the prevention of or treatment for AIDS from NGOs or government agencies in destination countries. Only 24 respondents comprising 10 Indian males, 13 Bangladeshi females and one Bangladeshi male received information on or treatment for HIV/AIDS. However, the level of information or treatment received varied significantly. Among the Indian male respondents, six respondents stated that they received information on the prevention of AIDS from NGOs and four said they had given their blood to the NGOs for examination. It is interesting to note that respondents stated that although they had given their blood to the NGOs, they did not receive any results. Some respondents questioned why NGOs had taken blood from them and not others. The researchers noted that few NGOs were working in the study sites but, a few years ago, all NGOs except SMC had been shut down. The immediate impact was that, when asked what they had learnt from the NGOs, the interviewees replied that they could not remember. It was also noted that

FIGURE 8.2
Non-functional local NGO office in the Bhurimari land port (Note the messages on HIV on the wall)

when the research team interviewed the respondents, most of them asked for gifts, as NGOs used to provide them with food and gifts. When the research team was unable to provide such incentives, potential respondents did not show any further interest in being interviewed. On the other hand, Bangladeshi male and female respondents received information on preventing AIDS from NGOs and government health workers. The study found that 87.6 per cent of total respondents did not get any information on or treatment for HIV/AIDS in their destination country.

In the FGDs with the local journalists of the Jessore, Dinajpur and Lalmonirhat districts, questions were asked about their role in preventing the disease. Journalists from the Dinajpur and Lalmonirhat districts stated that they have no funds with which to carry out awareness campaigns. However, they reported attending roundtable discussions or seminars at the local level organized by NGOs. FGDs with local journalists in the Jessore district about their involvement in HIV/AIDS prevention initiatives drew a negative response; they were totally against assuming any role in carrying out awareness programmes. They argued that Jessore is one of the main routes used for human trafficking and, as a result, people from other districts display a negative attitude towards them. They do not even give their sons and daughters in marriage to good families from the district. Under these circumstances, journalists stated that if they were to conduct a HIV/AIDS awareness campaign, people from other districts might think that Jessore is exporting HIV/AIDS to other districts, thus giving the place a bad name.

Questions were also posed to governmental officials and health complex officials at the study sites about their role in preventing the disease. They stated that they do not have specific programmes to raise awareness about HIV/AIDS. However, other related programmes included treatment on STDs or STIs for women. On International AIDS Day, they participated in the rallies organized by NGOs, with the government having no special funds or regulations in the organization of rallies, seminars or workshops on HIV/AIDS. However, the government officials and health complex officials mentioned that they have large physical structures in the *upazila* complex and union parishad complex, in which they allow NGOs to organize seminars, conferences or workshops with official staff supporting them.

FIGURE 8.3
The poor condition of a government billboard at the Hili land port

Perceptions of sexually transmitted diseases

There is a close connection between AIDS and other sexually transmitted diseases. Individuals carrying STDs are generally considered to be more vulnerable to HIV. The rate of STD patients getting infected with HIV is much higher than non-patients.[1] For the effective prevention of AIDS, it is important that STD patients avoid high-risk behaviour and, as such, they should be aware of STDs.

The study sought to determine the interviewee's understanding of STDs. Forty-six per cent of the respondents stated that they knew what STD was. Gender-segregated data found that 18.26 per cent men and 81.7 per cent women knew about STDs. Among the male respondents, nine Bangladeshis and 10 Indians knew what STD was. It was observed that the male respondents were less informed about STDs than the female respondents. However, in most cases, women failed to recognize the disease even though they knew many of the symptoms and signs of STDs.

TABLE 8.4
Interviewees' knowledge of STDs

Knowledge of STDs	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Yes	9	70	79	10	10
No	41	23	64	40	10

The study found that interviewees had difficulty describing the symptoms of the various STDs. Out of 89 respondents, 73 interviewees mentioned that by STD, they meant discharge, which is a common sign of gonorrhoea and chlamydia. Seventy-one identified an itching vulva, burning micturition and pain in the lower abdomen with diseases such as trychomonilious, vaginalis, genital harpis and candidasis. Genital wart, rash, scarves and bubo were detected by 46 of the interviewees, which may indicate trychomonilious, vaginalis, pelvic inflammatory disease (PID) and candidasis. Six interviewees said that they had heard about scrotal swelling and eight mentioned inaugural bubo.

TABLE 8.5
Interviewees' description of symptoms of STD/STI

Symptom	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Discharge	4	55	59	6	6
Itching vulva, burning micturition, pain in lower abdomen	8	53	61	10	10
Dysperunea		23	23	5	5
Genital wart, rash, scarves and bubo	6	37	43	3	3
Scrotal swelling	1	1	2	4	4
Inguanal bubo	1	4	5	3	3
N/A	41	23	64	40	40

The study also tried to identify respondents who could not describe the symptom of various STDs. Some of these respondents mentioned physical problems that related to such STDs instead. Twenty-seven of the interviewees were experiencing discharge; 32, an itching vulva, burning micturition and pain in the lower abdomen; eight, genital wart, rash, scarves and bubo; eight, scrotal swelling; and five, inaugural bubo. Thus, it can be concluded that, like other truck drivers and helpers and sex workers, many of them had no knowledge of STDs. Even though they were facing these physical problems, they were totally ignorant of the diseases causing them and the treatment required. Therefore, a campaign to create awareness is needed particularly in this area.

Experiences of sexually transmitted diseases

Some of the interviewees experienced STDs while others acquired information from other sources. Twenty-five per cent of the people interviewed for the study were found to have experienced STDs. Among them, 10 were male and 26 were female. Thus, females respondents constituted a higher percentage of people who had experienced STDs in this study. It is interesting to note that 12 per cent of interviewees confirmed that they had never had STDs in their

TABLE 8.6
Symptoms experienced by the interviewees

Symptom	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Discharge	6	16	22	5	5
Itching vulva, burning micturition, pain in lower abdomen	13	13	26	6	6
Dysperunea	2	3	5		
Genital wart, rash, scarves and bubo	3	3	6	2	2
Scrotal swelling	4		4	4	4
Inguanal bubo		2	2	3	3

life, but 69 per cent of interviewees said that they were not sure whether they had experienced STDs at sometime in their life. It suffices to conclude that the actual number of interviewees suffering from STDs/STIs may be higher than that found in the study.

TABLE 8.7
Interviewees' experience of STD

Experience of STD/STI	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Yes	3	26	29	7	7
No	6	14	20	3	3
Do not know	41	53	94	40	40

Treatment of STDs

A prolonged bout of STD is more congenial for the transmission of HIV/AIDS. Therefore, it is important to determine the proportion of interviewees with STDs who sought treatment. The study found that out of 36 respondents who had STDs, 29 went for treatment.

TABLE 8.8
Sources of treatment for STDs/STIs

Sources of treatment for STDs/STIs	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
On his/her own		3			
Government hospital		1		1	1
Private hospital		1		1	1
Private doctor		7		3	3
NGO clinic		6		2	2
Pharmacy		1			
Hekim/*Kabiraj*		3			
No treatment	3	4			
Total	3	26		7	7

Interviewees were found to have sought treatment in private hospitals, clinics and pharmacies and from doctors and *kabiraz*[2]. Three interviewees informed us that they treated themselves. Ten interviewees mentioned that they consulted doctors about their problems while eight visited NGO clinics. Two interviewees went to private hospitals, one to a government hospital and three took herbal medicines *kabiraz.* It is interesting to note that seven did not receive any treatment. Though STDs are common in rural areas, cross-border migrants are particularly vulnerable because of their exposure to extramarital sex and sex entertainment.

Perceptions about condom usage

It has been established in the previous section on sexual behaviour of cross-border migrants that condoms usage is very low among respondents. Various interesting reasons were underscored by respondents. In the study, 66 male and 56 female respondents were found to use condoms during penetrative sex. The other interviewees stated that they did not use condoms during sex. Forty-two respondents said that they did not like using condoms, 25 respondents mentioned the lack of condom available at local markets while four stated that they did not know how to use a condom.

It was revealed from the interviews that 62 interviewees did not know the proper way to use a condom. One hundred and thirty-one interviewees comprising 61 females and 70 males could describe the proper way to use a condom. Table 8.10 shows that most male respondents correctly mentioned about covering an erect penis with a condom. Seventy-eight respondents mentioned about

TABLE 8.9
Interviewees' reasons for not using condom

Reasons	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
Do not know how to use it	3		3	1	1
Do not like to use it	12	15	27	15	15
Lack of availability	1	22	23	2	2
Total	16	37	53	18	18

TABLE 8.10
Respondent's knowledge of the proper use of a condom

Proper use of a condom	Male			Female			Total		
	Yes	No	Total	Yes	No	Total	Yes	No	Total
Checking expiry date	6	44	50	11	82	93	14	36	50
Uncovering carefully	18	32	50	37	56	93	23	27	50
Holding the top tightly	15	35	50	30	63	93	16	34	50
Covering erected penis with condom	17	33	50	61	32	93	17	33	50
Uncover penis after ejaculation	8	42	50	33	60	93	8	42	50
Tie a knot before disposal of the condom	11	39	50	42	51	93	15	35	50
Use a new condom each time	19	31	50	36	57	93	21	29	50
Do not know how to use a condom	19			32			11		

uncovering a penis carefully and 107 of them mentioned checking the expiry date and using a new condom each time.

Conclusion

It can be seen from the above discussion that generally cross-border migrants lack a proper understanding of HIV/AIDS. Many of them had heard of the name of the virus or its syndrome though they could not describe how the virus spreads or how to prevent HIV. There were also prevailing misconceptions about the modes of HIV transmission, including touching or sharing essentials of an HIV-infected person. As there is social stigma attached to the disease, there was a tendency among infected persons to hide their infection.

The section also indicates that cross-border migrants lack access to the electronic and print media, as well as to other popular means of communication. Interviewees also expressed the opinion that the messages provided by television and radio advertisements were not comprehensive and did not highlight the importance of the issue. The generally low level of awareness about HIV/AIDS is

also partly due to the limited NGO involvement in the rural areas. Interviewees also said that there were hardly any awareness-raising programmes on preventing HIV/AIDS in their host country. Of course, respondents had viewed some billboards, wall writings and advertisements in the electronic media but these were not found to be sufficiently effective.

