

# PARTICIPATORY HIV/AIDS EDUCATION IN BANGLADESH: A CASE STUDY

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**ABSTRACT** This paper discusses research in which I examine the daily difficulties of a selected group of HIV-vulnerable people in Bangladesh, the challenges posed by these difficulties to HIV prevention work, and ultimately how one NGO implemented peer education as a participatory approach to HIV prevention. The perspectives employed are inspired by postcolonial theory and Freire's theory of participatory education. The research takes place in a predominantly Muslim cultural context where pronounced social stigma is attached to behaviours that increase the risk of HIV/AIDS. Although cultural approaches have been recognised as essential to sustainability in HIV prevention, NGOs relate to external guidelines and often fail to navigate effectively within discursive contexts. The importance of this research is that it describes how a peer education programme contributed to increasing participants' responses to their own health situation and that of their peers within marginalized communities. On the basis of my analysis, I suggest some principles for peer education to further promote the philosophy of Freire.

**SAMMENDRAG** Artikkelen diskuterer forskning hvor jeg undersøker de daglige vanskelighetene til en utvalgt gruppe HIV-utsatte mennesker i Bangladesh, relaterte utfordringer i HIV-forebyggende arbeid, og til slutt hvordan en lokal NGO implementerte *peer utdanning* som en deltakende tilnærming til HIV-forebygging. Artikkelenes perspektiver er inspirert av postkolonial teori og Freires utdanningsteori. Forskningen finner sted i en muslimsk kulturell kontekst hvor uttalt sosialt stigma er knyttet til atferd som øker risikoen for HIV/AIDS. Selv om kulturelle tilnærminger har blitt anerkjent som avgjørende for bærekraftighet i HIV-forebygging er frivillige organisasjoner ofte knyttet til eksterne retningslinjer og evner ofte ikke å navigere funksjonelt i diskursive kontekster. Betydningen av denne forskningen er at den beskriver hvordan et *peer* utdanningsprogram bidro til å øke deltakernes respons i forhold til egen og andres helsesituasjon, innenfor marginaliserte miljøer. Med utgangspunkt i analysen foreslår jeg noen prinsipp for *peer* utdanning, slik at denne ytterligere kan fremme filosofien til Freire.

**KEYWORDS** Education to counter HIV/AIDS, postcolonial context, Bangladesh NGO, participatory education, peer education

## **Introduction**

The issue that I study in this paper is a programme of participatory education for HIV prevention in a specific context in Bangladesh. HIV education for high-risk groups in Bangladesh represents an important educational initiative in a situation where people are subjected to stigma and seclusion. To illustrate this, I examine the situation of the difficult daily lives of a group of HIV-vulnerable people which, to some extent, illustrates the connection of poverty and HIV/AIDS globally. The respondents have feelings of shame and powerlessness, leading to a discussion of Spivak's (1988) question 'Can the subaltern speak?' These problems stem from the neo-colonial situations of poverty and marginalization that are still evident in Bangladesh. It is in this context that I examine the functions and possibilities of a peer education programme implemented by a specific NGO.

I have used a postcolonial focus in my analysis, as postcolonial theory is concerned with the adopting of an activist position, seeking social transformation (Young, 2001; Andreotti, 2011; Tuhiwai Smith, 2012). The importance attached to the use of postcolonial theory is to see how the processes of domination work through dialogue and practices, and the role that dialogue, discourse and critique have in uncovering and challenging domination (as inspired by the works of, among others, Fanon, 1952; Said, 1978; and

Bhabha, 2004). Postcolonial theory emphasizes how neo-colonial models of education are submerged in structures of Eurocentric epistemic domination, and assists in acknowledging the importance of community-based educational programmes focusing on interactive participation by learners and educators. It helped me in interpreting how a specific educational programme was functioning within its social context. Similarly, Paulo Freire's theory of participatory education (1970) has been of great assistance, and will be elaborated later.

Discourse analysis is undertaken as an overarching methodological approach which has assisted me in grasping discursive meaning through its realization in practices (Jørgensen and Phillips, 1999; Laffey and Weldes, 2004; Rogers *et al.*, 2005). Through the methodology and the theoretical framework I was able to gain significant insights into aspects of what is essential to HIV education within marginalized communities in Bangladesh.

