

Returnee Migrants and HIV Infection in Bangladesh

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Abstract: Despite their huge contribution to the national income, Bangladeshi returnee international migrants and their family members are seriously vulnerable to contagious communicable viruses like HIV. The overall objective of the study was to examine the relationship between international migration and HIV infection risk factors among the returnee migrants in Bangladesh. Twenty case studies and in-depth interviews were conducted with the returnee migrants with HIV. Qualitative data from case studies and in-depth interviews were analysed thematically and systematically. Before returning to Bangladesh, prolonged working life, separation from regular sex partners, copulating with Bangladeshi sex girls, peer pressure and inefficacious risk appraisal promoted unsafe sex behaviour among returnee migrants. Cultural contexts, unsafe blood transfusion, needle syringe sharing, social stigma and discriminatory treatment approaches intensified their vulnerability to HIV infection. Findings suggest pre-migration HIV knowledge and practices, behavior and practices on returns and existing healthcare policies of origin country might prevent new HIV infections among returnee migrants and their immediate family members.

Keywords: Returnee Migrants, International Migration, HIV Infection, Self-efficacy, Risk

I. INTRODUCTION

Globally, 36.7 million people are living with HIV referred to 48% decrease in AIDS related deaths from a peak of 1.9 million in 2005 to 1.0 million in 2016 [1]. New HIV infections in Asia and Pacific region experienced less declination than that of sub-Saharan Africa, the region documented five times more prevalence in the duration 1990-2016 [1] (UNAIDS, 2017). Global HIV/AIDS initiatives and interventions prioritized the sub-Saharan Africa region to continue HIV detection, surveillance and treatment. The Asia and Pacific region experienced 39% reduction of AIDS related deaths while western and central Africa substantiated 30% declination during the past years 2000-2016. According to UNAIDS estimates, the total number of HIV cases in Bangladesh turned around 12,000. In Government's estimation, approximately 7,500 HIV cases had been confirmed in Bangladesh [2]. However, there were approximately 244 million international migrants in the world [3]. During the past years 2000-2005, the number of international migrants increased by an average of 2% per year. Consequently, the yearly growth of international migrants witnessed 3% increase in the duration of 2005-2010. Since then, the rate slowed to decline 1.9% per year during 2010-2015. In 2015, 75 million migrants were reported in Asia, the second largest hot spot of worldwide migration [4, 5]. Nationally, more than eight million Bangladeshi people [6] were found to work outside the country. Approximately 500,000 Bangladeshi migrants were noted to leave the country for overseas employment in single year. In 2013, migrants contributed a record level of remittances 13 billion US\$. However, Bangladesh surprisingly reserved a large section of returnee migrants. Being a multi-dimensional reality [5, 6], returnee migrants and their immediate family members experience new HIV infections.

HIV cases displayed a notable smart prevalence among returnee migrants in Bangladesh. A recent analysis exhibited that out of 645 adult PLHIV, 64.3% experienced working abroad previously [7]. Statistical reports revealed that 51% of the 219 HIV cases were identified as returnee migrant workers in 2002 in Bangladesh. In another estimation, 57 of 102 newly confirmed HIV cases were returnee migrants in 2004 [8]. Unlike remittances and standard lifestyles, migration proved to be a risk factor for transmitting HIV viruses among returnee migrants and their immediate family members. Additionally, migrants usually get infected with HIV cases for risk practices and transmit it when they return home [9].

As a risk factor, migration itself is not always responsible for HIV infection. Separation from regular sex partner, family, communities and socio-cultural support [2] stimulates migrants' attitudes towards risky behaviors. Bangladesh bears testimony of a low prevalence of less than 1% HIV, but this public health issue accords with immense attention due to environmental and geopolitical position. According to UNAIDS/WHO guidelines, HIV surveillance in Bangladesh concentrated on specific groups of people known to be most-at-risk to achieve HIV infection. Inject Drug Users (IDUs), Commercial Sex Workers (CSWs), Males who have Sex with Males (MSMs), and Hijra (male transgender) emerged as the leading groups to expose HIV infection [10]. Recent study findings showed that Inject

Drug Users (IDUs) appeared as the topmost HIV infected people in cities. Secondly, migrant workers, who left their family and worked abroad, demonstrated the largest most-at-risk group to grow with HIV infection in Bangladesh. According to statistical estimates, 47 of the 259 confirmed HIV cases were identified from a migration background during the period 2000-2004. Of these, 29 males showcased as returnee from abroad, 07 were wives of migrant workers, and 04 were children of HIV positive migrant workers [11]. However, immediate family members like returnee's wife and children were noted to come into contact with HIV infection [12].

