HIV Vulnerability and Risks for MSM behavior among Bangladeshi Migrants

Migration in itself is not a risk factor for HIV infection but there are factors that might put migrant workers especially men who engage in sex with men in HIV risk. Available data shows that the returnee male migrants account for a significant percentage of HIV prevalence in Bangladesh, yet it is unclear as to how they were infected. While there is anecdotal evidence of MSM behaviour among migrants, little is known. This research aims to generate evidence on HIV risks and vulnerabilities of Bangladeshi migrants who engage in MSM behaviour while working abroad and upon return.

This qualitative research was conducted based on focus group discussions and in-depth interviews with four key identified populations - (i) returnee migrants who are self-identified MSM but not HIV positive, (ii) returnee migrants who are self-identified MSM and HIV positive, (iii) returnee migrants who are non-identified migrants, (iv) potential migrants who are self-identified MSM. Relevant stakeholders including networks and organizations of MSM, PLHIV, Migrant Workers as well as concerned government departments were also interviewed. An intensive desk research was furtherconducted to reviewavailable reports, publications, laws and policies, online activities of MSM groups etc.

This is an exploratoryqualitative study about the HIV vulnerability and risks for MSM behaviour among migrant workers. The study has jointly been conducted in three countries – Bangladesh, Pakistan and the Philippines with the technical support of CARAM Asia – Task Force on Migration, Health and HIV and the UNAIDS.

This flyer contains the key findings of Bangladesh part of the regional study conducted by OKUP (Ovibashi Karmi Unnayan Program), in cooperation with Bandhu Social Welfare Society, the MSM network in Bangladesh. The study is conducted by Shakirul Islam.

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Snapshots

Indicator	Official migration in 2014	Major destination country (region by %)	HIV prevalence among migrants	Estimated MSM population	HIV prevalence among MSM	Legality of men-to-men sex
Bangladesh Situation	425,684	81% MENA & 15% SEA	64.3% of adult identified returnee migrants (National prevalence 0.1%)	32,967 – 143,065	0.7% (2013)	Illegal and punishable by imprisonment up to lifetime by Penal Code 377

Overview:Overseas Labour Migration from Bangladesh

Being one of the major labour surplus countries in the world, Bangladesh has become a major labour sending countryespecially for the countries in Arab region and some South East Asian counties where the demand of cheap labour is huge. On average, Bangladesh deploys around 400,000 workers in overseas job annually. Since 1976, when Bangladesh started official recruitment of its workforce for overseas job, to the end of 2014, a total of 8.9 million[1] Bangladeshi workers have been employed in overseas job. In search of better livelihood, overseas migration through irregular channels is estimated equal to the official channel.

Around 81% of Bangladeshi workers are deployed in the Middle East countries, while about 15% ended up in the South East Asian countries especially Malaysia and Singapore.[1] Majority (96%) of Bangladeshi migrant workers are men. Half of them are engaged in less skilled job mainly in construction, manufacturing and service sectors.

Overview: HIV/AIDS and MSM Population in Bangladesh

According to the global HIV index, Bangladesh is a low prevalence (0.1%) country having only **4000** reported HIV cases since 1989 to the end of 2014.The National HIV Sero-Surveillance of 2011estimated around 6,300 or double the actual reported numbers infected with HIV/AIDS. The HIV Sero-Surveillance 2011 kept migrant workers out of the survey. However, the National AIDS/STD Programme (NASP) report 2014 exposedthat out of 645 adults who were HIV positive and had been employed, 64.3%had previously worked abroad.[1]This figure does necessarily not indicate that migration in itself is a risk factor for HIV infection; this might be due to reporting bias because HIV positive migrant workers have most likely undergone mandatory HIV testing while abroad, received notification of their HIV positive status, and been deported.

The term "MSM" stands for '*Men who have Sex with Men*'. The same group of people in the Western world is identified as 'gay'. In Bangladesh, very few MSM use the term 'gay' as identify. Large majority (>80%) of MSM in Bangladesh categorize themselves as 'straight' men.

In regards to sexual identities and gender typologies, the MSM community in Bangladesh commonly identify as kothi (feminized males, usually receivers who sometimes cross-dress), parik/panthi (lovers/sex partners of kothi, usually inserters), and do-parata (both receiver and inserter), with only a small percentage (2%) identifying as "gay." Kothi typically call the 'straight' men who they have sex with 'panthi.'This study has covered the experience of both self-identified migrants - kothi/panthi and those migrants who engage in sex with other men but do not necessarily ascribe to the term "MSM".

