ABSTRACT

This paper is a bridge between two studies by the author: (i) completed MA research; and (ii) on-going PhD research, on male sexual health and the street healing system in Bangladesh. Street healing, a traditional healing system in Bangladesh, is at the centre of the studies. This is a popular form of folk healing in Bangladesh, where male impotency is a central issue. The author has been researching street healing to understand male sexual health-seeking behaviour in Bangladesh. In this paper, the author brings in experiences from his MA research to explore the challenges of studying sexuality and street healing in Bangladesh and concludes by describing his plan to address those issues in his on-going PhD research.

INTRODUCTION

The study of sexuality is a challenging issue. It is a challenge for academia all over the world. Even the teaching experiences on this topic can be very challenging (Ashcraft, 2012; Valentine, 2001). Educators may find difficulty in talking about the topic in a classroom, and it could be difficult for some teachers to have an appropriate way to teach teen sexual behaviour (Ashcraft, 2012). Similar challenges exist at the university-level teaching of a course like human sexuality, where there can be the risk of negative student reactions, and it could even result in a professional stigma (Valentine 2001). Both Ashcraft (2012) and Valentine (2001) found this challenge in the US context, where there is a provision for classroom teaching on human sexuality. This situation led me to the research question: What could possibly be the challenges for a researcher to work on a topic related to sexuality in Bangladesh, where public discussion of sexuality is forbidden (Kabir, 2005)? In this paper, I discuss my MA level research experience (Anam, 2010) to search for a better tool to address/manage those issues in my PhD research.
Background of the study of street healing

The first time I heard the word ‘AIDS’ was from a street healer, though I was too young at the time to comprehend that word. That topic is still the most common source based on which young boys learn about sexuality and sexual diseases in Bangladeshi society. This is due not only to the fact that the healers talk about sex in the first place, but also to the fact that the very way they present it is an enormous factor in drawing the attention of people of all ages, even children. I can recall that time of my own case of learning the term AIDS. It was during a street healing event in front of the Bangladesh central mosque – Baitul Mokkaram. I went there as part of a recreational trip with my cousin-brother, with whom I was visiting markets near the mosque. Suddenly, we found a man surrounded by a large audience. This was not new to me. I was familiar with that type of gathering; we used to call it majma. In my village markets, I had seen such gatherings several times. I was very interested in this specific gathering and I asked my brother whether he wanted to go see the majma. He agreed and we joined the audience. I cannot recall everything the healer said, but I can still remember the term AIDS. It was not clear to me, but I understood AIDS as a severe disease. This scenario is representative even today for many Bangladeshi boys, who learn different sexual health ideas from street healers.

I began to conduct research on street healing because I like street canvassing, I enjoy the healers’ performances, and because I know the street language. Apart from my personal fascination, there was an academic purpose behind my choice of this topic for my research; there was no anthropological work on street healing despite the fact that it is an extremely important element in medical anthropology and in Bangladeshi society. This is a common problem in sexual health research. Lindau and colleagues have pointed out that in the United States, the sexual health problems of aged people have not been thoroughly explored (Lindau et al., 2007). This tendency is similarly true in South Asia. Hawkes and Collumbien (2007) argue that contemporary public health programs in South Asia do not concern themselves with the construction of masculinity and its consequences for male sexual health. Rather, they focus mostly on controlling sexually transmitted infections. But, on the other hand, men in South Asia are more worried about their ‘psycho-sexual conditions’. They are concerned about their discharge syndromes, weakness and erectile dysfunction. Hawkes and Collumbien think it would be difficult to achieve the Millennium Development Goals without understanding what men in South Asia want from sexual health services. Schensul, Mekki-Berrada, Nastasi, Saggurti, and Verma (2006) also find that South Asian men are more concerned about their performance rather than sexual diseases.

