

CHAPTER 3

MOBILITY PATTERNS AND HIV VULNERABILITY IN BANGLADESH

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3.1 Background and method

Bangladesh's total population was 130 million in 2001. Its population growth rate has declined from 2.1% in the 1980s to 1.6% in the period 1995-2000 (MHHDC 2001). Its population density is one of the highest, surpassed only by the city-states of Singapore and Hong Kong. The literacy rate has increased from 23.8% in 1981 to 40.8% in 2001. Bangladesh remains one of the least developed countries of the world: 25 million (19.23%) live in extreme poverty. A section of those who are landless or live below the poverty line move in search of shelter and livelihood.

Women constitute 49% of the population. In every respect ranging from health and education to nutrition and income, women are the poorest of the poor. Bangladesh is one of the two countries of the world where the life expectancy of women is lower than that of men. Since the early 1980s, a proportion of women, mostly young and unmarried, have migrated to the urban centers of Dhaka, Chittagong, and Khulna to join the garment, food and other manufacturing industries. Currently, 1.2 million women are employed in the garment sector alone. A quiet revolution has taken place in Bangladesh, which has resulted in increased mobility of women and rural-to-urban migration of women, not as spouses, but as independent migrants. A section of them have also taken up the challenge of joining the international labour market.

Bangladesh is a labour surplus country and it contributes significantly to the labour resource in the global market – mainly to the Middle-Eastern and Southeast Asian countries. On average, more than 225,000 Bangladeshis leave the country each year to take up overseas contract employment (Abrar 2002). A significant number of Bangladeshis also leave the country informally looking for jobs in the neighbouring countries of India and Pakistan. In addition, a large number of women and children are trafficked to those countries and some to Middle Eastern countries. All these people involved in different types of migration may become vulnerable to situations that expose them to contracting HIV/AIDS.

This paper focuses on international migrants and is based mostly on secondary information. It surveyed available conference, seminar and workshop proceedings, published books, training modules and reports. It also draws from expert group meetings organised by HIV/AIDS and STD Alliance Bangladesh (HASAB) in June 2003. In addition, some interviews were conducted with key informants: government functionaries, members of recruiting agencies, medical centers, NGO officials and members of development agencies.

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3.2 Present situation of HIV/AIDS in Bangladesh

The first person with HIV in Bangladesh was identified in 1989. Ten AIDS cases and 126 persons with HIV infections were reported by 1999. A recent newspaper report suggests that the current figure is 248 and, by November 2002, 20 persons had died due to such infection.² Some people think, however, that the actual number of people living with HIV/AIDS (PLWHA) in Bangladesh is much higher than the figure released by the government — 13,000 is the WHO/UNAIDS estimate (UNAIDS 2002) and Chowdhury (2002) puts it at 30,000. Lack of adequate policy as well as resources for testing HIV/AIDS among common people is the main reason for not identifying the actual prevalence in this country.

All the known HIV-risk behaviours and factors — unsafe sex industry, men having sex with men, injecting drug users, and sexually transmitted infections — are known to exist in Bangladesh (National Integrated Population and Health Programme 2001). Among the identified HIV positive cases, about one sixth are returnee migrant workers: 43 out of the 248 persons detected with HIV are returnee workers, or are from the migration prone area of greater Sylhet (*Prothom Alo* 2003). There have been ten cases of local transmissions among women who are infected by their emigrant worker husbands (*The Independent* 2002). But these are the only people who undergo regular medical tests and equivalent figures are not available for the rest of the population.

On the other hand, surveys have shown that 50% of 225,000 truck drivers and their helpers visit brothels during their trips to various parts of the country (Kabir 2001). Moreover, the international crew of the foreign vessels anchored in either Mongla or Chittagong Ports are likely to practice high-risk behaviours or potential persons living with HIV/AIDS, as they take the opportunity to procure sex from sex workers based in brothels located near the port areas (Husain 2002).³

3.3 International contract labour migrants

Numbers

Such workers can be both documented and undocumented and they are the dominant migrant force of Bangladesh. The Bureau of Manpower, Employment and Training (BMET) of the Ministry of Expatriates' Welfare and Overseas Employment maintains records on regular migrants. The average number of outgoing migrant workers was 225,000 a year in the 1990s, with the highest figure being 381,077 in 1997. According to official data, Bangladeshi migrants are predominantly male. However, it is now more or less accepted that every year a number of women are taking up overseas employment. Although officially their number accounts for only 0.65% of the total migrant labour force, women are migrating through unofficial channels. The government ban on emigration of less skilled women has been identified by studies as the major reason behind such unofficial migration flows (Siddiqui 2001a). The database of BMET is not disaggregated by age and education but small-scale studies conducted in high migrant-producing areas have shown that most migrants are young (15 - 30 years of age) when they first migrate (Siddiqui and Abrar 2000; Afsar 2000; Murshid 2000).

² *Daily Sangbad* 2002, Article published on 30 November.

³ See also NASROB 2002; National STD/AIDS Network 2002; QIP/SMC 2001; SEIU 1997; UNAIDS 2002; UNAIDS / WHO 1998; UNDP 1999; UNDP 2001; UNDP 2003; UNGA 2001.

BMET classifies temporary migrant populations into four categories. These are professional, skilled, semi-skilled and less skilled. Doctors, engineers, nurses and teachers are considered to be professionals. Manufacturing or garments workers, drivers, mechanics, and heavy machine operators are regarded as skilled, while tailors, masons, carpenters etc. are semi-skilled. Housemaids, cleaners, and all other kinds of labourers are classified as ‘unskilled’ or less skilled. Women are employed as nurses, garment workers, manufacturing labour and housemaids. Table 3.1 shows skill-wise distribution of the migrant workers from 1976 up to 2002. In recent years there has been a higher proportion of semi-skilled and unskilled migrant workers than skilled and professionals. Year 1997 shows abnormal growth in the semi-skilled category of workers. This is because in that year the Malaysian government provided legal work permit and visa to 150,000 Bangladeshi workers who were already working in Malaysia as undocumented workers. Most of them were provided semi-skilled work status.

Bangladesh sends contract migrant workers to 13 Middle-Eastern and Southeast Asian countries. Eight countries account for more than 82% of total migrants: Saudi Arabia, United Arab Emirates (UAE), Kuwait, Qatar, Iraq, Libya, Bahrain and Oman. The largest labour receiving country is Saudi Arabia. From the late 1980s to 1999, Malaysia was the second largest employer of Bangladeshi migrant workers but the number of Bangladeshis migrating to Malaysia has dropped drastically in recent years (Siddiqui 2001b).

Table 3.1 Annual official flow of Bangladeshi workers by skill level, 1976-2002

Year	Professional	Skilled	Semi-Skilled	Un-Skilled	Total
1976	568	1,775	543	3,201	6,087
1977	1,766	6,447	490	7,022	15,725
1978	3,455	8,190	1,050	10,114	22,809
1979	3,494	7,005	1,685	12,311	24,495
1980	1,983	12,209	2,343	13,538	30,073
1981	3,892	22,432	2,449	27,014	55,787
1982	3,898	20,611	3,272	34,981	62,762
1983	1,822	18,939	5,098	33,361	59,220
1984	2,642	17,183	5,484	31,405	56,714
1985	2,568	28,225	7,823	39,078	77,694
1986	2,210	26,294	9,265	30,889	68,658
1987	2,223	23,839	9,619	38,336	74,017
1988	2,670	25,286	10,890	29,356	68,121
1989	5,325	38,820	17,659	39,920	101,724
1990	6,004	35,613	20,792	41,405	103,814
1991	9,024	46,887	32,605	58,615	147,131
1992	11,375	50,689	30,977	95,083	188,124
1993	11,112	71,662	66,168	95,566	244,508
1994	8,390	61,040	46,519	70,377	186,326
1995	6,352	59,907	32,055	89,229	187,543
1996	3,188	64,301	34,689	109,536	211,714
1997	3,797	65,211	193,558	118,511	381,077
1998	9,574	74,718	51,590	131,785	267,667
1999	8,045	98,449	44,947	116,741	268,182
2000	10,669	99,606	26,461	85,950	222,686
2001	5,940	42,742	30,702	109,581	188,965
2002	14,450	56,265	36,025	109,285	216,025
Total	146,436	1,084,345	574,677	1,582,190	3,387,648

Note: 150 Bangladeshi workers were legalised in 1997 in Malaysia.

