Commentary

Social Exclusion Group and Key Population Group in Bangladesh and STIs/HIV: A Double Jeopardy

Shakeel Mahmood [1]

Abstract: In this paper, the author describes social exclusion of concentrating on the path amongst exclusion and sexual health about two-risk groups (social exclusion of risk groups and key population risk group in Bangladesh), which are vulnerable to human immunodeficiency virus (HIV) and sexually transmitted infections (STIs). Practice of the 'social exclusion' perception in the Bangladeshi articles (Khan et al., 2009), as well as other regions, is lately ranging widespread because of its importance to practice and policy (Mathieson et al., 2008; United Nations, 2007). "Social exclusion is an accumulation of confluent processes with successive ruptures arising from the heart of economy, politics and society (Estivill, 2003). It derives from exclusionary relationships based on power" (Beall & Piron, 2005). Both groups are at risk in contracting STIs and HIV due to their vulnerable activities and susceptibility toward the diseases. Empowering these two groups by validating their dimensions in analysing situations and proposing possible interventions would be the best option. Above all, both groups suffer from double jeopardy.

Keywords: Social exclusion group, key population group, STIs/HIV, Bangladesh

INTRODUCTION

Bangladesh considered being at threat for HIV outbreak due to diversity and importance of risk issues for spreading of STI and HIV. Since the detection of the first case in 1989 in Bangladesh, the prevalence of HIV positive cases has increased steadily, while the exact figure of HIV cases were not identified, nevertheless, previous two rounds of national STS and HIV surveillance depicts an image of increasing prevalence. The HIV 5th round serological and behaviour surveillance (2004-2005) in Bangladesh established a high prevalence of risky sexual behaviour, a high prevalence of syphilis, and injecting behaviours amongst documented high-risk groups (M. Mofizul Islam, Conigrave, Conigrave, & Islam, 2008).

Social exclusion group

Social exclusion of risk groups, such as women, female sex workers (FSWs), injecting drug users (IDUs), males who have sex with males (MSM), and the transgender population are the most significant risk groups in Bangladesh due to their behavioural associated risk factors, but unfortunately has not continuously been recognised as such. In various ways, social exclusion has been defined. Social exclusion includes dynamic processes, and consequences through focusing on policy involvements. Numerous magnitudes can be seen in social exclusion which includes social, political, and economic aspects, and these dimension groups could be omitted from general population (Nidhi, 2009). Kabeer replicates on social exclusion for example "... the multiple and overlapping nature of the disadvantages experienced by certain groups and dominant to stigma" (Kabeer, 2006).

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Bangladeshi women socially excluded, even though Bangladeshi women do not experience stigma, whereas female sex worker experience social and exclusion stigma (Nidhi, 2009). There are many factors causing social exclusion such as poverty, gender religion, ethnicity, and community settings, occupation, education; and health including HIV/AIDS (United Nations, 2007). Social, cultural, economic, and political features of exclusion impose deprivations of the basic facilities of life (Beall & Piron, 2005).

Key population group

Bangladesh surveillance policies regulated and planned by Ministry of Health focus on key populations (KPs). These key populations are identified as Female Sex Workers, Injecting Drug Users and Males who have Sex with Males (Md Mofizul Islam & Conigrave, 2008; Population Council, 2018) are often at potential risk of contracting HIV due to minimum access to prevention, treatment services and care and also because their behaviours are often stigmatized, and even criminalized (Population Council, 2018). However, this does not apply to the general population; thus, data from members of the population are not accessible and available. Since HIV is low among KPs, therefore, the rate comes that low for the general population (Mahmood, 2010a, 2020b; UNICEF, 2010).

This paper aims to understand and analyse experience of multiple dimensions of the exclusion group and key population group with an emphasis on gender and sexual practice, life environment, discrimination, and offensive occurrences. Both risk groups experience numerous magnitudes of exclusion. These experiences initiate negative health and rights outcome, predominantly in regard to their susceptibilities to STIs/HIV.