A recent study estimated that there are between 21,833 to 110,581 MSM (not including MSW), which equates to around 0.04-0.23% of the male population aged 15-64 in Bangladesh.[1]Another study by the National AIDS Programme estimated the MSM population in Bangladesh rangesbetween 32,967 to 143,065[1];while theBandhu Social Welfare Society, the only open network of MSM people in Bangladesh claims that they reached 300,000 MSM in six cities over four years between 2000 and 2004.[1]

Health, HIV/AIDS and MSM practices: Legal Environment and Social Climate in Bangladesh

Ministry of Expatriate Welfare and Overseas Employment (MoEWOE) recognized the importance of health education especially HIV/AIDS to the migrant workersin the Bangladesh Overseas Employment Policy (Sub-article 5.1.12) adopted in 2006 although rarely intervention is undertaken to translate the policy into actions. In 2008, the 'Health Check Up Policy for Potential Bangladeshi Migrants' stressed the importance of ensuring international standard for quality medical testing of migrant workers. However, the policy did not mention anything about the non-compliance of its' any clause. The spirit of the policy demonstrates the necessity of 'quality medical testing' to avoid resentment of destination countries in the competitive labour market let alone the rights of the migrants. The newly adopted "Overseas Employment and Migration Act 2013" has completely overlooked the health concerns of the migrant workers.

Overseas labour migrants remained excluded for long in several national guidelines and strategies adopted in response to HIV/AIDS. The National Strategic Plan 2011-2015 included migrant workers first time in the history. Following that the National AIDS/STD Programme (NASP), the concerned UN agencies and other stakeholders, have jointly formulated a "Plan of Action (PoA) on Migration and Health" with special focus on HIV for 2013-2015. The "Plan of Action" is yet to be implemented.

"Men who have sex with men" is still a taboo and faces severe stigma and discrimination in the socio-cultural and religious context of Bangladesh. Section 377 of the Bangladesh Penal Code, a remnant of British Common Law, makes homosexual sex a crime punishable by imprisonment for life. Bangladesh does not have official 'Sharia Law' for the punishment of homosexual activity; but there is mindset and attitude against homosexuality in the family and the society as an act against the religion and thus 'sinful' and'shameful' as well.

Health, HIV/AIDS and MSM practices: Legal Environment and Social Climate in Major Destination Countries

Majority of the countries in Arab region have undertaken National AIDS Prevention Programme for their nationals. Migrant workers are completely excluded there. Migrants' risk to infectious diseases including HIV/AIDS is controlled through putting 'mandatory test' as prerequisite of work and/or residence permit which follows "deportation" if any worker is screened positive.

In regardsto MSM practices, majority of the countries bothin Arab region as well as in South Asia explicitly criminalise homosexuality in the penal code.[1] Article 543 of the Lebanese Penal Code declares "all sexual intercourse against natureis punishable by imprisonment up to one year.Article 201 of Bahraini penal code calls for five years imprisonment and possibility of flogging. Article 193 of the Kuwait penal code punishes homosexuality with seven years in prison while that of Dubai punishes it with up to 10 years (Article 177), and up to 14 years jail in Abu Dhabi (Article 80).[1] Section 377A of Singapore Penal Code punishes imprisonment upto two years while Malaysian law currently provides for whipping and up to a 20-year prison sentence for homosexual acts involving either men or women.

Contrary, the shariah law in Saudi Arabia, Iraq, Iran, Mauritania, Qatar and some other countries term homosexuality "illegal" and is punishable by stoning to death.[1]

Despite the stern legal regimes and the social and religious condemnation in a public front especially in the Arab countries there are considerable spaces for homosexual behaviour in private. Vibrant communities of men who enjoy sex with other men are found in cosmopolitan cities in many Arab countries. Experts view that HIV in MENA is a concentrated epidemic among three certain key populations - men sex with men, female sex workers and people whouse drugs[1]. Reports show in 2013 alone MENA region lost 15,000 people to the AIDS disease, a 66% increase on 2005 while new infections declining globally by 38% since 2001[1]. However, the official HIV prevalence rate in the Arab countries (MENA region) is still 0.1%.