Source: Prepared from BMET data 2002.

Source areas and migration routes

Dhaka, Chittagong, Comilla, Tangail, Sylhet and Noakhali are areas that produce large numbers of migrants in Bangladesh. From all these places, aspirant migrants come to Dhaka

city in order to process their papers for overseas jobs. They usually stay in hotels during the processing of their papers, some also stay in their relative or friends' house. *Dalals*, friends or relatives often accompany them.⁴ Recruiting agents usually process all the papers and arrange the travel. Employers pick them up from the destination airport, or in some cases the migrant workers are supposed to go to the employers' places on their own.

The situation is very different in the case of irregular migrants, who do not go through the formal channels. Most of the irregular migrants also go by air and enter the destination countries, often as tourists. A small number of these irregular migrants first go to India taking a land route, and from there they go to the Middle Eastern countries via Pakistan. Since there is a ban on semi- and unskilled female labour migration, the rate of undocumented migration of female workers is higher (IOM 2001). Most of the female migrants take the air route. However, like male migrants, a section of them go to the destination countries in the Middle East via India and Pakistan, crossing the borders on land (IOM and UNDP 2000).

Table 3.2 Number of female migrants in total labour migration flow

Year	Female Migrants		Total Number of Migrants
	Number	% of Total	
1991-95	9308	0.98	953,632
1996	1567	0.74	211,714
1997	1389	0.74	381,077
1998	960	0.36	267,667
1999	320	0.12	268,182
Total	13544	0.65	2,082,272

Source: Siddiqui 2001a.

Living and working conditions

Living and working conditions of migrant workers vary with respect to the country of migration and the type of jobs. Those who migrate as professionals are provided with reasonably better accommodation, healthcare facilities, and work conditions. But the majority migrants work as semi-skilled and unskilled workers. Their living and working condition in general is a source of concern for many.

Employers usually provide male maintenance workers, menial workers and those employed in factories with accommodation. In most cases they are provided with housing in nearby areas but some are accommodated within the factory premises. Some migrants rent their own accommodation and live with other migrants from Bangladesh. In a typical situation, large groups of people are accommodated in small rooms, where the concept of privacy is absent (Siddiqui 2003). In the Middle East, those who work in agricultural fields and shepherding live a tough life. Some live on their own, isolated from the rest, and are provided with food by the employer once a week. Long working hours and work on weekends are common to many migrants. Officially in most of the countries where Bangladeshis migrate, there is the provision for paying overtime. The rate for overtime work is supposed to be 1.5 times of the normal pay during working days and two times during weekends but employers in many cases do not respect this provision. Besides, workers' mobility becomes restricted as employers usually take their passports and travel documents away as a means of coercion. Contract substitution and payment of wages lower than contracted have also been reported from countries of both Middle East and Southeast Asia.

⁴ *Dalals* are informal agents and sub-agents who work as intermediaries between the recruiting agents and potential migrants. Two most important functions of recruitment, mobilising potential clients and transaction of money take place through *dalals*.

The working conditions of women migrants also vary according to their jobs. Some of the women who worked as domestic workers were satisfied with their dwelling conditions. They were given separate rooms and wardrobes to keep their belongings. Special care is given with respect to their food. But others reported that they did not enjoy any privacy and were made to sleep in kitchens (Siddiqui 2001a). Most of them experienced verbal abuse and some physical abuse. Women who worked in factories lived in hostels either within the factory premises or outside. The employers mostly provided their accommodation. Heat was a major problem for some female migrants. Eating alien food was again a major problem for most of the female migrants.

Health risks

Health facilities provided to the workers vary from country to country. In Saudi Arabia the necessary primary health care services are available in major cities, under the government policy entitled 'Health for All'. All, irrespective of the worker's legal status, can access this service. In the United Arab Emirates (UAE) and Bahrain migrants can go to general hospitals. However, the cost of medicine and tests has to be borne by the migrants themselves. In some cases, companies/factories have their own prescribed doctors. In Malaysia and Singapore and also in the Middle East, workers who are formally employed, go through an annual medical check up. If someone is sick, the employer bears the cost of medical service, when recommended by the supervisor. In South Korea, however, the cost of health care has to be borne by the migrants and it is very expensive.

A small study based on 100 in-depth interviews with equal numbers of women and men found that only a small number of migrant workers (14%) received health advice in the destination country (Titumir 2003). A total of 44 migrants received regular medical check-ups at their respective country of destination: 30 females and 14 male respondents.

Vulnerability to HIV/AIDS

Mobility and migration are not in themselves risk factors for HIV. However, lack of protection of health rights and vulnerable work conditions in the receiving states and lack of awareness in both the sending and receiving ends do make migrants vulnerable to this disease. In the following, the risk factors during the pre-departure phase and in the country of destination have been discussed on the basis of two studies on vulnerability of migrant workers to HIV/AIDS (Akram 2003 and Titumir 2003).

Pre-departure phase

Akram's study (2003) was conducted on 50 males and 50 females who had been process of obtaining visas for overseas jobs. These people were going for short-term migration for the first time, and some of them had undergone medical tests and BMET briefing. The study showed that most of the people who migrated did not practice high-risk behaviour. It was observed that in most cases, their sexual partners were either their husbands or their wives. Only six males used to regularly buy commercial sex from sex workers, and another six males did so occasionally. A few of these people having multiple sex partners were not married. Among the outgoing migrant workers who had had sexual experiences (67 persons), the rate of condom use was very low (6 persons). The main reasons behind this were use of other family planning methods and dislike in using condoms. However, it was revealed that most of the respondents (89 persons) did not know the proper methods of using condoms. **Migrants also faced vulnerabilities at transit points. One respondent stated that he had marked commercial sex work in a hotel in Dhaka where he boarded to process his papers for migration.**

During stay in labour receiving countries

Titumir's study (2002) revealed a lack of basic knowledge about HIV/AIDS among migrant workers. Out of 100 respondents, 9 received commercial sexual services in the country of destination: 2 regularly used condoms during paid sexual intercourse; another 2 used them sometimes and 5 never used them. The main reasons for not using condoms are: they have to be purchased; they do not know how to use them and they are not available. **Among the respondents 3 reported that they had engaged in MSM activities. One stated that he was engaged forcibly by his employer in the country of destination. All the 3 stated that they seldom used condom.**

The low level of knowledge regarding STDs generally and HIV/AIDS in particular suggests that limited health-related information has reached migrants. This is due to: the linguistic barrier in the countries of destination; the lack of education in general, and sex education in particular, in schools in Bangladesh, and the difficulty of obtaining written or oral information, especially in their own language. Conservative cultural norms of Bangladesh as well as of destination countries make national HIV/AIDS and sex education and awareness difficult.