The complex forces that shape and influence human behaviour injurious to health are often poorly understood. In recent years, increasing attention has been paid to the manner in which social and cultural variables influence risk behaviour related to HIV transmission (Hasnain, 2005; Baxen and Breidlid, 2009; Cornish and Campbell, 2009). In order to succeed with HIV prevention, it is important to study the social dynamics and practices of the populations at risk. Analysis of the cultural context in which risk behaviour occurs provides meaningful insight into the

factors that shape and define the external reality within which this behaviour takes place.

Knowledge of why people behave in certain ways, as well as the resources available, is vital to be able to assist in accessing and utilising available preventive and therapeutic resources (Hasnain, 2005; Chowdhury and Chandra, 2006; Baxen, 2009). Freire's problem-posing approach (1970) to understanding the social conditions and factors that lead to risk has great potential in HIV prevention. If educators start by asking how HIV-vulnerable individuals see the problems, causes and solutions, and if this knowledge is recognized as basic and essential it is possible to be partners in supporting responses to addressing treatments and prevention.

Countries created in the context of colonialism carry within them the aftermath of colonial cultural norms (Hickling-Hudson, 2011). In the process of the partition of India after British rule, the decision of Pakistan and later Bangladesh to become culturally Muslim states has involved some tension and conflict regarding cultural norms (Ruud *et al*, 2011). Problematic issues with relevance to HIV/AIDS that I encountered in this study were connected with (a) the patron-client social orientation of society (cf. Ruud *et al*, 2011) where family networks and economic position play a major role in securing access to healthcare; (b) social construction of gender as static and determined by biology; (c) social construction of sexuality where heterosexuality is the 'normal' sexuality, and other sexualities are made deviant; (d) gender inequity; (e)

the denunciation of intoxicant use. Most of these challenges are common in decolonizing contexts.

As a Norwegian student, my socialization into Eurocentric epistemology was challenged by my experience of the research project that I describe in this paper. After I went to Bangladesh to work for a year through a youth exchange programme, I applied for admittance to a Masters in International Education and Development at Oslo University College. My colleagues were quota students from Sudan, Zambia and South Africa, and our discussions about global challenges of aid and education greatly influenced my thinking.

Going back to Bangladesh for field work, knowing the basics of the Bangla language, it became clearer to me how the world's unequal distribution of power and resources to a large extent is a result of colonialism and its aftermath with the current market-led globalization (cf. Bales, 1999). Wealthy countries and the powerful international agencies representing their interests bear a great deal of responsibility for the continuing underdevelopment of many of the new nations. The aid provided to the global South for reducing poverty is not only minimal (Klees, 2010) but it also, arguably, does not assist with the 'development' promised (Hickling-Hudson, 2011).

### **HIV/AIDS and the Bangladeshi context through a postcolonial lens**

Although there are some studies on issues related to HIV/AIDS in Bangladesh, there is a gap in the

literature concerning a cultural, postcolonial exploration of HIV education aimed at high-risk groups in this Islamic society. The transferability (Bryman, 2004) of studies on HIV education in other contexts is often limited. In Bangladesh, the official HIV/AIDS prevalence rate has remained less than 0.1% (UNAIDS, 2012). HIV is not considered to be a threat to the general population, but is associated with strongly stigmatized behaviour like intravenous drug use, male-to-male sex, and extramarital sex (Hasnain, 2005; Khosla, 2009). Drug use and homosexual practice is illegal by law, and sex workers are not legally protected (Ara, 2005; Knight, 2006; Imaan and Alam, 2008). Stigma and legal restrictions pose huge challenges to HIV prevention work as they prevent high-risk groups like men who have sex with men, sex workers, and injecting drug users from coming forward for appropriate counselling, HIV testing, and treatment, as this involves the disclosure of tabooed practices (Hasnain, 2005; Buncombe, 2008; Khosla, 2009). The HIV/AIDS prevalence rate has remained low, partly because of numerous international interventions and, paradoxically, because of cultural norms. However, if the contagion was to spread, the country's vulnerability is regarded as high (WHO, 2008; USAID, 2008).