Experiences of some respondents

"..I had a friend who seduced me in many ways to have sex with him. I had no experience about sex with man. I denied but couldn't help long because I had my desire and need. I broke up with him after two years but I couldn't stop my behaviour since I liked it."

"...I used to work in a factory and lived in a quarter given by the company. One night one of my colleagues came to my bed and started kissing. I remained silent in a fear if other roommates knew it. At the end I liked it and continue..."

"...while working, my boss came close to me, touched my hands or rubbed my back with his penis. I used to have sex with men before travelling to Saudi, so I realized what he wanted. I asked extra benefits every time he came to me.

"...I used to work as cleaner in a local hotel. One day a local guest asked me to massage his body. He gave me 300 SAR and offered 500 more to have sex with him. I felt greedy and agreed with. It opened my eyes to earn more money and pleasure."

"...I got relaxed to get a favour when I saw my male client as the magistrate in a court"

".....I had many clients. Some of them asked for a new man. I got double fees if I referred my client to a new person."

"... One day I was walking to come back home. One car stopped beside me and asked if I needed a lift. I agreed with and got into the car. The man took me to the desert in where another 8 guys were waiting who all raped me and left me there."

"...if I have sex with one guy once then it feels I already got what he has to offer, so I always try to find new partner and it happens from both sides."

"...I had no idea about any personal risk including HIV. One thing was in mind that we, as MSM, had no chance to get pregnant."

"....I had had sex with many partners abroad and most of them did not want to have sex with condom. So I had no choice because I had been paid for that"

Key Findings of the Study

- **Dynamics of MSM behaviour and practice**

Personal desire, need and contextual factor:
Migrant workers are human being. They have feeling, emotion, sexual desire, need etc. like other human beings. Different circumstantial context like workplace duress, distress, living environment, temptation by fellow workers etc. instigate personal desire that push many non-identified MSM migrants to engage in MSM behaviour. Many respondents of this study mentioned they had no experience of having sex with men before migration but they became accustomed to once they started liking this. Many respondents stated they engaged in MSM behaviour after a victim of unavoidable situation but found it a way of pleasure to remove loneliness and stress. Mutual agreement of MSM practices does require no money and no tension as it happens in the private sphere.

Diverse Demand and Supply in the closet:
Despite social, religious and legal regime,many respondents admitted there is presence of strong and lively network in the closet in many Arab and Muslim majority countries to find partners/clients. Such a vibrant MSM networks and considerable private spaces for MSM practices created demand and supply of MSM migrants in many destination countries. Referrals of new men between 'partner and client' are common among the self-identified MSM migrants since such referrals pay double fees.Many self-identified MSM migrants respond to the demands to gain economic benefits and also fulfill their desire.

Sexual abuse, exploitation and violence:
Some respondents of the study reported that their male employers or the customers of their workplace either entice or forced to make sexual relation. Many respondents shared they had experienced sexual violence or gang-rape either by the local people or the fellow workers from other nationalities. There is little scope to report such violence

because the complicated legal procedure might bring tragedy for themselves instead of justice. Sexual violence also happens in the case of paid sex between men.

- **Lack of knowledge and skills in HIV Prevention among MSM Migrants**

Limitation in using and accessing condoms

When MSM behaviour exits in diverse groups of people including migrants, most of the respondents admitted they rarely used condom in intimate relations. Because they had trust in partners, they didn't want to lessen sexual romance and pleasure. Many of them said, they had no need to use condoms since they had no change to get pregnant. Many male migrants who used to sell sex to earn more had no opinion because the use of condoms depended on their partners' choice. Some migrants said in the case of sexual violence or rape there was hardly chance to use condom.

In addition, accessing condom in many Arab countries is difficult for the single migrant worker while carrying condom is a risk for the migrants because the police could either harass or file charge against them.

Lack of HIV education for migrants at pre-departure stage of migration

Discussions with most of the respondentsdisclosed they had little orientation about vulnerabilities and risks to HIV for MSM behaviour.Bangladesh Ministry ofExpatriate Welfare and Overseas Employment introduced 2-hour mandatory "Pre-departure Briefing" for the out-bound male migrants. Data shows only 15.58% of the total migrants attended the briefing between October 1992 and December 2013[1]. However, the briefing has no particular session on HIV. Since 2010 a piece of IEC material is provided to the participants which contains simple informationaboutHIV/AIDS. The migrants remain lack to understand contexts and factors that might pushthem to risky behaviour includingMSM practices and infect with infectious diseases like HIV/AIDS.

