FOR MONEY AND SEX

The HIV Vulnerability and Risks of MSM Migrant Workers From Bangladesh, Pakistan and the Philippines

CARAM Asia
Task Force on Migration, Health and HIV

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RESEARCH TEAMS

01

01 RESEARCH TEAMS

PARTNER ORGANIZATIONS

The research was conducted by CARAM Asia member organizations in the three countries as follows:

BANGLADESH – *Ovibashi Karmi Unnayan Program (OKUP)*

PAKISTAN – *AMAL Human Development Network*

PHILIPPINES – *Action for Health Initiatives (ACHIEVE), Inc.*

Coordinated and written by the Convener of CARAM Asia's Task Force on Migration, Health and HIV

EXECUTIVE SUMMARY

02

02 EXECUTIVE SUMMARY

FOR MONEY AND SEX - THE HIV VULNERABILITY AND RISKS OF MSM MIGRANT WORKERS FROM BANGLADESH, PAKISTAN AND THE PHILIPPINES

Migration is being strongly promoted by governments as the solution to poverty in many of Asia's developing countries. Migrant workers coming from Bangladesh, Pakistan and the Philippines are mostly bound for countries with advanced economies in the Gulf region, most notably Saudi Arabia and the United Arab Emirates (UAE), and in the Association of Southeast Asian Nations (ASEAN) region, namely Malaysia and Singapore. The mechanisms that promote and facilitate migration primarily consider migrant workers as sources of remittances. Weak rights protection frameworks leave migrant workers vulnerable to certain rights violations and increase their vulnerability to certain health conditions, notably, HIV infection.

In this research, the Coordination of Action Research on AIDS and Mobility in Asia (CARAM Asia) has focused on a group of migrant workers who are especially vulnerable to HIV: males who have sex with males, otherwise known as "MSM." MSM migrant workers suffer multiple layers of stigma and discrimination, which, in combination with the risky sexual behaviors they engage in heightens their risk of HIV infection.

All the men interviewed for this research were migrant workers from Bangladesh, Pakistan and the Philippines who had either already returned from working abroad or who were prospective migrant workers. Being migrant workers, every one of them indicated that their primary reason for migrating to work abroad was to make money.

However, the research respondents from the South Asian countries who identified as MSM prior to migration indicated that they also had other motivations. These respondents, in particular, faced stigma and discrimination from their families for expressing their sexuality. This made the ability to engage more freely in MSM behaviors while abroad one of their motivations. Of this group, there was also a number who intended to go abroad to specific countries in order to be male sex workers.

While some of the respondents from the South Asian Muslim countries felt that they were escaping their home societies' oppressive rules against homosexuality, the destination countries they went to, although more socially permissive, had similar oppressive laws in place. Between common law in the form of Article 377, which has remained in place since British rule, and Sharia Law in Muslim countries, these men found themselves in foreign countries that also have institutionalized prohibitions against engaging in sexual behaviors with other men.

The contradiction of being in a permissive atmosphere which tacitly allows men to engage in MSM behavior, within limits, has allowed migrant men to also engage in MSM behaviors more freely than they could at home. They do so, however, with an invisible but real threat of punishment if caught. Although not an immediate threat, these restrictions became a palpable barrier when they tried to seek relevant sexual and reproductive health services, and also increased their susceptibility to sexual violence.

It was not laws against homosexuality, however, that was the most impending threat; it was the policies on mandatory HIV testing and related deportation which ended many of the respondents' ability to stay and work as migrants in the destination countries studied here. In fact, twenty-six (26) of the 72 research respondents, or 1 in 3, who had been abroad were deported for their HIV status. Upon return, few of the respondents were provided referral to HIV services or other social welfare assistance.

It was mainly through the efforts of MSM and PLHIV groups or non-government organizations (NGOs) that these men received necessary social support and accessed treatment services. Yet, prospective migrant workers who self-identify as MSM have indicated that they are not receiving specific information on the realities of MSM and HIV in the context of migration. This is worrisome because the three origin countries in this study have concentrated epidemics, with either MSM populations or returned migrant workers identified as groups having the highest HIV prevalence, inferring that MSM migrant workers may be one of the most vulnerable groups.

In conclusion, the results of this research show that there is a significant gap in HIV prevention coverage for MSM migrant workers. Without specific and targeted interventions for MSM migrant workers, and the reform of repressive laws and policies, migrant workers who engage in MSM behaviors while abroad will remain increasingly vulnerable to HIV and sexual violence, and will return home to circumstances that are less than conducive to accessing timely treatment and necessary services.

PREFACE

03

03 PREFACE

For many countries in Asia, poor families consider migration as the only viable possibility of improving their financial standing. Although there are increased numbers of women going abroad for work, in most countries, the majority of migrant workers are male. These men have a range of education and skill levels, and they fill a variety of job types while abroad. They go for the primary purpose of making money to improve their and their family's standing. Yet there are also a proportion of men who go abroad with other motives. They are males who have sex with males or MSM, and many of them are also migrating to enjoy certain freedoms in expressing their sexuality. With little economic opportunity at home, these men take the chance of going abroad for work. Usually, they take jobs that fit their skills set. There are also those who do not fit neatly in a work category, who are ambitious and strike out on their own and find work as a driver or a sex worker.

Regardless of the work they do, like all other migrant workers, their main intention is to go abroad to make money for themselves and their family so that they can have a better life. With this primary thought, few men consider the risk they are taking of possibly suffering exploitation or abuse as a migrant worker in a foreign country. For MSM who go abroad to express their sexuality as well as find work, few are aware or prepared for the risks related to MSM behaviors in a foreign country. Ranging from sexual health conditions, including HIV infection, to possibly even becoming the victim of sexual violence, there are a number of dangers associated with being a MSM migrant worker that these men are unaware of but which could have a significant impact on their health and well-being. In this report, the research team looked at the experiences of MSM migrant workers from Bangladesh, Pakistan and the Philippines, and assessed their vulnerabilities and the risks they take *for money and sex*.

RESEARCH METHODOLOGY

04

04 RESEARCH METHODOLOGY

RATIONALE OF THE RESEARCH

This research was an exploratory, qualitative research about MSM migrant workers' risks and vulnerabilities to HIV infection at home and abroad. It was intended to identify potential issues for further investigation, and to raise awareness on a topic about which little is known but which may have significant ramifications.

Objectives:

1. To collect data on the HIV risks and vulnerabilities of migrant workers who engage in male-to male sex while working abroad and upon return home.

2. To promote strategic resource allocation by governments and civil-society to key populations by providing evidence and recommending strategies for community-based HIV prevention and treatment interventions for male migrant workers who engage in MSM behaviors.

3. To utilize data to influence interventions at the policy, legal and programmatic level, and advocate for legal reform of HIV policies on entry and stay, and laws that criminalize MSM behaviors.

RESEARCH PARAMETERS

The research looked at the context and behavior of migrant men from Bangladesh, Pakistan and the Philippines who have engaged in MSM behaviors, or who may possibly engage in such behaviors in the future. The focus was on men who went to destination countries in the Gulf Cooperation Council (GCC) and the South East Asian countries of Malaysia and Singapore. A desk review was done to identify contextual factors, such as migration statistics, HIV statistics, and relevant information on MSM. The legal context was also assessed through this process.

Considering the sensitivity of the topic, the difficulty and time it would take to reach a large segment of this specific population, a small cross-sample of between 33 and 43 respondents (as was available) was approached for qualitative interviews in each of the home countries. Respondents who self-identified as MSM or PLHIV were approached through channels where they felt confident in revealing their status, such as through MSM networks or PLHIV support groups.

Specifically, two focus group discussions (FGDs) were conducted in both Bangladesh and Pakistan with MSM returned migrant workers who were infected with HIV, and in the Philippines two FGDs were conducted with land-based migrant workers who were self-identified as MSM and were HIV positive, and one with HIV positive seafarers, one of which was open about being MSM.

Almost all of the participants in these FGDs had been deported for their HIV status. In Pakistan there was also an FGD conducted with a group of returned MSM migrant workers who were HIV negative.

Both the Bangladesh and Pakistan partners conducted an FGD with a group of pre-departure MSM, while the Philippines partner conducted one FGD with pre-departure, non-MSM identified land-based migrant workers, and one FGD with non-MSM identified seafarers.

Each country partner then also conducted in-depth interviews with selected respondents from the FGDs to explore in-depth issues which arose. Finally, key stakeholders, mostly civil society organizations involved in providing services to MSM or migrant workers living with HIV, were interviewed to triangulate information and gain another perspective on the issues.

CATEGORIES OF RESPONDENTS

	Bangladesh (40 respondents)	Pakistan (29 respondents)	Philippines (43 respondents)
FGD 1 HIV POSITIVE RETURNED MIGRANT WORKERS	2 groups of overseas PLHIV MSM (10) (10)	2 groups of PLHIV: self-identified MSM (6); not self-identified as MSM (4)	2 groups of PLHIV MSM land based (9) (8); 1 group of PLHIV seafarers (4)
FGD 2 HIV NEGATIVE, MSM RETURNED MIGRANT WORKERS		1 group of returned MSM migrant workers (9)	
FGD 3 PRE-DEPARTURE GROUP OF MIGRANT WORKERS	1 group of pre-departure MSM migrant workers (8)	1 group of pre-departure MSM migrant workers (10)	1 group of land-based (not MSM identified) (11); 1 group of seafarers (not MSM identified) (10)
INDIVIDUAL INTERVIEWS / CASE STUDIES	1 victim of sexual abuse and HIV positive	1 victim of sexual abuse; 1 deported for HIV	3 HIV positive returned migrant workers (2 were victims of sexual abuse and 1 who had female partners and had children with different women)
	Five (5) key informants	Nine (9) key informants	Six (6) key informants
KEY INFORMANT INTERVIEWS	From civil society organizations: • MSM Peer educator • MSM network - Bondhu Social Welfare society • PLHIV network (MAB) • CCM, Secretary/ STI Network Bangladesh • Migrant service provider (OKUP)	From civil society organizations: • New Light AIDS Control Society • Pak Plus Society • Naz Male Health Alliance (NMHA) • MSM network representative From government agencies: • National AIDS Control Programme • Punjab AIDS Control Programme • Overseas Employment Corporation (OEC) • Bureau of Emigration and Overseas Employment (BOEOE)(2)	From civil society organizations: • TLF-SHARE Collective • The Love Yourself Project • KAKAMMPI • Take the Test • PAFPI • Young HIV positive MSM active migrant worker

GAPS, CAVEATS AND VALIDITY

Many respondents were self-identified MSM or members of PLHIV groups. However, there is a large group of male migrant workers who engage in MSM behaviors but do not identify as MSM. This group may be broad and difficult to reach. While the number reached in this research was of a small sample size, coming from a population of unknown proportions and diversity, it will not be possible to generalize from the results. However, the underlying contextual factors and behaviors identified in this research which contribute to these men's vulnerability and risk of HIV infection are similar across countries, and are enough to consider as evidence for the need to enhance HIV programs and services, specifically for MSM migrant workers.

OVERVIEW OF COUNTRY CONTEXTS IN THE RESEARCH SITES

05

05 OVERVIEW OF COUNTRY CONTEXTS IN THE RESEARCH SITES

In many developing countries in Asia, migrating abroad to find work has become normalized as the solution for pulling a family out of poverty. Here is some brief information about migration from Bangladesh, Pakistan and the Philippines.

Bangladesh

With over five (5) million migrant workers abroad, Bangladesh is a major labour sending country in Asia as well as in the global context. Every year hundreds of thousands of Bangladeshis migrate overseas and across borders in search of better employment and economic gains. In 2013, 409,253 migrants went overseas through regular channels; in 2012, around 607,798 people were recorded as overseas migrants, while in 2011 the number of regular migrants was 568, 062. [1] Overseas labour migration from Bangladesh is dominated primarily by male workers.

Out of the total labour migration using regular channels between 1976 and August 2014, 96% were male and half of them were engaged in low-skilled job categories such as construction, manufacturing and the service sector. Many of the Bangladeshi migrant workers who travel to Gulf countries obtain a 'Free Visa' which allows them to work freelance but under the purview of the sponsorship system. Bangladesh reportedly sends workers to 157 countries around the world. However, between 70-80% of the migrant workers coming from Bangladesh end up in countries in the Arab Gulf and Middle East, while another 8-10% end up in the South East Asian countries of Malaysia and Singapore.[2]

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[1] Bureau of Manpower Employment and Training (BMET), Government of Bangladesh

[2] Ibid

Pakistan

With over 4.5 million Pakistani migrant workers abroad, about 94% have gone to Gulf Cooperative Council (GCC) Countries for employment, with 82% of them concentrated in just two countries - Saudi Arabia and UAE. Migration from Pakistan peaked in 2012 when 638,587 were recorded to have left the country through regular channels, while in 2013 the total was 622,714. Prior to that, an average of 400,000 workers left the country annually through regular channels. [3] During the period between the years 2008-13, more than 50% of total emigrants from Pakistan originated from the Province of Punjab, followed by Khyber Pakhtunkhwa (28%), and Sindh (8%). [4] Of those who went through regular channels, 54% were considered semi-skilled or un-skilled workers.

Philippines

Approximately 4.25 million Filipino migrants are working abroad through regular channels, while another 750,000 are abroad in irregular situations.[5] Data from the Philippine Overseas Employment Administration (POEA) showed that a total of 1,836,345 Filipinos were deployed to work overseas in 2013.

Of this figure, 1,469,179 were land-based workers and the rest were seafarers. Among land-based overseas Filipino workers (OFWs), some of the top destination countries included: Saudi Arabia (26% or 382,553), UAE (18%), Singapore (12%), Qatar (6%), Malaysia (2%), and Bahrain (1.3% or 20,546). [6] In 2013, out of the 1,469,179 land-based Filipino workers who were deployed, 1,004,291 were re-hires or OFWs who had previous contracts which were renewed.