Titumir found that migrants knew that they would be repatriated if they had certain notifiable diseases or if they were pregnant. But they were uncertain which diseases were notifiable. This meant that they would keep silent about diseases or would go to a traditional healer or a private clinic if they could afford it, rather than go to a company clinic doctor or a doctor in a general hospital. This situation endangers their health and may make them more vulnerable to HIV and STDs. In relation to counseling on tests and the provision of other information, migrants stated that doctors were reluctant to provide them with information. This situation, according to the migrants, discouraged them from asking for information during subsequent visits. This, together with the language barrier, kept them ignorant about diseases and how they spread.

3.4 Cross-border migrants

Cross-border migrants are those who go to neighbouring countries in search of work, without authorisation from the countries that they are migrating to. They usually stay there for a short period and maintain their permanent residence in Bangladesh.

Numbers and routes

An unknown number of Bangladeshi people go to different states of India and Pakistan for work. Some of them use these countries as a transit point for migration to countries of the Middle East but many stay in India and Pakistan. Such movements also take place from India to Bangladesh. They are temporary in nature and both men and women are involved.

People from all over Bangladesh come to greater Rajshahi and Jessore by bus or train. They go to different parts of India through Shovapur, Ashriadaha, Kanapara and Sharshabad the borders of Rajshahi and Shalkona, Fulsara, Shikarpur, Raghunathpur, Goga, Hizli and the Rudrapur areas of Jessore. They mostly use land routes for crossing the border. In some bordering areas, river routes are more easily accessible than land routes. The point of migration is known as *Ghat*. The migrants cross the *Ghat* by paying a fee to the *Ghat* owner through a middleman. They also negotiate with border security guards, local muscleman and middlemen on their way to the country of employment. A nexus between *Ghat owners*, border security forces and middlemen make it possible for them to cross the border. The border is crossed on foot and after crossing the migrants take bus or train to reach Kolkata and other

bordering West Bengal districts of India. Those who are destined for Mumbai or Delhi take the train from Howrah or Shialdaha stations of Kolkata. Destinations are usually determined by social networks in the host country.

Cross-border migrant workers face many types of vulnerabilities. Very often they are victims of 'push-back' and 'push-in'. They have to face harassment by the hand of members of law enforcing agencies, local musclemen and middlemen. They have the added risk of HIV/AIDS. In 2003, Rozana Rashid conducted a micro study particularly on the vulnerability of cross border migrants to HIV/AIDS.⁵ The study found that some migrated for shorter periods — so-called seasonal migrants. Others stayed for a relatively longer period (9 to 12 months). These were like short-term labour migrants who go to the Middle East. The study also found that women migrate for relatively longer periods than men. It is the social network of cross-border labour migrants, which works as strong source of information for encouraging people to migrate in the neighbouring countries. Based on the findings of that study, the picture of vulnerability of cross-border migrants to HIV/AIDS has been presented below.

Living and working conditions

The majority of the 100 interviewees were engaged in labour intensive jobs. Men and women chose different sectors of work. Men were mostly employed as construction workers, hotel boys, salesmen, electricians, hawkers, and agricultural labourers. Women were mostly engaged as domestic workers and factory workers in small manufacturing industries, such as glass factories and bangle making. Another study conducted by Therese Blanchét shows that a section of cross border female migrants also voluntarily enter the sex industry of India (Blanchét 2002).⁶ They work as sex workers and bartenders in Mumbai and a few other large cities of India. They constitute a separate group from those who are trafficked.

Cross border migrant workers live in various types of accommodation in India, including rented houses, slums, brothels, construction sites, etc. (Rashid 2003). The highest number (44 persons) said that they used to live in slums, commonly known as *Jhopra Patti*. These slum areas consisted of long rows of houses made of wood, mud and tiles. Most of the women said that they used to live in one rented room in the slum with their families. Those who did not have family with them, shared rooms with fellow Bangladeshis, relatives or neighbours. Other types of residence included shops where they used to work, employer's houses, pavements and brothels. There is also a correlation between occupation and dwelling of the interviewees.

According to the interviewees, the vulnerability of the people living in slum areas was higher than for those who lived in employer's house or rented house. The residents enjoy a sense of independence in the latter type of dwelling. In the slum, they enjoy very little privacy. Men and women living in the slum areas are more susceptible to be motivated or forced by others into sexual acts. Female returnees who used to live in houses as domestic workers were found to be more safe and secure. Social interaction of these women was different from others in the sense that they had to spend most of the time with their family. Their movement was more or less restricted to the houses where they worked. Their social behaviour and vulnerability seemed much lower than those living on the pavements or other public places.

⁵ The study was conducted in Rajshahi and Jessore, two border districts of Bangladesh. Based on a semi-structured questionnaire, interviews of 100 cross-border labour migrants were done comprising 50 males and 50 females. Focus Group Discussions (FGDs) and interviews of experts on STDs were also conducted under the study.

⁶ The total number of interviewees was 496.

Health risks of migrants

The level of vulnerability of individuals to HIV/AIDS depends heavily on social behaviour and the involvement in risk behaviours. Rashid (2003) investigated how migrants spent their leisure time in the country of migration; the highest number (43 persons) pass their leisure time with friends: 28 went to the cinema, and 21 watched movies on VCD or VCR. Other activities included, gambling, drinking, spending time with family, visiting neighbours and relatives. Seven male interviewees in the sample visited sex workers in the host country. This practice may have severe consequences for HIV/AIDS. No female interviewees were found to be engaging in gambling, drinking and sex outside marriage. Thus male and female respondents demonstrated a sharp difference in the way they spend their leisure time in the country of employment. This may help us to conclude that in general men are more vulnerable than women for their easy access to high-risk behaviour.

Vulnerability to HIV/AIDS

Pre-departure phase

Sexual behaviour pattern before migration is an important criterion for assessment of vulnerability to HIV/AIDS. Among the 50 female cross border migrants, 46 were married, divorced, or separated. They had experience of sex prior to migration. Out of 50 only 1 female experienced sex outside marriage. Out of 39 married men, 10 experienced sex outside marriage. In case of the female migrant, her partners were lover and neighbour. In case of male migrants, their partners were lovers, neighbours, relatives and sex workers.

During stay in labour receiving countries

During stay in host country, it was revealed that 6 men and 29 women had sex with their wives and husbands, 12 male respondents used to have sex with neighbours and sex workers, and 2 women had sex with their lovers. 90 of those with sexual experience stated that they had vaginal sex. One returnee suffering from AIDS said that he had all kinds of sex such as vaginal, oral and anal. His partner for sex also varied. This indicates that a section of them do have experience of sex outside marriage. However, the condom use among them was very low, only 8 men used condom regularly.

The general level of awareness of irregular migrant workers about HIV/AIDS was very low. Only 3, including two males and one female among 100 interviewees, were found to have comprehensive knowledge about HIV/AIDS infection. A large number (60 persons) had 'zero' knowledge on the issue. Many of them thought they had heard the name of the virus or its syndrome, but could not elaborate on how this virus spread or how to prevent HIV. There was also the misconception that one can catch the virus through touching or sharing of essential items (cups, plates, etc) of an HIV infected person. As there is social stigma attached to the condition, a common tendency was also found among the infected persons to hide the fact.

There is a lack of access of irregular migrant workers to electronic and print media as well as other popular awareness campaigns. The message provided by the television/radio advertisements was not perceived as comprehensive and did not convey the importance of the issue. The general low level of awareness about HIV/AIDS is also partly due to limited NGO intervention on the issue in rural areas. Eighty seven percent of the migrants interviewed stated that there were no awareness campaign in the host country about HIV/AIDS and its prevention.