### *Social differences, poverty and HIV/AIDS*

Historically, Bangladesh came into existence with the partition of India and Pakistan, when it separated from Pakistan in 1971. After the war of liberation, international charitable aid to Bangladesh was of a

scale that placed the country among the world's ten largest aid recipients through the 1970s and 80s. Although this was meant to be a support to the country's own development efforts, the aid in this period constituted all of the funding of the country's development programmes and in some periods even more. Influence on public agencies which channelled the aid became the primary means to economic prosperity and to political power. The practice of favouring selected individuals, like relatives and supporters, was based on deep cultural norms of reciprocity in interpersonal relations. When an influential person granted a certain "assistance" to loyal companions or members of their extended family, this was recognized as decent behaviour. The military regimes at the time allowed the beneficiary policy to be developed as a political tool by using easily available state funds. Donors and the government allowed charity aid to fund and maintain an increasingly affluent middle class which was not made liable for tax. Instead, the relations between the government and its citizens began to be about the distribution of cheap money from aid, so that political leaders and the middle class were removed from obligations to the rest of society. A report in 1984 showed that the rural poor were becoming poorer despite charitable aid (Ruud *et al*, 2011).

Many factors contribute to creating social differences in a given society. In India and the parts that are now Bangladesh, colonial reinforcements of traditional caste divisions could also be noted (Loomba, 2005; Ashcroft *et al*, 2007). Poverty is often a problem following a colonial past, and this was indeed

the case in a Bangladesh struggling with debt after the war of liberation, having gone through several periods of governance trouble (Ruud *et al*, 2011). Impoverished countries are particularly vulnerable to HIV/AIDS because they often do not have the resources to buy the adequate medication and to treat and help patients with HIV/AIDS. Health care systems are often overburdened, or not well developed.

Resources for educating the public about prevention strategies and the consequences of stigma are equally limited (World Bank, 2013). HIV/AIDS high-risk groups like sex workers or drug users are often poverty-stricken or have fallen out of good society (from the goodwill of families, or from work markets), and face a multi-faceted challenge in a society where their disempowered situation hinders access to health services and suppresses their agency to protest.

### *Sexuality and HIV/AIDS*

European Renaissance travel writings and plays repeatedly connected deviant sexuality with racial and cultural outsiders and far away places. Non-European peoples were imagined as more easily given to same-sex relationships, and various accounts served to define deviant and normative behaviour in Europe. Colonialism thus entrenched the connections between foreign lands and deviant sexualities (Loomba, 2005). The Church in pre-industrial Europe, and the scientific study of 'sexuality' that grew in the 1800's, speaking of 'nature' and biology (Segal, 1997; Scott



and Marshall, 2009) were also influential to Western sexuality discourse. The continued condemnation of homosexual practice in Bangladesh, strengthened by Muslim norms, has implications in relation to HIV/AIDS in that some men who have sex with men hide core aspects of their identity, not daring to seek health information and services.

### *Gender inequity and HIV/AIDS*

In some Muslim societies, social norms systematically accord a lower status to women compared to men. In Bangladesh, this is apparent in heterosexual relations as well as in the economic and social spheres of life. This discrimination has adverse implications for the access of women to education, nutrition, health information, and services within and outside the household (Hasnain, 2005; Khosla, 2009). In relation to HIV/AIDS, gender inequity increases poverty and the silence surrounding risk behaviour. For many women there might be social barriers against demanding safer sexual behaviour from their husbands and partners (Rahman, 2005), which arguably has implications for the spread of HIV/AIDS.

### *Legal frameworks*

The legal frameworks affect HIV high-risk communities in Bangladesh. The Narcotics Control Act of 1990 makes possession of tools used for taking drugs punishable with a minimum imprisonment of six months (Knight, 2006; Imaan and Alam, 2008). In

the year 2000, an amendment to these drug-use laws offered government support for NGOs working with detoxification and support for drug users that actively seek to end their addiction, under the existing health system.

Needle-exchange programmes rely on strong advocacy by law-enforcement authorities (Knight, 2006). The relevance of this to the HIV/AIDS situation is essential, as the sharing of needles represents a major factor in the spread of the disease. Furthermore, for countries grappling with decolonization, a major problem is contestation over inherited laws. For instance, legal barriers for men who have sex with men in Bangladesh include Section 377 of the Penal Code (1860) that criminalizes homosexual practice (CommonLII, 1860). This prevents people from seeking prevention material and health care.

### **A participatory approach to HIV prevention through a Freirean lens**

Postcolonial theory critiques dominating approaches to education (Hickling-Hudson, 2011; Breidlid, 2013), and the challenge is to implement participatory models of education in the Bangladeshi, Islamic context. A Freirean approach to education is of significant value in this.