The study also made important findings about STD/STI prevalence among cross-border migrants. Some respondents, who had STIs or who knew about the different symptoms of STIs did not equate their disease with having STD; some were not even acquainted with the term. Those who had been infected often avoided treatment, either because they could not afford it or they did not want to make their infection public knowledge.

As was seen in the previous chapter, condom usage was found to be very low among the target population. An investigation into the reasons for the limited use suggests that there is a lack of awareness of the benefits of condom usage and its proper use, and prevailing misconceptions about condoms. The limited condom use can also be attributed to the greater use of birth control pills and injections by female partners.

Based on these findings, the concluding section will provide policy recommendations on how to minimize the threat of HIV/AIDS among cross-border migrants in Bangladesh and India.

Notes

1. It was found that Human Immune Virus (HIV) has a fatal attraction to lymphocytes. Lymphocytes remain in any area of infection. Some of the STIs such as syphilis, genital harpis, chancroid, granuloma, inguanalis and scaves cause ulcer in the genital area. During intercourse with a HIV/AIDS-infected person, the HIV virus gets into the body through this ulcer.
2. A person who provides herbal medicine.

9

CONCLUSION AND POLICY RECOMMENDATIONS

Conclusion

In today's globalized world, HIV/AIDS is a major threat that every country has to address. While HIV prevalence in Bangladesh is still very low—well below one per cent—recent data show that it is rising significantly, with the number of HIV-positive individuals increasing. Bangladesh shares a long border with India. People from both countries continue to cross the porous borders through many unofficial transit points with relative ease. It is a matter of great concern that the neighbouring countries of Bangladesh, India, Myanmar and Nepal are considered major sources of the Human Immunodeficiency Virus (HIV). Therefore, there is a risk of the spread of various diseases across the border. In order to protect a densely populated country like Bangladesh, it needs early and timely intervention. The assessment of cross-border migrants' vulnerability to HIV/AIDS is part of such an effort geared towards making a baseline survey for intervention.

For analytical rigor, this paper extends the notion of securitization in exploring and framing the concerns over the spread of HIV/AIDS. It claims that concerns over the spread of HIV/AIDS at the border regions constitute a security threat that demands urgency and sustained policy attention. Such a security threat is broadly captured from a perspective of human security or non-traditional security (NTS), which puts primacy on the people, instead of the state as a unitary actor. The linkages between population mobility and HIV/AIDS are related to the conditions and structures of the migration process, including in communities of origin, during transit, at destinations and upon return. Factors linking population mobility and increased vulnerability to HIV include poverty, a lack of legal protection, discrimination and exploitation. Given the wholesale

denial of their basic rights, migrants do not have the opportunity or power to negotiate or bargain collectively for basic services and rights. Cultural and language barriers prevent them from accessing services. Each of these factors may increase the likelihood that people encounter HIV and the same factors also reduce an individual's ability to protect himself or herself from the virus. In the absence of adequate services and information, migrants not only become vulnerable to HIV but also unknowingly become a link in the transmission of the virus to others, including their spouses, to whom they return at periodic intervals. Population mobility may also affect the HIV vulnerability of people who do not migrate at all, such as people in communities along major transit corridors. Therefore, a multi-pronged approach is needed to minimize the risk of HIV/AIDS. The cooperation between the states is important in enabling them to utilize their resources.

To understand the nature and scope of the population movements and threats of HIV/AIDS, the current study interviewed 193 individuals, who engaged in cross-border migration and sexual activities. Of these, 100 are male truck drivers and helpers and 93 are female sex workers. Of the 100 truck drives and helpers, 50 are Indian and 50 are Bangladeshi. All the sex workers are Bangladeshis. However, the study conducted FGDs among the Indian female sex workers within the border areas of the Bangladeshi territory. A FGD was also conducted among the transgender community in the Hilli land port of the Dinajpur district.

The study found that the people in the border areas became engaged in cross-border migration at a very early age, considering it to be natural and obvious and thinking of it as a lawful profession. Although cross-border migration involved substantial risk, it helped them—at least—to survive. It was also seen that most males were married while many female respondents were widowed, separated or divorced. The level of education of female respondents was very low and their household had, on an average, more than five members. Therefore, the burden of having to share the responsibilities in the family also forced multiple members to become involved in paid work. As a result, it was not only these respondents alone but often other family members who were involved in such income-generating work. However, the study also found that truck driving or work in the sex industry was often not their first occupation; many also worked as farmers, labourers, day labourers or rickshaw pullers or were involved in petty trading. It is interesting to note, however, that besides housework, most

female respondents had only one occupation and many of them were involved in informal border trade.

Cross-border migration is occurring among the marginal sections of society, especially among the female population. It is known that there is limited income-generating work for women. Therefore, women take the risk to migrate and engage in work in the sex industry. Female respondents migrate to India on foot, by boat, bus or train and male respondents by their trucks. Some of the common destinations of the female respondents are Mumbai, Delhi and Calcutta, where they mostly work as dancers or sex workers in brothels. Social networks play a part in cross-border migration. During their journey, the women were accompanied by their neighbours, relatives, friends or middlemen as the ones crossing the border for the first time did not know the route. Sometimes, border security forces, local muscleman, middlemen and the police hindered their movement. Sometimes, they had to have sex with these people. On the other hand, the pattern of cross-border migration is a very different phenomenon for people who are engaged in the transport industry. Although they can legally enter the country, mostly for local strike, the bureaucratic procedure for clearing goods and trucks force them to stay away from their home for a longer period of time.

The social behaviour of the respondents including their socialization, leisure time, entertainment and the conditions of the working place leave them very vulnerable. They spent their leisure and entertainment time with their family, neighbours and friends. Watching movies in VCRs and going to the cinema halls were popular modes of entertainment. Many of them also engage in sexual activities, alcohol drinking and injectable drugs use . Those who stay in slums are more likely to engage in behaviours that make them vulnerable to HIV/AIDS than those who live on their own or in rented houses. Their exposure to a different socio-economic environment may leave them more vulnerable, given their access to behaviour that put them at greater risk. The social behaviour of a person, in many ways, is reflected in his/her sexual behaviour.

As far as sexual behaviour is concerned, the study found that men and women were married and had sex at an age when they had little knowledge about safe sex. For such an individual, ignorance and the boredom of having one partner for sex ultimately results in him/her satisfying his/her sexual needs with persons other than their legitimate or regular partner. Knowledge about safe sex was absent among the interviewees even during the survey. This was particularly true for the female respondents.

The study revealed that given the limited choices for entertainment, a section of men deemed sex to be a form of entertainment. Buying sex from a sex worker results in severe consequences as far as the detection of HIV/AIDS cases is concerned. A comparative study of the interviewees' sex activities during the time of migration and after returning home indicates a higher level of sexual activism and that too with multiple partners. The study also found low and irregular usage of condoms by the cross-border labour migrants, which is a high-risk factor in HIV/AIDS infection. Practising safe sex in many ways depends on one's consciousness and knowledge about STD-HIV/AIDS.

The general level of awareness of cross-border migrants about HIV/AIDS is very low. Many of them, though they had heard of the name of the virus or its syndrome, could not elaborate on how the virus spreads or how to prevent HIV. There were also misconceptions prevailing about modes of HIV transmission, including the touching or sharing essentials of an HIV-infected person. As there is a social stigma attached to the disease, there was a tendency for infected persons to hide their infection. Cross-border migrants also lack access to electronic and print media, as well as other means of mass media. Interviewees also expressed the opinion that the messages communicated via television and radio advertisements are not comprehensive and do not highlight the importance of the issue. The generally low level of awareness about HIV/AIDS is also partly due to the limited NGO involvement in the HIV/AIDS programme in the rural areas. Interviewees also pointed out that there are hardly programmes to raise the awareness on HIV/AIDS prevention in their host country as well. Of course, respondents had viewed some billboards, wall writings and advertisements in the electronic media, but these were not found to be sufficiently effective.

Policy recommendation

Governments

- Both the Bangladesh and India governments should take on joint projects to combat AIDS at the border areas. Projects including training, counselling, public meeting and rallies may be undertaken for awareness-building to this effect. Both countries should share resources, ideas, knowledge and financial capability so that one can fill up the other's gap.

- At the border areas, local government administrations of both countries can organize joint awareness campaign about the risk of HIV/AIDS. People should be provided with details of how the virus can be transmitted to others. The Bangladeshi people should be aware of the prevalence of HIV/AIDS if they go to India.
- There should be a commitment among the political leaders of both countries to address the issue of HIV/AIDS. Their vision should be included in their election manifesto. The government has to create a platform for the politicians to work together from the state to the grassroots level.
- The government should set up blood testing centre so that the people at the border areas can get free access to HIV/AIDS testing.
- The government has to take initiative to create awareness about the HIV/AIDS among the people in both countries including those in the law enforcement agencies, particularly in the border areas, through the print and electronic media. Special advertisement should target the people in the border areas.
- The government can also work in partnership with the NGOs. Sometimes, local NGOs do not get any fund for this so the government can provide the resources.
- Sometimes, there is a shortage of condoms in the border areas. The government has to take the responsibility to ensure that there is a continuous supply of condoms in the border areas. The condoms should be provided free among the marginal group of people.
- Due to health concerns, Bangladesh should take the initiative to encourage Indian truck drivers either to stay in Bangladesh or to check their health certificate.
- The government should create more employment, for example, in agro-based industrialization in the border areas.

NGOs

- NGOs working on the HIV/AIDS programme must increase their vigilance at the grass-root level. Project including training, counselling, public meeting and rallies should be undertaken to create awareness to this effect. Community leader and activities may have a big role to play in motivating the people.

- Once launched, the programmes should be continued as most of the people are illiterate and there is a need to remind them regularly.
- All NGOs programmes should be sustained even if there is a lack of funds. They should not terminate the programmes if they face a shortage of fund; the big donor agencies should come forward with financial support.
- Both the local and national NGOs should not concentrate their work in just one state. At the border areas, both the national and local NGOs should work together with NGOs of other countries.