Rashid's study found low and irregular use of condom by the cross border labour migrants, which is a high risk factor for HIV. Only 19 of the interviewees, including 15 males and 4

females, reported that they or their partners used condoms. An investigation into the causes of limited use of condom suggests that there was a lack of awareness, misconception and religious taboo among them. This was also partly caused by the higher use of birth control pills and injections by the females as the common fertility control methods.

The prevalence of STDs is another point to discuss in looking at vulnerability to HIV/AIDS. Many cross border migrants, who had STDs or knew about different symptoms of STDs, could not equate their disease with STDs. Among 100 interviewees (Rashid 2003), only 25 male and 23 female respondents stated that they knew what a STD was. The rest of the interviewees were not even acquainted with the term. Twenty-five interviewees comprising nine men and 16 women said that they had suffered from a STD in their lives. However, only three of the infected persons went to a doctor. Others had no treatment either because they could not afford it or they were unwilling to make their condition public.

3.5 Women and children who are victims of trafficking

According to the UN Protocol 2000, 'trafficking' is defined as all acts involved in kidnapping, abduction, capture, acquisition, recruitment and transportation of persons, specially women and children, within and across national boundaries with an aim of selling, exchanging or using for any illegal purpose such as prostitution, servitude in the guise of marriage, bonded labour or sale of human organs by means of violence or threats of violence. Trafficking of women and children is one among different types of irregular movements of population. Over the last few decades, Bangladesh has become a source and transit country for trafficking and human smuggling. This section analyses the vulnerability of trafficked victims to HIV/AIDS.

There are some micro studies on trafficking of women and children in Bangladesh. One of such studies is the title *Beyond Boundaries: A Critical Look at Women Labour Migration and the Trafficking Within*, of Therese Blanchét (2002), referred to earlier. The study underlined the situation of Bangladeshi trafficked victims at Kolkata and Mumbai in India. In 2001, IOM undertook a study *In Search of Dream: Study on the Situation of the Trafficked Women and Children From Bangladesh and Nepal to India*. This empirical study identified cases of several trafficked in girls at Kolkata, Delhi and Mumbai in India. IOM published another study titled *Mapping Trafficking in Women and Children from Bangladesh* in 1999 (Shamim 1999). It is a compilation of news reports on trafficking over a period. Bangladesh National Women Lawyer's Association (BNWLA) conducted a socio-economic study on *Cause and Consequences of Children and Women Trafficking in Ten Villages of Bangladesh* in 1999.

These studies have pointed out the different types of vulnerabilities of trafficked women and children at different stages of trafficking. This part of the paper is based on the data and information provided in the above studies. It is also based on the Refugee Migratory Movements Research Unit (RRMRU) anti-trafficking training module that was prepared in 2003 for public representatives at the lowest unit of the local government (*Union Parishad*) at Jessore and Greater Rajshahi regions of Bangladesh. During the preparation of the module, RMMRU gathered grassroots level information on trafficking through need assessment programs.

Numbers and migration routes

According to an estimate by BNWLA, 10,000 Bangladeshi women and children fall prey to traffickers each year. Another NGO, *UBINIG*, claims that there are 200,000 Bangladeshi women in Pakistan jails who are victims of trafficking. Recently, the US Information Center of Bangladesh published a report which states that each day 50 women and children are

trafficked from Bangladesh. It is important to note that the above figures are not based on research or census. Those are based on secondary sources such as newspaper reports. Observations of rescued persons have demonstrated that a good number of them are not trafficked but they are irregular cross-border labour migrants.

Well-documented trafficking routes in the South Asian region include movement from Bangladesh to India and Pakistan. Bangladesh is surrounded by India on three sides and therefore it is easy to cross over by land routes to the main cities in India. The districts on the western border of Bangladesh are the most trafficking-prone areas. Of these Satkhira, Jessore and Chapainawabganj seem to have most number of transit points and trafficking routes going towards several points in India. Kushtia and Sundarban have now become new transit routes for women and children trafficking from Bangladesh. Women and girls from all over Bangladesh are collected and are taken to the border districts by bus or train. The traffickers generally use somewhat similar routes to those of the irregular migrants.

Living and working conditions

Studies showed that a large portion of trafficked victims is sold into the sex industry (IOM 2001). However, not all trafficked women and children are recruited for sex work. Other work includes bonded labour, domestic work and work in pornography. A proportion of trafficked women are given the status of third/fourth wife by those individuals who bought them in the North West Frontier Province of Pakistan (Siddiqui *et al.* 2003). These women are lured into marriage and made to engage in household tasks and sexual service. In many cases their 'husbands' sell them again.

Those who are sold into the sex industry generally live in brothels or brothel-type dwellings. Brothels are very congested too many people live in small accommodation. Sex workers, both new and old, their children and men involved in this business live in such accommodation. Brothels are unhealthy, infested with diseases and have inadequate water supply and sanitation systems. Apart from conventional brothels, individual women also run small-scale sex businesses from rented houses (Blanchét 2002). Such women, often former commercial sex workers from brothels, keep several girls (known as *chhukris*) under their authority and provide rooms from which they conduct their business (Blanchét 2002).

Initially force is applied to women and children to indulge in sex work. Studies show that in the initial stages trafficked victims in the sex industry are raped repeatedly to break their morale. At this stage they have to entertain a high number of customers. They are hardly permitted to go out of the brothel and they have no control over their earning. After two to three years they start working as *adhiya* (Blanchét 2002). This means giving 50% of their income to the *Malkeens*, the women controlling the business, and keeping 50% of the income for themselves.

Health Risks

The nature of the work and their dwelling places indicate that trafficked victims are at greater risk than many others of being exposed to HIV/AIDS. It is the powerlessness and absence of choice that increases the likelihood of transmission of HIV/AIDS among trafficked victims (UNDP 2003). In most cases victims of trafficking are placed in very vulnerable situations and have no control over their situation. Bangladeshi girls are in high demand in the Indian sex industry for their purity or virginity. There is a misconception in parts of Asia, as in Africa, that an HIV infected person will be cured through sexual intercourse with a virgin.

STOP, a Delhi-based NGO, estimates that 60% to 80% of trafficked girls suffer from life-threatening diseases, with increasing incidents of HIV/AIDS (UNDP 2003). This NGO, which

rescues and rehabilitates trafficked children and women, conducts focus group discussions among those it has rescued. In the course of one such discussion among 57 trafficked children and women, STOP found that 98% had never initiated condom use although they had some knowledge of safe sex. Thus those engaged in the sex industry cannot always exercise the liberty to use a condom. It depends totally on the whims of the customer. Brothel owners are likely to expel a girl the moment they discover that she is carrying the HIV/AIDS virus.

Though the rate of STDs among sex workers is high, there are hardly any instances of providing care to sex workers. In Kolkata, in India, social workers are active in some brothels and sex workers can gain some access to information through them (Blanchét 2002). *Durbar* is one of such association of sex workers operational in Kolkata. Such NGOs and associations provide services such as general health care, awareness campaigns about STDs including HIV/AIDS, treatment of STDs and counseling services. They also work in promoting birth control measures such as injections and condoms. Trafficked victims who were engaged in bonded labour or other kinds of work have little access to such services.

Vulnerability to HIV/AIDS

Studies show that brothel sex workers are most likely to become infected during the first six months of work, when they have the least bargaining power and have to attend to more customers than others. It is easier for customers who are unwilling to use condoms to use force on new girls as they lack bargaining power (UNDP 2003). The young girls are also subjected to abuse and frequent rapes to 'break them in', thereby increasing their exposure to HIV. According to one UN agency, the fear of infection of clients with HIV has driven traffickers to recruit younger girls, due to the notion that young girls are not likely to be infected by HIV/AIDS (UNDP 2003). As a result the number of those infected by HIV is increasing.