Paulo Freire worked in Brazil and created literacy education programs that promoted dialogue and power sharing between participants. Social critique and transformation were the goals of these education programmes. Components of this approach included

problem posing contrasted with problem solving, analysis of the root cause of conditions, and exchange between participants and educators. How knowledge is used and created, who creates it, and for what purpose were all stressed in Freire's popular education approach. Freire contrasted popular education with the model he called "banking" education, where a knowledgeable expert would 'deposit' knowledge into the minds of learners, much like a person making a deposit of cash into a bank account.

The banking model was seen as static, unidirectional, and reinforced the power of the expert, both as a source of knowledge and in the expert's role of replicating this knowledge (Freire, 1970; Mayo, 1999; Zanoni, 2013). "One cannot expect positive results from an educational or political action program that fails to respect the particular view of the world held by the people. Such a program constitutes cultural invasion, good intentions notwithstanding," he stressed (Freire 1970, p 84).

Peer education is an educational model that is inspired by Freire's approach. It is a process of carrying out informal or organized educational activities with individuals and small groups of peers, over a period of time. Peer education is based on the reality that many people make changes not only based on what they know, but on the opinions and actions of their close, trusted peers. The main role of peer educators is to help the participants define their concerns and seek solutions through the mutual sharing of information and experiences.

Peer educators are the best persons to disseminate new information to the peer participants and can become role models by ‘practicing what they preach’. Since the educators are from the same group, they can empathize and understand the emotions, thoughts, feelings and language of the participants and, therefore, relate better to them (Chowdhury and Chandra, 2006; Alcock *et al*, 2009; UNODC, 2013). Peer education can take place on a street corner, at a social club, in a train station or any other place where people feel comfortable.

## **Methodology**

Research is never neutral, and our representations of other people are intimately linked to our own socioeconomic, gendered, cultural, and historical positioning calling for a heightened self-reflexivity. Even in trying to describe and interpret culture from an insider’s perspective, knowledge will always be subjective and relative. I cannot know what it is to be a Bangladeshi participant in this local setting. I am aware that there is a possibility that I might bring those I am studying to silence through the way I write. My chosen methodologies are in themselves products of Western epistemology.

I used a discourse studies approach throughout my research (Jørgensen and Phillips, 1999; Laffey and Weldes, 2004; Rogers *et al*, 2005). The study was qualitative and designed as a case study using elements from ethnography. These are reflective methodologies (Bryman, 2004) that could lead to a greater depth in my understanding of the research findings. I collected data during three months of

participant observation at three health centres and at the main office of an NGO working with HIV/AIDS prevention in a city in the north-west of Bangladesh. In addition, data from four focus group discussions with participants at the NGO, and from 10 semi-structured interviews with peer educators, centre and project managers constitute the material for analysis. Interviews and focus group discussions were partly conducted, taped and transcribed with the assistance of a local interpreter, a female Master's student of social sciences who was a contemporary and acquaintance of mine. I trusted her accurate and distanced approach to the work. Data was also gathered through document analysis.

The fieldwork was conducted during August, September and October 2008. The project was based on the standards and ethical guidelines and terms of Oslo University College. Informed consent was obtained from the NGO. All potential participants were informed about the content and scope of the research, and the confidentiality and anonymity.

The validity of my analysis is premised on the communicative dialogue I had with my respondents and interpreter during field work, the oral quotations from them that I attached to my analysis, email correspondence with staff during analysis, and on my own epistemic background. The use of more than one method has hopefully helped to reduce biases which might have occurred if relying exclusively on one data collection method, source, analyst, or theory (Bryman, 2004).

Within a critical discourse analysis tradition, discourse has been defined as language use as social practice. According to Rogers *et al* (2005) "Critical Discourse Analysis focuses on how language as a cultural tool mediates relationships of power and privilege in social interactions, institutions, and bodies of knowledge" (p 367). I paid attention to the ways in which language was communicated and how discursive meaning was created and recreated through practices. The methodology helped to sense the everyday logic, customs, and reasoning of programme participants, peer educators and NGO staff.

In the next sections, I set out the main findings of the research.

### **The NGO**

The Non-Governmental Organization in focus had existed since the late 1980s, and was founded by a group of local adults to work for the victims of a flood. The NGO called itself a non-profit development organization that aimed to ensure access to basic human rights and social security for the most socially disadvantaged groups of society. HIV/AIDS prevention was one of its prioritized areas of work.