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[3] Bureau of Emigration and Overseas Employment, by Country Pakistan, July, 2014

[4] Bureau of Emigration and Overseas Employment, by Province Pakistan, July, 2014

[5] ILO, 2013

[6] POEA, 2013

The remaining 464,888 were new hires or first time OFWs. In 2013, the top destination countries for Filipino migrant workers going abroad for the first time were: Saudi Arabia (166,744), UAE (81,926), with ASEAN destinations including Singapore (16,787) and Malaysia (14,094). The last report that disaggregated migrant workers by sex was in 2010, which showed that 45% of Filipino overseas workers were male. [7]

5.1 ESTIMATES OF MSM POPULATIONS

> *A "gay" or "homosexual" identity rarely applies in Asia. Instead, many Asian MSM define themselves based on their adopted gender roles, with feminine and masculine roles shaping both sexual behavior and personal relationships. The term "MSM" has thus been adopted in an attempt to focus on behavior rather than identity, and to include all men who have sex with men, regardless of how they see themselves. It encompasses males who define themselves either by their sexual behaviors (e.g. gay men) or by their feminine gender identities (kothi, waria, katoey) in addition to their masculine defined sexual partners.* [8]

In this study, the term MSM (males who have sex with males) is used to refer to men who engage in sexual behavior with other men regardless of how they define their sexual orientation. There are also research respondents who engage in sex with other men but do not necessarily ascribe to the term "MSM" but their experiences are included in this study. The following is a brief discussion of the situation of MSM in the three countries of origin studied.

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[7] Ibid

[8] Khan, S., as referenced in Treat Asia, p.5

Bangladesh

Very few MSM in Bangladesh use the Western 'gay' identity. [9] A study on MSM indicated that the large majority (>80%) of MSM in Bangladesh categorize themselves as 'straight' men, and do not identify with the term MSM. Sexual identities and gender typologies that MSM commonly identify as include kothi (feminized males, usually receivers who sometimes cross-dress), parik/panthi (lovers/sex partners of kothi, usually inserters), and do-parata (both receiver and inserter), with only a small percentage (2%) identifying as "gay."

Kothi typically call the 'straight' men who they have sex with 'panthi.' A risk assessment done in 2006-07 by the National AIDS/STD Programme with males who have sex with males in Dhaka found that approximately one-third of the 418 males surveyed identified as kothi whereas half identified as panthi. [10] Research has consistently found that approximately 2 percent of all males in Bangladesh engage in same-sex (MSM) sexual behaviors, with a high prevalence of penetrative sex as well as related risk behaviours, such as low condom use. [11]

A recent study was conducted to assess the number of MSM, male sex workers (MSW) and hijra in Bangladesh. The study estimated that there are between 21,833 to 110,581 MSM (not including MSW), which equates to around 0.04-0.23% of the male population aged 15-64 in Bangladesh.[12]

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[9] The term "gay" evolved in the West to reflect not only sexual orientation, but also a political orientation involving a process of "coming out" and engaging with other gay identified men. In the context of Bangladesh, gay-identified men tend to be a class-based identity. (Source: www.bandhu-bd.org/breif.html)

[10] UNDP, Country Snapshots - Bangladesh, December 2012. p.2

[11] Ibid

[12] Khan, S.I., 2012, p.19

Another study by the National AIDS Programme estimated the MSM population in Bangladesh ranges between 32,967 to 143,065 [13]; while the Bandhu Social Welfare Society, the only open network of MSM in Bangladesh, on the other hand, claims that they reached 300,000 MSM in six cities over four years between 2000 and 2004. [14]

Pakistan

In Pakistan sex between men appears to be rather common in general society, beyond those classified as hijra and male sex workers. [15] While the repressive cultural atmosphere forces 'gay' or 'effeminate' members of the MSM community to hide their identity, many men are having sex with other men simply out of a need for sex, rather than as expression of attraction to another man. This behavior and mentality makes it difficult to define and estimate the MSM population. Because penalties for out of wedlock heterosexual sex are extremely strict, making women, even female sex workers, relatively inaccessible, sex between men is relatively inconsequential.

As a result, men are inclined to have sex with other men, sometimes male sex workers, just for the sake of having sex. [16]

> *"When talking about gender identities, the term 'men who have sex with men' is used to refer to several different identities in Pakistan, including: hijras, who identify themselves as neither men nor women, but of the third sex (younger generations of hijra are understood to increasingly identify as female and take the receptive role in anal sex); ...*

[13] UNDP, Country Snapshots Bangladesh, December 2012, p.2-3
[14] UNDP, Country Snapshots Bangladesh, December 2012, p.2-3
[15] UNDP, Country Snapshots Pakistan, December 2012, p.1
[16] LandInfo, 2014. p.12

> *... zenanas, who believe they are women trapped in men's bodies and are often married to women; chavas, who identify with the female gender and may switch roles in anal sex; giryas, who take the role of the husband to hijras and zenanas; and maalishias are males who are masseurs by profession, sell sex to men and identify with the male gender."* [17]

The National AIDS Authority does not disaggregate other MSM from hijras and male sex workers (MSW), leaving no clear data on the number of MSM in the general population. However, on the basis of research conducted with MSM in Pakistan, it is estimated that the number of men engaging in MSM behaviors in Pakistan could reach approximately 2.28 million. [18] According to Qasim Iqbal, Executive Director of the Naz Male Health Alliance (NMHA) which works with the MSM community in Pakistan, there are 35,000 MSM members registered with NMHA all over Pakistan.

Philippines

Filipino MSM are heterogeneous and do not fit into the mainstream conceptualization of 'gay' identity. Generally, identities are based on gender role expression (i.e., feminine or masculine), but are fluid and influenced by a host of factors, especially the social context they find themselves in.

An effeminate identity is one end of the spectrum, while the straight-identifying masculine MSM is on the other end. In between are the 'discreet' MSM, who are generally less comfortable appearing feminine in public.

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[17] LandInfo, 2014, p.2

[18] UNDP, Country Snapshots Pakistan, December 2012, p.1

The discreet MSM often tend to self-identify as *bakla* or gay only in the company of friends, partly because the less feminine an MSM acts, the less stigmatized and discriminated they feel. Transgenders have recently gained in confidence and have become more pronounced as a separate group from MSM. [19]

The latest size estimation of MSM in the Philippines was done in 2011 where it was estimated that there are between 390,733 and 689,529 (up to 700,000) males who have had sex with another male in the last 12 months, corresponding to 1.7% to 3.0% of total adult males.[20] In 2011, another finding indicated that of self-identified MSM, 51% reported to have ever sold sex, and 45% reported having sold sex in the last 12 months. [21]

5.2 LEGAL ENVIRONMENT AND SOCIAL CLIMATE

There are laws in place that criminalize MSM behaviors in many Asian countries, primarily in countries that were previously under British colonial rule. A number of countries have both Sharia Law, which is a form of Islamic justice, and the British legal legacy coded as Section 377 of the Penal Code. While it is uncommon for homosexuality to be prosecuted using common law, the greater threat is Sharia Law, which can be executed more rapidly, without due process, and with violence.

Understandably, these threats make MSM more likely to hide or dissemble their sexual orientation in their home countries. While there is an immediate threat to their personal safety due to these laws and practices, the other effect is the lack of sexual and reproductive health services for men who engage in male to male sex.

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[19] UNDP, Country Snapshots - Philippines, December 2012, p.2

[20] Ibid, p.2

[21] Ibid, p.2

Bangladesh

Section 377 of the Bangladesh Penal Code, a remnant of British Common Law, makes homosexual sex a crime punishable by imprisonment for life. Although legal action is rare, its presence deters those who engage in same-sex relationships and behaviors from coming out publicly and demanding their rights or protesting against discriminatory treatment. Bangladesh does not have official "Sharia Law" yet, but being a country with a Muslim majority where mullahs and imams have a strong influence on society and politics, the public view being propagated is that homosexuality does not exist in this country's conservative socio-cultural context.

This makes individuals who openly exhibit same-sex sexual orientation or a disparate gender identity from their birth sex subject to the full force of Islamic justice, which may include public humiliation, caning, or forced eviction from a village. Despite this social climate, intimate relationships between men are common, and sexual boundaries are crossed with relative ease.[22]

Yet there is support from civil society. The Bandhu Social Welfare Society (BSWS), established in 1996, acts as the main platform of the MSM community to "address concerns of human rights abuse and denial of sexual health rights, and provide a rights-based approach to health and social services for MSM, in particular kothis/hijras and their partners."

BSWS started as a small program in Central Dhaka and has expanded to provide social and health services to a broad range of 'Sexual Minority Populations' in 21 districts of Bangladesh. They played an important role in having sexual minority populations incorporated into the National Strategic Plan as well as the National HIV Response. The Coalition of LGBT in Bangladesh, which is the national LGBT network and includes MSM groups, has existed since 2009.

[22] Ibid, p.2

There are few other platforms for the hijra, MSW and MSM community apart from several clandestine online-based groups. These community-based organizations implement most of Bangladesh's MSM health outreach programmes. Law enforcement agencies are known, however, to impede these activities by harassing MSM outreach workers.

Pakistan

In Pakistan, sex other than that between husband and wife, including extra-marital heterosexual sex or male to male sex, is strictly forbidden by Sharia Law under the Hudood ordinance. Punishment can include up to 100 lashes or death by stoning. Pakistan also abides by Section 377 of the Penal Code of 1860. Punishment for someone caught engaging in same-sex sexual acts, namely sodomy, can be imprisoned for up to 10 years to life. [23]

While this punishment is rarely meted out, it creates a repressive atmosphere for those who identify as MSM or a gender other than their birth sex, limiting their ability to openly express their sexual orientation or gender identity, or access relevant rights. The most likely outcome for gay and bisexual men who are known by the police, especially male sex workers, is sporadic blackmail, harassment (including sexual harassment), fines, and possibly a jail sentence. [24]

The strict punishments of Sharia law apply in the districts of the Malakand Division of the Northwest Frontier Province, including lashings and the death penalty for sodomy. In parts of Pakistan, application of Sharia law penalties for homosexual conduct occurs periodically by tribal authorities, with reports of penalties of whipping having been applied for male-to-male sex in 1997 and 2005. There are no reports of the death penalty for homosexual sex in recent decades.

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[23] APCOM, Spotlight: Naz Male Health Alliance

[24] LandInfo, 2014. p.9

There is no National MSM network in Pakistan, but the Naz Male Health Alliance (NMHA), the first and only MSM and transgender community based organization in the country, was founded in 2011. HIV prevention efforts by the government which have targeted MSM have historically only focused on hijra sex workers and male sex workers, while activities for MSM, supported under the Global Fund, have been implemented by Naz Foundation International and other development agencies.

In a series of rulings in 2009, the Supreme Court of Pakistan held that transgender citizens should have equal rights and access to government benefits. The Court held that transgender people enjoy the protections guaranteed under Article 4 (rights of individuals to be dealt with in accordance of law) and Article 9 (security of person) of the Constitution of Pakistan. This is a ray of hope that the variety of sexual identities will be treated with respect and dignity in Pakistani society.

Philippines

While there are no laws or policies that discriminate people on the basis of their sexual orientation in the Philippines, there are also no laws or policies which explicitly protect people for their sexual orientation either. This means that localities can make discriminatory policies that target the lesbian, gay, bisexual and transgender (LGBT) community.

Furthermore, while there are no laws criminalizing homosexuality, local police are known to utilize other laws to harass MSM, such as using condoms as evidence of selling sex under the Anti-Trafficking law. On the other hand, the AIDS Prevention and Control Act of 1998 (RA 8504) of the Philippines forbids discrimination on the basis of HIV status. The Dangal National Network, which is the Philippines' national network of MSM and transgender people, was officially formed in October 2012 with the goal of addressing critical gaps in supporting and scaling up activities that reduce HIV and AIDS among MSM and transgender people.

The Philippine National AIDS Council has also recognized the needs of this community by incorporating the "National HIV and AIDS Strategic Plan for MSM and TG Populations 2012-2016" into its National AIDS Plan.

LGBT advocates have also been pushing for the enactment of an anti-discrimination law that includes the prohibition of discrimination on the basis of sexual orientation and gender identity and expression. Additionally, a number of local government units, like the major cities of Quezon and Cebu, have recently enacted anti-discrimination ordinances that protect and promote the rights of the LGBT community.

Destination Countries

Legislation in Arab countries criminalizes and punishes individuals for homosexuality or for performing homosexual "acts" or "acts against nature." These terms, however, are vague, and are left undefined leaving room for broad interpretation by police and courts. For example, such "acts" can include sodomy, which is also undefined, to dressing in women's clothing.

Article 534 of the Lebanese Penal Code declares that "all sexual intercourse against nature is punishable by imprisonment up to one year." In Qatar and Bahrain, Article 201 of the Penal Code calls for imprisonment up to five years for "male homosexual acts," while Article 194 of the Kuwaiti and Emerati Penal Code punishes homosexuality with prison. [25] In some Muslim countries, most notably Saudi Arabia, there are no codified laws prohibiting homosexuality. Instead, other laws such as Sharia Law are utilized to criminalize "homosexual acts" and punish offenders.

[25] Ferchichi., W., 2011

Saudi Arabia not only imposes incarceration, but also capital punishment such as flogging and possibly even execution. [26] In Saudi Arabia, under the country's strict interpretation of Sharia law, a married man engaging in sodomy or any non-Muslim who commits sodomy with a Muslim can be stoned to death.

> "For a married man the penalty is death by stoning, while the penalty for an unmarried man is 100 blows of the whip as well as banishment for a year. For a non-Muslim who commits sodomy with a Muslim, the penalty is death by stoning. Moreover all sexual relations outside of marriage are illegal in Saudi Arabia according to the Sharia law." [27]

In the United Arab Emirates and in Qatar, Sharia law applies only to Muslims, who can be put to death for extramarital sex, regardless of sexual orientation. [28] While the law has rarely been used, it has also been unsuccessfully removed. Singapore has a number of organizations which support LGBTcommunities and advocate for their rights, and has recently openly celebrated LGBT rights through the Pink Dot rally. Malaysia has also retained 377A and 377D, criminalizing sex between men. Although a Muslim country, Malaysia generally practices a more liberal interpretation of Sharia Law except in certain states controlled by the Parti Islam SeMalaysia (PAS) party. [29] Police are also known to harass venues and individuals forcarrying condoms in Kuala Lumpur.

There is no known MSM support group in Malaysia. [30]

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[26] Ibid

[27] "Violence Against the LGBT Community in the Middle East"; http://middleeasthomosexualviolence.weebly.com/current-middle-east-countries-homosexuality-laws.html

[28] Rupar, T.