Social exclusion group and their vulnerability

Literature on STIs stated that Bangladesh has a very high prevalence of STIs, which indicates the country's increased susceptibility to HIV (IFC, 2011; M. Mofizul Islam et al., 2008; Kabir, Maple, & Fatema, 2018; Mahmood, 2001, 2020b). Infections along with additional STIs escalate the possibility of spreading HIV. Treatment of STIs is one of the effective approaches of stopping HIV (M. Hossain, Mani, Sidik, Shahar, & Islam, 2014; M. Mofizul Islam, Conigrave, Miah, & Kalam, 2010; Mahmood, 2020b; Mondal, Hossain, & Rahman, 2008). Finally, the drug powerfully contributes to the spread of HIV disease (Moss, 2000). The social exclusion group is susceptible to HIV infection in Bangladesh and faced discrimination from individuals. In Bangladesh, these socially excluded people are very poor in the framework of STIs and HIV. These groups face numerous social/cultural, economic and legal discrimination (Kabeer, 2006). However, women may not face stigma as such, but these women are comparatively socially undervalued. Women in specific experience from access to healthcare, exclusion from the proper economy and overall participation in their community (Nazli, 1995). Social exclusion challenged by risk group is the outcome of overlapping shortcomings rising from the norms, values, and operative of social, economic, and authorized institutions in Bangladesh (Nazli, 1995).

The practice of a social exclusion on existing information creates important knowledge and policy implications regarding targeted prevention efforts. For instance, it has been realised that the different degrees of exclusion experienced by poor women, two 'populations' that do not explore as much depicted in the STIs/HIV literature as the risk groups. A social exclusion research can deliver a new spur to prevention efforts by highlighting the various shortcomings experienced by risk groups and allow health programmes (Nidhi, 2009).

The nationwide surveillance in Bangladesh established the vulnerability of transgender to STIs, comprising HIV. Transgender are selling unprotected sex with multiple partners. The highest rate of active syphilis with 10.4% among other most at-risk populations recorded in Dhaka city, the capital city of Bangladesh (Chan & Khan, 2007). Immediate HIV interventions for them is justified after revealing these findings. For providing treatment of STIs, several non-governmental (NGOs) and community-based organizations (CBOs) implement HIV interventions which primarily promote condoms and lubricants. Recognising the sociocultural and human rights features of deprivation and discrimination against the transgender community, this can help decrease STIs/HIV spread and protect this sidelined community (Khan et al., 2009). Minimalizing stigmatization and discrimination of these disenfranchised groups and for those with STIs/HIV is crucial for community recognition.

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Advocacy efforts and community education to stand against discrimination will be further reinforced (Bangladesh AIDS Prevention And Control Programme, 2000). Explanation of social exclusion, powerless transgender is not allowed to partake in political, social, economic, cultural and activities. Also, this group is not allowed to be associated with the mainstream social society, comprising health, education, legal and cultural (Beall & Piron, 2005 2832; Khan et al., 2009). This transgender group are also abused, dominated by the members of mainstream society, and unable to use power or to create rights within society and home.

Key Population group and their vulnerability

HIV in key populations (KPs) are raised in Bangladesh. Conversely, FSWs shown to have close sexual links with multiple male client groups, not limited to IDUs (NASP, 2004). HIV is an increasing trend (Tasnim Azim et al., 2008) among people who inject drugs (PWID) (Tasnim Azim et al., 2000; Mahmood, 2007a, 2007b, 2010a). The prevalence increased to 3.9 % (2016) from 0.7% (2011). In 2002, it was 0.3 %. When the first study was (1998-99) conducted, the rate was 0.4 % in 1998-99. The report mentioned that the infection went up due to IDUs. Since the identification of the first case from 1989 to 2017, the number of people living with HIV reached up to 5,586 in Bangladesh as confirmed by the government. Among HIV cases, 924 have died of AIDS. As of 2017, the estimated number of people living with HIV is around 13,000, which shows that a large number of Bangladeshi people are not aware of their HIV status. 31 percent were among the returnee migrant workers, of total 865 new HIV cases in 2018, (CIA, 2019; Hasib, 2018).