Although women trafficked into sex work are at the top of the list of high-risk group, others who serve as domestic aides, in bonded labour or in pornography are not beyond risk. They are also at risk of coercive sex. Those who are bought and bonded as third/fourth wife in Baluchistan are common victims of sexual coercion and violation. Sometimes their husbands 'sell' them to brothels. Thus they go through similar types of experiences to those of trafficked victims in the sex industry.

Rescue, repatriation and rehabilitation of trafficked victims contain other sources of vulnerability for them to be infected by HIV/AIDS. In many cases families or societies at large, refuse to accept repatriated trafficked girls. Stigmatisation of these girls creates a new form of vulnerability and some, under such circumstances, have little option but to re-migrate to join their old profession.

3.6 The prevention of HIV infection among migrants – a review of existing programs, policies and interventions

Relevant Legislation and Policies on Labour Migration

Up to 1982, The Immigration Act of 1922 framed by the British was the only law concerning emigration. It was replaced with the promulgation of a new Emigration Ordinance in 1982. The new Ordinance is the key regulatory instrument in respect to migration. The Emigration Ordinance, 1982 only allowed persons with valid travel documents to emigrate. A letter of appointment or work permit from a foreign employer or an employment or emigration visa from a foreign government is considered to be a valid document. A person who is selected by

a foreign employer through an organization or a recruiting agent recognized by the government under an agreement between two governments will also be allowed to emigrate. Under the Ordinance, the government is authorized to grant licenses to individuals and companies who wished to be engaged in recruitment for overseas employment. Illegal emigrations are punishable for a term of up to one-year imprisonment with a fine.

In the early 1970s the Bangladesh Government did not have any concrete policy either to encourage or discourage female migration. On individual or agency initiative, Bangladeshi women began taking up jobs in the Middle East. However, since early 1980s, successive governments either put a complete ban on migration of all categories of female workers except the professionals, or imposed restriction on migration of women of unskilled and semi-skilled category. Currently unskilled and semi-skilled women are not allowed to migrate on their own. They can only migrate when a male partner accompanies them.

Bangladesh has ratified the ILO instrument, Migration for Employment Convention 1949 and Migrant Workers Supplementary Convention 1975. Bangladesh had signed the 1990 UN International Convention on Protection of Rights of All Migrant Workers and Members of Their Families. It is yet to ratify the instrument. The convention ensured full applicability of human rights legislation on women migrants. The convention has come into force in July 2003 with ratification by twenty countries.

Policy on HIV/AIDS: The government of Bangladesh does not have any policy to ensure treatment of the worker concerned if she/he is infected by HIV/AIDS while she/he is in the country of destination. That is, the 1982 Emigration Ordinance does not cover health rights.

There is hardly any data available for legal and protection strategy of HIV/AIDS in the Middle Eastern countries. Sex work is completely prohibited in these countries. None of the major labour receiving countries in the Middle East and Southeast Asia have ratified or acceded to the 1990 UN Convention on Rights of Migrant Workers and Members of their Families, and only a few countries have ratified some of the ILO Conventions relating to migrant workers. These countries pursue a policy of mandatory check-up for HIV/AIDS prior to departure. If detected with HIV/AIDS, the labour receiving countries immediately deport the migrant worker to their home country. BMET agrees to the receiving countries' policy of undertaking mandatory HIV/AIDS tests prior to departure. While providing clearance for departure, BMET checks if such medical tests have been carried out.

Relevant Legislation and Policies on Cross-border Migration

Cross-border movements of people come under the 11 (C) clause of Passport Act 1973. Under this law, anyone arrested while crossing border or staying illegally without visa is liable of a penalty of Tk 200 or a few days imprisonment. Cross border migrants, once caught in India or Pakistan are put into prison again under their respective foreigners' act and alien act. When adults are caught with children, they are separated. The adults are put in jails, but children are sent to safe custody or shelter homes. No legal frameworks are available with respect to cross-border movements and HIV/AIDS.

Relevant Legislation and Policies on Trafficking in Women and Children

The Ministry of Law adopted Repression on Women and Children Prevention Act 2000. The law prohibits kidnapping, trafficking, or trading women for illegal and immoral acts forcibly, and suggests death penalty or imprisonment of maximum 20 years. Apart from this, the Penal Code 1860, Child Act 1974, and Prevention of Economic Trafficking Act 1933. These laws

also prohibit detention, abduction, slavery, forced labour, and forced prostitution of women aged less than 18 years. Human rights organizations point out that when a trafficked in persons are rescued they are put in jail with the traffickers. In such situations ensuring their protection are found to be difficult. Another important problem regarding punishing the trafficker is that the police in majority instances file case under the passport act instead of the Repression on Women and Children Prevention Act 2000. Therefore, the trafficker gets released within a week through payment of Tk 200 penalty, whereas the trafficked in person is left in jail for a long period as no one is there to pay for their penalty.

Services Available

Most people only have access to the general mass HIV/AIDS prevention campaigns that are conducted in both electronic and print media by the Ministry of Health through the National AIDS Committee.

- a) In the case of overseas contract labour migrants, BMET is the government organisation that processes migration and is the only agency that offers pre-migration briefing on a regular basis (Malik 2000; Haque 2002). Currently it does not disseminate information on HIV/AIDS and STDs and only provides general information on health issues and STDs. The information is not given out in the printed handbook supplied by BMET (BMET 2002). Private recruiting agencies and the medical centers also do not have any program in this regard (Islam 2002). Therefore, people are going abroad for overseas employment without the necessary information on HIV/AIDS.
- b) Cross-border migration is not a process that is managed or encouraged by the state. No services are available for those who undertake such migration.
- c) In respect of trafficking, the Coordinated Program to Combat Child Trafficking (CPCCT) has been undertaken by the Ministry of Women and Children's Affairs. Under this program funds are channeled to different NGOs for the prevention of trafficking and the provision of shelter facilities. However, there is no special component on HIV/AIDS.

Services to HIV/AIDS infected people are currently provided by some specialised NGOs in Bangladesh. If a migrant worker is infected, she/he can avail themselves of such services. Some NGOs are active at the grassroots level, including along the borders of Bangladesh. Some run programs on reproductive health care and safe sex that indirectly cover HIV/AIDS prevention measures and some programs specifically serve PLWHA.

3.7 Policy gaps and recommendations

Policy gaps

- **The 1982 Ordinance is incapable of ensuring migrant workers' health rights in receiving countries. Although the Immigration Ordinance was ostensibly enacted to protect the migrant workers from all forms of fraudulent and exploitative practices, the law itself made the migrant workers vulnerable. Under Section 24 of the Ordinance a migrant worker is liable to suffer imprisonment if he/she returns home without completing the term of his/her employment. This is in violation of all norms and rights to refusal to continue to work.**

The national laws, rules and regulations pertaining to migrant workers do not address the issue of their protection in any significant way. The 1982 Ordinance, framed at a time when Bangladesh was actively promoting export of workers, has focused mainly on the procedural and regulatory aspects of migration. While governments have taken a proactive role in

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promoting male migration through promulgation of ordinances and statutes, in the context of women, the government's actions are geared toward restricting women's out migration as principal migrants. Such policy is discriminatory against women and breached constitutional provisions guaranteeing equal opportunity to men and women. It has been argued that restrictions on legal migration of women have not been to stop them from migrating; rather they have made the women migrant workers more vulnerable and might have contributed to women trafficking.