[29] Robinson B.A., 2002

[30] UNDP, Country Snapshots - Malaysia, December 2012, p.2-3

5.3 HIV SITUATION: BANGLADESH, PAKISTAN AND PHILIPPINES

All three origin countries studied here have low general HIV prevalence and concentrated epidemics among MSM. These three countries also have high numbers of nationals going abroad as migrant workers, with indications that returned migrant workers contribute significantly to the national HIV incidence.

Bangladesh

Following the detection of the first HIV case in Bangladesh in 1989, the cumulative number of reported HIV cases at the end of 2013 stood at 3,241. [31] According to the 9th round of the National HIV Sero-Surveillance in 2011, Bangladesh still has a low prevalence of around 0. 1% [32], but the total number of people infected with HIV was estimated at 6,300, or double the actual number reported. [33] Prevalence is also generally low among key affected populations, although there are pockets of high prevalence in some geographic areas such as border areas. There has been low prevalence among men who have sex with men (MSM) and hijras, but sero-surveillance has not been consistent with this group over time. The majority of passively reported HIV positive cases have been among returned international migrant workers and their families, with recent data on PLHIV showing that out of 645 adults who were HIV positive and had been employed, 64.3% had previously worked abroad. [34] The rate of HIV infection among migrant workers may seem high, but there is also a reporting bias for this category because HIV positive migrant workers have most likely undergone mandatory HIV testing while abroad, received notification of their HIV positive status, and been deported. [35]

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[31] National AIDS/STD Programme, Bangladesh, 2014, p.37

[32] Ibid

[33] UNAIDS Datahub, "Bangladesh Country review", 2011, p.2

[34] National AIDS/STD Programme, Bangladesh, 2014, p.42

[35] UNDP, Country Snapshots Bangaldesh, December 2012, p.2 (quoting: APCOM Report, 2008)

In 2002, a study found that 3 out of 100 respondents reported that they have had MSM sex while abroad, and those three had not used condoms.[36] In 2007, another study found that around 4% of male respondents had had sex with another man while abroad. [37]

The government has just recently, for the first time, recognized migrant workers as a vulnerable population to HIV and AIDS by including them in the 2011-2015 National Strategic Plan. The mid-term review of the Strategic Plan has been done, and it showed that the main focus of interventions for migrant workers was on pre-departure orientation and provision of counselling for HIV testing services. It also found that the needs of migrant workers in destination countries and upon return have not yet been addressed. The National AIDS/STD Programme (NASP), under the Ministry of Health and Family Welfare, as well as concerned UN agencies and other stakeholders, have jointly formulated a "Plan of Action (PoA) on Migration and Health" with special focus on HIV for 2013-2015. The overall objective of the PoA is to uphold the health rights–physical, mental and social wellbeing – of Bangladeshi migrant workers. This PoA, however, has yet to be implemented.

Pakistan

HIV prevalence is still very low in Pakistan with the general prevalence at around 0.1%, but recent trends indicate an increase in prevalence among the most vulnerable groups. [38] The 2011 Integrated Behavioural and Biologic Surveillance (IBBS) conducted in 19 cities by the Government of Pakistan's HIV and AIDS Surveillance Project (HASP) confirmed that HIV prevalence rose to 27.2% among people who inject drugs (PWID), to 1.6% among MSW, and to 0.6% among female sex workers (FSW). [39]

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[36] Titumir, 2002

[37] Mercer, A., 2007, p.268–9

[38] UNAIDS Datahub, "Pakistan Country review", 2011, p.2.

[39] Ibid

In a study published in 2010, a survey was done with 396 MSM and transgenders. The results showed that 60% (165) of respondents reported being married, and 8.8% (35) reported being engaged in sex work. Of the 396 study respondents recruited across the three study sites (Karachi, Sangar, and Larkana), 385 were male-identified, 10.9 % (42) of whom tested positive for HIV. Of the participants recruited in Larkana, 18% tested positive for HIV, whereas this figure was 12.4 % in Karachi and 2.8% in Sangar.[40] In Punjab and Sindh regions where Naz Male Health Alliance (NMHA) has interventions, 2.53% of MSM who tested for HIV were positive in 2013. [41]

NMHA has noted that there is a growing phenomenon of boys in college and university selling sex to earn money for tuition. [42] There is also a nexus between male sex workers (MSW) and other populations. For example, it was reported that men who sell sex to other men also buy sex from women, and hijras who sell sex to men also buy sex from male sex workers. In 2007-08, a study showed that 9.5% to 15% of hijra sex workers had also reportedly paid a man for sex. [43]

At the end of 2013, Pakistan had an estimated 83,468 people living with HIV, with 7,568 PLHIV registered in 18 HIV centers and only 4,391 of them on ART. [44] Among those with HIV who have been identified as migrant workers, most have been deported from Gulf States for having been found to be HIV positive. Returned migrant workers with HIV are found in pockets in villages that have high numbers of men migrating abroad for work. The Khyber Pakhtunkhwa (KPK), for example, is an area that has had a total of 1,257 PLHIV registered, with 41.8% (526) identified as having been migrant workers.

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[40] Khanani, M. R., M. Somani, et al. (2010) as referenced in: UNDP Country Snapshots-Pakistan, 2012, p.2.

[41] National AIDS Control Program - Pakistan, 2014, P.32

[42] National AIDS Control Program, Pakistan, 2014. P.8

[43] National AIDS/STD Programme, Bangladesh, 2014, p.42

[44] National AIDS Control Program - Pakistan, 2014, P.41

As spousal transmission is a concern, it was noted that the spouses of 248 of those migrants were negative. [45] At the end of 2013, among the 819 on ART in this area, 28.9% (237) were returned migrant workers.

Philippines

The Philippines is among only nine countries in the world with an increasing HIV epidemic, registering an increase of over 25% in HIV incidence from 2001 to 2011. [46] 2013 HIV data from the National Epidemiology Center of the Department of Health puts the total cumulative number of confirmed sero-positive cases of HIV and AIDS at 16,516, which is only half of the projected number of actual HIV cases in the country based on the Department of Health's AIDS Epidemic Model.

Of this figure, 89% of the cumulative total were males, and more than half (52%) of the total reported HIV cases were between the ages 20-29. For the year 2013 alone, a total of 4,814 confirmed cases of HIV infection were recorded. In 2013, MSMs made up about 82% of the reported HIV cases for the year, and about 74% of the total reported cumulative cases. [47]

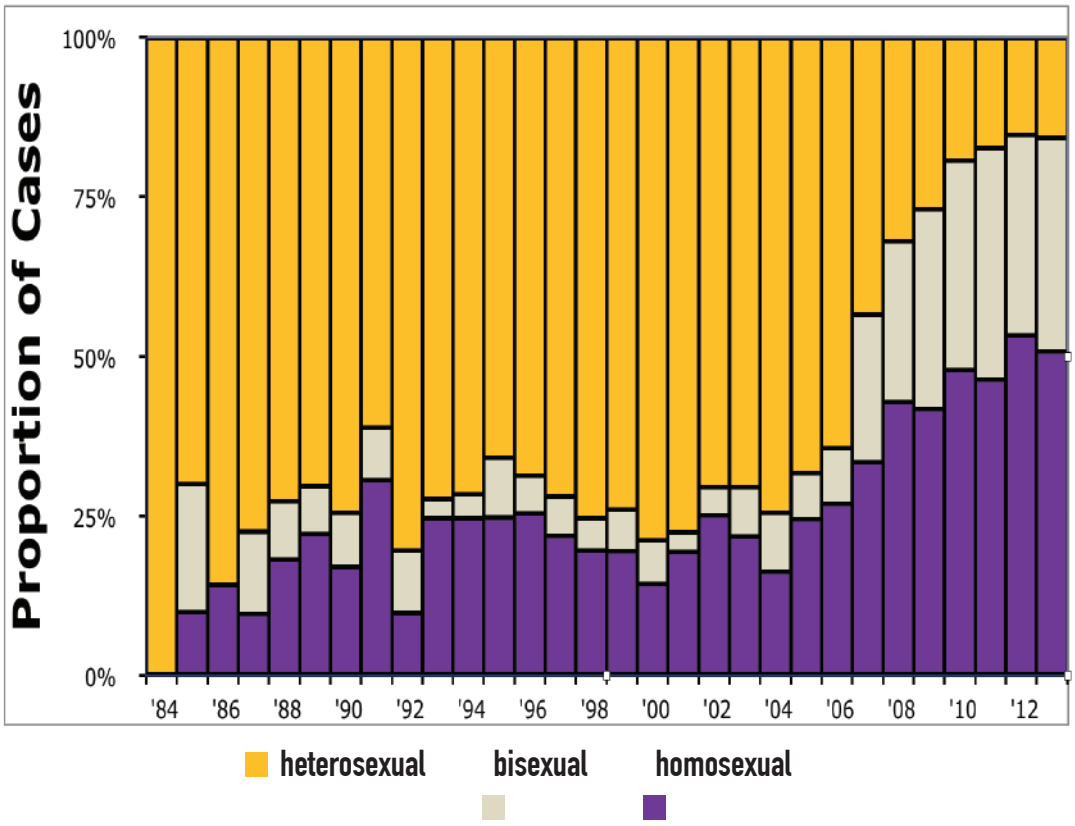
The current trends in the HIV situation in the Philippines show that a great majority of new infections are happening locally, and mainly among males who have sex with males (MSM).

[45] National AIDS Control Program - Pakistan, 2014, P.23

[46] Philippine HIV Registry, National Epidemiology Center, Department of Health, Dec 2013

[47] Ibid

CHART 1:
THE CHANGING DYNAMIC OF INFECTION THROUGH SEXUAL CONTACT IN THE PHILIPPINES



Source: Philippines HIV Registry, December 2013.
National Epidemiology Center, Department of Health

In the 2011 IHBSS, the percentage of men having anal sex in the sample was 61.5 %, while the reported use of condoms during last anal sex was only 34.1 %. Across six cities sampled, MSM were more likely to report condom use with a male partner over the last 12 months (37%) than with a female partner (21%), inferring that men who are bisexual could be acting as a bridging population. [48]

[48] The National Comprehensive HIV and AIDS Strategic Plan for the MSM and TG Population for the Philippines, 2012-2016., p.14.

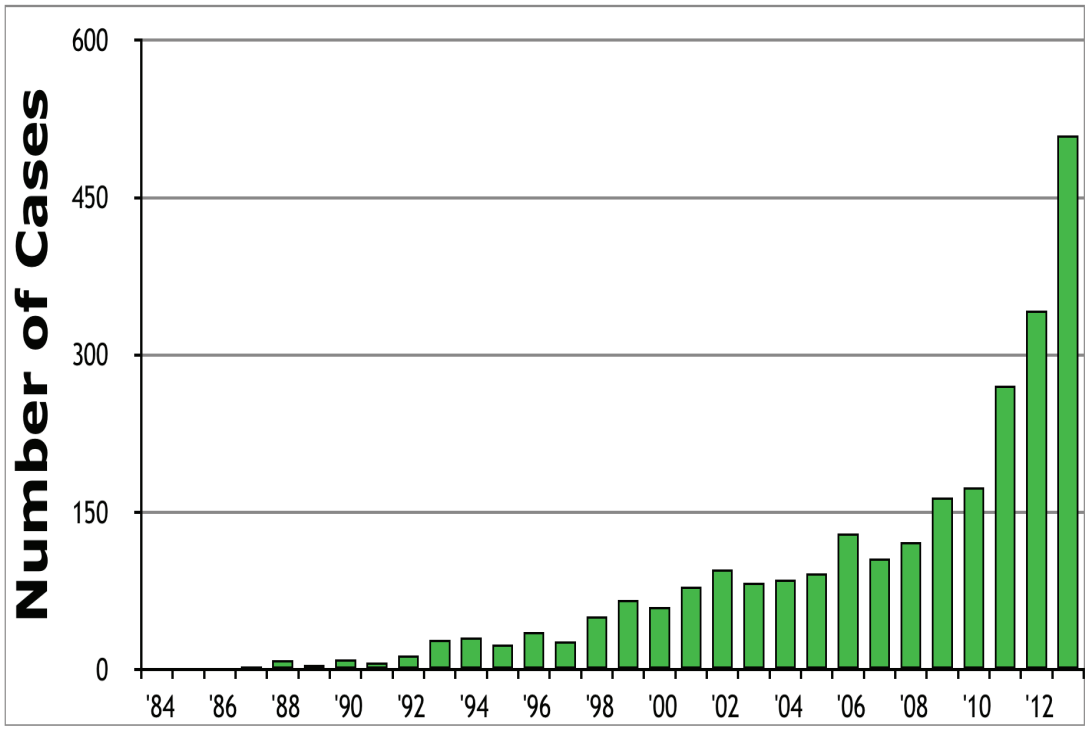
Overseas Filipino Workers (OFW) have always figured prominently in the country's HIV statistics. The first person to be diagnosed with HIV in the Philippines was a returnee OFW from the United States. Since then, OFWs have comprised as much as one-third of the total reported HIV cases and almost half of yearly cases.

As of December 2013, OFWs accounted for 11% of all reported HIV cases for the year, and 16% of all confirmed cases of HIV ever recorded in the HIV Registry. While no longer contributing as significant a portion, the actual number of OFWs getting infected with HIV has continued to increase. From January to December of 2013, a total of 509 OFWs tested positive for HIV - a considerable increase from the 122 confirmed HIV positive cases among OFWs in 2008.

Males comprised 80% of all HIV positive OFWs ever recorded, with 47% reportedly infected through unprotected male-to-male sex; 95% of the OFW HIV cases in 2013 were male, and 71% reported that they were infected through unprotected male-to-male sex. [49] This means that there has been a marked increase in the percentage of OFWs being infected through unprotected male-to-male sex over time. Anecdotal reports from the community of people living with HIV (PLHIV) have also pointed to an increasing number of OFWs being deported back to the Philippines for being infected with HIV.

[49] Philippine HIV Registry, National Epidemiology Center, Department of Health, December 2013.