As with most initiatives to prevent the spread of HIV/AIDS in Bangladesh, the NGO worked with bi- and multilateral aid partners to target high-risk communities. The NGO operated three drop-in health centres in the city; one for men who have sex with men, one for female sex workers, and one for drug users. Peer educators conducting outreach work

guided people from the different groups to come to the health centres. At these centres, participants could get free health check-ups and further HIV/STI education. They were welcomed to individual counselling, HIV testing, and given free syringes and/or condoms. Participants could drop in to rest, to sleep, or to chat.

The NGO sent project proposals to funding aid agencies. Staff at the NGO emphasized that peer education had long proved functional, and they maintained the validity of this approach. They stressed that the content was negotiated in cooperation between the parties. The NGO was dependent upon external funding. Some aid came with strict conditions, whilst some opened for a more individual approach. Staff explained that some funding lasted for three years; some for longer.

What the NGO considered to be HIV prevention could be seen by critics as the promotion of an irreligious lifestyle (cf. Buncombe, 2008). The NGO tried to remain in continuous dialogue with religious leaders. “Some Imams approve of utilising Friday sermons to reach out to the greater society with an HIV message. Many do not approve. It is anyway in the interest of our projects to stay in continuous dialogue,” one of the centre managers stressed. Religious leaders are part of many personal interactions and conversations. Religious discourses of respect for life, and not harming others, could be referenced to encourage social action on health. “Imams have a great opportunity to do a lot in our society. Everyone respects the Imams,” he continued. However, the common attitude that ‘irreligious’ practices should not

exist and therefore should not be the subject of focus, represented a challenge for the NGO. The staff continuously needed to justify their efforts. They explained to neighbours of the health centres and to community stakeholders that HIV/AIDS is a real problem of significance in society, and that stigma provokes its spread.

Both ignorance and an overarching social stigma towards high-risk populations made it difficult for the NGO to gain social and material acceptance for its work in the local community, to involve religious leaders and other community stakeholders effectively, to reach the high-risk communities, and to be trusted and understood by these. The NGO worked cautiously and emphasized the importance of a cultural approach in its efforts.

In a cultural approach to HIV prevention, insight into daily life is essential. In the following section, I will examine some of the daily life challenges of participants in the NGO's peer education programme.

### **Daily difficulties of individuals from HIV high-risk groups**

While sexuality and gender is linked with core social identity creation (Foucault, 1976; Butler, 1997), sex work and drug use may be discussed as poverty problems. There are various reasons why people engage in behaviour that put them at particular health risk: for pleasure, love, to earn money, or because they are forced to do so.



*Men who have sex with men (MSM)*

The men at the NGO Health Centre for men who have sex with men fell in love with people of the same sex, or/and identified as transgenders (*hijras*), or/and as male sex workers. The term ‘homosexual/-ity’ was not commonly used. One participant expressed conflicting feelings about love and sexual practice. “I have asked myself and God many times; ‘why are we MSM?’ [...] Biologically I am a man but I fall in love with people of the same sex. It is very difficult to be so different from other people.” The young man was trying to find answers to his perception of being different from others, from a publicly ‘normal’ model of being. It bothered him to an extent that he had repeatedly asked God to alter him in this wish. Several respondents expressed the difficulties of getting work.

A respondent who identified as transgender stressed that “the general population does not wish to work with us. They do not know our feelings, and they do not want to know either. People may not tolerate the fact that we behave in feminine ways.” It seemed as though behaving in ‘feminine ways’ was not socially tolerated, resulting in a degree of exclusion from job markets, and consequently from social communities. Expectations of masculinity were strong. “It is even difficult for us to move through the streets,” another respondent stressed. “Many people hate us because we are different. They cannot tolerate us.” This person’s hesitation to move around freely was caused by previous traumatic experiences of harassment in his neighbourhood. Overall, they expressed deeply

internalised feelings of shame, related to both love and illicit sexual practice.

Colonial constructions of sexuality and gender, with the condemnation of same-sex relationships had an impact on the lives of these men. Islamic-normative expectations that sex is for the purpose of conceiving children within heterosexual marriage, underpinned this. The interviewed participants emphasized the burden of the strong stigma upon people who deviated from the discursive expectations. This stigma prevented individuals from moving peacefully through the streets and from getting work. Physical experiences made them attempt to hide their status as MSM at home and in public, not daring to seek information, try to get condoms, or test for HIV. The confidentiality of the NGO health centre seemed to be an appreciated, supportive sanctuary.