Others

- Encourage media coverage in both countries to instil trust and confidence in the minds of the policy makers and politicians.
- Both sex workers and truck drivers and helpers should be encouraged to keep their sexual relationships within their marriage. They should be educated so that they would avoid having sex with sex workers.
- As the respondents were found to first experience sex at a relatively early age, education about safe sex should be provided to the illiterate mass. Radio, TV programmes, visual aids and multimedia on AIDS should be produced to augment their awareness level.
- Target groups should be educated about condom use and condoms should be made available at affordable prices.
- General information about the various types of STIs may be provided to potentials migrants and their families. They should be encouraged to see doctors and visit clinics and hospitals for the treatment of STIs.
- To reduce the vulnerability of mobile populations in the long term to HIV, the socio-economic factors that drive mobility should be addressed, including the uneven distribution of resources, unemployment, socio-economic insecurity, economic instability and political unrest.

10

CASE STUDIES

Bhurimari land port of the Lalmonirhat district

Case study 1

Rabeya is a sex worker who is in her mid 20s. She has her own homestead and cultivable land, which she managed to buy with her savings. She lives with her parents, a sister and three sons. Like her, her mother and sister are also sex workers. Her father is a stone-collector who collects stones from the river bank and her husband is a van-puller-cum-farmer. She has relatives in India and Bhutan. Her maternal grandfather is from Murshidabad, India, and her paternal uncle lives in Bhutan. She used to visit her relatives in both the countries by crossing the borders. She got married at the age of 12. Though she had her first experience of sex with her lover at the age of 10, she started to work as a sex worker in Bangladesh only two years after her marriage. She works as a sex worker in India too when she visits her relatives there. She goes to different places in India, like Changrabanda, Siliguri, Dugguri and Methliganj. In her earlier days, she did not face any problem crossing the border as she was with her relatives. She has visited various districts inside Bangladesh, like Lalmonirhat, Rangpur, Panchagarh and Nilphamari. She also worked as a sex worker in Bhutan but she could not recall the name of the place where she had worked. Her clients are truck drivers and helpers from both Bangladesh and India. She always tries to use condom during intercourse. But, sometimes she cannot use it due to their unavailability. She knows the proper method of using a condom. She heard about the term "AIDS" from the local NGO, but could not remember what it was all about. She is an "injecting drug user" (IDU) and shares needle/syringe. She has STDs and visits the local doctors for treatment. She loves to gamble.

Case study 2

Rokeya is a 30-year-old sex worker. She lives in Patgram Upzilla of the Lalmonirhat district. She used to go to India in her childhood to visit her relatives there. She used to live in the Johor Ali enclave, which is between Burimari and Changrabanda. For that reason, she was able to enter India by showing her voter card or identity card given by the UP chairman. Eventually, she started to smuggle sugar from India to Bangladesh. She also worked as a sex worker during that time both in India and Bangladesh. She went to different places in India, like Changrabanda, Shiliguri, Batabari, Methliganj and Jalpaiguri. In Bangladesh, she went to Lalmonirhat, Rangpur, Dinajpur, Bonmari and Jaldhaka. Though she got married at 12, she had her first experience with sex with her boyfriend at the age of 10. After marriage, she crossed the border for both smuggling and work in the sex industry. Therefore, the number of her clients increased, including truck drivers and helpers from both Bangladesh and India. She still works as a sex worker and also continues to do informal border trade. She has heard about "AIDS" but has forgotten everything about it.

Case study 3

Laboni is 33 years old and works as a peer for the HIV programme in an NGO. When she was 12, she travelled to India for the first time with her relatives. She is from a well-bred family but got involved in work in the sex industry in India out of interest. She got married at the age of 13. Though she was always economically solvent, she continued her sex work. She went to different places in India like Changrabanda, Shiliguri, Batabari, and Jalpaiguri for this purpose, She also worked as a sex worker in Lalmonirhat, Rangpur, Dinajpur, Jessore and Dhaka. She in still involved in this work because she really enjoys this. She is bisexual. Earlier, she also worked as a middleman (*dalal)* and took women to India for work in the sex industry. But, now she avoids crossing the border as it has become more risky. Her clients are the Bangladesh Rifles (BDR), the Border Security Force (BSF), the police (both in India and Bangladesh) and people coming from other places, like Dhaka.

She has a son and two daughters and one of them got married a few months back. She is an injecting drug user (IDU). She sometimes shares the same syringe with her close friends. She had STD but got cured after treatment. As a peer, she is well aware of AIDS and the benefits of using condoms. During her work as a public relation (PR) officer, she faces demeaning com-

ments from the local people. They say that the NGOs and their workers are spreading HIV as they have never heard about the disease before. People in the local communities avoid her and insult her whenever they get the chance. Moreover, the NGO for which she has been working has wound down their activities due to fund constraints. So, now, it is extremely difficult for her to continue her work without any wages. Her target group, the sex workers, is also less concerned about HIV and they have reduced the use of condoms due to its lack of availability.

Case study 4

Rafiq, a truck driver, is 27 years old. He has driving experience of almost seven to eight years. Before that, he was a helper. He studied up to Class VIII. His home district is Rangpur. He got married at the age of 16 and he has three sons. His monthly income is Tk. 6000. He has his own homestead. He has been visiting Changrabanda, India to supply goods for the last one year. In Bangladesh, he has visited places like Dhaka, Haluwaghat of Mymensingh and the Lalmonirhat station. When he visits these places, he has to stay for four to five days. During his leisure time, he plays cards with friends, consumes alcohol or has sex with sex workers. He has STDs but he has never used and still does not use condom while having sex. He once visited a local NGO for treatment but he is still suffering from STD due to his ignorance. He knows that it is possible to stop AIDS by using a condom but he is reluctant to use one.

Case study 5

Though Samina got married at the age of 10, her husband left her a few months later. She started work in the sex industry because she was unable to find any other means of livelihood. For this purpose, she went to India in 2004 and resided there for one year. She crossed the border from Burimari to Changrabanda on foot and went to Shiliguri by bus. From there, she went to Delhi by train. Her clients are both Bangladeshi and Indian truck drivers and helpers. She has also visited many places in Bangladesh—like Rangpur, Lalonirhat, Nilphamari, Gaibandha, Panchagarh and Rajshahi—with her clients. She has no idea about AIDS or how it spreads. Though she is not aware of STDs, she has STDs. Her clients do not use condoms when having sex with her.

Case study 6

Jarina started her married life at the age of 18. But, her entire life changed after that. She and her husband went to Shiliguri, India, in search of a better life. She stayed there for five years and began her work in the sex industry to earn more money. During that time, she visited places like Mathabhanga and Malbazar for work in the sex trade. She did not stop as a sex worker after returning to Bangladesh as it gave her economic independence. Her clients are both Indian and Bangladeshi truck drivers and helpers and Bangladeshi bus drivers. Her husband works in a hotel and also works as a *dalal* to bring clients to her and other sex workers.

Jarina, who does not know how to read and write, has visited Rangpur and Dinajpur for work in the sex trade. Though she does not know about STDs, she has all the symptoms. She does not know whether her clients have STDs. Her clients do not use condoms and she does not know how to use it. She heard about AIDS from a local NGO and she only knows that if someone has sex with an AIDS patient, she or he can be infected too. She knows that if someone has only one sex partner, he or she can be protected from AIDS.

Hilli land port of Dinajpur district

Case study 7

Aleya is a woman of 40. She crossed the border the first time for smuggling when she was only 13 years old. She had to have sex with the Bangladesh Rifles (BDR) personnel before she was allowed to cross the border. After that, she became a sex worker. Now, she lives beside the rail station with her two daughters and husband. She maintains her family and bears the expenses of her children's education, as her husband is a jobless vagabond. A woman, who is a *dalal*, suggested to her that she could cross the border to smuggle things like fruits, saris and cosmetics. She also encouraged her to work as a sex worker in India. Now, Aleya regularly crosses the border for smuggling and works in the sex industry. She often stays there if her clients so wish her to.

She went to the various districts of Bangladesh, like Rangpur, Dinajpur, Bogra, Lalmonirhat, Naogaon, Joypurhat, Rajshahi, Dhaka, Naraynganj, Panchagarh, Khulna, Jessore and Chittagong. She went to different places in India with her truck driver clients. They took her in and out of Bangladesh. She visited places

like Dakshin Dinjpur, Kolkata, Delhi, Mumbai, Shiliguri and Tirmoni in India.

She does not know how to read and write. Her clients include the BDR, the BSF, both Indian and Bangladeshi police and truck drivers and wholesalers in India. She is an alcoholic and is addicted to phensidyl. In her leisure time, she goes to the cinema or watches television. As she is a bisexual, she also has sex with her girlfriend when she has the time. She always asks her clients to use the condom but she does not know the correct way to use it. She uses condom to avoid unwanted pregnancy. Though she is familiar with term AIDS through NGO campaigns, she cannot remember how it is spread or how to remain safe from AIDS.

Case study 8

Tara, who is now 30 years old, was a *Jatra* artist since her childhood. She still sometimes goes there and earns Tk. 300 to Tk. 500. Her first marriage was with a man from the group. Unfortunately, the marriage did not last long. She has an 11-year-old son. Her father died when she was young and her mother got married again. She was brought up in her maternal grandparent's house.

Her lover, whom she met in Pabna after her divorce, had sex with her and promised to marry her. But, the man sold her to Lokman Palli—a brothel area—in Iswardi. She escaped from there two or three years later. In that place, she had neither heard of HIV/AIDS nor used condoms when she had sex with her clients. She heard about the disease two or three years ago when some people in her area carried out an HIV/AIDS awareness campaign. Some women visited her and taught her about the disease.

She does not have more than two clients per day. She earns Tk. 150 to Tk. 200 per customer. Her Indian clients—truck drivers and BSF—use condoms. BSF, both officers and soldiers, pay her Rs. 100 per person. They go in a group of two or three and she has five or seven BSF clients. Bangladeshi truck drivers do not want to use condoms. Many people from Dhaka, who come to the area for various reasons, also have sex with her. Some of these clients do not want to use condoms, even though they know about the risk of contracting HIV. She takes her clients to rented houses which cost Tk. 20 per day. She usually avoids the BDR as they pay less—only Tk. 20 to Tk. 30. But, when she crosses the border for smuggling, she sometimes has to have sex with them. She brings items like sugar, cosmetics and potato from India, and sells them in the local market.