CHART 2: NUMBER OF HIV CASES AMONG OFWs, 1984-2013



Source: Philippine HIV Registry, December 2013.
National Epidemiology Center, Department of Health

SUMMARY OF SITUATION AND CONTEXT IN BANGLADESH, PAKISTAN, PHILIPPINES

Indicators	Bangladesh	Pakistan	Philippines
Number of migrant workers going through regular channels in 2013	409,253 (85% male) [B]	622,714 (mostly men no official number) [B]	1,836,345 (45% male) [B]
Destination country or region by percent	81% go to Gulf countries; 14.5% go to Malaysia and Singapore[B]	94% go to Gulf countries; 80% of which are in Saudi Arabia and UAE[B]	44% in Gulf Countries of Saudi Arabia and UAE, 12% in Singapore and 2% Malaysia [B]
HIV prevalence among migrant workers	64% of adult PLHIV were identified as returned migrant workers (National prevalence 0.1%)[D]	No national numbers but one locality (KPK) showed 42% of PLHIV were former migrant workers[C]	11% of all known HIV cases were migrant workers in 2013, and 71% of those were infected through unprotected MSM behavior [C]
Estimated number of MSM nationally	32,967-143,065 (2010)[A]	2,285,500 (2010)[A]	390,700-700,00 (2011)[A]
% of HIV cases that are MSM (as portion of national epidemic)	N/A	2.6% (2008)[A]	61.3% (2011)[A]
HIV prevalence among MSM nationally	0.7% (2013) [D]	Local samples: 2.53% (2013) [D]; 10.9% (2009)[A] (MSM not in IHBSS)	1.7% (2011)[A]
No. of HIV-positive MSM needing ART	N/A	17,275 (2010)[A]	6,360 (2011)[A]
MSM reported having vaginal sex in last month	N/A	MSW reported having sex with FSW[A]	34% (2011)[A]
Government spending on HIV Prevention for MSM	N/A	US$738,492 or 4.8% of National AIDS Budget (2009)[A]	US$234,447 or 3% of National AIDS Budget (2009)[A]
National network of MSM	Bandhu Social Welfare Society	NAZ Male Health Alliance	Dangal National Network
Legality of Male-male sex	Illegal: Section 377 of Penal Code; Sharia Law	Illegal: Section 377 of Penal Code; Sharia Law (Hudood)	Legal (but no protections)

Source:

a) UNDP, Country Snapshots, "HIV and Men Who Have Sex with Men" December, 2012 (Bangladesh, Pakistan, Philippines);

b) Bureau of Manpower Employment and Training (BMET), Government of Bangladesh; Bureau of Emigration and Overseas Employment, Pakistan; Philippine Overseas Employment Administration (POEA), OFW Statistics

c) National AIDS/STD Programme, Bangladesh;
National AIDS Control Program, Pakistan;
Philippine HIV Registry, National Epidemiology Center, Department of Health

d) "Country Progress reports," for the Global AIDS Response Progress Report (GARPR) – Bangladesh, Pakistan

DISCUSSION OF RESEARCH FINDINGS

06

06 DISCUSSION OF RESEARCH FINDINGS

6.1 PRE-DEPARTURE

MOTIVATION TO MIGRATE

As with most migrant workers, the main motivation of respondents was to work abroad to make money. All the respondents felt they had more economic opportunities abroad and would earn good wages. "I dreamed of a prosperous life abroad," was how one respondent put it. Some wanted to go to exotic places and have new experiences: "I get to eat apples from different countries," said one respondent. "I mainly want to see the world," said another. Some respondents went to a specific country in order to follow a partner or because a family member or relative was there. There were also those who went, in part, to express their sexuality or escape a repressive situation back home. Some of the respondents even went with the intention to sell sex.

SEXUAL ORIENTATION PRIOR TO MIGRATION

Bangladeshi respondents, specifically, felt they could not express their sexual orientation at home, whereas the other nationalities could express their sexuality more so, although to varying degrees. Some of the respondents hid their status at home by getting married and having children. In many cases, they married under duress of the family. Others chose not to hide their sexuality, which commonly resulted in being ostracized by their family, although not necessarily by immediate family members. Two of the thirty-three (33) respondents from Pakistan were married; and two (2) of the twenty-five (25) Filipino respondents who were open about being MSM were married, one of who indicated he was bisexual with children from three different women.

The Bangladeshi respondents were most likely to be pressured into marriage, with eight of the thirty-two (32) MSM respondents who had migrated being married.

> *"I want to go away from my family."*
> *– Bangladeshi pre-departure migrant*

While there were those who self-identified as MSM prior to departure, a number of respondents discovered their sexual orientation while abroad. Some also identified as being bisexual at some point. Of the Bangladeshi respondents, only one (1) out of five (5) self-identified MSM returned migrant workers had had sex with other men before migrating. More than half of the respondents (25 out of 43) from the Philippines were openly MSM, and all but one (1) of the sixteen (16) Filipino respondents who were deported for HIV was openly MSM. However, some of the Filipino self-identified MSM had not engaged in MSM behavior prior to migrating. On the other hand, ninety percent (90%) of the men from Pakistan engaged in male-to-male sex prior to departure, with some also being bisexual.

MSM sexual roles that migrant workers engaged in before going abroad varied. In this research it was found that there was a mix of some being an anal inserter and some being an anal receiver, and that being effeminate or masculine did not necessarily correspond to a specific behavior.

STIGMA AND DISCRIMINATION

The levels of acceptance or rejection of being MSM differs in each country. The related stigma and discrimination also varies, but has a clear impact on the well-being of these MSM.

In both Bangladesh and Pakistan, MSM behaviours are expected to be hidden. All of the respondents from Pakistan who openly displayed their being MSM were not living with their families because they had been thrown out of their house. This was commonly a result of maintaining familial pride, and they were more likely rejected by relatives rather than direct family members. Being rejected by their family also influenced these MSM's decision to migrate. Many MSM respondents from Pakistan had even suffered verbal violence in public for acting effeminately. In cases of harassment or worse, the respondents felt that they were unable to go to the police for help. In Bangladesh, MSM who openly express their sexuality cannot go to the police because there are reports that police have sexually abused and raped MSM. Respondents from these two countries also felt that institutions, in general, treated them poorly, and specifically, they could not go to hospitals for health services as doctors would end up preaching Islamic values rather than provide them with medical treatment.

In the Philippines, there is more acceptance of MSM behavior than the other countries, but that does not mean there is no stigma and discrimination. Some MSM's families tolerate their open expression of being gay, but there are also many MSM who only feel comfortable being open about their sexual orientation with other MSM, but not with their families. Generally, the expression of gender is the main source of discrimination, especially in regards to physical appearance.

Being effeminately gay is partially accepted, but it is unacceptable to dress as a woman or to openly have a relationship with another man. Being a masculine MSM is preferred, as it is easier to avoid stigmatization and scrutiny. Regardless, it is more difficult for any MSM to conceal his sexual orientation once he has been infected with HIV and disclosed his status. Religion also matters. In parts of the country that are Muslim, gay men cannot openly express themselves. In Manila and other major cities or tourist areas, gay culture is generally tolerated but there is still discrimination.

AWARENESS OF MIGRATION REALITIES

One condition which contributes to migrant workers' vulnerability to HIV and rights violations when they go abroad is a lack of accurate information regarding the destination country. Prior to departure, migrant workers are commonly unaware of the working conditions they will face, cultural and social mores of the host country, basic rights and limitations, and how to access services. This is due to the lack of commitment from recruitment companies and government agencies that are primarily responsible for providing information to prospective migrant workers prior to departure to the destination country.

The depth, quality and content of pre-departure information provided varies. In some countries, for specific types of placement, information and relevant skills that must be provided to the migrant in pre-departure are clearly established in MOUs or bilateral agreements. For other types of general labor though, there are no established guidelines. The information that is provided is often narrowly focused on a specific aspect of migration, such as work duties or how to remit money home. There is commonly very little practical information provided on sexual health and HIV, and the information given may be very brief and lacking in contextual relevance to the situation migrant workers will find themselves in.

In general, outbound migrant workers receive little to no relevant information on the migration realities they will face in the destination country. Some migrant workers get information through word of mouth from previous migrants or family members who have been abroad, but again, the nature of this info is often narrowly focused on a certain aspect of migration and can be misleading or exaggerated. Although most migrant workers from Pakistan go to Saudi Arabia and UAE, only very basic information on these countries was provided. No information on culture or rights was provided to migrant workers other than "it is a good country for earning."

No advice was provided on ways to dress and how to present oneself in society. The respondents cited getting information from travel agents, peers and TV or other electronic media. "Travel agent was the only source of information for me, and sometimes I saw Dubai on TV". Some of the respondents from the group from Pakistan went through irregular channels while others went through recruitment agents, but no one reported having received pre-departure training.

Respondents from Bangladesh also said they had received little to no relevant information prior to departure. Some indicated they were informed by their broker of what kind of work they would do, their salary and living place, but in most cases the information provided was wrong or fabricated. One person indicated that he had gotten accurate information because he was going through arrangements made by his brother who was already abroad. Generally, there is already a perception among migrant workers about the social context in Arab countries, i.e. that they are very religious, conservative and abide by the Sharia law, while those going to Singapore consider it as a "free country."

Respondents from Bangladesh said that pre-departure trainings provided by the government mainly focused on sending remittances through the bank, warned workers not to violate local laws or get into politics, and encouraged them to follow their religion by being a good Muslim. It seems that there is a standardized training available which is supposed to last two hours. The contents include basic rules and "do's and don'ts" to be a good employee, as well as remittance management. However, many migrant workers do not receive any sort of pre-departure information at all. While it has been mandated that participation in pre-departure training is required to leave the country, there has only been fifteen percent (15%) coverage. Pretty much all respondents from the Philippines had received formal pre-departure training from government-accredited pre-departure orientation seminar (PDOS) providers.

The contents of the training included information about the strict rules and laws that govern Arab societies, and they had received information about working and living conditions from the recruitment agents. Seafarers received preparatory training as mandated by International Maritime Standards, but it was very technical. Many respondents also received information informally from family members who had been or were still abroad. This type of information was not covered by any formal agency and included things such as how interactions between men and women are limited, how easy it is to have sex with other men, and how to protect oneself against rape and abduction by Arab men and other migrant workers.

> *"Grow your beard so you don't look feminine to avoid unwanted attention from Arab men." - Former Filipino waiter in Saudi Arabia*

CHOOSING A DESTINATION COUNTRY

While the primary motivation to migrate for work is to make money, the selection of destination country and type of work may be influenced by a variety of factors. Respondents indicated that they chose countries where job opportunities matched their skills set, where there was possibility of high wages, and where there was high possibility of sexual encounters with other men. Other considerations included personal connections such as familial relations, having previously worked in a country, and having personal connections that enabled greater independence through sponsorship.

Respondents from Bangladesh indicated a variety of scenarios regarding country selection and employment, reflecting the diversity in educational range and skills. Those who were educated went on visas for opportunities that matched their skills set. Some of the respondents with lower educational attainment were employed as laborers working in factories, construction, as a driver and in a shipyard.

Some of these migrants were resourceful and found ways to work independently, including those who went through a "free visa" under the sponsorship system. In some of the Arab countries, the sponsorship system does not oblige the migrant to work under his sponsor, allowing the individual to work under others or even independently, simply by paying a fee to the sponsor. This is often issued through a recruitment agency, which gets clearance in advance of the migrant workers' departure. This arrangement is commonly organized by repeat migrants through individuals who they have met previously in that country, or through relatives who are working in that country. Other respondents mentioned being able to access MSM sex in Arab countries, but did not mention it as a main reason for selecting a country.

Respondents from Bangladesh who mentioned Singapore as their choice destination country identified the ease of having MSM relations in addition to job opportunities.

> *"…I will go to Singapore. I am an electrician. So I will be able to make more money there. I do not know much about this, but one of my relatives works there; he might help me. Abroad I can work and also meet my mental and physical desire easily."*
> *– Bangladeshi pre-departure respondent*

Most of the respondents from Pakistan were very independent. A number of them got sponsorships by going through recruitment agents and ended up doing service work, such as in a hotel or call center. Others went on a tourist visa and got small jobs and extended their visas. There were a couple of respondents who were students, and one who was a manual laborer. Many of the respondents indicated that they used their regular job status as a cover, which allowed them to do sex work on the side or even as a main money making venture.

Most respondents from Pakistan went to the GCC, either to UAE or Saudi Arabia, while other destinations mentioned included Malaysia, Thailand, Iran, India and New York. They indicated that the UAE was culturally similar to Pakistan, and that Iran and India were even more restrictive and dangerous for MSM than their home country. Dubai was singled out for having had negative experiences, even though it was the more glorious destination. "Cars, gold and clothes always inspired me to follow his way to Dubai." Prospective migrant workers indicated that they anticipated more freedom in expressing their sexuality while abroad.

Respondents from the Philippines did a variety of different jobs and went to a diverse range of destination countries. The diversity included doing administrative work in an office in a Gulf country, information technology (IT) in East Asia, and a health professional went to work in Singapore. A significant number of Filipino respondents went to the Middle East to work in the service sector, such as hotels and restaurants. Most went to Gulf countries because that is where the most number of jobs were available, and because the processing time for visas and work permits was the cheapest and fastest.

A significant amount of the world's seafarers come from the Philippines. Reflecting this, thirty-seven percent (37%) of respondents were seafarers, with most working on cruise ships. A significant number of MSM respondents chose to work on cruise ships in part because of opportunities for male-to-male sex as well as the job oriented benefits. Some cruise ships may even have openly gay crew members, but it is not possible to openly engage in MSM behavior on other types of ships.

AWARENESS OF HIV PREVENTION IN THE CONTEXT OF MIGRATION

While many MSM looked forward to engaging in sex while abroad, most were severely unprepared with proper knowledge about HIV and how to prevent infection.

Generally, there was little accurate information on HIV available publicly through mass media, and a disappointing amount provided during pre-departure trainings. The little accurate information provided, and without the proper context, inadvertently increased the risk of HIV infection. In the Philippines, many respondents indicated that they knew about HIV prior to departure but did not think that it was relevant to them or that they were at risk of HIV.