### *Female sex workers*

Combinations of various circumstances including poverty, misfortune, limited options for women in working life, and family ejection, are reasons why women may find that sex work is the only option. The conditions for women in sex work in Bangladesh are extremely harsh. Sex work in venues other than registered brothels is illegal (Chan and Khan, 2007). No legislation has been passed since independence (1971) that recognises commercial sex work as a legal way of earning income, which means that sex workers have no right to any formal licence (Ara, 2005). This ambiguity makes harassment of sex workers easier

and their access to healthcare services more difficult. It also prevents the creation of, and access to, work safety mechanisms (Khosla, 2009). To illustrate this lack, one programme participant stressed: “We earn money to the client’s choice. We cannot say anything. We want to say a fixed price but we may be tortured if we do so, and no-one is there to help.”

The participants at this second Health Centre expressed a need for housing. “Our main worry is that we need a personal house. On Fridays, when [the NGO] is closed, we stay the whole day within the railway station boundaries and the railway people and door-to-door salesmen know that we are staying there and they disturb us,” a respondent said. This provides insight into a situation marked by insecurity. Some mentioned violence and harassment awaiting those of them forced to live on the streets. The lack of family acceptance was equally emphasized. “We have no families.” “I have a husband. He hit me yesterday.” “I want to build my family but it is impossible because my husband doesn’t allow me to come home to the family. I was tricked into prostitution and my husband said I am no good girl.” These women had little option but to be submissive to husbands’ decisions. It was difficult to escape the sex trade. “All people say: Change your lives, come back to our society. But when we try to come back to society, this same society cannot accept us. So we cannot change.” The sex workers felt trapped within their situation because of stigma, and further stigmatised through their practice.

In traditional Islam as in many religions, the value of sex for the purpose of children and within marriage

is basic and essential. Sex work is an infringement of such values. The female victims of this trade were treated with disrespect, experienced physical and psychological violence and danger, and faced a constant struggle to acquire money. They were excluded from families and social networks, and did not dare to seek public health services. Some of the respondents were illiterate and stressed that they had no accurate knowledge of disease or prevention prior to their involvement with the NGO.

### *Individuals addicted to drugs*

The third centre under study was the Health Centre for drug users. Here, there were predominately male adults who expressed a wish to quit drugs, and some had overcome bad addictions. Many of them used or had used syringes as a way of taking drugs. As a consequence of official laws, “[i]t is not legal to sell needles and syringes without prescription in Bangladesh. Illegal shops are there though, selling needles for a high price,” the manager at the centre explained. Without the opportunity to buy equipment easily, the solution for injecting drug users is often to share syringes, and to use each syringe until it breaks or gets lost, hence increasing their vulnerability to HIV along with their spouses and sex partners.

Drug use is a major problem particularly among rickshaw-pullers and mini-taxi-drivers, and among male and female students, programme participants stressed, being mostly unemployed themselves. They had a hope to improve their lives in general, wishing to

get work or to develop their own businesses. Their major worries were expressed as being related to money, or a lack thereof, and a lack of something meaningful to do. For some, a lack of social inclusion or acceptance was also an issue.

Getting tested for HIV at the centre was encouraged, and free. However, the participants expressed reluctance about getting tested. This seemed to stem from a combination of indifference and, as one stated: “It is difficult for people to explain the topic of HIV/AIDS in our families.” Discussing HIV/AIDS meant discussing drug use and sexual behaviour, something which some participants attempted to avoid at home. Not daring to discuss their problems in public for fear of social exclusion and imprisonment seemed to hinder their rehabilitation into the community.

### *Visions for the future*

Respondents at the three centres expressed visions of a better future. The MSM respondents desired to be accepted by society, to not have to feel shame when they fell in love or challenged expectations of masculinity. The drug users desired to get clean from drugs, to get work or to be able to start their own businesses. The women working as sex workers expressed a wish for a personal house or shelter, a need for safety, for the opportunity to be part of a family, to see their children, and they clearly stressed the need for assistance to alter their

situations: “We want to change our lives. If [this NGO], some other NGO or a government initiative would give us the opportunity to earn money in a right way, we could change our lives. It could be courses on handicrafts, sewing, or garments labour. This life is not safe and we cannot escape it on our own.” The various respondents’ visions for the future were basic and concrete: shelter, money, work, safety, love and families.