Healthcare deprivation

In Bangladesh, the social and cultural status of males are higher compared to females in social norms (Nazli, 1995; Sajeda, Ian, Ruchira, & Margaret, 1998). This inequity has contrary consequences in terms of women's access to education, health information, nutrition, and services to household (Kabeer, 2006) and to mandate safe sex behaviour of their partner and spouses. The health of a men highly prioritized at the household level compared to female household members, and healthcare for men is regularly monitored than the health care of women (Schuler, Bates, & Islam, 2002). These standards interpret exclusion of women from the health-care system (Schuler et al., 2002). In Bangladesh, health facilities for transgender group are non-existent and the knowledge of medical professions on gender and sexuality is very limited. The doctors are sometimes judgemental and inclined to treat this group of population, thus, this shows the utmost absence of health facilities for transgender culture (Khan et al., 2009).

Condom use

Women find it extremely hard to discuss the usage of condoms and/or sexual relations with their partners/spouses, hence it increases the threat for STIs/HIV from their partners or spouses (MOHFW, 2004). In a research conducted in Dhaka city, 0.8% of women who had active syphilis are attending healthcare clinics, (Mercer, Khanam, Gurley, & Azim, 2007). Information revealed that gender-gaps in health for instance, knowledge about HIV transmission is higher among men than women (Rahman & Rahman, 2007), and this is due to independence of economic layer (MOHFW, 2004). According to Islam et. al. (2008), 50% MSMs performed unsafe anal sex with women, plus their partner/wives. Most of the cases this group kept this information private about their MSMs practices to their wives (M. Mofizul Islam et al., 2008).

Sexual abuse

Another potential risk factor for women is sexual and physical exploitation from their husbands. According to one study (sample of 3000 married men), more than one in these married men had physically or sexually abused their wives and extramarital affairs were part of a common practice. Moreover, these married men were also diagnosed with STI symptoms in the previous year. Additionally, these men are unlikely to disclose their symptoms to their wives compared to those men who are not imposing sexual or physical violence (A. Rahman & Razzaque, 2000).

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Essential services

FSWs are not getting any access to essential services such as housing, recreation, education, and sanitation. Condoms use confront and bring aggression to and from the clients. Keeping condoms also carry provocation from local police (Hosain & Chatterjee, 2005). The increase in violence started when illegal status of sex works was established due to shutting down of brothels by the government of Bangladesh (1998-2000). This move reduced the safety of the brothel-based business and FSWs started working on the streets, which increased the risk of violence towards FSWs, and shortened the option to use condoms, thus, the incidence of violence in brothels are amplified (Jenkins & Rahman, 2002).

Drug abuse

A study of female IDUs revealed that some of women, who were FSWs also injected drugs experienced more violence than female IDUs. The rate of imprisonment is higher with these FSWs than female IDUs. Moreover, compared to male IDUs, there was a bigger overlap between the sex and drug networks for female IDUs, henceforth, putting this group at bigger risks (Tasnim Azim et al., 2006). This further limits the ability of women to make informed choices, guard, and protect themselves from STIs/HIV. It reveals that poverty and bias against women are key exclusionary effects (Nidhi, 2009). According to Irfan, et. al,. (2021), women who inject drugs (IDUs) experience various complexities, risks and vulnerabilities attributed to unequal gendered power differentials (Irfan, Khan, & Khan, 2021).