> *"I knew nothing about HIV and AIDS until I was infected,"*

> *"I have heard about [HIV], but I was not interested to learn about it."*

> *"I knew that HIV is sexually transmitted, but I thought you could tell who were infected."*

Many believed in common misconceptions. One person thought you could visually tell who was infected and came up with a simple rationale: avoid those who were unnaturally thin and only have sex with men who were chubby. Another person thought only other nationalities (meaning not Filipinos) had HIV, so he only had sex with other Filipinos. Sources of information respondents identified included: mass-media, pre-departure trainings, and for a few with the most accurate information, through medical courses at school like nursing and physical therapy.

The RA 8504 requires that all Filipinos about to be deployed for overseas employment undergo HIV orientation. There were participants who said that even though they received pre-departure training, they did not receive any information about HIV and AIDS, or could not remember it. Senior officers gave HIV information to their junior officers onboard ships and seafarers generally received accurate HIV information provided by the recruitment agency as part of strict maritime standards, although the information was not contextualized in the experiences of migrant workers nor of realities faced by MSM.

While there are a number of HIV support organizations working with the MSM community in the Philippines, none of these address the issue of MSM in the context of migration. Similarly, organizations providing support for returned HIV positive migrant workers do not have specific services for those who are MSM. These two separate streams leave a gap in HIV prevention for prospective MSM migrant workers.

In Bangladesh, vague, scare-oriented messages are transmitted over the TV, such as, "If you want to live, you have to know." But reportedly, the male migrant workers only knew that condoms were associated with contraception.

> *"I had no idea about any personal risk including HIV. One thing was in our mind -that we had no chance to get pregnant."*
> *- Bangladeshi MSM migrant worker*

The two-hour pre-departure training in Bangladesh mentions HIV but does not allow room for discussion or questions. Supposedly the session provides general information on how HIV is transmitted, but more commonly reverts to moralistic and religious teachings on refraining from engaging in sex. There are also printed materials on health, HIV and migration from the International Organization for Migration (IOM) which are given as a handout since 2010, but many of the migrant workers have low literacy and are unable to read or understand it.

One-third of the respondents from Pakistan knew about HIV and had heard of AIDS, but did not clearly understand the information. Only one out of thirteen knew any details about transmission. For the rest, they only knew that "AIDS kills you." An example of the information provided in the media is a recent public TV spot which said: "AIDS is incurable, be careful."

Respondents revealed they did not receive any formal pre-departure training from a formal institution or government department.

> *"HIV information..?....(laughs) there was no training…"*

The most accurate information on HIV came from CSOs, but, even these MSM service providers seem to lack information about HIV risks specifically in the context of migration.

AWARENESS OF LAWS AND POLICIES IN DESTINATION COUNTRY

With many self-identified MSM going abroad with at least some intention of engaging in sex with other men, it was interesting to note a high awareness level about punitive policies or laws including religious laws/ edicts that punish men for engaging in MSM behaviors in host countries. On the other hand, there was a low awareness regarding policies on HIV testing and related deportation.

Respondents from the Philippines mostly knew about the policy that prohibits MSM behaviors in Arab countries. Also, most knew that it is not easy to access women for sex in GCC countries but that it is easy to access men. Many of the respondents from the Philippines also knew about mandatory HIV testing through word of mouth.

Respondents from Bangladesh and Pakistan both knew that it is not easy to access women, and is in fact punishable to have sex with a woman out of wedlock, but that it is easier to access men for sex. They also knew about anti-sodomy laws in GCC and were especially familiar with Sharia law. At the same time, they also felt there was more personal freedom in these countries which allowed for MSM sex. The migrant workers knew that there was a health test and that their blood was tested, but none knew that they were tested for HIV.

6.2 DESTINATION COUNTRY

Commonly, the reality migrant workers face in destination countries differs greatly from what was described back home. Agents are known to mislead prospective migrant workers with falsities or exaggerations. Sometimes even other returned migrants, whether family members or friends, may provide misleading information to cover up their own difficulties out of embarrassment or pride. Regardless of the accuracy of information provided in advance, migrant workers tend to face numerous challenges while abroad, from demanding working conditions, unsanitary or crowded housing, to loneliness and abuse.

They also have positive experiences that they would be unable to have at home, which is part of the allure of going abroad for work. Most notably for these respondents this meant having male-to-male sexual encounters. Generally, the respondents here were not prepared for the realities they were to face, and many had unrealistic visions of what to expect.

> *"I thought I am migrating to Heaven, where I will achieve my ambitions, but…." - Respondent from Pakistan*

CULTURAL ADAPTATION AND STEREOTYPES

Those from the Philippines had the greatest difficulties adjusting culturally. For Filipino migrants working in the Middle East, the food and climate were significantly different from home. The difference in religion, with most respondents being Catholic, also caused tensions. Filipino respondents felt that there was significant competition with workers of other nationalities. On the other hand, the MSM Filipino migrants also felt that they had an advantage, because they had good English speaking skills, which provided them with more opportunities for work and sexual encounters.

With significant numbers of Filipino men engaging in male-to-male sex work on the side, Filipino men have been saddled with a stereotype of being easily available for sex, which is beneficial for those who are engaging in sex work, but also dangerous, as it makes all Filipino men a potential target for sexual harassment and abuse.

The respondents from Pakistan and Bangladesh, being from Islamic countries, felt that the culture in GCC countries was similar to their home culture. They could learn the local language quickly as they had learned Arabic in order to read the Quran, and they were quite happy with the Halal food. MSM respondents from both countries also indicated that they felt they had more freedom to express their sexuality and meet men in the GCC countries than at home. However, respondents from both countries indicated that they also suffered stereotypes, with those from Pakistan being known as "taxi driving rapists," and those from Bangladesh being known as being "poor people."

LIVING CONDITIONS

Bangladeshi male migrants who worked overseas in construction and factories lived in dormitories with single beds. Some of the respondents indicated that this sort of arrangement was conducive to furtive male-to-male sex, where they would wake up some nights and find that they were receiving 'special attention' in the middle of night.

> *"I used to work in a factory and lived in a quarter given by the company. One night I found one of my co-workers came to my bed... I surrendered to him out of fear of him disclosing to others. At the end I liked it and so it continued…"*
> *– Respondent from Bangladesh*

Other respondents, who had more liberty in their living arrangements such as in Singapore, indicated that MSM could rent and share a room or house and live as a couple. Similarly, with greater freedom in housing, MSM migrant workers could also increasingly engage in risky behaviors. For example, there were reports of more established men who had been in the destination country more than five years and rented a room where they brought newcomers to take advantage of and even rape. Another respondent indicated that he did sex-work and rented an apartment where he brought clients; he even hired a guard.

Among respondents from Pakistan, the numbers sharing a room often coincided with their lifestyle and income. Those who were primarily sex-workers lived in good places, often with only two to three people sharing a single room. For those who had a primary form of employment and were only doing sex work on the side, they would live eight to ten men in a room. Men from the Philippines working in the service sector would share a room in a dormitory together, whereas those working construction would stay in an interracial dorm with migrant workers of other nationalities. Those with higher salaried positions could stay on their own.

SEXUAL NETWORKING, FINDING PARTNERS

When it comes to socializing, respondents from all three countries found it relatively easy to meet other men for sex. Respondents from the Philippines indicated that it was very easy for them to meet men while abroad, especially in Gulf Countries. At home they may have been considered unattractive or were the ones who had to pay for sex. In the GCC, local men and of other nationalities found them attractive and were willing to pay them for sex. One respondent shared,

> *"Given the way I look, men ignored me [in the Philippines]. But [in Dubai], men were lining up to have sex with me."*

The respondents from all three countries usually meet their sexual partners in public places like shopping malls, groceries, along the streets, in parks and beaches. They also hook up at work or in their living quarters. Clubs and bars are a popular hangout according to the Bangladeshi respondents, especially for those who are looking for clients for sex.

> *"I would be walking down the street or hanging out in beaches, or even buying groceries and locals would follow me in the grocery or a car would stop alongside us on the road and ask us to take a ride with them. Sometimes they just invite you to dinner or offer to give you a ride home, but you know what they really mean."*
> *– Filipino respondent from Saudi Arabia*

The internet, through social networking and dating sites, is a convenient way to meet sexual partners and clients. Local men would send random messages online through Facebook such as, "Hi, I'm from Jeddah. I will pay you. Tell me how much." Some migrant workers used social networking proactively. Even before departure, one research participant said that he would search sites for "bookings".

> *"Before I am scheduled for deployment, I would go online to announce that I would be reaching that country on these dates. Then I wait for people to respond if they are interested. I also search the Internet for bath houses, gay clubs, and cruising sites in the country I am bound for."*
> *– Filipino respondent from Malaysia*

After having had some experience, many of the respondents found it easy to find new clients through local networks. Sometimes clients would make a recommendation to their friends, or other MSM migrant workers would pass on their clients to friends.

These respondents also utilized social networks, including Facebook, to give out mobile phone numbers and pass on references for clients. Some clients would give a fee for referring them to another Bangladeshi man selling sex, resulting in clients being passed on to others in their social network.

> *"I was surprised when a stranger just called me up and he said that his friend told him that he had a good time with me."*
> *– Filipino respondent from Saudi Arabia.*

The sexual acts can happen anywhere and with men, or even women, from a wide range of backgrounds. The Pakistani respondents who engaged in sex work said that most of their clients were also fellow Pakistani but they also had clients among the locals and other nationalities. One respondent who was a manual laborer admitted to having sex with Filipino guys, but only as a top. Some of the Pakistani respondents had sexual relations with both men and women while abroad.

> *"…women enter our living places without knocking the door at holidays and ask for sex for 10 Riyals."*

Sex also commonly happened among roommates and co-workers. This was enabled by the sharing of beds, with eight to ten men in a single room. Those who had their own apartments would invite their partners or clients over for sex. Hotels are also options for the respondents who worked in more open cities or countries like Singapore. Sometimes, the encounter was unexpected and unplanned but since the opportunity has presented itself, sex also takes place in cars or in bathrooms of public establishments. These sexual relationships sometimes lead to steady romantic relationships.

Other than sex, it is common for these men to exchange favors with each other like washing each other's clothes during days off or cooking for each other. For those who engage in sex work, when the encounters develop into romantic relationships, the payments for every sexual encounter also stop and take the form of gifts or monthly allowances.

MOTIVATIONS FOR ENGAGING IN SEX AND HAVING MULTIPLE PARTNERS

The choice to do sex work was motivated primarily by a desire to make money. "I can earn extra income through sex work." "…there's money to be had and we need the money," were common refrains from respondents from all three countries. Sex work for MSM in the Gulf Countries is lucrative. In the UAE, the usual cost for a sexual encounter ranges from 1,500 to 2,000 AED (US$400-$540). In Saudi Arabia, the cost ranged from 300 to 1,000 Riyals (US 80-265). "My salary was small. I needed the money." In some cases the men went with a clear intention to do sex work; for others the choice came by chance or necessity.

> *"I was 23 when I first went to Saudi. I never had any sexual experience in the Philippines, so I experienced all that for the first time in Saudi. I did it with other Filipinos from work. Later on, I realized I could earn money from it. So whenever they would approach me to have sex, I would say, 'Sure, get in line,' and go with the person with the highest offer."*
> *– Filipino respondent from Saudi Arabia*
>
> *"[Engaging in sex with the locals in exchange for money] was the norm when I got there." – Filipino respondent from Dubai*

Some saw selling sex as a win-win situation where they could have pleasure and get paid for it.

"…While working, my boss came close to me and either touched my hands or rubbed my back with his penis. I used to have sex with men before my migration to Saudi, so I realized easily what he wanted. I negotiated with what he would give me if I agreed with his proposal. I benefited doubly – meeting my pleasure and also earning extra income." - Bangladeshi respondent

Some of those who engaged in sex work may have had more than one partner in a day. Some also had regular partners. Filipino respondents said that they had around two (2) to twenty (20) different partners in one month, but they did not necessarily always have penetrative sex as it depended on what satisfied the client.

There were respondents who had steady boyfriends and said that they were monogamous, while most of the other respondents indicated that they had multiple sex partners, especially if they sold sex. There were some men who were monogamous but whose partners may not have been, and there were also those who were in a relationship and sold sex.

"……I had a Lebanese friend in Saudi Arabia…He seduced me to have sex with him. That time I had no orientation about sex with men… We continued the relationship two years until I came to know about his relations with other men. I left him but I could not stop having sex with other men." – Bangladeshi respondent

Engaging in sex work often necessitated having multiple partners. They also liked to find new partners regularly: "If I have sex with a guy once it feels like I already got what he has to offer and I know what he has got, so I always try to find [someone] new," said one respondent from Bangladesh.

Most respondents were anal receivers. They could also get more money for being the receiver. Some of the respondents also identified as being "versatile" as either inserter or receiver. A number of those who are receivers said that they are motivated to have different partners in order to experience large penis size. "Bigger penis causes joy… Smaller causes pain…" joked one of the respondents from Pakistan. There were respondents who also just wanted to have a lot of sex. One respondent from the Philippines revealed that he had an average of 20 sexual partners in a month, but he did not do it for the money. He said, "It was just sex."

ACCESSING AND USING CONDOMS

Although limitations faced as migrant workers affected the respondents' ability to practice safer sex to some degree, poor knowledge, contextual factors and behaviors had greater influence.

Condoms are available to varying degrees in the Arab countries where the research participants worked. In Dubai and Qatar, condoms are displayed on shelves in convenience stores, supermarkets and pharmacies where customers can easily pick them up, while in Saudi Arabia, condoms can only be purchased from behind the counter by married men. While this made it more difficult for migrant workers to purchase condoms on their own in Saudi Arabia, it was not impossible, and a couple of respondents from Bangladesh had help from friends who worked at a pharmacy.

In general, all the respondents indicated low condom use. Although it seemed that condoms were accessible, they did not like to buy them, in part because in certain countries it was difficult. The Filipino respondents also indicated that the condoms were too large to fit properly. The Pakistani respondents indicated few problems purchasing condoms, but cited the inconvenience of carrying a box of three and preferred to buy condoms individually.

Other factors that affected condom use included having multiple sexual partners, sometimes at one time; the desire for intimacy in romantic relationships and issues of trust; and the usual excuses that condoms are inconvenient, destroy the mood, and limit pleasure. There was a lot of random and unplanned sexual encounters among the Pakistani group, which made using condoms inconvenient due to the spontaneity and location. Many respondents who were receivers preferred not to use condoms because it diminished pleasure, especially with bigger penises.