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From above discussion it may be concluded that the national laws, rules and regulations pertaining to migrant workers do not address the issue of their protection in any significant way. The 1982 Ordinance, framed at a time when Bangladesh was actively promoting export of workers, has focused mainly on the procedural and regulatory aspects of migration.

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- **Both the government and civil society agencies do not perceive it as important to provide preventive healthcare services to all possible migrants during the formal migration process. When government is interested to promote migration as an avenue for foreign exchange earning, then it is very important to reduce migrant workers' vulnerability to HIV/AIDS and ensure safe migration.**
- At present recruiting agents play a major role in the whole contract labour migration process but take no responsibility for managing the sector. On the government's part, there is no initiative to allocate some responsibility to the recruiting agents for ensuring safe migration.
- There is a serious lack of coordination among different ministries and NGOs working in labour migration sector. There is also a lack of coordination among states in the region and among donor agencies. This situation has led to a duplication of programs, imprudent use of scarce resources and a non-sharing of experiences of good practices.
- There are serious gaps with respect to research into different aspects of migration and health care. Migrants' social and sexual behaviour in different destination points is still unknown.
- **Migration within South Asia is a major livelihood strategy of the poor people. Migration of Bangladeshis to different parts of India has become a major area of concern between the two countries. However, migration to Pakistan is not yet a major political issue between the two states. There is a major research gap in respect to magnitude, scale, nature, causes and consequences of cross-border movement. Extent of vulnerability concerning HIV/AIDS also not that well-known.**
- **Cross-border migration involves different states. However, there is yet to emerge a joint strategy or plan of action with regard to cross-border.**
- **Government of Bangladesh has underscored the importance of combating trafficking of women and children. It has framed tough legislation accordingly. However, there is little progress in implementing the legislation. Besides the trafficking issue is also a cross-border phenomenon. Common strategies of South Asian governments are yet to emerge for combating trafficking.**
- **Donors have channeled large amount of resources in conducting research on trafficking. However, studies available on trafficking are mostly micro-analysis and thus far had limited success in capturing macro perspectives. Many human rights organisations and service providing NGOs fail to distinguish between irregular migrants and trafficked in persons, which complicates the problem of intervention further.**

Specific recommendations

Contract labour migrant workers

- *Information dissemination on HIV/AIDS in BMET pre-departure orientation*
BMET's current half-day briefing program should be replaced with a well-designed pre-departure orientation/training program. This training should be residential in nature and at least of two weeks duration. HIV/AIDS and STDs awareness should be an integral part of the training. Experts should be invited to brief outgoing migrant workers and acquaint them with the consequences of high-risk behavior. Among other things, lectures should cover high-risk behaviours, concept of 'safe sex' and the availability of medical and legal services in destination countries. In doing so, BMET may develop a team of experts on HIV/AIDS.
- *Involvement of NGOs and migrant support groups in pre-departure orientation*
BMET alone cannot provide training to all the outgoing migrants. Selected specialised agencies, NGOs and migrant support groups, could be involved to impart pre-departure orientation training. Each of the NGOs and migrant support groups engaged in pre-departure orientation training should conduct the training in four to six places. This would mean at least 20 different locations covering major migration source areas of the country such as Chittagong, Comilla, Sylhet, Noakhali, Dhaka. Recruiting agents should direct their client migrant workers to undertake such training from the above-mentioned government or NGO institutions.
- *Pre-departure information dissemination in medical centres*
Information tools like leaflets and videos prepared by specialised agencies should be made available to the medical centres involved in the labour migration process. The information tools should include high-risk behaviour warnings, concept of 'safe sex' and availability of medical services in destination countries. The medical centres should disseminate such information tools when outgoing migrant workers visit them for tests. Before conducting the tests the medical centres should inform the migrant workers of the tests that they are conducting. Videos may be shown in the waiting rooms.
- *Pre-departure information dissemination by recruiting agents*
Similar tools should be made available to the recruiting agents as well. NGOs working on the production and dissemination of HIV/AIDS information should also try to generate funds from the recruiting agents for preparing such information tools. They should be instructed on the advantages for them of such training.
- *Pre-departure information dissemination by migrant workers' associations*
The role of migrant workers' associations is very important for disseminating information on HIV/AIDS and creating awareness in the concerned locality. People have developed a certain degree of trust on such associations and this must be capitalised through outreach programs developed for people at the grassroots. Outgoing migrant workers may be made members of these associations and returnee migrants may be employed in briefing them, among other important things, on the proliferation and prevention of HIV/AIDS and STDs.
- *Role of host governments*
Government and international organisations should encourage receiving country governments to enable the sale of condoms and to enable appropriate information campaigns on HIV/AIDS. Migrant workers should be helped to develop their own

organisations — clubs, associations and unions — though which information dissemination could be made possible.

▪ *Role of foreign missions in Bangladesh*

The Foreign Ministry of Bangladesh may consider joining with other countries to provide 'Migrant Resource Centers' in labour receiving countries. This could provide migrants with a forum to interact and share and solve mutual problems. It could also be the institutional framework through which missions run information campaigns among migrant workers on vulnerabilities from risk behavior, importance of safe sex, and health care facilities. Such awareness campaigns could also be conducted through community based organisations such as mosques and clubs.

▪ *Receiving-country research*

Sources of vulnerability of labour migrants in destination countries need to be investigated.

Cross-border migrant workers

▪ **Detail collaborative field based research by South Asian scholars should be undertaken to have clear idea on nature of vulnerabilities of cross-border migrants. International agencies can play a role in facilitating such collaborative research. The civil society organizations and researchers of South Asia should try to engage themselves in de-politicising the issue of movement of people within the region.**

▪ **HIV prevention programs of all South Asian governments' must include cross-border labour migrants. Traditional mass awareness programs on the prevention of HIV/AIDS in the destination countries may not be easily accessible to migrants due to language barriers. Programmes should be designed with such considerations in mind.**

▪ UNDP can maintain contact with human rights organisations, NGOs and trade unions operating among migrant workers in India and Pakistan. These organisations can be funded to provide services to migrants.

Trafficked women and children

▪ **The networks which have emerged among the South Asian academics and activists should try to incorporate HIV/AIDS awareness as an integrated part of their programmes.**

▪ Community based organisations at the receiving end can play a positive role in creating awareness as well as in promotion of condom and STD treatment to sex workers. UNDP should extend support to community organisations that provide services to the sex workers.

▪ Many areas need research – the condition of trafficked victims in sex industry and bonded labour in destination countries; socio-economic and psychological condition of trafficked victims at the receiving end; nature of intervention about trafficked victims in the country of destination; psychosocial state of repatriated and/or rehabilitated trafficked victims.

General Recommendations

- **Efforts must be directed to situate HIV AIDS in the overall gender and poverty context of the countries of the region, that serve as source, transit and destination areas of various types of migrants. A multi-sectoral holistic approach needs to be taken in framing effective policies and actions.**
- **The agents of change among various sectors are to be identified nationally to develop a common vision and alignment on HIV AIDS and migration. Opportunities are to be created for national agents of change to interact with their counterparts of other countries of the region.**
- **The national Planning Commissions play a critical role in development planning of each of the South Asian countries. The issue of migration does not receive adequate attention in the planning documents. HIV AIDS and migration issues need to be integrated in the planning processes. It is with this aim the Planning Commissions need to be sensitized.**
- By utilizing common research methodology, comparative research has to be undertaken. Issues which need to be looked into for all kinds of migrants are the type and magnitude of risk behaviour of people from migration intensity areas of Bangladesh; HIV positive people in Bangladesh focusing on their life style, socio-economic condition, involvement in high-risk behaviour, present situation and perception of their rights; sources of vulnerability of labour migrants in the destination country; living and working condition, the leisure, entertainment and social behaviour of cross-border labour migrants in the country of destination; STD prevalence among irregular migrants; health services available at home and in the destination country for prevention and treatment of HIV/AIDS and evaluation of the effectiveness of existing HIV prevention projects in Bangladesh; condition of trafficked victims in the sex industry and bonded labour in destination countries; socio-economic and psychological condition of trafficked victims at the receiving end; nature of intervention for trafficked victims in the country of destination; psychosocial state of repatriated and/or rehabilitated trafficked victims.