DISCUSSION

A social science research has documented the influences between social and financial inequalities, structural violence, migration, and HIV/AIDS (Bennet, 2006; Paul Farmer, 2004; Parker, Easton, & Klein, 2000). A United Nations Population Fund (UNFPA) report articulates that women of Bangladesh are one of the most maltreated in the world with 47% of women being battered by men. Papua New Guinea tops the global chart, with 67% of women affected. Wife beating, rape, maiming by acid, physical and verbal harassment are a few of the several methods of violence in Bangladesh. According to press reports, men, husbands, and boyfriends who approach women, but rejected, resorted to assault. "The situation of women is really deplorable," the United Nations Family Planning (UNFPA) report mentioned, adding, "gender-based violence was endemic" (Mahmood, 2004). Mostly in rural areas, unlawful, domestic violence and additional violent acts against women are widespread, and closely linked to women's restricted movement and isolation. According to the 2007 Bangladesh Demographic and Health Surveys, published by the National Institute for Population Research and Training (NIPORT), forty nine percent (49%) of women, who had ever been married had experienced violence in their present or most recent marriage. In one survey, it was revealed that one in four (¼) married women said they had experienced sexual and/or physical violence often or sometimes in the past years (IFC, 2011). Reported rape occurrences also increased rapidly in mid to late 1990s, and as of 2004 the sexual exploitation remained high (Perman & David, 2004). According to Kuttab (2006), social exclusion has analysed gender inequality as the foundation of exclusion and holds predominantly concentrated on women (Kuttab, 2006). In 2010 Gender Inequality Index, Bangladesh ranked 116th in the UNDP's Human Development Index, nonetheless, it is not apparent that Bangladesh has a lot in relations to gender equality (N. Hossain, 2012).

In his *Pathologies of Power*, Farmer (2003) states that structural violence abolishes, and damages more breathes per day than does an era's debate on the value of witchcraft. These deaths are images of structural violence, and a fundamental trauma for the human rights community. All over the world, women opposed by sexism, a philosophy that points women as substandard to men. When a group of women's rights anthropologists (1974) measured the status of women living in separate locations, they decided that in every society in which they studied the status of women, the latter was not genuinely equal in any culture but that men are in superior positions to women. This power discrepancy has aimed that women's rights have continued to be dishonoured in indefinite ways. Though male victims are clearly dominant in studies of torture, females almost completely suffer the much more common crimes of violence and rape. Crimes of rape and violence are not yet conversed and are hence unseen in many societies (P Farmer, 2003).

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Complicated indeed are the instruments by which such structural violence can be effected and apparent consequence of personal choice or cultural differences inflated (P. Farmer, Connors, & Simmons, 1996). Gender inequality and poverty are two explanations why the fastest rising epidemics are amongst women (P Farmer, 2003). In the social and cultural dimensions of social exclusion, gender is included (Khan et al., 2009). On another dimension, these two groups are sexually harassed publicly. These are evidently disruptions of human rights against sexual minorities (COMMISSIONER, 2006). The incidences of sexual harassment further force them to take risky life style, which contributes to HIV transmission (Lwabaayi, 2004). Though many people agree that gender and inequality are the sturdiest enablers of risk for exposure to HIV, however, this subject has been ignored in both the social science and biomedical narrative on HIV/AIDS (P. Farmer et al., 1996).

HIV mainly affects women, especially from key populations. Amongst FSWs, HIV prevalence estimated globally at 12%, rising to 30% in settings with medium to high HIV prevalence. Women, specially from key populations predominantly face violence (UNAIDS, 2013). It is also vital to push for greater implementation of the Domestic Violence Act by the Government of Bangladesh (Mahmood, 2020a, 2020b; Naved, Rahman, Willan, Jewkes, & Gibbs, 2018). Scientists should investigate the HIV prevention policies and interventions which are required to control the epidemic amongst key populations (Mahmood, 2010b), including female garment workers (FGWs) in Bangladesh. Al Gore, former vice president of United States of America once stated in 2004, *"We hope that justice, not power, can supplant suppression. As Lincoln said in his greatest trial, 'We, even we here, hold the power and bear the responsibility'"* (Mahmood, 2005, 2020b). Thus, we honour Dr. Martin Luther King's influence on American society, and his enduring impact on social justice. Dr. King once said that "*injustice anywhere is a threat to justice everywhere*" (Christina Quint, 2020; Mahmood, 2020b). Now more than ever, we must turn to make right one of the greatest social injustices of our time -empowering women (Mahmood, 2020b). In this connection, the statement of late Jonathan Mann is very pertinent. He said "*For AIDS to be conquered anywhere, it must be conquered everywhere*" (Choudhury MR, 1996; Mahmood, 2007b, 2020b). Hence, these disenfranchised, disadvantaged, vulnerable poor and/or powerless two-risk groups exposed to HIV than before and establish that these women are susceptible to HIV risk, created the gradients of power.