She works as a peer for an NGO. She regularly tests her blood. She had

STDs but with regular treatment, she recovered. She bought 2.3 decimal lands for homestead, where she built a tin-shed one-storey cement house. She and her son live there. She has taken loans from two NGOs of Tk. 8,000 and Tk.9,000 respectively. She now repays Tk. 700 per week.

Benapole land port of Jessore district

Case study 9

Marium is a resident of Shashtitala of the Jessore district. She studied up to class VIII. Though most of the girls in her village get married between the ages of 13 to 18 years, she got married at the age of 27. As she has been a sex worker since her adolescence, it was difficult for her to marry someone. Now, she has a daughter and a son. Her husband is a fish seller.

When she was only 15 years old, her parents died. She had to look after her four younger siblings and this is why she became a sex worker. When she had her first sexual intercourse, she experienced massive bleeding and her client arranged for her treatment. Later, she went to India with her co-workers to earn more money. She used to smuggle goods from India to Bangladesh and also earned extra as a sex worker. She went to places like Petrapole, Bonga and the Hawra station. She even went to Mumbai by train from Hawra. She stayed there for three months to work as a bar dancer and commercial sex worker in a hotel.

She does not know about AIDS or STDs. According to her, STDs were not there 10 years ago and that is why her male partners did not use condoms. But, now she regularly uses condom during sex with her clients, including anal sex. She drinks alcohol when she is with her clients. She has visited many districts in Bangladesh, like Jessore, Khulna and Dhaka.

Case study 10

As Jamila has lived in the border area for the last 10 years, it was easy for her to get involved in smuggling. She goes to Kolkata, India, to bring goods across to Bangladesh. She goes to Petrpole by bus and then sells them to the *mohajan* in Bangladesh. She had stayed in Mumbai too, having gone there by train from the Hawra station. She worked there as a bar dancer and sex worker. She had sex many times a day with her clients. Jamila has learnt how to read and write at home as this was necessary for her work.

Jamila's first experience with sex was at the age of 14 with her boyfriend. Though she was married twice, now, at the age of 27, she lives alone. She works in a mess as a cook. But, her main income source comes from her work as a sex worker. Due to the barbed-wire fencing in the Indian border, it is now hard for her to cross the border. Before this, she used to cross the border 50 to 60 times a month. She had to have sex with the BDR personnel before she was allowed to cross the border. Sometimes they paid her and sometimes they did not. Her clients in Bangladesh include the BDR, Bangladeshi truck drivers and helpers and the local people.

She is an injecting drug user (IDU) and shares syringes as she cannot afford to buy syringes every time. She has STD and she seeks treatment from a *kabiraz*. Some of her clients also have STDs and they receive treatment from local private doctors or a *kabiraz*. She has a fair idea about AIDS and how it spreads. She tried to use condoms with her clients but they did not want to use them.

Case study 11

Rahela is a 30-year-old sex worker. She was married twice. She lives with her second husband who is a van-puller. Her husband sometimes smuggles goods from the other side of the border. One of her two sons helps her in smuggling. Last year, she crossed border between 80 to 100 times for her work. Her family's monthly income is Tk. 24,000.

Rahela has had a total of 18 years' experience as a sex worker. She was raped by her neighbour at the age of 12 and she got involved in work in the sex trade consequently. As she lives near the border area, it is normal for her to get involved in smuggling. She went to Banga in India and Dhaka and Jessore in Bangladesh for work in the sex trade and smuggling. Her clients are the BDR, both Bangladeshi and Indian truck drivers and helpers, local residents and outsiders who come to Benapole for various purpose. When she crosses the border, she has to have sex with the BDR. If she does not agree, they will not let her bring her goods across the border. The same is true of the sellers of her goods.

She knows how AIDS is transmitted and how she can be protected from AIDS. She first knew about this from the local people and advertisement. She has some misconceptions about how it is spread, for example, by having baths together with an AIDS patient, sleeping in the same bed as an infected person and from mosquito bites. She has STDs and some of her clients also have them. She self-medicates without consulting any doctor.

ANNEXES

Annex 1

List of land ports and immigration points (from the Indian side)

Land frontiers	Land customs	Routes
Calcutta and Howrah Area	Armenian and Kulpighat Steamer Station	The river routes from Calcutta to Bangladesh via Beharikhal.
	Baghbazar Railway Station	(a) The Sealdah-Poradah Railway line passing through Gede Railway Station and the Calcutta-Khulna Railway line passing through Bongaon. (b) The Sealdah-Lalgola Railway line.
	Baja Ghat	The river routes from Calcutta to Bangladesh via Namkhana-Beharikhal.
	Bandaghat and Moraporaghat	The river routes from Calcutta to Bangladesh via Beharikhal.
	Bengal River Service Godown next to Nimtolaghat	The river routes from Calcutta to Bangladesh via Beharikhal.
	Calcutta Jetties No.4 and 6	The river routes from Calcutta to Bangladesh via Namkhana.
	Chitpur Railway Station and Dhaniaghat River Station.	(a) The Sealdah-Poradah Railway Line passing through Gede Railway Station and the Calcutta-Khulna Railway line passing throughBongaon. (b) The Sealdah-Lalgola Railway line River routes from Calcutta to Bangladesh via Beharikhal.
	Cossipore Railway Station and Cossipore Hydraulic Press Ghat.	(a) The Sealdah-Poradah Railway Line passing through Gede Railway Station and the Calcutta-Khulna Railway line passing through Bongaon. (b) The Sealdah-Lalgola Railway line. The River routes from Calcutta to Bangladesh via Beharikhal.
	Government Salt Gola, Salkia	The river routes from Calcutta to Bangladesh via Beharikhal
	Hanuman Jute Press Ghat and Panditghat	The river routes from Calcutta to Bangladesh via Beharikhal
	Howrah Coal Depot	(a) The river routes from Calcutta to Bangladesh via Beharikhal. The road route from Howrah to Petrapole via Calcutta-Jessore Road passing through Petrapole Road Customs Station leading to Bangladesh (The route specified in item (b) above is for export of coal only).

Land frontiers	Land customs	Routes
	Howrah Railway Station	The Sealdah-Poradah Railway line passing through Gede Railway Station and the Calcutta-Khulna Railway line passing through Bongaon. All Railway routes to Bangladesh.
	Jagannathghat Steamer Station and Rajaghat	The river routes from Calcutta to Bangladesh via Beharikhal.
	Kantapukur Railway Station	The Sealdah-Poradah Railway line passing through Gede Railway Station and the Calcutta-Khulna Railway line passing through Bongaon.
	Nimtola Railway Station and Katgolaghat	(a) The Sealdah-Poradah Railway line passing through Gede Railway Station and the Calcutta-Khulna Railway line passing through Bongaon. (b) The Sealdah-Lalgola Railway line. (c) The river routes from Calcutta to Bangladesh via Beharikhal.
	Outram Ghat	The river routes from Calcutta to Bangladesh via Namkhana-Beharikhal
	Pathuriaghat	The river routes from Calcutta to Bangladesh via Beharikhal.
	Rajabagan Dockyard	The river routes from Calcutta to Bangladesh via Namkhana-Beharikhal
	Rathcola Railway Station	(a) The Sealdah-Poradah Railway line passing through Gede Railway Station and the Calcutta-Khulna Railway line passing through Bongaon. (b) The Sealdah-Lalgola Railway line.
	Sahebbazar Railway Station	(a) The Sealdah-Poradah Railway line passing through Gede Railway Station and the Calcutta-Khulna Railway line passing through Bongaon. (b) The Sealdah-Lalgola Railway line.
	Sealdah Railway Station	(a) The Sealdah-Poradah Railway line passing through Gede Railway Station and the Calcutta-Khulna Railway line passing through Bongaon. (b) The Sealdah-Lalgola Railway line.
	Shalimar Coal Depot	(a) The river routes from Calcutta to Bangladesh via Beharikhal. (b) The road routes from Shalimar to Petrapole via Calcutta-Jessore Road passing through Petrapole Road Customs Station leading to Bangladesh. (The route specified in item (b) above is for export of coal only).

Land frontiers	Land customs	Routes
	Surinamghat	The river routes from Calcutta to Bangladesh via Beharikhal.
	T.T. Shed (Kidderpore)	The river routes from Calcutta to Bangladesh via Beharikhal.
	Ultadanga Railway Station	The Sealdah-Poradah Railway line passing through Gede Railway Station and the Calcutta-Khulna Railway line passing through Bongaon. The Sealdah-Lalgola Railway line.
	Union South Jute Mill Shed	The river routes from Calcutta to Bangladesh via Beharikhal.
Cachar District	Karimganj Ferry Station	(a) Kusiyara river (b) Longai river (c) Surma river
	Karimganj Steamerghat	(a) Kusiyara river (b) Surma river (c) Longai river
	Mahisasan Railway Station	Railway line from Karimganj to Latu Railway Station
	Silchar R.M.S. Office	
	Sutarkandi	Sylhet-Karimganj Trunk Road.
Cooch Behar District	Changrabandh	The road connecting Changrabandh in India and Burimari in Bangladesh
	Changrabandha Railway Station	Changrabandha-Burimari Railway line.
	Gitaldah Railway Station	Gitaldah-Mogalhat Railway line.
	Gitaldah river	The river routes from Gitaldah to Mogalhat in Bangladesh across Dharla river and the portion of river between Gitaldah and the Bhorampayathi.
	Gitaldah road	The main road leading from Gitaldah to Mogalhat in Bangladesh across the Dharla river.
	Haldibari Railway Station	Haldibari-Chilhati Railway line
	Hassimara Railway Station	(a) The road from Gitaldah to Hassimara and Hassimara to Bhutan through Jaigaon (b) The Railway line from Bangladesh passing through Gitaldah to Hassimara.