Verma, Rangaiyan, Singh, Sharma, and Pelto (2001) examined the vocabularies men use in South Asia to address their sexual health problems. These vocabularies are
When Sexuality is in a Research Topic! The Methodological Challenges in Sexuality and Street Healing Research in Bangladesh

mostly related to non-disease dimensions of sexual health. The authors highlighted two major male sexual health problems, Kamjori and Garmi. In the South Asian context, Kamjori refers to sexual weakness, and Garmi refers to heat and excessive sexual desire. Both of the concepts refer to the non-disease dimension of male sexual health problems. In the local vocabularies, people are referring to a particular health problem that is not there at the public health level. Khan et al., (2008) draw similar attention to the inadequate public health programs in the non-disease dimension of male sexual health concerns in Bangladesh. They discuss men’s perceptions of the penis and its links with masculinity. In the Bangladeshi context, the size, shape and action of the penis are related to male sexual power. Therefore, to prove a sexually powerful man, men in Bangladesh want to have a good-sized and well-shaped penis (Khan et al., 2008: 41). Additionally, failure to have prolonged sexual intercourse and premature ejaculation are seen to be two main threats to male sexual performance. Khan et al argue that for South Asian men, the penis is situated at the core of masculinity and that penile erections equate to male power and potency.

Though the South Asian public health authorities are not concerned about the construction of masculinity and its influences on male sexual health, the South Asian culture has this element in its cultural practices. Street healing is the cultural practice which addresses the relationship between health, domination, and sexuality. Therefore, I have chosen street healing as a means of understanding male sexual health in Bangladesh. When I started my MA level fieldwork, I initially believed to have the privilege to easily access this topic as a male Bangladeshi native myself. But I was wrong; my research subjects, male sexual health and the street healers’ profession, were not so easy to deal with. My field experiences repeatedly compelled me to think about my research topic, method and the research settings. I was dealing with a research topic which is extremely sensitive; moreover, I chose public places – open market places – as my field, which made research more challenging.

**Majma: The field of street healing**

*Majma* is a well-known word in Bangladesh; it refers to a gathering of people to observe a performance. In street healing, healers try to get the attention of the people from nearby stations, bazaars, or from a communal place by playing music, performing theatrical activities or telling stories. People’s attention is the key to selling street medicine. The performance is very important for a healer in order to be accepted by the audiences. Therefore, it is not only the *majma* that is significant for selling medicine, the performance of a healer is equally important.

*Majma* is a short, temporary gathering of males from different age and economic groups. People may not know each other in the gathering where the street healer, as a
central performer, delivers his speech to the audience. The presentations of the healer are
designed with advice, stories, information, and references to the quality of the healing.
The healer, as a salesman, shows the importance of his medicine in his speech, while the
audience members observe and some of them buy medicine. Since the spectators are also
busy with their visiting or marketing purposes, a healer does not have a lot of time for his
majma: He tries to convince the audience to buy within a short period of time.

This majma culture is a form of information sharing in the Bangladeshi context.
Majma is conducted mainly in the market places, because markets are not only places
for economic or trading issues, but rather places for all kinds of information sharing. Majma,
therefore, is one of the centres of the market, a place where healing is being
addressed.

The title of my MA research was ‘Masculinity in Majma: An Ethnography of Street
Healing in Bangladesh’. One may ask about the justification of the term ‘ethnography’
in the research title. My fieldwork only lasted three months; therefore the tradition of
year-round participant observation was not there in my fieldwork. If one were to strictly
define ethnography as being the output of twelve months of fieldwork, then in that
sense I cannot claim that this work was an ethnographical project. Moreover, during
that limited time, it was not possible for me to examine street healing in a holistic
mode. This would be one of the reasons to continue my work on street healing within
the framework of a PhD.

I teach Anthropology at Jahangirnagar University, located in Savar, Dhaka. I was
therefore interested in doing my MA fieldwork somewhere around Savar. Since I had
my university accommodation there, I hoped to use this advantage during my fieldwork
period. I also knew that there were at least three daily markets in Savar and its nearby
areas where street healing was a common sight. There were no statistical data available
on street healing in this region. However, from my personal experience and contacts, I
knew that street healers were actively selling and healing in all three market places.
These conditions influenced me to select Savar for my field work.