CONCLUSION

Even though other health challenges, since 1985, Bangladesh documented HIV as one of the unprecedented social and health challenges, before the first case detected in 1989. The increase trend of HIV and risky behaviours among high groups and high prevalence may counterbalance the prevention efforts, which are in place. Apart from previously mentioned group, The 9th Round HIV Serological Surveillance incorporated the clients of sex workers, dock workers, rickshaw pullers and truckers as risky groups (Mondal et al., 2008). However, according to Strategic plan of the national AIDS programme of Bangladesh (1997-2003), the extension of surveillance must incorporate the remaining high-risk groups. In other words, the bridging population include those uniformed forces, young people, working children, women in domestic work or in the workplace setting and female garment workers, internal and international male migrants, slum dwellers, and tribal people, thus, continuation of both behavioural and serological of surveillance are important (M. Mofizul Islam et al., 2008. Bangladesh AIDS Prevention And Control Programme, 2000). Social exclusion focuses on unequal power, changing aspects and operate in political, economic, social and cultural at distinct heights, which comprises persons, groups, families, societies, countries, and entire world. Social exclusion summarized as a series between inclusion and exclusion (Mathieson et al., 2008). However, self-actualization and practices of excluded cannot be ignored, while analysing and determining social exclusion of any groups (Khan et al., 2009).

"A process and a state that prevents individuals or groups from full participation in social, economic and political life and from asserting their rights. It derives from exclusionary relationships based on power" (Beall & Piron, 2005). I have endeavoured to analyse the connection between social exclusion group and key population group, and HIV risk to these two-risk groups existence to contribute to the formulation of policy guidelines. This constitutive pathway connects social exclusion to health challenges (Mathieson et al., 2008). Thus, rigid gendered social structure and social systems need to be analysed.

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There is an ample evidence to suggest that certain awareness and motivational activities are very important in the prevention of HIV /AIDS (T. Azim et al., 2007; L. Gibney, Choudhury, Khawaja, Sarker, & Vermud, 2009; Laura Gibney, Saquib, & Metzger, 2003; Hasan, Hassan, Khan, Nuzhat, & Hassan, 2013; M. Hossain et al., 2014; Md Mofizul Islam & Conigrave, 2008; Jesmin, Chaudhuri, & Abdullah, 2013; Kaptanoğlu, Süer, Diktaş, & Hınçal, 2013; Mondal M.N.I., 2005; Rana, 2016; Shah & Kristensen, 2000). In the same vein, reducing gender inequality through education can be a viable option for increasing HIV knowledge status (Yaya, Bishwajit, Danhoundo, Shah, & Ekholuenetale, 2016). It reflects the positive influence of literacy for improvement of knowledge (Jahan, 2000). Accordingly, alternative planning paradigms which challenge power, bring diversity, and the possibility of empowerment into the debate are required for those understood to be 'powerless' (P. Farmer et al., 1996). As indicated by UNAIDS (2020), what needs to be developed are strategies that improve access to prevention options, with 90% of people by 2020.

Government of Bangladesh also needs to revisit the Bangladesh human rights law and explore how to improve the quality of these disenfranchised two-groups lives. Both groups are at risk in contracting STIs and HIV due to their vulnerable activities and susceptibility toward the diseases. Empowering these two groups by validating their ability in analysing situations and propositioning promising HIV interventions would be the best option. Above all, both groups suffer from double jeopardy.

AUTHOR'S CONTRIBUTIONS

SM designed and conducted the literature review and contributed to the manuscript structure as well as drafting and overall editing of the manuscript. Author read and approved the final manuscript.

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CONFLICTS OF INTERESTS

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