Land frontiers	Land customs	Routes
Darjeeling District	Phulbari	Road connecting Phulbari in India and Bangla Bandhu in Bangladesh.
Garo Hills District	Baghmara	(a) Baghmara Durgapur Road (b) Someshwari river
	Dalu	(a) Bhugai river (b) Dalu-Naltabari road.
	Ghasuapara	Ghasuapara (Garo Hills, India) to Baluaghat (Mymensingh, Bangladesh).
	Mahendraganj	Road from Mahendraganj Police Station to Dhanua-Kamalpur (Bangladesh). Road from Mahendraganj Police Station to the river Jinjiram.
Goalpara District	Dhubri Steamerghat	Dhubri-Rahumari-Bahadurabad section of the Steamer route on the river Brahmaputra.
	Manikarchar	(a) Kalo river from the approach of Tura road to the Jinjiram river. (b) Tura-Rahumari road
	Golakganj	(Road from Sonahat to Golakganj)
Jaintia Hills District	Dawki	(a) Piyan River (b) Shillong-Sylhet road
Kamrup District	Gauhati Steamerghat	Rahumari-Dhubri-Gauhati Section of the Steamer route on the river Brahmaputra.
Khasi Hills District	Bolanganj	(a) Darogakhal river (b) Dear Valley (c) Dholai river (d) Duba channel (e) Komorrah-Chhatak Ropeway (f) Public Works Department bridle path from Bholaganj to Companyganj. (g) Sonal river
	Barsora	Trolley track from Cherragaon quarry (India) to Cherragaon (Bangladesh) dumping ground in Bangladesh. Barsora (India)-Tahirpur via Barsora (Bangladesh). Trolley track from Chalitacherra quarry to Samsar in Bangladesh. Trolley track from Gauripur (India) quarry to Samsar in Bangladesh. Jadukata river

Land frontiers	Land customs	Routes
	Ryngku	(a) Chillai River (b) Kaimara River
	Shella Bazar	Ichamati river (b) Land route from Pyrkan through Pharangkaruh (near B.P. No. 1231-S) to Bastola in Bangladesh Shella river
Lungiei District	Demagir	Karnaphuli river
Malda District	Kotawalighat (Mehedipur)	Road from English Bazar to Kansat under Shibganj Police station in Bangladesh on the English Bazar Shibganj road.
	Singabad Railway Station	Malda-Singabad-Amhura section of the North-East Frontier Railway passing through Singabad.
Murshidabad District	Dhulian	River line route from Dhulian to Bangladesh via Aurangabad across the Ganges
	Gede Railway Station	The Sealdah-Gede-Poradah Railway Line.
	Khanduaghat	Riverline routes from Khanduaghat to Bangladesh across the river Padma.
	Lalgola Town	Riverline routes originating from Lalgola Town to Godagarighat in Bangladesh across the river Padma.
	Ranaghat Railway Station	Sealdah-Ranaghat-Gede Poradah Railway line. Sealdah-Khulna Railway Line passing through Ranaghat and Bongaon.
	Tungi	Majdia-Hansada (in Bangladesh) road passing through Tungi in India Union.
24 Pagrana District	Bongaon Railway Station	The Railway line passing through Bongaon Railway Station to Bangladesh via Petrapol Railway Station.
	Budge Budge	Budge Budge-Sealdah-Darsana Railway line passing through Gede Railway Station. (b) Budge Budge-Sealdah-Khulna Railway line passing through Bongaon Railway Station. (c) The inland waterway from Budge Budge to Bangladesh via Beharikhal.
	Ghojadanga	That portion of the main road from Itinda to Ghojadanga, which passes to Satkhira via Bhomra in Bangladesh.
	Hingalganj	The river routes from Hingalganj to Basantapur in Bangladesh across River Ichamati.

Land frontiers	Land customs	Routes
	Jalalpur	The river routes from Jalalpur to Bangladesh across the river Ichamati.
	Naihati Railway Station	The Sealdah-Poradah Railway line passing through Gede Railway Station and Calcutta-Khulna Railway line passing through Bongaon. The Sealdah-Lalgola Railway line.
	Namkhana	The inland waterway from the junction of Katakhal, Channel creek and Namkhana to Satikhira sub-division in Bangladesh across the river Raimanagar via Terobanki and Beharikhal
	Orient Jute Mill Jetty	The inland waterway from Budge-Budge to Bangladesh via Beharikhal.
	Petrapol Railway Station	The Calcutta-Khulna Railway line passing through Petrapole.
	Petrapol Road	The portion of Calcutta-Jessore road passing through Petrapole road to Bangladesh.
Purnea District	Kathihar Railway Station	Kathihar-Godagari Railway line. Kathihar-Parbatipur Railway line.
Tripura North District	Dhalaighat Manu (Kailasahar sub-division)	The river Dhalai from Halhali to Dhalai Checking Station. The road from Halhali to Kamalpur. Motorable road from Kailasahar to Murtichera leading to Samshernagar. Motorable road from Kailasahar to Muraichera Motorable road from Kailasahar to Samshernagar River Manu from Fatikrai to Manughat.
Tripura South District	Old Raghna Bazar	Road from Dharmanagar-Old Raghna Bazar to Betuli-Fultala (Bangladesh).
	Muhurighat	(a) The river Muhuri upto Muhurighat. (b) The road from Muhurighat leading to Belonia Railway Station.
Tripura West District	Agartala	The Road between Agartala and Akhaura road Police Outpost.
	Khowaighat	The river Khowai from Teliamura to Khowaighat. The road from Kalyanpur to Khowaighat.
	Srimantapur	The river Gumti. Udaipur-Comilla road.

Land frontiers	Land customs	Routes
West Dinajpur district	Dangi	The main road leading from Balurghat to Chowghat in Bangladesh via Kalaibairi.
	Hilli (West)	(a) The main road leading from Hilli through the Railway level crossing on the northern side of the Hilli Railway Station to Ghoraghat, Bangladesh. (b) That portion of the road from Panchbibi to Boalder in Bangladesh, which passes through Basudevpur. [Dakashinapara Hilli and Hindu Mission of Hilli (West) to Indian Union].
	Kukradah Road leading from Kukradah to Bhadreshwari (via Jagdol in Bangladesh).	
	Radhikapur Railway Station	(a) The Kathihar-Parbatipur Railway line passing through Radhikapur. (b) The main road leading from Kaliaganj passing to Dinajpur through Gotagon."

Source: Government of India, Ministry of Finance, Department of Revenue, New Delhi, www.chennaicustoms.gov.in/note/PN2002/SEAPORT/pn359_2002.htm

Annex 2

HIV/AIDS infection and deaths in December 2006

Number of people living with HIV in 2006	
Total	39.5 million (34.1–47.1 million)
Adults	37.2 million (32.1–44.5 million)
Women	17.7 million (15.1–20.9 million)
Children under 15 years	2.3 million (1.7–3.5 million)
People newly infected with HIV in 2006	
Total	4.3 million (3.6–6.6 million)
Adults	3.8 million (3.2–5.7 million)
Children under 15 years	530,000 (410,000–660,000)
AIDS deaths in 2006	
Total	2.9 million (2.5–3.5 million)
Adults	2.6 million (2.2–3.0 million)
Children under 15 years	380,000 (290,000–500,000)

Source: AIDS Epidemic Update, December 2006, UNAIDS and WHO (2006)

Annex 3

Regional HIV and AIDS statistics and features 2004 and 2006

Region		Adults and children living with HIV	Adults and children newly infected with HIV	Adult (15–49) prevalence (%)	Adult and child deaths due to AIDS
Sub-Saharan Africa	2006	24.7 million [21.8–27.7 million]	2.1 million [2.4–3.2 million]	2.8 million [5.2%–6.7%]	5.9% [1.8–2.4 million]
	2004	23.6 million [20.9–26.4 million]	2.6 million [2.2–2.9 million]	6.0% [5.3%–6.8%]	1.9 million [1.7–2.3 million]
Middle East and North Africa	2006	460,000 [270,000–760,000]	68,000 [41,000–220,000]	0.2% [0.1%–0.3%]	36,000 [20,000–60,000]
	2004	400,000 [230,000–650,000]	59,000 [34,000–170,000]	0.2% [0.1%–0.3%]	33,000 [18,000–55,000]
South and South-East Asia	2006	7.8 million [5.2–12.0 million]	860,000 [550,000–2.3 million]	0.6% [0.4%–1.0%]	590,000 [390,000–850,000]
	2004	7.2 million [4.8–11.2 million]	770,000 [480,000–2.1 million]	0.6% [0.4%–1.0%]	510,000 [330,000–740,000]
East Asia	2006	750,000 [460,000–1.2 million]	100,000 [56,000–300,000]	0.1% [< 0.2%]	43,000 [26,000–64,000]
	2004	620,000 [380,000–1.0 million]	90,000 [50,000–270,000]	0.1% [< 0.2%]	33,000 [20,000–49,000]
Oceania	2006	81,000 [50,000–170,000]	7,100 [3,400–54,000]	0.4% [0.2%–0.9%]	4,000 [2,300–6,600]
	2004	72,000 [44,000–150,000]	8,000 [3,900–61,000]	0.3% [0.2%–0.8%]	2,900 [1,600–4,600]

Latin America	2006	1.7 million [1.3–2.5 million]	140,000 [100,000–410,000]	0.5% [0.4%–1.2%]	65,000 [51,000–84,000]
	2004	1.5 million [1.2–2.2 million]	130,000 [100,000–320,000]	0.5% [0.4%–0.7%]	53,000 [41,000–69,000]
Caribbean	2006	250,000 [190,000–320,000]	27,000 [20,000–41,000]	1.2% [0.9%–1.7%]	19,000 [14,000–25,000]
	2004	240,000 [180,000–300,000]	25,000 [0.9%–1.5%]	1.1% [19,000–35,000]	21,000 [15,000–28,000]
Eastern Europe and Central Asia	2006	1.7 million [1.2–2.6 million]	270,000 [170,000–820,000]	0.9% [0.6%–1.4%]	84,000 [58,000–120,000]
	2004	1.4 million [950,000–2.1 million]	160,000 [110,000–470,000]	0.7% [0.5%–1.1%]	48,000 [34,000–66,000]
Western and Central Europe	2006	740,000 [580,000–970,000]	22,000 [18,000–33,000]	0.3% [0.2%–0.4%]	12,000 [< 15,000]
	2004	700,000 [550,000–920,000]	22,000 [18,000–33,000]	0.3% [0.2%–0.4%]	12,000 [< 15,000]
North America	2006	1.4 million [880,000–2.2 million]	43,000 [34,000–65,000]	0.8% [0.6%–1.1%]	18,000 [11,000–26,000]
	2004	1.2 million [710,000–1.9 million]	43,000 [34,000–65,000]	0.7% [0.4%–1.0%]	18,000 [11,000–26,000]
Total	2006	39.5 million [34.1–47.1 million]	4.3 million [3.6–6.6 million]	1.0% [0.9%–1.2%]	2.9 million [2.5–3.5 million]
	2004	36.9 million [31.9–43.8 million]	3.9 million [3.3–5.8 million]	1.0% [0.8%–1.2%]	2.7 million [2.3–3.2 million]