Reach of migrants at both origin and destination challenges official surveillance and records keeping process. Apparently, records of official database never showcased the real number of inbound and outbound Bangladeshi migrants. Migrants usually belonged to the general population provided that they did not hold any special character. Besides, behavioural changes outside the country rarely appeared when they returned home. Low perceived HIV risk, multiple partnering, clients of sex workers and limited condom use propagated HIV infection for returnee migrants. In two ICDDR, B surveillance areas in Bangladesh, 1200 (10.8%) of married women of reproductive age were noted to have a husband living abroad. Similarly, another study in Nepal showed that a high proportion of men work abroad had sex with a sex worker and had higher rates of HIV infection than those who did not leave Nepal [13, 14].

The study findings also showed that a distinctive proportion of married men who travelled abroad had sex with female sex workers. A few men used a condom during sex with a sex worker (24-31%), or with their spouse (28-31%). Return from workplace in a high-prevalence country demonstrated as one of the routes to contract HIV into low-prevalence settings. Unavailability of condoms, cultural constructions, health beliefs and low risk perception [15] were reported as the most contributing factors to limit use of condoms among returnee migrants. In a recent study in Moscow, Tajik migrants identified undocumented status in city, drunkenness of sex workers, inadequate flesh-to-flesh touch and moderate physical pleasure [16] as the influencing factors to promote low condom use during sex. In a qualitative study finding, frustration from loneliness and economic hardship, isolation from family, peer pressure, and availability of sex workers appeared to be the important factors to influence sexual behaviour of migrant workers [17]. Away from regular sexual partners, socio-cultural control and community restrictions, returnee migrants admitted having sex with multiple female partners [15].

The risk and cultural approach bear out the grid/group pattern of Douglas and Wildavsky. However, theorists argued that risks are socially constructed as each culture along with supported social institutions corroborates certain risks [18]. The central theme of cultural theory substantiates that "human attitudes towards risk perception do not document homogenous but very systematically followed by cultural biases" [19]. However, the way people perceive and act upon the world shows up the cornerstone of cultural theory entitled grid group typology. By the way, variation in social participation can be accounted by the dynamics between two dimensions like grid and group. In the grid layout, outward imposed descriptions keep individual's life within bounds whereas restrictions in thought and action motivate people towards social unit larger than individual exhibited in the group dimension. Moreover, modes of social organization and the responses to risk appears theoretically correlated maneuverer by the dimensions of the grid/group scheme [20].

Generally, risk practices appear as a great concern to prove health related complexities in today's world. Risk perception tremendously varies from person to person, society to society in this new knowledge based postmodern society. IDUs, female sex workers, commercial blood users, foreign return migrant workers are high risk populations to contact HIV in our country. Risk should be regarded as a catalyst between perceived susceptibility and perceived severity of the people, though it substantiates socio-culturally balanced model showcasing the psychometric notions of the victims [19]. The existing social stigma facts are strongly supported by the cultural theory of Douglas. Moreover, HIV infected people usually restrict health promotion behaviour due to socio-cultural contexts [18] and eventually this situation keeps PLHIV more vulnerable to early detection, diagnosis and discrimination free life. Despite having low risk of HIV infection in Bangladesh, the potential HIV expansion should not be ignored due to multiple factors like rapid urbanization, migration (both internal and external), unemployment crisis and economic hurdles [21]. Moreover, the prevalence of HIV remained relatively higher among people who were unaware of the potential routes of transmission [22]. Additionally, the risk of further HIV expansion still demonstrates severe public health threats because of high prevalence in closest neighbouring countries like India, Myanmar, Nepal, and Thailand [21]. The overall objective of the study demonstrated to examine the relationship between international migration and HIV infection risk factors among the returnee migrants in Bangladesh.

II. METHODOLOGY

Study Design and Data Collection

The study applied qualitative techniques of data collection. Case studies and in-depth interviews were conducted with the returnee Migrant People Living with HIV/AIDS (MPLHIV) already infected with HIV during 2015-2016. The study objectives and overall plan of fieldwork were initially discussed with NGO representatives from HIV healthcare

centres to track PLHIV who spent more than two years in overseas workplaces and returned Bangladesh. The study respondents were sampled purposively from selective health centres and Drop in Centres (DIC) spearheaded by different NGOs located at Dhaka, the capital city of Bangladesh during counselling and treatment receiving official hours. As the HIV health centres are centred at Dhaka, PLHIV from different places usually head in the capital for treatment and care. The current study accounted for twenty case studies and in-depth interviews. The units of the study included international migrants who left their past jobs abroad. The field work for the present study was conducted for a period of two months, from March 2015 to April 2016.