I was happy with my field selection; I was staying in my university apartment and
visiting my field on a regular basis. I had three different sites in my research area.
Nabinogor Bazaar was one of the sites, which was two kilometres away from my university
campus. The other two sites were the Ashulia Bazaar and the Savar Town Bazaar. The
Ashulia Bazaar was four kilometres away from the university campus but the Savar
Bazaar was very close to the university. I had chosen three different sites because of
the nature of street healing sessions. Street healers have their own routines and routes
to conduct sessions in different places. I was following the street healers, who were my
key informants.
The Nabinogor Bazaar is a market place and a bus stand. The Savar military station and the Dhaka export processing zone (DEPZ) are important places close to this bazaar. The factory workers and the military personnel often visit the market. A national monument also stands here, and visitors from inside and outside the country come very frequently. These conditions are favourable to the street healers because they provide them with more viewers. I found street healers almost every week day in this marketplace, but Friday was the most important day for them. Friday is the weekly holiday in Bangladesh – therefore a good number of monument visitors come to visit this place. Workers of the DEPZ and the relatives of military personnel also used to come here as visitors on Friday. This made Friday a very special day for street healers, because they had large audiences on that day. Street healers preferred the monument entrance for their majma; however they had an understanding among them regarding the performance site location.

Ashulia was my second field site, a weekly market taking place on Wednesdays. It had a few permanent shops which were open every day, but the traders and the buyers came from different parts of Savar and Ashulia on Wednesdays. This place took on a totally different colour on market day, not like the other days of the week at all; the number of people coming to buy and sell goods increased substantially. There was a special place in the market reserved specifically for street healers. I observed 20 street healers in a day in that particular place. This could be very unusual for a newcomer; on my first day in this field, I was really surprised to observe a huge gathering. Later, I realized that the number of buyers was the reason for it. Besides this gathering, this place also had a reputation for being a source of all kinds of remedies, which were necessary for different street healers.

My third field site was the Savar Town Bazaar. Here, the number of street healers was not as high as in the Ashulia or Nabinogor bazaars, due to the busy and commercial nature of this place. It was difficult for the healers to manage a place for majma in this bazaar. This place was less attractive for the street healers.

In all of the three sites named above, I found street healing, majma, to be a popular means of selling medications in Bangladesh. While healers sell different kinds of medicines, those that offer enhancement of male potency are the most prominent. Street healing is, first and foremost, a profession, a means of earning money for the street healers, and only secondly related to healing. A good performance is a must in street healing. The performance can consist of storytelling, music or magic. A good performance is also related to the healer’s quality or importance towards the audience. It is a self-promoting profession; therefore street healers advertise their quality and their healing quality in a Majma. It also assists street healers to have attention from the audience.
Self-advertisement is therefore a must in *majma*. Healers’ stories on different achievements on healing and their own body are part of this self-advertisement process. However, street posters and flyer advertisements on male sexual health are also common phenomena in everyday life in Bangladesh (Rashid, Akram and Anam, 2012). The printed advertisements state the health problems the healer will address and the proposed treatment. The health-seekers are requested to meet in a particular chamber in a particular time frame. In the *majma*, the advertising centres more on the healers’ capabilities and offers healing at the same time. A strong biography helps the street healer to achieve the audience’s attention but he needs a story at the same time. This story can be the story of an impotent male; it can be a story of a nymphomaniac female or it can be about an everyday food habit. The subject of the story and its delivery are important for the street healers, as these are the means by which they draw the attention of their audiences. This ultimately assists street healers’ authority on male sexual health.

In Bangladesh, morally, discussions about sexuality are a sign of social norms being broken (Kabir, 2005). Therefore though street healers talk about sexuality, they do have a code of conduct for their deliberation. They talk openly about sex but they do not permit children or females in their *Majma*. During my fieldwork, healers would check for children in the crowd, and if they found any, they would immediately ask them to leave the place. Healers also requested their audiences not to permit children to listen to the *Majma*. It is also very common that the healers request the females to leave the site of their performance.