There were also misconceptions about risk. Pakistani and Bangladeshi respondents were not aware of the risk of HIV transmission from having sex with men. They did not know about the HIV prevention benefits of condoms and many thought condoms were only for contraception. Most Filipino respondents said that they were not so concerned about the danger of getting infected with HIV, but were more fearful of getting caught having male to male sex. There is also the factor of diminished capacity to make decisions about safer sex because the respondents are already intoxicated with alcohol or drugs. The respondents from Pakistan shared that weekends were declared as 'fun days' and commonly included sharing pornographic videos, drinking alcohol, using drugs, including hashish and heroin, and buying or selling sex.

Considerations of being the receiver for paid sex was also significant, as the choice to use a condom often depended on the paying customer, who was usually the inserter. Some respondents reportedly were prepared with condoms for their customers, and in many cases lubrication was used during sex, but it is unclear how often they used condoms. Those who were paid to be receivers felt that they had no power to negotiate for condoms. If the customer was an inserter and brought a condom, they would accept it. None of the Bangladeshi respondents carried condoms. One Filipino had a condom break when he was a receiver. This made him fearful of pieces being left inside his anus, so he refused to use condoms after that.

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

NAVIGATING PUNITIVE LAWS ON MSM BEHAVIORS

Respondents exhibited varying levels of understanding about policies and laws that prohibit MSM behaviors in GCC and other destination countries. In the Philippines, all respondents knew that such behaviors could be punished by imprisonment. Half of the respondents from Pakistan were of the view that there are no laws prohibiting MSM practices.

"If there are laws, how come we can easily find MSM and gays present at roads, malls and in hotels for sex work?" – Respondent from Pakistan

Others felt that being Islamic countries, GCC countries have strict punishments and laws against MSM, and to avoid punishment they simply have to be extra careful when engaging in MSM behaviors.

Although laws are in place prohibiting male-to-male sexual behavior in all the destination countries in this study, there was common knowledge among respondents that it was relatively easy to engage in MSM behaviors in these countries. As long as it is not done publicly and no one gets caught, there are local men who regularly engage in MSM behaviors with foreign men.

"In their culture in Saudi Arabia, it is more difficult to have casual sex with women so their other option is to do it with men. Besides, it's not something you do in public because you know you will get caught."

"Even when it's prohibited, they're the ones who entice us."

"(It seems that) male-to-male sex is very common in their culture because it is not so easy to have casual sex with women. But because it is taboo, they do not broadcast it even though it is happening widely."

– Respondents from Philippines

The problem is that while many men engage in MSM behavior, there is a very real threat of corporal punishment if they are caught. This places migrant men who engage in MSM behaviors in a bind. Besides making it virtually impossible to maintain their sexual health, they are also reluctant to report any violations or abuses that may occur when engaging in MSM behaviors. There are local men and other migrant workers who understand this and use it to their advantage.

CASE STUDY: FAIZI (FROM PAKISTAN)

Faizi was born to a poor family in Punjab. Financial constraints stopped his education at grade 5. He started earning a livelihood from early childhood, but never found a regular job. From his early childhood he endured sexual abuse by his cousins, and later engaged freely in sexual practices with other boys.

Over time, the monetary benefits and other gifts from his sexual partners were an attraction to engage more in MSM behaviors. He eventually did sex work as a source of income. He freelanced and had sex with multiple male partners over time, yet never used condoms during sexual intercourse. At the age of 16, a family friend offered to help him migrate for work.

He accepted the offer and after a few months flew to Qatar and found a job. After six months he went to Dubai and became a waiter in a hotel with the help of his friend. The salary was less than his expenditures and compelled him to engage in sex work for extra income. Initially, he started to visit parks and shopping malls to find customers after working hours. With the passage of time he made many connections and became quite popular among his sexual network. He never used condoms, but sometimes used lubricant.

Being a "receiver" he liked his sexual partner to have a large penis size. He never considered himself at risk of STIs or HIV and AIDS because he was unaware. The only risk he assessed from his MSM behaviors was being arrested by an undercover police officer. Faizi was in love with an Arab boy who occasionally visited his hotel and had sex with him.

Once, the boy asked him to come to the beach with him for a party. He took Faizi to a wooden cabin at the beach, where five men were already waiting. "They asked me to have sex with them all, but I refused and tried to escape. They pointed a gun at me and beat me badly. They threatened to kill me and then all of them raped me, and at midnight left me far away from the place at the beach. They snatched all my belongings including cell phone and cash." He did not report this incident to the police for fear of being arrested. "The police would have arrested me rather than the Arab boys."

He had to quit his job at the hotel because those abusers used to visit that hotel frequently and he feared for his life. After a few weeks, he returned to Pakistan. He is currently 25 years old and unmarried.

Faizi has been tested for HIV and is currently negative.

SEXUAL VIOLENCE

Sexual violence stalks migrant men who engage in MSM behaviors in Gulf countries. Even though there are limited news reports, [50] migrant workers are aware of the threat through word of mouth. Yet, they remain vulnerable. Those engaging in sex work are most vulnerable to sexual violence. Migrant workers from the Philippines and Bangladesh also seem especially susceptible. For example, five (5) of the Filipino respondents who had been abroad had experienced sexual violence.

Bangladeshi respondents reported being victims of gang-rape in the UAE.

"…One day I was going back home walking by the road side. A car stopped and asked me if I needed a lift. I agreed with his offer. When I entered the car, the man took me to the desert where I found another eight guys who all raped me and left me in the desert."

A Pakistani respondent doing sex work went to have paid sex with an Arab man. They negotiated the price and once in the car, the man took him far away to a remote area where he was raped by six other men who were waiting for him.

[50] Littauer, D. 2013; Mabuhay Radio, 2007

CASE STUDY: YAN (FROM THE PHILIPPINES)

Yan was married with two children when he left the Philippines to work in Saudi Arabia as a tailor. After two contracts, his situation at work started to go bad. His salary was delayed, sometimes for months. He talked to his employer about the situation and suggested that his employer allow him to look for another job and another sponsor. His employer refused to let him go, so Yan decided to run away because his family needed his regular remittances. He became an undocumented worker, trying different kinds of work but never getting a regular contract because his sponsor did not release him.

In a clothes shop where he worked as a tailor, he met a man - a Saudi national who was a regular client. They became friends and the man invited him over to his house. When Yan got there, he saw that the house was in disarray. He felt bad for his friend so he put things in order. After that, he went regularly to his friend's house and would even sleep there. He took on housekeeping roles for his friend and his friend gave him generous tips whenever he had his clothes made or repaired at the shop when Yan worked. Their friendship flourished until Yan ended up living with his friend.

Yan was cleaning the house when his friend invited him to watch TV. It turned out that his friend was watching porn. After that his friend asked him if he wanted to try out what they were watching. Yan agreed. It was the first time he was exposed to porn and to male-to-male sex. He found that he enjoyed it. After that, they became lovers and Yan considered it a romantic relationship. But after eight months, it became a nightmare. "I came home to find him with several friends. They were having drinks. I went straight to the bed room. He came after me and told me that he and his friends wanted to have sex with me.

I said I did not want to have sex with all of them. But he kept pressuring me and then his friends came and held me down. They took turns on me. There were eight (8) of them. I kept begging them to stop because it was so painful. They only stopped after they got tired. When they went to sleep I escaped. I left that house and never went back.

I was lucky to find an employer after that gruesome experience. My new employer was willing to give me a visa so I could start over and be properly documented. As a requirement before I could get my work permit, I had to undergo HIV testing. I tested positive for HIV. At that time, I had no idea what HIV was. But I did recall that my former boyfriend, the one who had his friends rape me, once told me that he had HIV. I ignored him when he told me this because I did not understand what he was saying. When I was diagnosed, I remembered what he had said to me. I was sent back to the Philippines after the diagnosis."

Although many of the perpetrators are local men, there are also migrant workers who prey upon other migrants. For example, it was reported that there was one long-residing Bangladeshi migrant in Singapore who had his own apartment. He would make good relations with newcomers, spend time with them and help them out. Later he would invite them to his place and rape them. There were also unsubstantiated rumours of Pakistani taxi drivers abducting and raping Bangladeshi and Filipino men.

Those who have experienced sexual abuse, particularly in the hands of locals, are too scared to file cases because they are also liable to be punished for being MSM. There is still a strong stigma around sexual abuse, in general, and the respondents feel that the shame is greater for male victims.

SEXUAL HEALTH

Another danger that haunts MSM migrant workers are sexual health problems. Generally, respondents had poor information regarding sexual health and no knowledge of sexually transmitted infections (STIs). Migrant workers' health insurance did not cover STIs. In fact, they could be deported for having an STI, especially HIV infection. As a result, MSM migrant workers avoided public health services. They also felt that if treatment was not covered by health insurance, it would cost too much to go to a private health service provider. Commonly, they consulted each other on how to treat STIs. Some reported taking pain relievers when they had symptoms.

Some migrant workers were savvy when it came to seeking health services though. Knowing that one of the potential consequences of having a health problem is deportation, some of the South Asian respondents reported seeking out South Asian doctors. A Bangladeshi respondent said,

> *"….Once I had an infection in my penis and I went to an Indian doctor privately in Saudi Arabia and he gave me some medication (injection and medicine) which helped me and the infection recovered quickly."*

In some countries, as long as they were properly documented, respondents indicated that they could go to private health care providers for treatment. One respondent had an STI and went to a private hospital in Dubai. There he had to pay a high price, but did not have to worry about being reported to the police.

In another case, a South Asian doctor advised one Bangladeshi patient to return home after treating him. It appears that the doctor tested his blood but did not tell the migrant he was infected with HIV, only to go home as soon as possible.

A few of the Pakistani respondents indicated that when they had STIs, they went to a private clinic with a Pakistani doctor. However, both at home and abroad, these men faced stigma and discrimination by doctors. Respondents reported being chastised by doctors and having the doctors preach about upholding Islamic values and being more devout. Some doctors brought in other doctors to look at the "MSM specimens." This further discouraged these respondents from accessing testing for HIV and other sexual health services, and resulted in delaying or avoiding treatment when they got sick.

MANDATORY HIV TESTING

While most respondents feared laws against MSM behaviors, none reported facing any legal consequences. On the other hand, policies on HIV and migration had a very direct and negative impact on many respondents. Many destination countries where migrant workers from these three countries go, including GCC countries, as well as Malaysia and Singapore, require health screening that includes HIV in order to receive a work visa. The health screening is done without proper consent, and commonly without any information provided on what conditions are tested.

Migrant workers are processed in production-line style testing where the medical tests are done on one prospective migrant after another as efficiently as possible. This means there is no time available to ask questions or provide counseling. As a result, most migrant workers can only tell what test procedure was done, such as urine analysis, blood tests, and x-ray. When a migrant does find out his result, it is usually only indicated as being deemed "fit" or "unfit." If that person is in the home country undergoing this testing as part of the pre-departure process, and is found to be HIV positive, under good conditions, he will be notified that he is "unfit" and referred onto an HIV organization or other health facility for confirmatory testing and counseling.

In the worst cases, the migrant is informed straight out that he is infected with HIV and is "unfit" without any other information or services provided.

Migrant workers must also undergo this health testing once they are in the country of destination, sometimes upon arrival. Depending on the destination country and type of work, health testing which includes HIV and STIs is done regularly, usually once or twice a year and every time the migrant worker renews his work visa. If a migrant worker is found to be infected in the destination country, he may be detained or quarantined and then deported.

As the health testing makes no attempt to uphold confidentiality, the employer, police, health and immigration agencies are notified when a migrant is found to have HIV or an STI. In some cases, the migrant may be informed before authorities arrive, and is able to flee; in other cases, migrant workers suffer the indignation of being apprehended and treated as a criminal for their HIV status. However, migrant workers are resourceful, and even those who know their HIV status have found ways of entering countries without having to undergo health testing. The problem with this is that it puts them and their partners' health at risk because they are unable to access treatment and condom use is generally low.

As is the case with most migrant workers, most respondents from the three countries who were former migrant workers were completely unaware of the health testing requirements or the fact that they included HIV testing prior to migrating. [51] Some of the respondents were aware that health screening was a process that they have to undergo if they want to work abroad. However, the perception is that it is just a requirement that determines whether they are "fit" or "unfit" to work abroad.

[51] CARAM Asia, 2007

The respondents from Pakistan who were aware of these testing requirements were those who were members of the MSM network. Those from the Philippines know that they will have to undergo a medical exam but are unaware of the consequences of having an STI or HIV. In other words, not only were these men unaware of the risks they were taking with HIV infection, they were also unaware of the potential impact it would have on their migration status and livelihood.

Migrant workers who underwent testing in both origin and destination countries verified that they did not see the test result sheet with the list of conditions tested at any time, and no one received post-test counseling when they received their results. Respondents from the Philippines who tested HIV positive at home when they were re-migrating indicated that they realized that they had been tested for HIV only when they saw the referral form. In the destination country, no one who was HIV positive received their test results. They were simply quarantined and eventually deported.

> *"Somebody from the hospital called me and told me to go to them because they said there was a problem with my blood sample. I was confused. Even my sister was confused why I was being asked to go to that hospital when that was not where I had my test. So, I called my employer and he accompanied me to the hospital. He told me to go through a certain door where the hospital staff met me. They made me take off my clothes to change into the hospital clothes. Then they told me to enter a room and once I stepped inside they locked the door behind me."*
>
> *– Filipino respondent from Dubai*

Some employers may have a say as to whether or not their employees are tested regularly, and may even have some influence on the inevitable outcome for those who are tested HIV positive.

A recent example comes from a high-level employer in Saudi Arabia who allowed the Filipino respondent to complete his contract after testing HIV positive. After his contract ended, the Filipino respondent went to the UAE to find work but was subsequently tested for HIV and deported as a result.

A few migrant workers indicated that they underwent voluntary HIV testing. This was rare and usually entailed having a clear suspicion of being infected. One example was a Filipino respondent who was working in Dubai and decided to get tested after his partner tested positive for HIV and was deported. When the respondent asked the doctor if he could be tested for HIV and not report the results if he was positive, the doctor responded that he was obligated to report the result. So, he decided against taking the test. Unfortunately, later he had to undergo the health test for a work permit, was found to be HIV positive and was deported.