Data Analysis

Data from case studies and in-depth interviews were analysed thematically and systematically. Specific themes related to the study objectives were listed using a particular code separately. Manual coding system was applied to analyse the relevant themes appeared in interview texts and in-depth interview filed notes. A constant comparison technique [23] was adopted to check and compare qualitative data showcased in field feedbacks. The most obvious verbatim field notes, in-depth interviews, and case study transcripts were contextualized and reported when deemed appropriate in the analysis.

III. FINDINGS

Unprotected Sex and HIV Infection

Majority of returnee migrants had sex with female sex workers during their stay in abroad. The study participants responded to have rarely used condoms or any other contraceptives during sexual intercourse. Moreover, returnee migrants did not possess any knowledge, or few ideas about HIV infection. In his recollection, a male respondent expressed that. I worked in Malaysia for several years. I explored a place where Pilipino, Nepalese, Indonesian and Indian working girls lived and involved in sex with clients. With Nepalese friends, I went to the place and had sex with girls from different origins. I did not feel comfortable with condoms during sex. Additionally, I also met some smart European girls adjacent to that particular place. By the way, I met with that girls and copulated with them again.

The current study found that large sections of returnee migrants rarely thought about HIV infection. Most of the participants experienced frequent visiting of sex partners when they worked abroad. A thirty-year-old man respondent stated the point. I worked in South Africa for more than ten years. In 2009, doctors confirmed me as HIV positive in Africa. I might have been infected with HIV through blood transfusion. I had a contract marriage with an African local girl. I also visited sex workers in different brothels. I did not use condom for sex abroad. I am supposed to have HIV infection through blood transfusion. I got married again when I came back in Bangladesh. I live with my wife and use condoms for safe sex. I do not wish to have a child as it may be infected with HIV.

Few case study participants claimed their long stay away from family, low emotional support and availability of sex workers from home and neighbouring country influenced them to come up with unsafe sexual practice. Because of having no language or cultural barriers in overseas countries, girls from client's origin country received more attention to support migrant workers in abroad.

A twenty-year young man from Ghatla, Noakhali made a remark on

In Bahrain I along with my friends sometimes went to hotel and met up commercial sex workers. I could not control my sexual urge because of my long stay outside of my family. I came into contact with sex workers for intimate relationship more than four times when I stayed in Bahrain. I frequently completed sexual intercourse with a nice Thai girl without any protective measure or contraceptives. I believed that sexual desires could not be achieved by using any contraceptive like condom. Like other Asian and European girls, I fortunately met a beautiful girl who was originally from Bangladesh. Apart from regular sex partner and family members, returnee migrants considered isolation and separation to come into intimate relationship with sex workers. Low cost sex, copulating with Bangladeshi sex girls, contract marriage, availability of multiple partners, peer pressure, and low risk perception had been reported as the contributing factors for HIV infection.

Drugs and Needle Syringe Sharing

Needle Syringe Sharing (NSS) and substance use have become the risk factors to contract HIV for returnee migrants. Peer pressure, availability of drugs, cultural structure at destination country, cross border migration, and remaining jobless at origin usually promoted drug use for migrants when they returned back to their home country. Some of the respondents concentrated on borrowing or sharing needles when they injected drugs with friends. In his statement, a male migrant respondent said Away from family members in Munsiganj, I usually inhabit around the premise of Golap Sha Mazar, a religious leader's monument located at Dhaka. I am habituated at taking drugs on regular basis called heroine, pathedrin, Gaza, and Yaba. Generally, I find interest to share my syringes and needles with others who are equally professionals and enthusiastic about injecting drugs. I never wish to go back to my family again. A few days ago, I went for sexual intercourse in a shanty place in city. The police caught me red handed and sent me to jail. When I

appeared at the court for trial, I was offered drugs by police and thereby kept mentally balanced. I passed many days in jail because of stock of illegal drugs or intimate relationship with sex workers. I am still confused whether I had been infected with HIV from the women sex workers or injecting drugs.