Source: AIDS Epidemic Update, December 2006, UNAIDS and WHO (2006)

Annex 4
Regional HIV statistics and features for women, 2004 and 2006

Region		Number of women (15+) living with	Percent of adults (15+) HIV living with HIV who are women (15+) (%)
Sub-Saharan Africa	2006	13.3 million [11.5–15.2 million]	59
	2004	12.7 million [11.0–14.5 million]	59
Middle East and North Africa	2006	200,000 [100,000–370,000]	48
	2004	180,000 [89,000–330,000]	49
South and South-East Asia	2006	2.2 million [1.3–3.6 million]	29
	2004	2.0 million [1.2–3.3 million]	29
East Asia	2006	210,000 [110,000–370,000]	29
	2004	160,000 [90,000–280,000]	27
Oceania	2006	36,000 [17,000–90,000]	47
	2004	32,000 [16,000–81,000]	47
Latin America	2006	510,000 [350,000–800,000]	31
	2004	450,000 [310,000–670,000]	30
Caribbean	2006	120,000 [85,000–160,000]	50
	2004	110,000 [80,000–150,000]	50
Eastern Europe and Central Asia	2006	510,000 [330,000–810,000]	30
	2004	410,000 [260,000–650,000]	30
Western and Central Europe	2006	210,000 [160,000–300,000]	28
	2004	190,000 [140,000–260,000]	28
North America	2006	350,000 [190,000–570,000]	26
	2004	300,000 [160,000–510,000]	26
Total	2006	17.7 million [15.1–20.9 million]	48
	2004	16.5 million [14.2–19.5 million]	48

Source: AIDS Epidemic Update, December 2006, UNAIDS and WHO (2006)

Annex 5
Main socio-economic characteristics of three upazila

Socio-economic characteristics	Sharsha Upazila (Jessore district)	Hakimpur Upazila (Dinajpur district)	Patgram Upazila (Lalmonirhat district)
Population	3434 (54.19% male and 45.81% female)	66875 (51.77% male and 48.23% female)	189077 (male 51.45%, female 48.55%;
Religion	Muslim 97.02%, Hindu 2.85% and others 0.13%.	Muslim 91.56%, Hindu 6.27%, Christian 1.04% and others 2.13%.	Muslim 91.29%, Hindus 8.33%; others 0.38%.
Literacy rate	25.5% (Male 32.6% and female 17.9%)	30.1% (Male 39.3% and female 20.3%)	25.2% (Male 33% and female 16.7%)
Educational institutions	College 9, High School 30, government primary school 73, non-government primary school 29 and madrasa 75	College 2, high school 17, government primary school 24, non-government primary school 17 and madrasa 12	government college 1, non-government college 2, government girl's high school 1, non-government high school 13, government primary school 66, non-government primary school 47 and madrasa 25
Main occupations	Agriculture 45.37%, agricultural labourer 27.73%, wage labourer 2.10%, commerce 10.19%, service 2.83%, transport 2% and others 9.78%	Agriculture 43.95%, agricultural labourer 24.43%, wage labourer 2.37%, commerce 16.63%, service 4.6%, and others 8.02%	Agriculture 53.97%, agricultural labourer 25.44%, commerce 6.77%, wage labourer 4.1%, services 2.36%, and others 7.36%
Agriculture land	Cultivable land is 33635.26 hectares and fallow land 131.89 hectares	cultivable land is 22450 hectare and fallow land 866.05 hectares	cultivable land 24705 hectares, land under cultivation 21322 hectares
Cultivable land uses	single crop 45%, double crop 20% and treble crop land 35%	single crop 27.32%, double crop 57.89% and treble crop land 14.79%	single crop, 23%, double crop land 62.62%, and treble crop land 11.35%
Land under irrigation	70%	56%	47%

Socio-economic characteristics	Sharsha Upazila (Jessore district)	Hakimpur Upazila (Dinajpur district)	Patgram Upazila (Lalmonirhat district)
Land control among peasants	24% are landless, 35% small, 28% intermediate and 13% rich	45% landless, 20% small, 32% medium, and 3% rich	
Cultivable land per head	0.15 hectare	0.9 hectare	0.13 hectare
Main crops	paddy, wheat, jute, sesame, mustard	paddy, wheat, potato, sugarcane and oil seed	paddy, tobacco, wheat, potato, jute and ground nut
Communication facilities	pucca 72 km, semi pucca 120 km and mud road 1200 km; and railways 35 km	pucca 23.8 km, semi pucca 6 km, mud road 33.60 km and railways 9 km	pucca 76.5 km, semi pucca 4 km and mud road 395 km and railway 26 km
Factories	manufactories comb and button factory 1, rice mill 121, flour mill 18, ice factory 7, steel factory 4, cotton mill 6, biscuit factory 2 and printing press 8	Rice mill, flour mill, ice factory, biscuit factory, etc.	Flour mill 1, ice factory 3, toffee factory 2.
NGOs operates	BRAC, ASA, Mahila Sangha, RDRS and Proshika	BRACITCL, CARE, ASA, Grameen Bank, TMSS, and Samaj Unnayan Karma Sangstha	BRAC, RDRS, PROSHIKA, Grameen Krishi Foundation, Kandari, Ganabima, Swanirvar Bangla and Palli Unnayan Sangshta
Health complex and others	1 Upazilla health complex and 11 health and family planning centres.	1 Upazilla health complex and 3 union health and family planning centres.	1 health complex, family planning 4, and health project 1.

Source: GoB (2002) "Upazila Profile", Ministry of Planning and BBS

Annex 6

The Socio-Economic Condition of 31 Border Districts in Bangladesh

Districts	Administrative unit (division)	Total population (both male and female)	Size of household (1991)	Economically active person (Age 15 and over) both sex (1995–1996)	Number of international migrants (*)	Literacy rate (%)
Bandarban	Chittagong	246301	5.2	260	49	39.5
Rangamati	Chittagong	430403	5.4	260	64	36.5
Khagrachari	Chittagong	365669	4.9	216	187	26.3
Chittagong	Chittagong	5743969	5.9	2352	34230	43.2
Cox's Bazar	Chittagong	1502067	6.6	660	2653	21.9
Brahman Baria	Chittagong	2267632	6.1	922	21400	26.6
Comilla	Chittagong	4263538	6.0	1734	43352	33.1
Feni	Chittagong	1158117	6.0	554	11289	40.7
Habiganj	Sylhet	1611334	5.8	724	4620	22.51
Moulavibazar	Sylhet	1454000	5.8	820	8354	30.8
Sunamgong	Sylhet	1802135	6.2	6.35	3263	22.3
Sylhet	Sylhet	2281903	6.4	904	11063	44.5
Sherpur	Dhaka	1178921	4.9	-	605	32.4
Mymensing	Dhaka	4096486	5.3	1777	8476	30.7
Netrokona	Dhaka	1790785	5.4	735	864	26
Jessore	Khulna	2192138	5.6	1196	3174	33.4
Jhenaidah	Khulna	1419759	5.8	601	2557	25.95
Satkhira	Khulna	1659911	5.6	693	1376	30.35
Chuadanga	Khulna	843981	5.6	580	1110	25.2
Meharpur	Khulna	511220	5.4	-	1505	25.23
Kustia	Khulna	1562504	5.6	758	2784	25.8
Joypurhat	Rajshahi	801903	5.2	327	668	19.8
Dinajpur	Rajshahi	2371183	5.4	1104	650	27.4
Panchagarh	Rajshahi	745978	5.2	428	94	30.6
Thakurgaon	Rajshahi	1059522	5.3	519	279	27.3
Naogaon	Rajshahi	2250600	5.5	1043	2239	28.4
Nawabganj	Rajshahi	1231596	6.1	474	4158	23.8
Rajshahi	Rajshahi	1988061	5.4	1415	1208	30.61
Kurigram	Rajshahi	1680660	5.5	735	457	22.3
Lalmonirhat	Rajshahi	999466	5.3	333	133	66.6
Nilphamari	Rajshahi	1415768	5.3	691	270	25.35

Source: Bureau of Statistic, 2001 'Bangladesh Statistic Year Book of 1999', Government of Bangladesh
GoB (2002), Overseas employment and job seekers registration', Bangladesh Bureau of Manpower, Employment and Training (BMET).
GoB (2002) 'Upazilla/Thana Profile 2002, Ministry of Planning, Bangladesh Bureau of Statistics and FA & MIS Wing and National Accounting Wing, Dhaka.
GoB, 2007 'Overseas employment and job seekers registration', Bangladesh Bureau of Manpower, Employment and Training (BMET), Ministry of Expertise Welfare and Overseas Employment, Government of People Republic of Bangladesh. www.bmetbd.org

Annex7
The total number of incidents of Bangladeshi in each categories of border violence (until 23 October 2007)

Year	People killed	People injured	People arrested	People abducted	People missing	People raped	Incidents of looting
2000	39	38	11	106	0	2	13
2001	94	244	60	45	0	1	10
2002	105	54	110	118	30	0	12
2003	43	82	21	120	7	2	8
2004	76	35	9	73	0	0	5
2005	104	66	26	78	14	3	4
2006	146	144	21	165	32	2	9
2007	94	64	4	89	6	3	3

Source: *Odhikar*, a nationwide networks of human rights defenders and its won fact-finding missions. *Odhikar* gathered the statistic from reports in Bangladesh daily newspapers.

