



Men who have sex with men

the missing piece in national
responses to AIDS in Asia and the Pacific



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Preface

“Men who have sex with Men – a missing piece” describes the status of a sizeable population group in Asia and the Pacific which is invisible in many ways on our social or public health radar. In many countries male-male sex is illegal; stigma towards such population is astounding and ignorance among medical profession significant. This makes the issue specific to MSM population exceptionally urgent from both social and disease prevention point of view. Indeed, an analysis of current response in the paper shows meager attention to MSM population in most of the current national responses to HIV that requires urgent attention of policy makers, social activists and the politicians.

This paper is just one of the many efforts to raise awareness on this important issue related to MSM population and its link to HIV epidemic based on scientific evidence and research carried out in the region. As described in the publication, the future of the epidemic in Asia will largely depend on how well and how soon we can make the link visible by addressing rights, stigma, services and funding for the MSM population in our response to the epidemic.

JVR Prasada Rao



*Director
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Executive Summary

Across Asia and the Pacific governments are putting more money and resources into HIV prevention and AIDS treatment, but few countries have addressed the entirety of the challenge. A key component missing from virtually all national programmes are services for men who have sex with men (MSM¹). The omission, if it persists, can undermine government achievements on other fronts.

In the Asia-Pacific region countries do not face a single AIDS epidemic but multiple, overlapping epidemics with a number of drivers². The region

has experienced, in the past 10-15 years, how quickly these epidemics can accelerate through vulnerable populations³, particularly sex workers, clients of sex workers, injecting drug users and men who have sex with men. To contain and ultimately defeat these epidemics, countries need action against all the components of the epidemic. But while countries in the region have devoted increasing attention and investment to deal with the epidemic among heterosexuals, most treat the epidemic among men who have sex with men, and practice of sex between men, as if it doesn't exist.

¹ While we use the term 'men who have sex with men' here it is within the context of understanding that the word 'man'/'men' is socially constructed. Nor does its use imply that it is an identity term referring to an identifiable community that can be segregated and so labeled. Within the framework of male-to-male sex, there are a range of masculinities, along with diverse sexual and gender identities, communities, networks, and collectives, as well as just behaviours without any sense of affiliation to an identity or community.

² Driver relates to the structural and social factors, such as poverty, gender and human rights that are not easily measured that increase people's vulnerability to HIV infection.

Last J (ed). (1995). A dictionary of epidemiology, 3rd edition. Oxford University Press.

³ Vulnerable populations are populations most likely to be exposed to HIV or populations at higher risk of exposure.

UNAIDS' Editors' Notes for authors1 (August 2006). http://data.unaids.org/pub//InformationNote/2006/EditorsNotes_en.pdf

Summary of observations

- Sex between men occurs in all countries and cultures
- MSM are a significant and a growing component of the epidemic in the Asia-Pacific region
- Stigma and discrimination drive the epidemic
- MSM are largely absent in national AIDS plans
- Effective national responses should be based on the results of broad partnerships between governments, health care providers, MSM community and civil society organizations



Sex between men occurs in all countries and cultures

At least 5% to 10% of all HIV infections in the world are transmitted through unprotected sex between men. The number of men who engage in sex with men is estimated at 2% to 5% worldwide (Caceres et al., 2006). Male-male sex occurs in every culture. Early Sanskrit writings describe same-sex relationships, as do ancient Chinese and Korean texts. In East Asia, studies estimate 3% to 5% of men have same sex relations at some point in their life and in South and South East Asia 6% to 18%.

Most studies are believed to underestimate the prevalence of male-male sex. That is partly because, of all the many sensitive issues of sex and gender raised by the AIDS epidemic, the issue of male-male sex remains most heavily shrouded in stigma and denial and is thus the most difficult for people to discuss frankly and openly. It is also because of the sheer diversity of the people who engage in male-male sex and the social circumstances in which it occurs.

Men who have sex with men are not a uniform group or an isolated social minority with a single sexual preference. They come from all social classes. They range from men who maintain conventional masculine identities and do not identify themselves as homosexual or gay or even bisexual, to transgenders⁴ -- men who do not accept their gender and identify as women, like India's hijras, Indonesia's waria and Thailand's katoey.