DEPORTATION DUE TO HIV STATUS

Twenty-one (21) of the Filipino migrant worker participants who were HIV positive had been diagnosed with HIV under conditions of mandatory HIV testing as required by destination countries. Of these, sixteen (16) had been deported, and five (5) had been tested at home during the process of re-applying for overseas work. Those who were deported reported being doubly traumatized by the experience. Eight (8) of the respondents from Pakistan had also been deported for HIV. While none of the respondents from Bangladesh had been deported, some had returned home prematurely suspecting they had a health problem.

From the large number of respondents from the Philippines who were deported from the Middle East for their HIV status, all but one was quarantined prior to deportation. Generally, they spent a couple of days to a week in quarantine before getting deported.

Their experiences in quarantine and the deportation process varied depending on the country and the year when it happened. All those who were deported from Dubai had been quarantined in the same hospital. The respondents from Pakistan indicated that they were not treated well in the hospital during quarantine and some were verbally abused, but it is unclear what year that was. One respondent was so shocked that he fell into a "coma" upon realization of his HIV status and being quarantined, delaying his return home by two months.

Generally, the experiences of those who were deported more recently were not as bad as those who were deported years before. [52] For example, HIV positive migrant workers are no longer shackled to their bed without the ability to communicate with the outside world. Now the hospital staff treat them better, there is color television, the quality of food has improved, and they can keep and use their phones freely. While it seems that quarantined HIV positive migrant workers are kept under better conditions, the process of quarantining and deporting migrant workers for their HIV status still violates their basic rights and dignity. The most difficult part, according to respondents, was being confined inside the hospital and knowing that their dreams of improving their economic situation – the whole reason they migrated in the first place - were dashed.

6.3 RETURN

In most cases, when migrants go abroad for work they are expected to financially support their family. Commonly, their families go into debt to pay recruitment and placement fees. Returning home empty-handed places the family in an even more precarious position as they may have to sell land or other assets to pay off the debt. [53]

[52] CARAM Asia, 2007

[53] Ibid

Under these circumstances, with so much hope and expectations riding on the migrant, it makes it even more difficult for an HIV positive MSM migrant worker to explain the reason why he returned home prematurely. As has been found in previous research, migrant workers deported for HIV have trouble accessing services or treatment, partly because they are unaware of what services are available, and partly out of fear of revealing their HIV status to others. [54] When this scenario includes male migrants being returned for having been infected with HIV through male to male sex, it raises the possibility of multiple stigma, including self-stigma, especially when they have already experienced discrimination because of their sexuality prior to migrating.

SELF-STIGMA, DISCLOSURE OF SEXUAL ORIENTATION AND PARTNER TRANSMISSION

A major obstacle to accessing treatment for returned HIV positive migrant workers is self-stigma and fear of rejection by family and community. While all HIV positive migrants who are deported home face the shame of having failed their families as unsuccessful migrants and having been infected with HIV while abroad, for MSMs, there is additional fear and shame: many have not yet disclosed their sexual orientation to others. By disclosing their HIV status, they invite questions about how they got infected, which can possibly lead to disclosing their sexual orientation or sexual practices. According to many of the respondents, it can be more difficult to come out about their sexual orientation than to talk about being infected with HIV, especially to families. It may be even more difficult when their gender expression is masculine compared to someone who was more feminine. In fact, respondents' disclosure levels of their sexual orientation ranged from being fully disclosed, to having disclosed only to certain individuals such as immediate family or only to friends, to those who had not made any disclosure and had in fact maintained their marriage with a woman. There were also those who did not self-identify as MSM.

[54] Ibid

Among respondents from the Philippines, for example, two of the MSM were married, but their female partners were not infected with HIV. Two other respondents were married and HIV positive but not MSM, and one respondent admitted that he infected his wife. Some of the Filipino MSM respondents who experienced discrimination when they revealed their HIV status moved away from home to Metro Manila. Some of the respondents have not told anyone of their HIV status and instead told people that they had other health conditions, such as TB, a heart condition or even cancer. One respondent indicated that his family would not understand that he was gay because he was very masculine.

Another respondent who had to live with and support his mother was saddened by the way she stigmatized him and emotionally isolated herself from him when he revealed his HIV status.

On the other hand, some families were supportive when the respondents revealed their HIV status. In the Philippines it was noted that sexual orientation is complex and does not restrict people to a certain lifestyle. One MSM respondent indicated that he was bi-sexual and had three children from three women and takes care of all the children, while at the same time has a regular male partner.

In Bangladesh, one of the PLHIV MSM respondents was married; his wife was also infected, but not their child. His brothers and sisters ostracized him, so he does not live in his home village and he will not receive property from the family inheritance. Another respondent also has a wife who is infected. His wife was diagnosed with HIV first; only he and his wife know about their situation. Another respondent indicated he does not want to get married because of his HIV status.

Among Bangladeshi migrants who were MSM but not HIV positive, seven (7) out of ten (10) are married, and two (2) of the seven (7) are married because of family pressure.

In the discussions with prospective male migrant workers, many do not want to reveal their MSM status; they also do not want to get married. Yet, many were suffering familial pressure to get married, and that was part of the motivation for going abroad.

CASE STUDY: ROCKY (FROM BANGLADESH)

Rocky is a 30 year old Bangladeshi returned migrant worker who stayed nearly 14 years in Saudi Arabia, Dubai and Oman. He is a self-identified MSM and living with HIV.

Rocky used to live in a small Bangladeshi town. From his childhood he was always attracted to boys but could not tell anyone. Since he did not do well in his studies, his father decided to send him abroad when he was only around the age of 16. His elder brother who lived in Saudi Arabia sent him a visa and managed everything.

Upon arrival, Rocky stayed with his brother and his roommates in Dammam in Saudi Arabia until he got an Iqama (work permit). One day when all of the roommates went out for work, he, out of curiosity, went outside to see the local area. A local man approached him. The man tried to say something but Rocky could not understand. All of a sudden, the man came close to him, held him and started to kiss him. Rocky felt nervous but at the same time liked it. The man then took him to a toilet in the basement and started to rub his penis on Rocky's back. After 20 minutes the man finished and gave Rocky one hundred Saudi Riyals. Rocky was quite surprised.

Rocky did not tell anyone, but he stopped going outside. A few days later he got the work permit and then got a job at a laundry shop. He noticed that other co-workers looked at him strangely.

They tried to seduce him to have sexual relations but he did not like any of them. He immediately informed one of his uncles who found a job for Rocky in construction.

He did not like the construction work but continued several months until he got a job at a residential hotel. In his new job he greeted clients as he had learnt some Arabic language. He cleaned rooms and delivered room service as well. One day a guest asked Rocky to give him a massage, but Rocky responded that he needed permission from the employer. His employer gave him permission with a big smile. He was very excited as it was a good way for him to earn extra money. However, when he finished the massage, the guest asked him softly if he liked sex! He replied it was not allowed. The guest offered him 500 riyals (US $133) extra apart from the massage fee of 300 Riyals (US $80) along with the commission of the employer.

"I felt greedy and agreed. This was how I started sex with other men regularly earning money. I had sex with 7-8 people every day, 6 days a week, and continued for nearly 8 or 9 years". During those days Rocky had no idea about HIV or AIDS, and he did not know the importance of using condoms. He seldom used a condom, even when a client brought condoms.

After five years in Saudi Arabia, Rocky came back to Bangladesh and stayed around five months. The family members asked him to get married but he did not agree. Instead, he re-migrated again to Saudi Arabia. In his words, "sexual violence is not very uncommon in Saudi." One day after finishing his hotel duty, he was walking home. A guy with a car came to him and offered him a lift, but he did not want to go. The guy did not listen to him. He used force, put Rocky in the car and drove to the desert. Rocky saw six other guys waiting for him.

"They all raped me all together for 3-4 hours, and then dropped me at the same place where I was picked up. I was badly injured - my anus was bleeding. The next morning I went to an Indian doctor who gave me medicine. It took 15 days to cure the pain."

After five years, he came back to Bangladesh again. This time, his family arranged a marriage for him. Though he did not want to get married, he did it thinking of his family, fitting into society and for his security. But after a few months of staying in Bangladesh, Rocky decided to re-migrate again. This time he went to Dubai.

In Dubai, Rocky did not take too much time to integrate as he knew the language. He started to sell CD/DVDs on the streets independently. In Dubai, he ended up having sex with one of his Pakistani roommates. Later, he moved and took a single room, but then started to have sex in exchange for money again. Within a few months, he made a long list of clients in the guise of selling DVDs.

After spending two years in Dubai, his wife threatened him with divorce. He came back home but could not adjust. They got separated and divorced in the end. Rocky decided to migrate again. He went to Oman this time.

In Oman, he started the same CD/DVD selling business as well as sex work. This time he met a Pakistani doctor who took him to a night club and introduced him to the dancers. Rocky started to dance at the club wearing women's clothes. This made a good opportunity for him to make a wider network of clients.

After nearly two years, he had a car accident in Oman and broke his leg. Rocky decided to get treatment in Bangladesh because it would cost less for his treatment and he would get support from the family.

After coming back to Bangladesh, though, Rocky became sick. It worsened and there were no signs of improvement. His doctor referred him to a government hospital in Dhaka. The doctor diagnosed his blood and referred him to the NGO Bandhu Social Welfare Society (BSWS) without telling him the results of his blood test. His blood was tested again under the BSWS services. The BSWS's staff counseled him several hours before disclosing that he was HIV positive. Since then Rocky is living with HIV and getting services from the BSWS.

In Pakistan, the families of thirteen (13) respondents who were HIV positive knew about their HIV status; and eight (8) of them had been deported for their HIV status. Most of the Pakistani respondents embraced their sexual orientation, however, many also indicated that they had experienced stigma from their families for being MSM and HIV positive, but mostly by relatives than from immediate family. More than half lived away from home because they had been kicked out. In most cases, the respondents from Pakistan had disclosed their HIV status to MSM group members first. Back in their home country some were working in massage parlors, which also provided sexual services, some worked as male beauticians, and one was a fashion designer.

Out of the thirty-three (33) respondents from Pakistan, only 2 were married. They were both HIV positive though. Only one of the men's wives was infected, but not their three children. The husband had been deported for HIV but hid his status when he returned. Reportedly, he had sex with "anyone" while he was abroad. As he did not identify as MSM, he had no linkage with the MSM group. So, upon return he had no one approach him. Finally, through "word of mouth referral" he was approached by a PLHIV group, which later connected him to the MSM network.

The rest of the respondents from Pakistan who were still living with their families were being forced to marry. Most said that they would eventually succumb and marry; the PLHIV respondents said that they would not reveal either their HIV or MSM status to their wives if they got married, but would practice safe sex with them. Those who were HIV negative and MSM said they will probably get married, but would not reveal their MSM status. They also indicated that they would, "stop engaging in male-to-male sex and become 'family men.'" One of the respondents who was openly MSM and HIV positive, had disclosed his HIV status to his boyfriend, but his partner did not want to use condoms because they were "in love."

ACCESS TO SERVICES AND SUPPORT GROUPS

Accessing HIV services upon their return home proved challenging for most of the respondents. They were generally unaware of the available HIV services in their home countries and there are virtually no HIV-related reintegration programs for migrant workers in all the three origin countries in this study. There is no "referral system" from the destination country to Bangladesh for migrant workers who are deported for HIV or any other infectious disease. In fact, HIV-related services is not integrated in the public health service in Bangladesh and that is partly the reason there is no referral mechanism. When migrant workers return, they usually hide their HIV status if they know it, and will only go to a doctor once they start to get sick. A common scenario is that the doctor treats the returned migrants' condition until realizing that it is not improving. Eventually the doctor will suspect HIV and refer the patient on.

Counseling, care, support and ART are provided by NGOs in Bangladesh, not the government. There are two main PLHIV networks which provide ART services: ASHAR Alo Society, and Mukto Akash Bangladesh. These groups have monthly meetings where they dispense ARV and provide counseling, nutrition and care to PLHIV members.

There are two other organizations which provide only HIV testing services and refer HIV positive individuals to PLHIV groups for treatment. ASHAR has an MOU with Bandhu Social Welfare Society, the MSM network, to refer MSM PLHIV, most of who are returned migrant workers, for monthly counseling sessions. Bandhu has sixty (60) drop in centers serving MSM and hijra by providing condoms and lubricant, STI treatment and counseling. The centers are promoted primarily through word of mouth. Recently, migrant workers were clearly recognized under Bangladesh's National AIDS Strategic Plan's targets. As part of these targets, US$2 million is being provided under the Global Fund to support a plan to provide testing and counseling services and treatment for returned migrants through health facilities.

In Pakistan, respondents who returned with HIV indicated they were not made aware of any services upon return. There was no referral from the destination country, "just immigration stamping 'deported' in our passports." Most respondents were only able to access relevant services at local hospitals after they had returned home for a period of time. In part this was facilitated through PLHIV and MSM support groups who contacted them through outreach. PLHIV respondents who did not identify as MSM were members of PLHIV groups. These PLHIV support groups not only assisted HIV positive individuals by providing counseling and assistance with referral to treatment, they also assisted in sensitizing families and normalizing their lives.

The NAZ Male Health Alliance (NAZ) acts as an important linkage for MSM PLHIV to access government treatment centers. At the time of this research there were eight (8) treatment centers in Punjab Province, which is where most of the MSM respondents were from. NAZ also has PLHIV support groups which provide counseling. NAZ uses social media for outreach, and has six (6) outreach offices/drop-in centers. These centers are community-oriented and provide a variety of services including counseling and support groups as well as recreational activities.

Most of the respondents shared that they regularly went to the drop-in center provided by NAZ, and considered the people there as a second family.

Many of the members of NAZ do not have HIV; they are simply MSM. NAZ, however, provides HIV sensitization to all its members. On the other hand, although there are considerable numbers of NAZ members who plan to go abroad, NAZ does not provide specific information regarding MSM and HIV risks in the context of migration. One of the only interventions NAZ has specifically for returned migrants is a peer outreach network in the community which keeps abreast of members' HIV status upon return, and encourages these people to get follow up HIV testing and a CD4 count if they are HIV positive. Between NAZ and the PLHIV support groups, all respondents reported that they were receiving ART and regular CD4 monitoring.