- **Lack of migrant friendlyHIV Policies and Programmesin the Host countries**

Travelers and migrants are considered as carrier of infectious diseases in most of the host countries. They are treated as a potential burden on their health care system although the UNAIDS-IOM (2004) report disagreed with this perception as the epidemiological data on HIV transmission of the host countries differs with. Migrant workers' HIV vulnerability and their specific needs have yet to be focused in most of the host country's national HIV policies and programmes.

Instead of response to the reality the social and religious reprimand and the stern legal regime kept the whole MSM community including migrants invisible, refrain from access information and services, and increase risks to HIV infection. The current form of Mandatory HIV Testing for migrants breach international guidelines on HIV testing and violate the human rights of migrants thatincrease further transmission risks.

Around 265 international, national, local and community based organizations or self help groups of PLHIV, Sex Workers, Transgender people, PWIDetc. has actively been working in Bangladesh in the field of HIV prevention, treatment and reduce stigma and discrimination related to HIV/AIDS.

Despite the law and religious opposition, ***Bandhu Social Welfare Society*** *which is the only open network of MSM people in Bangladesh established in 1996, has been working to "address concerns of human rights abuse and denial of sexual health rights, and providing a rights-based approach to health and social services for the most stigmatized and vulnerable populations, in particular kothis/panties and their partners.*

While ***Ovibashi Karmi Unnayan Program (OKUP)*** *is the only migrant organization in Bangladesh has been working to promote the health rights of migrant migrants especially HIV/AIDS since 2004. Over the years, OKUP has conducted several research and study to bring up HIV vulnerabilities of the migrant workers. It has integrated HIV preventive education in orientations and trainings for the potential migrants and the spouses of the current migrants abroad without particular fund and projects to response to the need of migrant workers.*

Conclusion and Recommendations

Migration itself is not a risk factor for HIV although the study confers three particular factors – dynamics of MSM behaviour and practice, lack of their knowledge and skills in HIV prevention, and unfriendly policies and programmes that contribute to increase HIV vulnerability and risks among the Bangladeshi male migrants who engage in sex with other men.

Keeping in mind the sensitivity of the issue, practical response is imperative. The study proposes several recommendations both for the policy and programmatic improvement. The recommendations are:

- Increase government commitments to combating HIV – by recognizing migrants' vulnerability to HIV and harmonizing migration and HIV related laws and policies;
  - by undertaking national HIV response for migrant workers through enhancing cooperation and collaboration between relevant government ministries and departments and allocating *appropriate budget and resources*;
  - by enhancing collaboration with destination countries for *inclusion of migrant workers in their National AIDS Programme, and/or* removal/ improve of discriminatory provisions in the mandatory health test, especially deportation in regards to HIV;
- Ensure and Improve HIV education for male migrant workers – by integrating HIV session with due focus on Sexual orientation, gender identities and expression (SOGIE), socio-religious laws and practices of major destination countries regards to homosexuality, sodomy, and life skills for protection against HIV infection in the existing mandatory 3-day **Induction Training** for the departing male migrants and also through community-based decentralized orientations and trainings for the potential male migrant workers.
- Enhance HIV programs and services for migrant workers, PLHIV and MSM – by enhancing capacity of migration and MSM CBOs, PLHIV support groups and government agencies on the nexus of HIV, SOGIE and migration, with focus on the experiences of MSM migrant workers; sensitizing embassy and consulate staffs on issues of male migrant workers who are victims of sexual violence or rape.
- Enhance knowledgebase on MSM migrant workers – by identifying and disaggregating migration related data in National Integrated HIV Behavioral and Serological Surveillance among MSMs and migrants; by conducting more studies on the realities faced by male migrant workers who engage or are forced to engage in male-to-male sex, with special focus on the hard to reach migrants who engage themselves in MSM practice but are non-self-identifying MSM.

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OKUP is a migrant association working for the promotion and protection of the rights of migrant workers including health and HIV/AIDS across the borders.