*The questions of agency and the ability to ‘speak’*

The respondents were in different ways disempowered in the social context of a combination of the aftermath of colonialism and the norms of traditional religion and patriarchy. However, when emphasizing the destructive power of colonialism, one may wonder if it is necessary to position colonized people as victims, incapable of answering back. On the other hand, if suggesting that the colonial subjects can ‘speak’ and question authority, one may romanticize such resistant subjects and underplay colonial violence. One may ask if the voice of the subaltern can be represented by the intellectual. In ‘Can the Subaltern Speak?’ (1988), Gayatri Spivak suggests that the combined workings of colonialism and patriarchy in fact make it extremely difficult for the oppressed colonial subject to speak or be heard. However, her picture of subaltern ‘silence’ is problematic if adopted as the definitive statement about colonial relations.

How are the questions of agency applicable to the socially stigmatized and marginalized people in this local setting? An answer to this is that people are not trapped in their subjectivity beyond the power of choice, recognition or resistance. A person exercises power even by being (Butler, 1997). Individuals make choices also by keeping quiet, and the discourse is recreated also by silence. Relevant to this is the conclusion to *Black Skin: White Masks* where Frantz Fanon rhetorically proclaims an almost Cartesian agency for the colonized subject: “I am my own foundation. And it is by going beyond the historical, instrumental hypothesis that I will initiate the cycle of my freedom” (Fanon, 1952, p. 231).

In the very processes of the emergence of colonial and neo-colonial discourses, they are diluted and hybridized. People in these contexts can negotiate the cracks of dominant discourses in a variety of ways (Bhabha, 2004; Loomba, 2005). In theory, peer education provides a framework for problem posing dialogue that should increase agency, which may assist people in negotiating disempowering discourses. In the following section, I will discuss the form of peer education that was implemented in this particular setting.

### **Peer Education in the setting of HIV prevention work**

Peer education in the HIV prevention field has varying outcomes. Much remains to be learned about

the factors which lead some projects to succeed while others fail (Cornish and Campbell, 2009).

The peer education approach assisted the NGO in getting through with their messages. A female project manager at the main office stressed: “It is difficult for us; we cannot easily go to talk with the sex workers in their own communities. [...] I know where they are living but they are not free or relaxed with me.” Furthermore, she stressed: “Peer educators are selected from targeted populations’ own communities. The peer educators know the lives of the people; they are working with social networks that are known to them.”

The peer educators seemed motivated by an authentic interest in the programme. A female peer educator who had been addicted to intoxicants in the past explained how she wished to assist others out of addiction. Rehabilitation required a long process of counselling, she stressed. “We have been there ourselves. We know that we need to be patient. [...] At first the drug users may not talk about their drug problem with us, they have to take drugs first. But we wait until they are clean again before talking. And after talking sometimes, they understand that we want to help them.” She stressed the need for patience, and she spoke of her work with enthusiasm.

The peer educators working from the MSM centre emphasized the message that ‘*your body is your life*’ to get participants engaged in discussion. This approach was part of their training as educators. However, “the societal condemnation is huge. When we try to discuss this message with our peers they cannot easily



understand it,” one of them stressed. The message can be interpreted to incorporate a view on sexuality and on individual choice that may be rather radical in the traditional setting it was to function. However, in the discussion that followed participants could share and discuss their concerns, experiences, and emotional issues that emerged. To encourage active participation role playing was used in the group meetings to improve, for instance, communication with partners and clients about safer sex practices. Problem posing was employed to assist participants work together to solve problems (cf. Freire, 1970).

The educational dialogue employed in the programme may be seen as to increase the ‘effectiveness’ of HIV prevention, but in this setting it can also be seen as problem posing in that participants created a space to raise concerns and offer critique of disempowering forces. What happened was frank dialogue about social practices that provided the context for the use of the content knowledge. While there were summary points at the end of the educational sessions about what the ‘take home’ messages should be, what participants also gained was viewpoints about themselves and their own practices in a context that could address and support their health, family and community (Zimmerman *et al*, 1997).

The peer education in this particular setting functioned well in basic ways: high-risk communities were reached, and the peer educators’ messages were understood by the community members in the field. These dared to come to the centres for educational

follow-up and health check-ups. Furthermore, peer education proved enabling for the participants to build social networks which could potentially lead to improved preventive behaviour and social action to improve their lives in general.