Many men who have sex with men have also had sex with women. Many married men also engage in male-male sex: 42% of the respondents in a survey of MSM in Andhra Pradesh, India were married (Dandona et al., 2005). A sample of 482 men who had sex with men in Beijing (Gibson et al., 2004) found that nearly two-thirds had sex with a woman, 28 % of them within the past six months. Many men who sell sex to men have a wife or female partner; others also sell sex to, and buy it from, women. Sex between men

⁴ Broadly speaking, transgender people are individuals whose gender expression and/or gender identity differs from conventional expectations based on the physical sex they were born into. The word transgender is an umbrella term which is often used to describe a wide range of identities and experiences, including: female-to-male and male-to-female sexual reassigned persons, cross-dressers, drag queens, drag kings, gender queers, and many more. [In the Asia and Pacific region this would include hijras, some kothis, zenanas and metis, kathoey, waria, bakla, fa'fa'finis, etc.] Because transgender is an umbrella term, it is often thought to be an imprecise term that does not adequately describe the particulars of specific identities and experiences. (For example, the identity/experience of a post-operative female to male transsexual will probably be very different from that of a female-identified drag king who performs on weekends, but both are often lumped together under the term "transgender people"). web.mit.edu/hudson/www/terminology.html

may happen because it is what is immediately available, for example in prisons or among truck drivers (Khan and Hyder, 1998). Those who engage in it also may not think of themselves as homosexual and in other situations will have sex with women.

The overlap between heterosexual and MSM communities matters in the fight against AIDS. There is a clear risk that MSM who become infected with HIV will pass it on to their wives or female partners. The epidemic among MSM, therefore, is not as separate from the epidemics in the general community as some might think; efforts to prevent the spread of HIV among MSM are essential to prevent transmission of HIV at large.

Although data are limited, the prevalence of HIV infection among men who have sex with men, wherever it has been measured, is substantially higher than in the general population. That applies to such diverse locations as Thailand, where national adult HIV prevalence was 1.4% in 2005 and the infection rate among self identified MSM in Bangkok was 28% or Viet Nam, where national prevalence is 0.5% and among a sample

of MSM in Ho Chi Minh City, HIV prevalence was 8% (Tuan et al., 2004), or in India, where national adult prevalence was estimated at 0.9% in 2005 and a study in Mumbai in 2001 found 17% of MSM had the virus (National AIDS Control Organization, 2001). MSM also report a much higher incidence of other sexually transmitted infections which significantly increase the risk of HIV transmission (MAP, 2004).

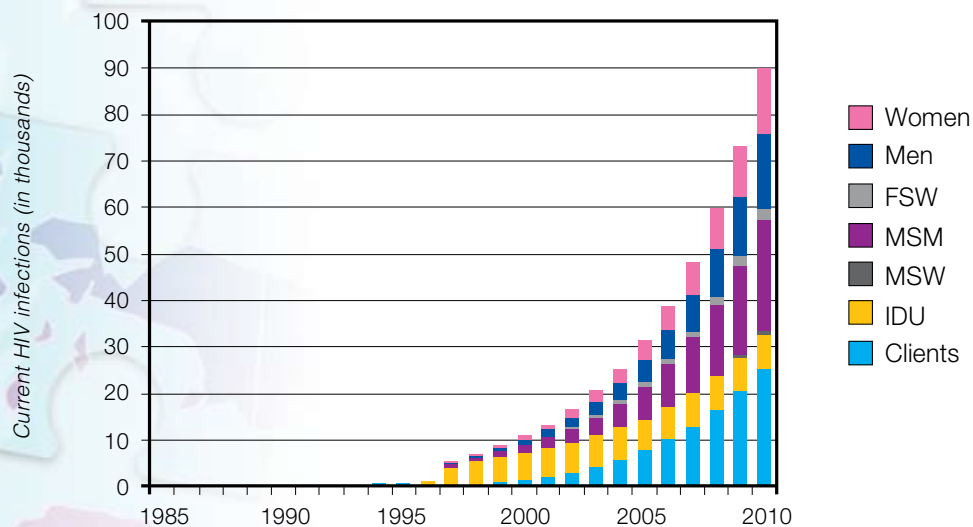
Injecting drug use among men who have sex with men is yet another overlap important for HIV prevention and treatment. Injecting drug users often have high rates of HIV infection (due to the efficiency of needle-borne HIV transmission) and drug use can increase high risk sexual behaviour. In Nepal, 4% of MSM in a 2004 survey took drugs while in Indonesia 27% of MSM who did not sell sex and 47% of male sex workers in Indonesia reported injecting drugs in the previous year (MAP 2004).