I have come across the idea of a real man as promoted within *majnas*; a real man must be able to satisfy the sexual desire of his wife. This concept of a real man is also linked with different moral ideas, such as that masturbation, sex during the menstruation period, and prostitution, are immoral practices. Within the framework of street healing, these immoral practices are believed to create male sexual health problems, but street healers offer treatments for these health problems. In the healers’ narratives, I have found the combination of pornographic and traditional ideas, which ultimately influences the construction of sexual performance anxiety among viewers. These anxieties focus on loss of semen, premature ejaculation and penis size. However, healers also promote the services of other disease and non-disease dimensions of male sexual health problems. This whole process helps us to understand an informal and popular form of male sexual health-seeking behaviour and advertisement scenario in Bangladesh. It also shows publicly declared male sexual anxieties and the causes behind those anxieties.

**Encounters in the field: the experiences in MA research**

In my MA research, I worked with three different street healers, Ridoy Hasan, Azad Ali and Delowar Hossain. They had different backgrounds and each had his own

*The Oriental Anthropologist*
approach to street healing. All of them claimed to have a strong healing power.

Every Friday Ridoy Hassan sold medicine in Nobinogor Bazaar, one of my fieldwork sites. His main clients stemmed from visitors to the monument and military personnel. He sold Joker Tel, a kind of leech’s oil. He claimed to be a traditional kabiraj (healer), who has learned healing techniques from his ancestors. He stated it as his family occupation for serving people. Ridoy’s grandfather started this family tradition after learning the skills from an old kobiraj who had a remarkable reputation. Leech’s oil was the main product in Ridoy’s Majma; he also used to sell Monmohua tree. Both of these medicines, he claimed, had been used by his grandfather. Leech is a very commonly found annelid category in Bangladesh but according to Ridoy, his grandfather had been the one to find its medicinal quality. This was a way to draw his audience’s attention and earn credentials as a very authentic healer. Ridoy also shared the oil processing mechanism with his audiences. He explained the ways his grandfather had invented and produced the oil. He claimed to continue his duty, which had been given as a part of family responsibility. Therefore his Majma was not only for money making; it was rather a family tradition. Ridoy claimed that he had enough property of his own and he did not need to earn money from street healing.

Azad Ali was a self-proclaimed Ayurvedic healer. He was the owner of the ‘Azad Unani Complex’. This Unani complex produced a tablet called shakti. The Bengali term shakit refers to ‘power’. Azad claimed that shakti could prolong sexual intercourse to increase the sexual satisfaction of couples. He claimed to be the inventor of the shakti tablet, which he learned from his ‘Ayurvedic knowledge’. Because the tablet is made from tree, he explained ‘tree’ as a source of sexual energy and claimed that the people of the previous generation had known about this power, therefore they had not faced any sexual problems. But, according to him, in today’s world people have almost forgotten about these plants. He therefore focused on plants to produce his medicine. He claimed to have received training in Ayurveda in India, where he learned the uses of different plants and herbs.

Azad claimed to be an Ayurvedic healer, but he produced Unani medicine. This may be an example of the ambiguity of the local understanding of Ayurveda and Unani, where most of the people think herb-based treatments are related to both Ayurveda and Unani. However, these two have a long tradition of different healing methods. People’s acceptances of plant-based treatments help Azad and many other street healers to produce male sexual medicine with so-called ‘herbal ingredients’. Azad also claimed that he had trained in Ayurveda in India; it was his way to establish himself as a street healer and gain importance in the eyes of the spectators. Azad promoted his medicine as herbal, and at the same time he added information about his own training to earn credibility. In comparison, Ridoy claimed his healing knowledge to be learned from his
family and Azad drew attention to his foreign training, both with an aim to earn credentials as healers.

Delowar Hossain was the third street healer. He sold medicine on the street for a company called Green Life Herbal Company. Hossain did not claim his business to be a family tradition or self-invented, but rather argued that he was working for a company which was ‘scientific’ and ‘modern’. He claimed to have received training in a modern pharmaceutical environment and to have proper knowledge of herbal medicine.