Annex 8

Firing Incidents along Bangladesh-India border

Year	Killed	Injured	Number of Incidents
1976	42 including 10 x BDR	33 including 9 x BDR	29
1977	43 including 9 x BDR	18 including 10 x BDR	23
1978	7 including 2 x BDR	9 including 04x BDR	16
1979	16 including 1 x BDR	31 including 4 x BDR	76
1980	14 including 3 x BDR	17 Including 9 x BDR	29
1981	20	26 including 03x BDR	38
1982	29 including 19 x BDR	12 including 9 x BDR	26
1983	11	11	21
1984	8	1	12
1985	-	3	2
1986	1	-	3
1987	3	9 including 3 x BDR	19
1988	1	7	13
1989	10	4 including 1 x BDR	22
1990	44 including 15 x BDR	28 including 6 x BDR	37
1991	20 including 3 x BDR	31 including 2 x BDR	35
1992	16 including 3 x BDR	11	19
1993	13	3	16
1994	19	13	30
1995	12	10	26
1996	9	12	29
1997	11 including 1 x BDR	6	26
1998	22 including 1 x BDR	16 including 2 x BDR	47
1999	31 including 3 x BDR	34 including 2 x BDR	44
2000	13	13	29
2001	58 including 3 x BDR	34 including 5 x BDR	82

Source: Chowdhury, Abdus Salam (2003) 'Bangladesh- India Border Issues and Management', *NDC Journal,* vol. 2, No. 1, pp. 71.

Annex 9
Routes of cross-border migration (multiple)

Districts		Routes	Number of respondents
Jessore	Bangladeshi sex workers	Benapole (BD) to Petrapole (IN)	13
		Benapole to Petrapole to Bongaon	8
		Benapole to Petrapole to Bongaon to Calcutta	2
		Benapole to Petrapole to Howra to Mumbai	5
	Bangladeshi truck drivers and helpers	Benapole (BD) to Petrapole (IN)	25
		Hilli (BD) to Dakshin Dinajpur (IN)	7
		Bhurimari (BD) to Changrabandh (IN)	8
		Bhomra (BD) to Ghojadnga (IN)	8
		Tamabil (BD) to Shillong (IN)	4
		Akhaura (BD) to Agartala (IN)	3
		Sonamasjid (BD) to Radhikapur (IN)	3
		Bangla Bandhu (BD) to Phulbari (IN)	3
		Haluaghat (BD) to Ghasuapara (IN)	1
	Indian truck drivers and helpers	Petrapole (IN) (BD) to Benapole	25
		Ghojadnga (IN)) to Bhomra (BD	8
		Dakshin Dinajpur (IN) to Hilli (BD)	8
		Mehedipur (IN) to Shibgonj (BD)	3
		Changrabandh (IN) to Bhurimari (BD)	2
		Radhikapur (IN)) to Sonamasjid (BD	1
Dinajpur	Bangladeshi sex workers	Hilli (BD) to Dakshin Dinajpur (IN)	20
		Hilli (B) to Dakshin Dinajpur (IN) to Balurhat (IN)	19
		Hilli (B) to Dakshin Dinajpur (IN) to Calcutta (IN)	1
		Hilli (B) to Dakshin Dinajpur (IN) to Balurhat (IN) to Patirampur (IN)	1
		Hilli (B) to Dakshin Dinajpur (IN) to Balurhat (IN) to Patirampur (IN) to Delhi (IN)	1
		Hilli (B) to Dakshin Dinajpur (IN) to Balurhat (IN) to Shiliruri (IN)	1
		Hilli (B) to Dakshin Dinajpur (IN) to Balurhat (IN) to Malda (IN)	1

Districts		Routes	Number of respondents
	Indian truck drivers and helpers	Dakshin Dinajpur (IN) to Hilli (BD)	10
		Changrabandh (IN) to Bhurimari (BD)	2
Lalmonirhat	Bangladeshi sex workers	Bhurimari (BD) to Changrabandh (IN)	56
		Bhurimari (BD) to Changrabandh (IN) to Shiligori (IN)	36
		Bhurimari (BD) to Changrabandh (IN) to Panishala (IN)	3
		Bhurimari (BD) to Changrabandh (IN) to Jalpaiguri (IN)	8
		Bhurimari (BD) to Changrabandh (IN) to Batabari (IN)	1
		Bhurimari (BD) to Changrabandh (IN) to Calcutta (IN)	6
		Bhurimari (BD) to Changrabandh (IN) to Calcutta (IN) to Delhi (IN)	3
		Bhurimari (BD) to Changrabandh (IN) to Jalpaiguri (IN) to Bhutan	2
		Tamabil (BD) to Shillong (IN)	6
	Bangladeshi Truck drivers and helpers	Bhurimari (BD) to Changrabandh (IN)	25
		Sonamasjid (BD) to Radhikapur (IN)	7
		Bhomra (BD) to Ghojadnga (IN)	9
		Benapole (BD) to Petrapole (IN)	8
		Karimganj (BD) to Sutarkandi	3
		Hilli (B) to Dakshin Dinajpur (IN)	7
		Akhaura (BD) to Agartala (IN)	3
		Bangla Bandhu (BD) to Phulbari (IN)	1
		Teknaf (BD) to Myanmar	1
	Indian Truck Drivers and Helpers	Changrabandh (IN) to Bhurimari (BD)	15
		Dakshin Dinajpur (IN) to Hilli (BD)	3

* BD: Bangladesh, IN: India

Annex 10

Number of respondents of sex experiences at different places

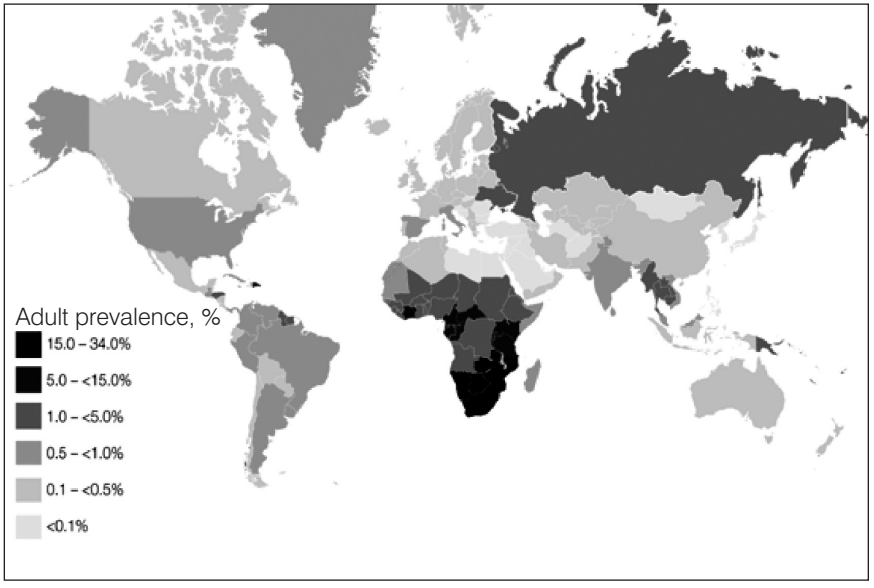
Places (country, states and districts)	Bangladeshi			Indian	
	Male	Female	Total	Male	Total
India					
Petrapole land port		9			
Dakshin Dinajpur land port		19			
Changrabandh land port		36			
Calcutta district	7	14		19	
Bakura district		2		3	
Bribhum district				3	
Coochbehar district		25		4	
Darjeling district				1	
Hoghly district				1	
Howra district		1		1	
Jalpaighuri district	2	57		19	
Malda district				1	
Murshidabad district		6		0	
Nadia district				5	
Purla district				0	
North 24 Parganas district		1		12	
South 24 Parganas district		4		2	
Mumbai state		6		2	
Chastrisgar state				3	
Bihar state				2	
Uttar Pradash state				1	
Delhi		1		0	
Gujrat state				1	
Andhrapradesh state				3	
Bengalore state				1	
Asam state				3	
Bangladesh					
Benapole land port	20	14		6	
Jessore district	19	8		1	

Naryangonj district		3		1	
Rajbari district	1	1			
Dhaka district	17	20			
Sylhet district	2	3		1	
Mymensing district	2	2		1	
Chittagong district	14	5			
Jhenaida district	1				
Panchagar district	1	8			
Bagura district	3	8			
Ishardi district	2	1			
Jamalpur district	4				
Tangail district	4				
Tangi	2				
Ranjpur district	6	32			
Sayedpur district		1			
Dinajpur district	3	16			
Gopalgonj district	1				
Barisal district	3				
Faridpur district	3				
Khulna	1	5			
Kustia	1	2			
Kisorgong		1			
Pabna	5				
Patgram Upazilla of Lalmonirhat district	5	4			
Sonamosjid of Chapainawabganj district	1			3	
Bhurimari land port of Lalmonirhat district	4	56		1	
Hili land port of Dinajpor district	1	21		6	
Nilphamari district	1	7			
Sirajgong district	1				
Lalmonirhat district	4	33			
Naoga district		6			
Magura district		1			
Gaibandha district		8			
Rajshahi district		7			

Thakurgao district		4			
Joypurhat district		6			
Kurigram district		4			
Mongla port of Khulan district	1				
Daulatdia ferry ghat of Faridpur district	13				
Aricha ferry ghat of Manikgong district	1				
Kachpur					
Nepal				7	
Bhutan				3	