MSM are a significant and growing component of the Asia-Pacific epidemic

Clear evidence exists that the HIV epidemic among MSM is accelerating. The infection rate among men who have sex with men was reported to be 28% in Bangkok in 2005 compared with 17% in 2003 (van Griensven et al., 2005). In Ho Chi Minh City, it accelerated from 5% in 2003 to 8% in 2005 (Tuan et al., 2004). Without prompt and effective action to address the issue, other Asia-Pacific countries may witness similar acceleration of HIV rates in MSM.

A process model that replicates the primary groups and transmission modes driving HIV in Asia has been recently developed (Brown and Peerapatanapokin 2004). This Asian Epidemic Model suggests that by 2010, the annual number of new HIV infections attributed to MSM in Asia is likely to overtake that from injecting drug use (IDU) and male (MSW) and female sex workers (FSW) (see Figure 1).

Figure 1. Estimated number of new infections per year among adults in an Asian country of 100 million with average levels of risk



Source: Tim Brown et al, 2006

Indeed, the coverage and the effectiveness of national programmes to reduce risk behaviors among men who have sex with men, with sex workers and injecting drug users will be a key determinant of the size of national HIV epidemics and the financial costs, countries will incur in tackling it.

Many factors are driving these trends. An important one is that men who have sex with men demonstrate little knowledge and many misconceptions about the risks associated with unprotected male-male sex. Among 423 MSM in a recent survey in Myanmar, knowledge and awareness of HIV was high, yet 90% believed they were not at risk. The belief that HIV is not transmitted by healthy-looking individuals is widespread (TREAT Asia 2006).

Such high levels of ignorance and misinformation are reflected in the high risk behaviours prevalent among men having sex with men. Their average number of sexual partners is high and the use of condoms is low – much lower than among female sex workers. As many as half the participants in a survey of MSM in China reported unprotected anal sex in the preceding six months, but only

15% saw themselves as at risk (Choi et al, 2006a and 2006b).

Behavioral surveillance by India's National AIDS Control Organization found that condom use among male sex workers was just 12% compared with 57% among clients of female sex workers. Low condom use can result from a range of factors: lack of availability, lack of awareness of their importance for protection, the expense of buying them, or because the furtive and hurried circumstances in which sex is performed does not allow for negotiation of condom use.



Stigma and discrimination drive the epidemic

Studies also underline another driver in the growth of HIV among men who have sex with men in Asia and the Pacific: the way that stigma, discrimination and laws criminalising male-male sex act as a catalyst for unsafe practices and limit availability and access to services thus creating conditions that encourage the spread of the HIV epidemic.

A 2006 survey found that sex between men was illegal in 16 of 20 countries in the Asia-Pacific region. Not all countries with these laws enforce them, but they still pose a serious handicap to outreach and interventions for men who have sex with men (Sanders 2006).

In India, some doctors have reportedly threatened to report MSM to the police, while in Sri Lanka cases have occurred where medical staff revealed the identity of HIV-positive patients who were MSM. High levels of rape and beatings of MSM are reported in Pakistan and Nepal. Even where sex between men is legal, the stigma associated with this behaviour results in discrimination by authorities, health workers and employers (APN+, 2004)

“It is homophobia, not homosexuality, that we should fear.”