Unsafe Blood Transfusion and HIV Infection

Transfusion transmitted infection to the HIV has become an important risk factor to expose with HIV viruses. Evidences displayed that 5-10% of HIV infections occurred due to blood transfusion in developing country [24]. Immediate family members like female partners and children were found to infect with HIV viruses during pregnancy and/or breast-feeding periods. Women (15-24 years) have become eight times more vulnerable to HIV infection than that of any other age group [25]. A female respondent stated the opinion. I am a married woman from Oboanagar, Jessor. According to my parents' choice, I was married off to a returnee migrant worker and left my origin country Bangladesh in search of job abroad. In 1998, I became severely ill and received blood for my operation purposes. Just few days later, I met with an accident again in my life and few bags of blood were used in my body. In 2008, I came back to Bangladesh and went for blood test in CMH, Dhaka and was tagged as HIV positive. I strongly believe that I have been infected with HIV through blood transfusion. Doctors and the concerned people in blood bank always stay in the dark about testing blood for HIV viruses before transferring into human body.

A few respondents showed confusion about the ways of being infecting with HIV. As a way of infecting with HIV, returnee migrants strongly claimed blood transfusion instead of intimate relationship or sexual contact with sex workers abroad. A male returnee migrant shared the view. I worked abroad for 17 years. I got an engagement with sexual contact in the destination country four or five years ago. But, I was supposed to contact with HIV through blood transfusion from a minor operation in 2007. My health situation deteriorated when every medicine failed to cure me. In the long run after different treatment trials, I was called for testing HIV and proved to be PLHIV in 2008.

HIV Stigma and Vulnerability

HIV knowledge gap has intensified the vulnerability of women and children. Women have been treated as the prime source of carrying HIV virus. Furthermore, women have to tolerate humiliating comments from husband's family members. A large number of female respondents believed that sex with multiple partners demonstrated a risk factor for HIV infection. A female respondent from Benapole, Jessor commented that. I believed that it was more questionable whether I would be able to find bridegroom to marry my elder son. I seriously got insulted and feared of becoming an outcast from the society. If this news reached to people they might not allow us to stay with society. Uncertainty of life made me more pale and sick. Mentally I was supposed to carry out an unexpected life.

Inadequate HIV knowledge, less confidentiality, fear of cultural affairs, and stressed with uncertainty has stigmatized female PLHIV and their immediate children. However, most of the male migrants wished not to disclose the fact they were contacted with HIV. It indisputably intensified the vulnerability and severity of risk for women and children respectively. Few female respondents did not experience pregnancy once they could figure out their male partner's HIV infection. Being shocked at the sudden death of her husband in 2008, a female respondent claimed that

My husband did not disclose the fact of HIV infection to me. He worked in Kuwait for five years. Undoubtedly, I became infected with HIV viruses when we got married in 2006 and left Bangladesh in 2007. I turned only 21 when my husband left me in 2008. During the initial stage, my husband's family members showed negligence and oppressive attitudes towards me. They forced me to stay alone. I was likely to sacrifice all hopes and aspirations. I lost any further interest to marry again. Inadequate support from in laws family, ostracization, and disinterest about remarriage triggered HIV vulnerability for female victims. Women were found to go for HIV test trials, once HIV infection appeared in family level. In laws family's dominant attitudes, cultural settings, socially constructed ideologies usually worsened women's situation and their immediate child were culturally attacked and harassed. Other local studies also revealed a similar picture [26, 27].

Discriminatory Health System and HIV Test

The government is yet to administer cost-free HIV test and take necessary initiatives to diagnose the virus. Medical doctors usually show discriminatory attitudes towards returnee MPLHIV and their immediate family members. A national daily reports. One couple of Jessor was infected with HIV and at the same time experienced with eye-related complexities. The authority of Asar Alo Society wanted formal permission offering letter to National Eye Institute and Hospital with a view to treating the victim, but the concerned authority ignored their proposal about cataract operations.

There are 96 Voluntary Counseling and Testing [VCT] centres in Bangladesh, established with an objective of testing blood for HIV detection with no cost [28]. These centres are controlled by some selective NGOs like Asar Alo Society, Mukto Akash and Confidential Approach to AIDS Prevention etc. Repeated treatment failure, low risk perception, treatment delay, health practitioner's negligence, and socio-cultural sentiment were considered as the important risk factors to test HIV on time. In most cases, delayed testing and late diagnosis made the MPLHIV more vulnerable to

AIDS. A returnee wife of a migrant worker expressed her opinion. My husband was forced to come back to the country after being infected with Hepatitis. He was provided with medical treatment and counselling from different sources for a long time. But these attempts failed to make him cured. At last, my husband was counselled to test blood for diagnosing the disease. He was tested in Medinova healthcare center, Dhaka and reported to be HIV positive.