CASE STUDY: RAKHA (FROM PAKISTAN)

Rakha is now 42 years old and is from Punjab. He has no education. During puberty he had sex in the culturally endorsed role of a transgender and received financial support and gifts in exchange for sexual encounters in this role.

When he grew up he adopted his ancestor's profession of being a mason to earn his livelihood. He never wanted to get married. "Woman is a tension", he said, but in the end he succumbed and married because of his culture. He continued to engage in MSM behaviors even while he was married. Now he has 3 children. Due to the prolonged financial crises, there were problems in supporting the family, so Rakha decided to migrate illegally to Japan through Thailand and Malaysia. He only made it to Malaysia, and then moved back to Pakistan. He spent 13 years in Pakistan before he migrated to Dubai through a travel agent in 2009.

The only motivation for him to migrate to Dubai was to earn better wages. He worked there for four years. He was engaged as a mason in a construction company in Dubai, and lived with co-workers at a camp near the work site. He often had sex with female sex workers and male sex workers to relax. He was attracted to Filipino boys because, "they have soft and hairless skin and are available everywhere." He never used a condom for sexual encounters abroad, and most of the time he was drunk while having sex.

He underwent health testing annually for medical clearance to renew his visa, but he never knew that he was being tested for HIV or what it was until he was told that he was HIV positive. "AIDS" was a familiar word and he was concerned, but he was totally unfamiliar with the word "HIV" until the day of his positive test result.

"That was a shock. I could not express my feelings at the moment I was told that I have 'AIDS'." The authorities did not inform him directly. They called the "foreman" and he informed Rakha later. After confirmation of his HIV positive status, Rakha was detained for a few hours in a separate cell attached to the hospital. The authorities prepared deportation documents, handed them to him and deported him. That was in 2013.

Initially he thought about suicide. Later he decided to stay away from his family and community by shifting to some other city, in part because his foreman told him to stay away from his children and wife to keep them safe from "AIDS". On arrival his friends were there to receive him, so he had to go home with them. He took some days to inform his wife about his HIV status. Initially his wife was too scared to be with him, but later he took her to the doctor and an NGO, who provided counseling about HIV. With the passage of time, the attitudes and behaviors of his family and friends normalized.

At one point, a part of his face was damaged due to an unknown health condition. This was a challenge because for the first time he felt stigmatization and discrimination from his friends who were saying this was a symptom of AIDS. The stigma and discrimination remained, but he found the inner strength to face the challenges of being HIV positive.

Currently he is associated with a PLHIV group, where he has accessed care and support and he is also taking ARVs regularly from the government of Pakistan. His wife got tested for HIV and she is HIV negative as they have protected sex. Although he does not take hard jobs like masonry as before, he still does minor assignments occasionally.

The Philippines has the most developed system for assisting migrant workers who have been deported for their HIV status. This is due to the efforts of civil society. When Filipino migrant workers are sent home after testing positive for HIV in a foreign country, they are supposed to be referred on to the Department of Health or the National Reference Lab for confirmatory testing. After receiving post-test counseling at these centers, all PLHIV are given a contact list of organizations that provide HIV services. There are currently nine (9) PLHIV support groups, none of which are specific to returned migrants. There are also three (3) on-line support groups, making it easier to connect. Some of these groups are more advocacy-oriented and do not provide social support but they are also helpful in the referral network. There are also MSM and transgender support groups, some of which provide outreach, either online or in community based settings. Some of these organizations provide community-based HIV testing. There are also cases when an NGO in the Philippines may be notified that a migrant is being deported, and will await that person's arrival at the airport to assist.

Some HIV positive migrant workers who return home unannounced may search out services on the internet through relevant sites such as UNAIDS, ACHIEVE, Pinoy Plus Association, and Positive Action Foundation Philippines, Inc. (PAFPI). MSM returned migrants can also find MSM organizations on their own on the internet in a similar fashion, while others are contacted through outreach by MSM organizations and networks. Most of the HIV and MSM organizations in the Philippines provide referral to HIV treatment hubs, of which there are sixteen (16) around the country. Treatment hubs also have PLHIV stationed at these facilities, many of who are MSM or female migrant workers, to assist in receiving people who suspect they are infected with HIV or need to confirm their status, as in the case with deported migrant workers. ACHIEVE and PAFPI are two organizations which provide capacity building to PLHIV former migrant workers so that they can give pre-departure information to prospective migrant workers and also assist at treatment hubs.

All Filipino PLHIV are encouraged to maintain their Philippine Health Insurance Corporation (PhilHealth) membership because it covers antiretroviral treatment. Upon return they do not receive any special benefits, but their HIV status entitles them to enjoy benefits provided under a program called the Outpatient HIV/AIDS Treatment (OHAT) Package. The Philippines is still using the 350 CD4 count as the protocol for initiating ART, with the exception of one treatment hub which is now using a 500 CD4 count. The timing of initiating treatment raises the question of "treatment as prevention" and promoting undetectable viral load, especially as many of the MSM on treatment are still sexually active but do not use condoms consistently. There is also the question in the timing of accessing services, as it is essential that returned PLHIV migrants find out their CD4 count as soon as possible to initiate treatment. All the PLHIV respondents from the Philippines except two (2) were on ARV at the time of this research.

CONCLUSION

07

07 CONCLUSION

There were a combination of factors at work that increased the MSM migrant workers' and their partners' vulnerability to HIV. The respondents from the three countries studied here went abroad to seek work in more economically developed countries, which also have policies that criminalize male to male sex and impose punitive immigration measures on migrants with HIV.

They went to these countries primarily to find work with higher wages, but there were some who engaged in MSM behaviors and sought to freely express their sexuality. Some of the respondents went for work but ended up selling sex, often for financial gain. Most of them engaged in unsafe sex despite having multiple partners, including locals and other migrants.

Yet, they were unable to assess their own risk and were unprepared to protect themselves from HIV because most of them left their home countries with little or no accurate information about HIV or migration realities. While these MSM migrant workers engage in risky sexual behaviors abroad, in part encouraged by the permissive social environment of many destination countries, their ability to access HIV prevention services, condoms, sexual health services and voluntary HIV testing services, are hampered by the repressive policies in place.

It is these policies which criminalize MSM behaviors and deport foreigners for their HIV status that are increasing MSM migrant workers' vulnerability to HIV, and as a result, they are getting infected with HIV.

What is also worrisome is that the policies that restrict MSM behaviors also inadvertently encourage sexual violence against MSM migrant workers. Those who were raped were afraid to report the crime out of fear of being further punished rather than receiving justice because they could be identified as MSM. As a result, the perpetrators were encouraged to act with impunity and victims have nowhere to turn.

For those MSM migrant workers who were deported for being HIV positive, they underwent the indignity of being quarantined and deported, which added to the sense of hopelessness they already felt for returning home empty handed and infected with HIV. Upon return, they had to face the fear associated with being deported for HIV.

In many cases, being MSM, as well as being HIV positive posed additional levels of stigma which led to fear of disclosing their HIV status to their partners. This in turn increased the vulnerability of their partners or wives for those who were also married.

Access to services after being deported is generally difficult for most of the HIV positive respondents mainly because there are no clear referral mechanisms and the level of stigma is very high. Yet, there are HIV support groups and MSM networks with extensive reach into the MSM and migrant communities in these countries. In fact, all HIV positive respondents had contact with these groups and were receiving necessary HIV services and treatment.

However, there is a gap. These groups are missing awareness on the MSM, HIV and migration nexus. With greater sensitivity to sexual orientation, gender identities and expression (SOGIE) in channels that manage migrant workers and among HIV service providers, accompanied by greater awareness of migration realities among MSM and PLHIV groups, interventions can be enhanced and implemented to provide MSM migrant workers with targeted HIV information and services.

RECOMMEN-DATIONS

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08 RECOMMENDATIONS

Considering the sensitivities around social acceptance of MSM behaviors, mainstreaming targeted HIV prevention messages for MSM is difficult. Moreover, there is concern that governments could react negatively by imposing even more stigmatizing and repressive measures against MSM migrant workers. Considering these sensitivities, the CARAM Asia research team provides the following recommendations:

INCREASE GOVERNMENT COMMITMENTS TO COMBATING HIV

- Review and reform all policies and laws, including religious edicts, that are discriminatory or stigmatizing towards MSM or migrant workers living with HIV;
- Identify migrant workers as key affected populations under National HIV Plans;
- Increase spending on HIV prevention and treatment for migrant workers;

IMPROVE HIV EDUCATION PROGRAMS FOR MALE MIGRANT WORKERS IN THEIR COMMUNITIES AT ALL PHASES OF MIGRATION (PRE-DEPARTURE, ON-SITE AND RETURN)

- Include information about sexual orientation, gender identities and expression (SOGIE) in interventions and media targeting male migrant workers, potential migrant workers and their communities;

- Include information on anal sex and related risks more prominently in HIV prevention activities for migrant workers, potential migrant workers and their communities, and fill in gaps and misconceptions on condom use and HIV prevention;

- Provide HIV education, including information on risks of anal sex, to all migrant workers during the medical testing and in pre-departure trainings, as possible, in partnership with relevant CSOs and HIV support groups;

- Use alternative forms of media including social media and videos to provide male migrant workers with easy to understand and culturally appropriate but straightforward information on HIV related risks of male to male sex;

- Provide information on HIV service providers to migrant workers, including those that cater to the needs of men with various sexual orientations and gender identities.

ENHANCE HIV PROGRAMS AND SERVICES FOR MIGRANT WORKERS, PLHIV AND MSM AT ALL PHASES OF MIGRATION (PRE-DEPARTURE, ON-SITE AND RETURN)

- Capacitate relevant migration and MSM CSOs, PLHIV support groups and government agencies on the nexus of HIV, SOGIE and migration, with focus on the experiences of MSM migrant workers;

- Sensitize embassy and consulate staff, including labor attaches, on issues of male migrant workers who are victims of sexual violence or rape and promote linkages to service providers like crisis centers;

- Sensitize health care providers to sexual health conditions of male migrant workers, including those who engage in male-to-male sex;

- Develop information materials for social media and utilize social networking sites to disseminate information on HIV, health, migration realities and available services in origin and destination countries;

- Establish comprehensive psycho-social and health services for male migrant workers who have been deported because of HIV and those who have experienced sexual abuse;

- Develop psycho-social support programs, including training counselors, to address HIV and sexuality issues among MSM migrant workers;

- Establish or strengthen referral mechanisms for migrant workers being deported for HIV or other health conditions and ensure they are sensitized on MSM needs.

REVISE POLICIES AND FILL IN POLICY GAPS TO BE MORE SENSITIVE TO MSM AND MIGRATION

- Review and enhance labor migration policies to include HIV and AIDS as a concern of migrant workers;

- Expand gender dimensions of labor migration policies to be responsive to the needs of MSM migrant workers;

- Sensitize policy makers on SOGIE, particularly in relation to HIV and migration;

- Improve policy framework for reintegration of HIV positive MSM migrant workers and provide specific safeguards against stigma and discrimination for MSM migrant workers infected with HIV;

- Advocate for the removal of mandatory HIV testing and deportation of HIV positive migrant workers, and increase availability of voluntary and confidential HIV testing for migrant workers at all stages of migration.

ENHANCE THE KNOWLEDGE BASE ON MSM MIGRANT WORKERS

- Conduct more studies on the realities faced by male migrant workers who engage in male-to-male sex, with a focus on the hard to reach population of non-self-identifying MSM;

- Identify and disaggregate migration related data in National Integrated HIV Behavioral and Serologic Surveillance among MSMs, and include MSM and migrants as key affected populations in countries where not yet monitored;

- Develop studies to come up with population estimates for MSMs among migrant workers.

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09

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ABBREVIATIONS

10

10 ABBREVIATIONS

ACHIEVE	Action for Health Initiatives, Inc.
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
ARV	Antiretroviral drugs
ASEAN	Association of South East Asian Nations
BSWS	Bandhu Social Welfare Society
CARAM Asia	Coordination of Action Research on AIDS and Mobility in Asia
CBO	Community based organization
CSO	Civil society organization
CD/DVD	Compact disc / digital video disc
CD4	Cluster of differentiation 4
FGD	Focus group discussion
FSW	Female sex worker
GCC	Gulf Cooperation Council
HIV	Human Immunodeficiency Virus
IBBS / IHBSS	Integrated Biological and Behavioral Survey / Integrated HIV Biological and Serorologic Surveillance
LGBT	Lesbian, gay, bi-sexual and transgender
MSM	Males who have sex with males
MSW	Male sex worker
NASP	National AIDS STD Programme
NGO	Non-governmental organization
NMHA	Naz Male Health Alliance
OFW	Overseas Filipino Worker
OHAT	Outpatient HIV/AIDS Treatment
OKUP	Ovibashi Karmi Unnayan Program
PAFPI	Positive Action Foundation Philippines, Inc.
PLHIV	Persons Living with HIV
PWID	People who inject drugs
SOGIE	Sexual orientation, gender identities and expression
STI / STD	Sexually transmitted infection / disease
UAE	United Arab Emirates

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CARAM Asia has been working to promote and protect the health and labor rights of migrant workers in Asia through research, advocacy and capacity building. CARAM Asia has undertaken evidence-based research and produced a number of reports on migrant workers' health rights including: "The Forgotten Spaces," "State of Health: Access to Health," "State of Health: Mandatory HIV Testing," and "HIV Vulnerabilities of Migrant Women: from Asia to the Arab States." CARAM Asia partner's key thrust is to develop continuous information through participatory action research with migrants and their communities at all stages of migration to strengthen the migrant perspective.

CARAM Asia has used the results of its research to pursue advocacy to protect migrantworkers' health rights at national, regional and international levels.

CARAM Asia (Coordination of Action Research on AIDS and Mobility in Asia) is a Regional Network/ NGO in Special Consultative Status with the Economic and Social Council of the United Nations. The Network comprised of 42 member organizations in 21 countries across Asia was set up in response to the growing phenomenon of migration and emphasizes a regional approach in addressing migrant workers' health issues. Since its inception in 1997, CARAM Asia Network has moved actively to do special interventions for migrant population at all stages of migration in order to reduce vulnerabilities including HIV and advance their health rights.