Many participants came to the centres daily. It was explained to me that after time and further training many got engaged in work as peer educators. However, the work for the peer educators was not paid. It is a matter of discussion why the poorest people of society should remain unpaid for their work. 'Empowerment' of communities is sometimes used as a euphemism for the reduction of costly services, as communities are expected to take on responsibility for their health, with little or no pay. A further problem is the inadequacy of consultation. In the peer education programme neither participants, nor peer educators were directly included in the programme planning and curriculum design.

'Sustainability' is another euphemism, used to mean the continuation of a programme after funding ends. If acknowledging that current behaviour patterns are a product of a powerful set of social conditions, to change this whole system will require enormous investment of time and resources. The impetus to achieve 'sustainability' should not lead to unrealistic assessments of the speed at which the development of independence and power among community members can be achieved (Cornish and Campbell, 2009). Staff stressed the amount of extra work, and the very limited outcomes, that short-time programmes would bring about.

## **Concluding remarks**

The context of HIV/AIDS in a postcolonial, Muslim cultural context in Bangladesh represented particular challenges in HIV prevention work. The participants at the NGO faced challenges in their daily lives. The existing social and legal frameworks did not provide an environment for any safe disclosure of risky circumstances, and they were reluctant to share their needs in public and to seek information and health services. This has implications for the spread of HIV/AIDS. If the consequences of moving away from existing patterns of discursive dominance are too threatening, people may attempt to avoid them, upholding the dominant discourses, and exacerbating their own vulnerability to the disease.

Through the discussion of daily life challenges I attempted to show the importance of emphasizing context in HIV prevention. A cultural approach was vital for the NGO to succeed, and the NGO worked cautiously through peer education and through involving community stakeholders like Imams. The NGO's cultural approach, as contrasted to a more biomedical approach, was well suited to the challenges of HIV prevention within these marginalized communities. This programme showed that it is possible to partially compensate for very disempowering social conditions by addressing the community's social challenges. However, to strengthen this focus the participants could have been involved more directly in programme planning and curriculum design.

The programme participants were provided with health information. In addition, the educational dialogue offered an opportunity to raise social concerns. To be able to see oneself in a social context where discourse is created and recreated, is a step on the way towards combating shame, which is a major hindrance for agency. In the process of conscientization, the 'banking education' from an authority or formal expert may prove counterproductive. This study showed how participants and educators developed a form of ownership of the programme, working together to solve problems and making decisions about issues of concern to them.

On the basis of my analysis of this particular setting, I suggest the following principles for peer education that would deepen its resonance with the philosophy of Freire:

*Address the social, cultural challenges disempowering the communities.*

Core problems and disadvantages such as poverty and stigma limit the impact of any efforts to change health-related behaviour.

*Involve religious leaders and community stakeholders.*

Community intervention is a complex social process which depends for success upon the action and support of various community members. Any

effort directed at HIV prevention must take into consideration the powerful impact of religious leaders in the community as they play a critical role in Muslim culture. For HIV prevention programmes to be successful, continuous dialogue with religious leaders and community stakeholders is a key element.

*Anticipate a lengthy time frame.*

Social change is a slow and gradual process, and quick fixes are unlikely to work. Project planning needs to allow for an extended period of time and very gradual improvements.

*Involve the participants directly in the programme planning and curriculum design.*

The active involvement of the key participants in programme planning, curriculum design, and implementation is more likely to produce a programme sensitive to the local context, and with local commitment. The participants in this setting were clear in their visions for the future, expressing concrete needs that could help them to live more functional daily lives. Their experiences represent extremely important knowledge about what is helpful for these groups.

*Support active participant groups.*

Decolonization cannot be limited to deconstructing the dominant story and revealing local

voices, or local histories. This and much more is needed to assist people improve their current conditions and reduce their vulnerability to getting HIV/AIDS. Peer education is a tool for decolonization; it is about constructing one's own responses in cooperation. However, historically disempowered communities are not immediately in a position to run and lead a challenging programme or activist group. Without intensive support the impact of such initiatives is limited.

This paper has sought to understand a programme of participatory education for HIV prevention in a specific context in Bangladesh. The programme reached out with factual knowledge of disease and prevention to marginalized communities. In addition, the peer education worked as a force of critique with the participants. These discussed social practices and responded to their disempowering situations through active participation as educators and peers. However, the cultural, participatory approach can be promoted even further in peer education. It is a promising educational approach to challenge neo-colonial discourses.

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