The above description of the three street healers is useful for understanding the context of street healing, and can help us to address the challenges in sexuality studies. I would like to start this discussion with my own identity. I have faced a huge challenge due to my own identity. Ahmed (2000) describes the problems of ethnographic fieldwork in the native country, raising questions of insider and outsider positions in field work. He shows his own field experiences: ‘I believe that my ethnographic role was contested, resisted and negotiated by “the native”, although I was carrying a “native” stamp. Indeed, my local identity may have hindered my fieldwork’ (Ahmed 2000: 207). Ahmed claims that his background, identity and objectives placed him in a position which was beyond his control. In a similar vein, I recognized that my background and identity during the MA research placed me in a position which was beyond my control.

I was doing my MA at Heidelberg University in Germany while I also had a faculty position in Bangladesh. Both of these identities, of student in Heidelberg and university lecturer in Bangladesh, created another dilemma in my field work, since the healers pointed out my presence to the audiences, telling them about my research and using it to strengthen the importance of their medicine. Sometimes they addressed the audience by saying:

Look brother – this man is a university teacher. He is doing research on my medicine. He is doing this research in a foreign university – do you know Germany? He is doing research there. Will you still think about my medicine?

Several times I asked them not to refer to me in front of the audiences, sometimes they listened to me, and sometimes they did not. I did not know what the best solution to avoid this situation could be, but these dilemmas reminded me several times about the limitation of my research. I was working in a situation where my identity was important for my informant, therefore he was interested in disclosing my identity. I was not sure whether this situation could influence audiences to buy medicine or not, but I faced questions from the audience members whether this medicine really works or not. It was a really difficult situation for me as a researcher: On the one hand, I was depending on the street healers since I was observing their sessions, recording them and interviewing them. On the other hand, they were ‘just mentioning’ my name to
obtain extra attention from the audiences; it was a very simple demand for them. The questions from the audiences were similarly problematic for me: Both yes or no answers were problematic; even if I said I did not know the function of the medicine, sometimes it could mean that I was thinking negatively about the medicine. This situation was very influential on my researcher identity and my relationship with my informants. The street healers were just asking me for something in return for what they were giving me, but, on the other hand, it was necessary to keep myself ‘neutral’.

It is important that ethnographers’ personal history as well as their disciplinary and the sociocultural circumstances have a profound influence on research topics and the people selected for study. Additionally, an ethnographer’s relation with his informants in the field is influential in the process of an ethnographer’s participation. In this way, ethnographers contribute to constructing the observation that is their ultimate field data (Davies, 2008). Therefore, we see anthropological associations or societies strongly recommend in their code of ethics that informants be kept anonymous. According to the Australian Anthropological Society’s Code of Ethics (AAS 2003):

An anthropologist should not reveal personal identities or confidential information except by agreement with those whose identities or knowledge have been recorded by the anthropologist. In the case of deceased persons, anthropologists should have due regard to the interests and feelings of their surviving kin and fellow community members (AAS, 2003: 2).

The Australian Anthropological Society strongly directs researchers to keep confidentiality according to the agreement with the informants. The American Anthropological Association (2012) (AAA) and the Association of Social Anthropologists (1987) (ASA) have similar guidelines regarding the confidentiality of the informants. AAA advises that ‘Anthropologists have an ethical obligation to consider the potential impact of both their research and the communication or dissemination of the results of their research’ (American Anthropological Association, 2012). We can see that the AAS, AAA and ASA are careful about the possible risk of revealing an informant’s identity. However, my case was different, as my informants were revealing my identity. They wanted to reveal a researcher’s identity to establish their medicine among their prospective clients. How could I control the revealing process? Am I responsible for that? It was important for me to have a good relation with the healers. They disclosed my identity to their audience, and wanted to establish the efficacy of their medicine. In that case, I would say they were very welcoming, but at the same time they were examining me. It was a mixed response.