3.8 List of resources

Government of Bangladesh

Ministries: The Ministry of Expatriates' Welfare and Overseas Employment is the line ministry of the Government of Bangladesh in charge of managing migration. The Ministry is vested with the power of implementing the rules framed in 2002 under the Emigration Ordinance 1982 and accordingly, of promoting, monitoring and regulating the migration sector. The Ministry of Home Affairs, the Ministry of Foreign Affairs and the Ministry of Civil Aviation and Tourism are the other three important related ministries. The functions that Bangladesh missions abroad currently perform regarding labour export are: (a) exploring potential labour market; (b) attestation of documents pertaining to recruitment; (c) providing consular service to Bangladeshi workers; and (d) ensuring welfare of migrant workers. Ministry of Finance and Bangladesh Bank play a major role in respect to management of remittance of the migrant workers.

The Ministry of Law, Department of Women's Affairs of the Ministry of Women and Children Affairs of GoB have taken strong measures in respect to trafficking. The Law ministry enacted Repression on Women and Children Prevention Act 2000. The Department of Women's Affairs of the Ministry of Women and Children Affairs has undertaken a combat

trafficking project where a large number of NGOs are involved in an awareness campaign, rescue and rehabilitation of trafficked persons. Its current phase started in 2002 and will end in 2007. However, these programs are yet to integrate HIV/AIDS awareness and medical assistance.

With respect to HIV/AIDS the Ministry of Health and Family Welfare (MOHFW), as the coordinating and supreme executive body, has taken up strategies to prevent the proliferation of the disease through the National AIDS/STD Program (NASP) (GoB 2003). Under this program, among other activities, migrant workers in Dhaka, and Belkuchi, Sirajganj, have been provided with information on HIV/AIDS/STDs, safe sex behaviour and STD prevention by promoting STD referral and condom use.

BMET: Bureau of Manpower, Employment and Training (BMET) is the executing agency of Ministry Expatriates' Welfare and Overseas Employment with respect to processing labour migration. BMET was created in 1976 by the government to ensure maximum benefit for labour export. Since the promulgation of the Emigration Ordinance of 1982, it has been working as the implementing agency of the Ordinance. Currently BMET is involved in all kinds of functions – control and regulation of recruiting agents, collection and analysis of labour market information, registration of job seekers for local and foreign employment, development and implementation of training programs in light of specific labour needs both in national and international labour market, implementation of apprentice and in-plant programs in the existing industries, organizing pre-departure briefing sessions, and resolving legal disputes.

National AIDS Committee: The National AIDS Committee (NAC) is mainly a government body, but has representatives from NGOs and civil society (GoB 2003). It is the national advisory body that provides advice on all matters related to HIV/AIDS.

Technical Committee: The Technical Committee is the technical arm of the NAC, comprising of leading experts from different fields like health, media, education, demography and NGOs.

National Integrated Work Plan on HIV/AIDS 2002: The Work Plan for the period 2002-2006 was developed through an initiative by MOHFW-NASP and UNAIDS, with consultation and strategic review by all concerned development partners, including the UN, bilateral agencies, involved ministries and civil society.

Private recruiting agencies

Since 1980, agencies have recruited people for overseas employment under a license from the government. The agencies collected information on demands and orders for foreign employment, recruited workers as per specifications of the foreign employers, and then processed their cases for deployment. Up to 2002, 45% of the total number of labour migrants went through these agencies. Over time the recruiting agencies became organised under the Bangladesh Association of International Recruiting Agencies (BAIRA). In 2002, the association had a membership of around 700 agencies.

BOESL

In 1984, the Government also set up Bangladesh Overseas Employment Services Limited (BOESL) as a limited company to take up a direct recruitment role. Since its inception up until February 1999, BOESL has recruited 8,900 workers. This constitutes 0.31% of the total

number of those who went overseas through the official channel. A thorough evaluation of this institution needs to be done to assess its strengths and weaknesses.

Civil Society Organisations

Though Bangladesh has been a major labour sending country, civil society institutions have not been involved in any major way in providing services and protecting the rights of migrant workers. Over the last few years some human rights organisations and research bodies have initiated limited activities concerning labour migration. The Christian Commission for Development in Bangladesh (CCDB) was involved in a collaborative project with Kuala Lumpur-based Caram Asia on HIV AIDS and mobility. To reach its target group it funded SHISUK, an NGO, for developing an association of migrant workers. Currently SHISUK is involved in providing pre-departure orientation for Bangladeshi migrant workers going to Malaysia. *Ain O Shalish Kendra* (ASK), Bangladesh Legal Aid and Services Trust (BLAST) and Bangladesh Society for Enforcement of Human Rights (BSEHR), on different occasions, provided legal aid to migrant workers when they were cheated by recruiting agents.

A section of the returnee migrants have developed their own organisations. Over the last few years, three such organisations have emerged. The Welfare Association of the Bangladeshi Repatriated Employees (WARBE) has been involved in organising returnee migrants since 1997. The Association acts as a pressure group for promoting and protecting the rights of migrant workers. The Bangladesh Migrant Centre (BMC) focuses its activities on returnees from Korea and the Bangladeshi Women Migrants' Association (BWMA) is engaged in a campaign to lift the ban on women migrants.

The international migration issue has drawn limited attention from the research community of Bangladesh. Researchers of the Bangladesh Institute of Development Studies have worked on some aspects of labour migration (Mahmood 1994, 1996, 1998; Afsar *et al.* 2000; Murshid 2000). *Bangladesh Unnoyon Parishad* (BUP) has undertaken a study on the utilisation of remittances in the district of Sylhet (Ahmad and Zohora 1997). The Dhaka University based Refugee and Migratory Movements Research Unit (RMMRU) has been specialising in migration. Along with research, it has conducted two advocacy campaigns pertaining to labour migration: one on lifting the bar imposed on less skilled female migration and the other for ratification for the 1990 UN Convention on the Rights of Migrant Workers. In addition, the Unit has developed two training modules on migration: one for young academics and professionals on 'Social Science Research and Migration' and the other for information dissemination on 'Labour Migration Process through Community Leaders and Activists'.

A good number of national and local NGOs are currently working on trafficking in women and children in Bangladesh. Some of the leading NGOs are: *Ain-O-Shalish Kendra* (ASK), Association for Community Development (ACD), BNWLA, Centre for Women and Children Studies (CWCS), Dhaka Ahsania Mission (DAM), Rights Jessore, RMMRU, and UBINIG. These organizations are involved in different aspects of trafficking. A number of local NGOs have undertaken anti-trafficking awareness campaign programs in bordering areas. These include, ACD, CCD, Rights Jessore, etc. Research organisations such as RMMRU and CWCS support such programs with their research. BNWLA, DAM and ACD have shelter homes and thus, they work on repatriation and rehabilitation of trafficking victims. NGOs in Bangladesh such as BNWLA and ACD also provide legal assistance to the trafficking victims. ATSEC is a network of NGOs working on the prevention of trafficking of women and children.