Annex 11

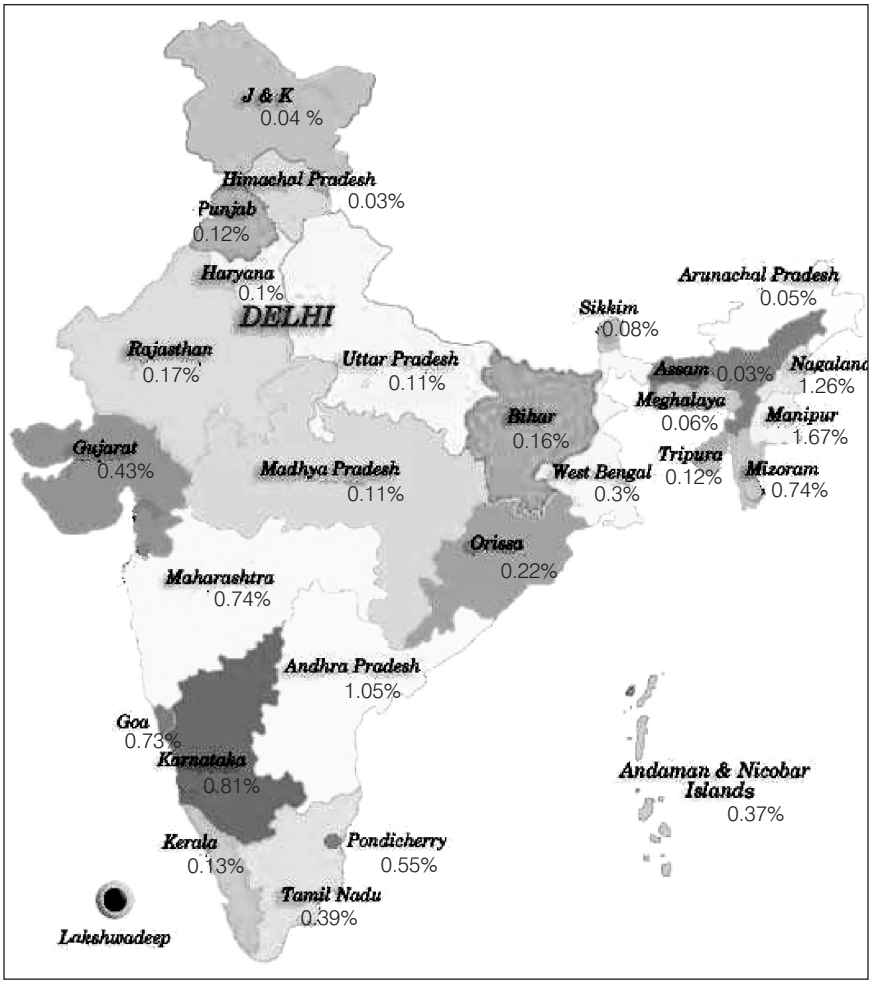
Map of adult prevalence of HIV worldwide



Source: AIDS Epidemic Update, December 2006, UNAIDS and WHO (2006)

Annex 12

Map of estimated adult HIV prevalence, state-wise, India

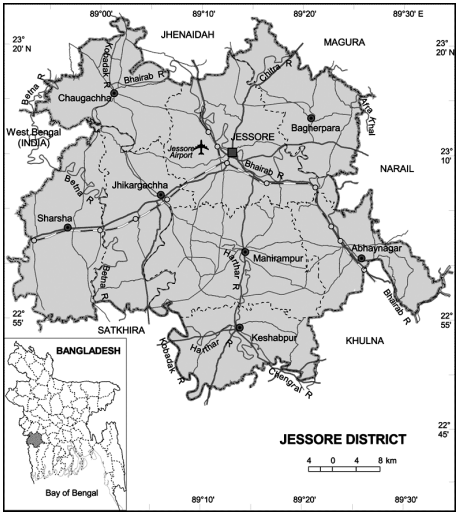


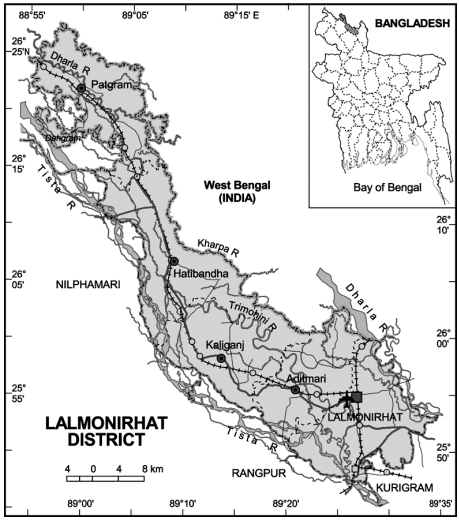
* Included: Jharkhand: 0.11%, Chhattisgarh: 0.17%, Delhi: 0.27%, All India: 0.36%.

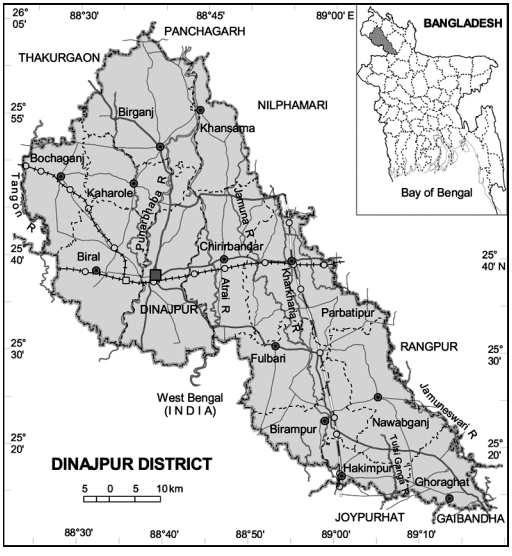
Source: NACO, 2006

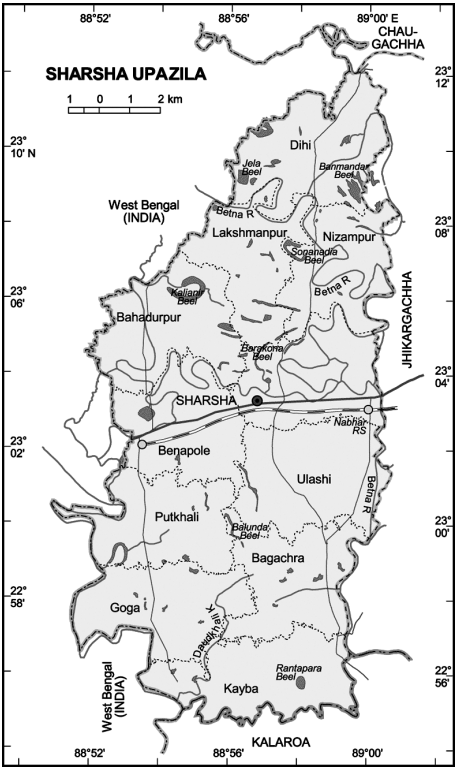
Annex 13

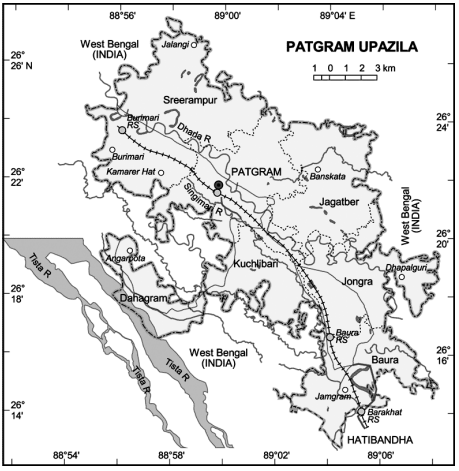
Physical maps of the areas under study (districts and upzila)

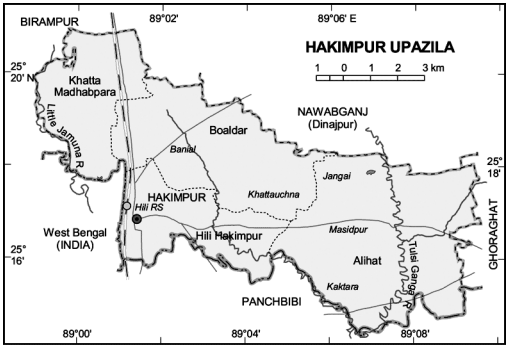







SHARSHA UPAZILA
1 0 1 2 km
88°52'
88°56'
89°00' E
CHAU-GACHHA
23° 12'
23° 10' N
23° 08'
23° 06'
23° 04'
23° 02'
23° 00'
22° 58'
22° 56'
Dihi
Jela Beel
Banmandar Beel
West Bengal (INDIA)
Betna R
Lakshmanpur
Nizampur
Sopanadia Beel
Kallani Beel
Bahadurpur
Barakona Beel
JHIKARGACHHA
SHARSHA
Nabhir RS
Benapole
Ulashi
Betna R
Putkhali
Balunda Beel
Bagachra
Goga
Hali Khanda R
Rantapara Beel
Kayba
West Bengal (INDIA)
KALAROA
88°52'
88°56'
89°00'


PATGRAM UPAZILA
1 0 1 2 3 km
88°56'
89°00'
89°04' E
West Bengal (INDIA)
Jalangi
26° 26' N
26° 24'
26° 22'
26° 20'
26° 18'
26° 16'
26° 14'
Sreerampur
Burimari RS
Dhapta R
Burimari
Kamarer Hat
PATGRAM
Banskata
Jagatber
Shanmari R
West Bengal (INDIA)
Adarpota
Kuchlibari
Dhapalguri
Jongra
Tista R
Dahagram
Baura RS
West Bengal (INDIA)
Baura
Tista R
Jamgram
Barakhat RS
HATIBANDHA
88°54'
88°58'
89°02'
89°06'


HAKIMPUR UPAZILA
1 0 1 2 3 km
BIRAMPUR
89°02'
89°06' E
25° 20' N
25° 18'
25° 16'
Khatta Madhabpara
Punarbhaba R
NAWABGANJ (Dinajpur)
Boaldar
Banial
Jangai
Khattauchna
HAKIMPUR
Hili RS
West Bengal (INDIA)
Hili Hakimpur
Masidpur
Alihat
Tulsi Ganga
GHORAGHAT
Kaktara
PANCHBIBI
89°00'
89°04'
89°08'

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This monograph extends the notion of securitization in exploring and framing the concerns over the spread of HIV/AIDS. It claims that concerns over the spread of HIV/AIDS along territorial border regions constitute a security threat that demands urgent and sustained policy attention. Such a security threat is broadly captured from a perspective of human security or non-traditional security (NTS), which places an emphasis on the security of people. In this light, this monograph examines the socio-economic status of people living near the borders between Bangladesh and India. By uncovering the realities that explain the nature of cross-border migration and sexual behaviour/habits of the migrants, this monograph seeks to understand to what extent these activities have an effect on their level of socio-economic development. Attention is also given to the role of the state in the process of such dynamics.

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