Since I was aware of the ethical considerations, I promised to inform my informants of every detail of my research and research techniques. After having obtained informed
consent from each of them, I started my work. When I introduced myself to the street healers, I received mixed responses from them: They were very friendly with me but at the same time they could not trust me fully. They thought that I might write these street healing issues in newspapers, which could lead to negative consequences for their profession. But at the same time, they had shown that they were not doing anything ‘bad’ which could be the subject of news reporting. I agreed with them but still faced this situation several times. They also told me about their link with different powerful persons, which was clearly a message that even if I wanted I could not do any damage to their profession.

I did my best to be positive with respondents all the time; I assured them about my position, but still it was not convincing for them all the time. Sometimes they asked me to advocate for them in different ways to increase their business. They requested that I write positive articles for the newspapers so that the government would undertake a serious policy for the improvement of street healing. Both experiences were not very good for me: Sometimes the healers took me as a friend, sometimes they did not.

This experience is not new in ethnographic studies. Evans-Pritchard’s classical work *The Nuer* is an example (Evans-Pritchard, 1940) of this dilemma within field work. Johnson (1982) describes Evans-Pritchard’s interaction with the Nuer and the Sudan Political Service. He describes these relations based on his analysis of Evans-Pritchard’s conversations with civil secretaries. Evans-Pritchard was highly criticized due to his personal cooperations with administrators. He had a good relationship with administrators and he regularly updated the authorities on conditions in the field. He even pointed out his difficulties to get information in the field. Johnson (1982) quoted from a letter Evans-Pritchard sent to MacMichae who was an administrator:

> From our point of view the natives of this area are too unsettled & too resentful and frightened to make good informants & the breakdown of their customs & traditions too sudden & severe to enable an anthropologist to obtain quick results (Johnson, 1982: 236).

Evans-Pritchard found the local people to be unwilling to act as good informants. They were frightened by the way in which Evans-Pritchard attempted to obtain quick results in his field work. Evans-Pritchard was an outsider. He was providing information about the native to the administrators. On the other hand, in my case, I was part of my informants’ community. I did not work on behalf of the government or other public or private entities. The mistrust between the informants and researcher exists beyond the colonial settings and time. It is present even today in the researcher’s native community.

It is expected that ethnographers should be kind and friendly toward their
informants. Fine (1993) found ethnographers acting as a good friend of their informants; they appear to be kindly souls. But, at the end, he found some of the ethnographers turned out to be finks, spies or undercover agents. In my case, my informants were measuring me; I was trying to prove myself as a good friend of them. Fine made me think about my friendship. I was definitely not a spy or an undercover agent; but was I a true friend of theirs? The goal of my friendship was rooted in obtaining good information. I did not do any harm to their profession. But had I truly tried to improve the condition of their profession? I will need to rethink my relationship with healers in my on-going PhD research. The encounters described above were related to healers. But the following encounters are more about my friends and academic colleagues.

Some of my colleagues were also interested in my research topic and my findings; some were very keen to know about the ‘adult contents’ of street healers’ narratives. I discussed my research with them in order to get their feedback. I received very few comments from them, but there were also rumours that I was going to produce a pornographic magazine. Not only the colleagues but also my students at Jahangirnagar University were interested in the research. Some of them even visited the field to observe my Majma listening situation. Even some of my friends were very skeptical about my field work. They were very interested to know about my own status, whether I was taking these medicines or not.

It is encouraging for any researcher to get attention from academia. I got attention from my colleagues, students and friends. However, the nature of attention needs to be examined. Those people giving me this attention were more interested in ‘adult gossip’ and ‘content’. It would be encouraging if I could get academic debates or criticism on my research. I should bring in Valentine’s (2001) teaching experience of human sexuality here. She argued that sexuality as a teaching and research area is not appropriate. She quoted Michael, Laumann, Kolata, and Gagnon (1994), and Allgeier and Allgeier (1998) and wrote, ‘… unlike other controversial teaching and research areas, such as race and gender, sexuality continues to be viewed as “tainted, marginal, dirty,” an inappropriate if not illegitimate arena for serious scholarly consideration’ (Valentine, 2001: 48). I encountered a similar experience, and it was very similar to Valentine’s teaching experiences of human sexuality as “walking egg shells’ (Valentine, 2001: 49).