IV. DISCUSSION

Prolonged working life, separation from post-marital sex, availability of sex workers, inadequate cultural control, inefficacious risk appraisal, and inadequate health knowledge promoted sex with multiple partners. Occasional use of condoms or contraceptives threatened migrant's sexual behaviour mostly and got them exposed to HIV infection. Similar trends were found among Mexican labor migrants in USA. Migrants from Mexico experienced inadequate knowledge about condom use. Approximately 50% of male migrants used condoms with occasional partners and about 25% never used condoms with occasional partners [15]. Unsafe blood transfusion, inefficiency of doctors, delay HIV testing and discriminatory medical diagnosis had been claimed for HIV infection instead of condom-less physical contact with sex workers. In most cases, returnee migrants experienced discomfort to disclose their involvement with sex workers and claimed the other possible routes for HIV infection.

As a strong cultural norm, drugs and needle syringe sharing were noted among returnee migrants. Mutual understandings, management of law enforcing issues, occupying same profession, social exclusion, depression and partial family bondage were considered as the dominant factors to borrow and share needle syringe and drug materials. According to National HIV Serological Surveillance 2011 [29], IDUs demonstrated about 5.3% HIV infection, the highest among HIV risk population groups. The study findings were found to be similar with another Asian country. Migrants with tattoos, sign of sharing needles had higher HIV prevalence in comparison with other fishermen living in the Gulf of Thailand and the Adaman Sea [15]. Among IDUs in Bangladesh, NSS was preferred as convenient (18%), norm for IDUs (15%) and cheap (10%) respectively. Availability of drugs, earning sources of law enforcing staffs, low social support, and absence of community engagement shaped NSS and drug culture. Eventually, it catalysed to increase HIV exposure. The findings looked similar in a study conducted in Russia. Eastern European labour migrants reported higher alcohol and drug use associated with higher sexual risk. Conversely, Central Asian labour migrants exposed to low levels of substance use and moderate sexual risk [30].

Repeated surgical operations, unhygienic testing instruments, untested blood in reserve bank, and expiry date of blood reserve generate unsafe blood transfusion in most of the health centres. In addition, unskilled people in blood bank and irresponsible health practitioners in hospitals contributed to transfuse unsafe blood and increased HIV infection risks. The findings associated with an estimated result of another study. Around 2.0% of HIV cases appeared as notable to be reported for HIV transmissions. Inconsistent dates on blood bags, ineligible writing, inadequate refrigeration, date entry errors, equipment failure and lack of quality-assurance program had been identified as the significant problems for transfusion risks in the hospitals [31, 32, 33].

Socio-cultural settings contributed to increase the vulnerability of migrants' wives and their children and tagged them as HIV positive. Women were reported as the carriers of HIV virus by their male returnee partners. Spouse selection, decision making about personal choice, dependency on family members and family poverty appeared as the background barriers for female HIV infected people. For women, stigma started with husband at family level. Social stigma, attitudinal changes and behavioural approach strongly displayed people's discriminatory attitudes towards PLHIV. Majority of new HIV cases was reported among returnee migrants and their immediate family members. Bangladesh is still claimed as a low HIV prevalence country. However, HIV testing and counselling is manipulated and funded by NGOs. The state predominantly depended on remittances, but it rarely financed to test and counsel for returnee migrants and their spouses. HIV detection and intervention in Bangladesh were seriously dependent on foreign funding sources. The health systems were not fairly designed for returnee migrants in Bangladesh.

In order to minimize HIV infection in Bangladesh, intervention strategies might consider multivariate initiatives for migrants at the origin and destination countries. With the concerned authority from migrant receiver countries, strong collaboration might contribute to promote a comprehensive knowledge about HIV infection risks. Individual behavior change is a must to prevent HIV transmission risks. In Bangladesh, migrant friendly health system must be ensured for returnee migrants and their immediate family members. Few trained health teams might employ for monitoring and supervising surveillance for migrants at the entrance hot spots in Bangladesh. As a beneficiary institution for foreign remittances, the state cannot overlook early HIV testing and health screening to prevent new HIV infection for returnee migrant's immediate family members. As the HIV discourse is interestingly connected with development at national level, international collaboration and domestic funding should be increased to promote protected health behaviour and prevent new HIV infections for returnee migrants in Bangladesh.

V. CONCLUSION

Though still considered as a low prevalence country, migrants and their partners remained quite susceptible to HIV epidemic because of unsafe migration process and risky surroundings centering on returnee migrants both at their place of origin and destination. Individual behaviour change and comprehensive HIV knowledge can prevent new HIV infections among returnee migrants and their immediate family members. This public health discourse should be addressed by a high-powered inter-ministerial committee involving all stakeholders both home and abroad.

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