The CARE-Shakti project, which is supported by the Department for International Development (DFID) (UK), has been implemented by CARE and six partner organisations since July 1995. The project includes effective clinic service with the aim to prevent

HIV/AIDS among three target groups, i.e., intravenous drug users, sex workers and MSMs in Dhaka and other major towns in Bangladesh. The National STD/AIDS Network is a forum of NGOs working on different aspects of HIV/AIDS in Bangladesh, and has been working since 1992. The Network has been engaged in providing assistance in policy formulation, analysis and advocacy. HASAB, supported by international organisations, extends supports to NGOs and other community based organisations that respond to HIV/AIDS issues. HASAB is involved in advocacy and behaviour change communication, and research and documentation on the issue. The Social Marketing Company, with support from USAID and DFID, has been involved in a client service program making condoms available to its clients in risk locations such as brothels and slums through its 300,000 sales outlets.

Multilateral Bodies

In the context of Bangladesh, until recently, not many international agencies had a migration sector in their programs. However, quite a few multilateral bodies have covered the issue of HIV/AIDS. Among the UN bodies and affiliates, International Labor Organization (ILO), and International Organization for Migration (IOM) are the major organizations that have mandates on migration. Over the years, ILO has commissioned two important studies in Bangladesh regarding migration. The studies are, 'International Labour Migration from Bangladesh and the Trade Unions' and 'Migrant Workers Remittances and Micro Finance in Bangladesh'. Once the regional office of IOM was established in Dhaka in 1999, it took different initiatives with regard to migration. IOM, Geneva and INSTRAW jointly commissioned a study on temporary labour migration of women from Bangladesh. In collaboration with UNDP, IOM commissioned and published five studies covering various aspects of migration. It provides support to different migrant workers' associations to hold rallies and programs during events such as the International Migrant Workers' Day. Currently, it has also undertaken a project for capacity building of the Ministry of Expatriates' welfare and overseas' employment. UNDP is also partially involved in migration issues. It supported IOM for the five studies. It also funded translating the reports into Bangla and publishing them in both English and Bangla. Recently the Asian Development Bank has done some exploratory work on trafficking issues. So far the World Bank has not undertaken any migration related initiative. USAID made a major contribution with respect to combating trafficking. However, like many others, it is yet to undertake any program with respect to labour migration or long-term migration. The Policy Division of the Department for International Development (DFID), UK has recently taken interest in migration. It has commissioned five country studies in Asia, including Bangladesh, and organised a regional conference in Dhaka in June 2003 where 80 experts participated from different parts of the world.

UNAIDS of Bangladesh is the most important institution in respect of HIV/AIDS. UNAIDS is co-sponsored by UNICEF, UNDP, UNFPA, UNESCO, WHO, World Bank, UNDCP and ILO. All these eight agencies' heads are represented on the UN Theme Group of HIV/AIDS in Bangladesh. UNAIDS provides assistance to different government and non-government organisations working on HIV/AIDS. The following table summarises the situation in Bangladesh and highlights the most vulnerable groups.

Table 3.3 Summary of vulnerable groups, responses and recommendations

Vulnerable groups	Current situation	Responses	Recommendations
Majority of the trafficked women are forced to work in the sex industries of India and Pakistan. They are extremely vulnerable.	IOM data suggests an average of 50 women and children are being trafficked from Bangladesh every day.	Department of Women’s Affairs of the Ministry of Women and Children Affairs of GoB have taken strong measures in respect of trafficking. Enacted Repression on Women and Children Prevention Act 2000. Large number of NGOs are involved in an awareness campaign and the rescue and rehabilitation of trafficked persons. However, programs are yet to integrated into HIV/AIDS awareness and medical assistance. HIV infected trafficked persons can avail themselves of services through HASAB and STD/AIDS Network.	<ul style="list-style-type: none"> ▪ Community based organizations in the host countries may be used extensively to promote condom and STD treatment among sex workers. ▪ Research should be conducted on the condition of trafficked Bangladeshi women in Indian and Pakistani sex industries.
<p>A section of cross-border female migrants who work in the entertainment and sex industry of Bombay and regularly visit Bangladesh are among the most vulnerable people.</p> <p>Cross-border irregular migrants lack information. A section of women are often disempowered, exploited and abused in domestic service or as wives.</p>	<p>60% of all sex workers of Bombay are HIV infected. There is no separate figure on HIV level of Bangladeshi sex workers.</p> <p>Those who work as domestic workers, bonded labourers, so called wives, persons involved in other professions like guards, gardeners etc. do not have access to any targeted intervention.</p>	<p>Some social workers provide information in brothels in India.</p> <p>The government of Bangladesh does not want its population to move irregularly. It does not recognize those as its nationals and no government services are available in respect of this type of migrants.</p>	<ul style="list-style-type: none"> ▪ Extensive awareness campaign in the bordering areas of Bangladesh should be undertaken through NGOs on risk of HIV/AIDS. ▪ Research should be conducted on sex behaviours of cross-border labour migrants particularly in receiving countries.
Epistemological scenario in the Middle East does not put the contract labour migrants in high risk situation. But they are vulnerable due to lack of knowledge of HIV/AIDS and safe sex practices.	Very sparse services/policies/ programs Labour receiving states do not take any responsibility when a migrant worker is detected as HIV positive. The government of Bangladesh also does not have any follow up on returnee migrants.	The government does not provide any services to migrant workers at pre, during and post-return phases concerning HIV/AIDS.	<ul style="list-style-type: none"> ▪ Access to health services offshore ▪ Innovative HIV/ AIDS awareness campaigns at home and offshore ▪ Develop resource centres offshore - could be shared by a number of countries ▪ Coordination between IOs, NGOs and GoB ▪ Research should be conducted on sex behaviours of labour migrants offshore.

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Appendix 1: List of Persons Contacted

1. Mr. Shahudul Haque, Director General, Bureau of Manpower Employment and Training (BMET), 24 September 2002.
2. Mr. Nazrul Islam, President, GCC Approved Medical Centres' Association (GAMCA), 2 November 2002.
3. Dr. Hasrat Ara, Marie Stopes Clinic (MSC), 10 December 2002.
4. Dr. Rosella Morelli, Senior Programme Coordinator, UNICEF, 11 September 2003.
5. Mr. Saiful Haque Asif, Vice Chairman, Welfare Association of Repatriated Bangladeshi Employees (WARBE), 25 August 2003.
6. Mr. Ghulam Mustafa, Secretary General, Bangladesh Association of International Recruiting Agencies (BAIRA), 29 August 2003.
7. Mrs. Pam Baatsen, Country Director, Family Health International, 26 May 2003.
8. Ms. Victoria Hollertz, Program Officer, International Organization for Migration (IOM), 26 May 2003.
9. Mr. Manabendra Mandal, Executive Director, Socio-Legal Aid Research and Training Centre (SLARTC), Kolkata, 26 March 2003
10. Ms. Indrani Sinha, Secretary, *Sanlaap*, 25 March 2003.
11. Mr. Md. Touhid Hossain, Deputy High Commissioner, Deputy High Commission of Bangladesh, Kolkata, 27 March 2003.
12. Ms. Baitali Ganguly, Executive Director, Jabala Action Research Organisation, Kolkata, 26 March 2003.
13. Advocate Zia Ahmed Awan, President, Lawyers for Human Rights and Legal Aid (LHRLA), Karachi, 23 June 2003.