The experiences were challenging, and embarrassing. One may ask why I am continuing my research on sexuality, if I found it to be so challenging and embarrassing. To be honest, in the initial stage of my PhD, I did not want to continue my research on sexuality. I had a fear of academic stigma. I was also confused about my own perception. Street healers’ narratives influenced my thinking about my own sexuality. I am still not sure whether I would be comfortable talking about my own sexuality or not. If someone asks me about my own sexuality, I am not sure what my own position would be. Maybe
I would be cooperative, but would I comment on my own sexual experience to an unknown or known researcher? I do not know the answer yet.

**Towards a reflexive ethnography**

These challenges contribute to my rethinking of my study topic and influence me to do further research on sexuality in Bangladesh. If I stopped and did not work intensively in this area, I might establish the fear of academic stigma. But on the other hand, this is an important area to investigate. Therefore, I took the challenge to abolish the academic stigma and open a new window to work on sexuality in Bangladesh. In my PhD research, I am reviewing the field encounters of my past research and searching for a better strategy to address the methodological aspects. I believe that in the social research it would be my double hermeneutic duty (Sayer, 2000) to answer both to the scientific community and to those being studied. I will need to work in both directions. I cannot work only to pass the scientific critiques; rather, I need to pass among the people in the field. My PhD research will accommodate both aspects in the line of reflexive ethnography. Davies (2008) defined reflexivity:

Reflexivity, broadly defined, means a turning back on oneself, a process of self-reference. In the context of social research, reflexivity at its most immediately obvious level refers to the ways in which the products of research are affected by the personnel and process of doing research. These effects are to be found in all phases of the research process from initial selection of topic to final reporting of results (Davies 2008: 4).

The idea of reflexivity would be useful for me to address my position. I am dealing with a sensitive topic, sexual health. This topic itself can create dilemma for a research in the field, which I have found in my previous research. Therefore, it would be important to re-examine future dilemma to deal with the topic. My informants would be another issue, they might concern about their own interest and they might not feel comfort to talk about such sensitive issue. Therefore I will need to be flexible enough. This would enrich my understanding of the research process. I wanted to bridge street healing with public health program; that can be another challenge. Public health professional might not see street healers scientific enough for public health. I would need to be diplomatic enough to place this bridging issue. My colleagues would have shown extra attention again; therefore I would need to be courage enough to break the stigma. I might need to be open enough to talk about my own sexual practices as my informants might ask me to know my status. Therefore the challenges will be there. I would need to search the answers of my research questions. But the way of getting answer would not be easy. Though I am planning for street ethnography, I would need to think about the idea of reflexivity all the time. I would work on street; I would not be able to
abolish my social identity being a middle class male in Bangladesh. I would not try to abolishing it rather will face the reality and do a reflexive street ethnography. Therefore, in my ethnography, I will be visible enough, both in the text and in the field.

Note

1 Savar is an upazila (sub-district) of Dhaka district, Bangladesh. It is approximately 25 km North-West from Dhaka. According to the 2001 Bangladesh census, Savar has a population of 587,041. Males constitute 54.67% of the population, and females 45.33% (BBS, 2001). There are many national and international organizations working in Savar. This area has both urban and rural characteristics; agriculture remains an important source of income, and the garment industry is the most important economic activity of this region. The Dhaka Export Processing Zone (EPZ) of Bangladesh operates in Savar, therefore, this area has a wide variety of people, economic strata, professions and lifestyles.

2 These are pseudonym.

3 According to Ridoy, Moomohua is a local tree. But he could not show me the tree. He told me that he used to sell it but nowadays he only sells leech oil. I tried to learn more about the tree from another healer but he could not provide me with any further information.

Reference