Mass media campaign message, Mexico, 2005

China does not have laws specifically criminalising male-male sex but MSM are difficult to reach because of fear of police raids. In Thailand and Viet Nam, police sometimes take this as far as to target the carrying or distribution of condoms as evidence of commercial sex, thus discouraging the availability and use of a key resource for reducing risk and curbing the spread of AIDS. The effect of such stigma and oppression is to increase, rather than to reduce, high risk behaviour.

Discrimination discourages men who have sex with men from identifying their sexual orientation, disclosing to their partners, and accessing health services; It does not facilitate the provision of strategic information on MSM that can inform national policy and thus promote public health.

Stigma and discrimination also discourage policy makers from finding out what is needed to curb this important component of their national epidemics, or from acting on the knowledge they have. Until 2000, academic journals in China were banned from addressing MSM issues. Lack of information feeds denial about the extent and significance of the MSM epidemic. It also permits governments to avoid committing funds for the services and resources crucially needed to tackle it.



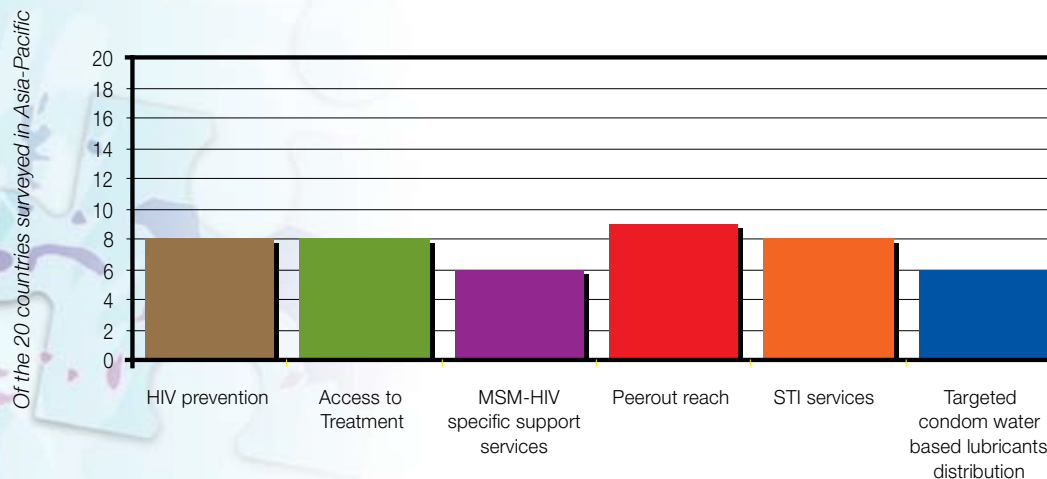
MSM in national AIDS plans: conspicuous by their absence

In some countries the environment is changing. In 2005, China's Vice Minister of Health, Wang Long de said the government must admit the existence of MSM in its efforts to tackle AIDS and the Ministry of Health instructed its disease control institutions to carry out interventions for men who have sex with men. In February 2006, a major report on MSM written by a Chinese gay writer was released. Its sponsors included the Beijing Gender Health Education Institute,

China's first homosexual counseling agency. Soon after, China's State Council issued the first comprehensive regulations on HIV prevention. One of these regulations outlaws discrimination against people infected with HIV.

As shown in figure 2, most national plans for tackling the AIDS epidemic in Asia and the Pacific largely ignore men who have sex with men. Among 20 Asia-Pacific countries surveyed

Figure 2: Countries with MSM-HIV specific programmes/interventions in the National AIDS plans



Source: UNAIDS response survey, 2006

“The generalized discomfort with male-male sex...has helped generate a familiar vicious cycle: No data equals no problem; no problem equals no intervention; and no intervention equals no need to collect data.”

MAP (Monitoring the AIDS Pandemic Report, July 2005)

in 2006, only nine of the National Strategic Plan on AIDS had included MSM and HIV specific programmes or interventions, such as peer outreach. Although Asia's AIDS pandemic first appeared among MSM, most governments have focused HIV prevention and treatment strategies to date on the general public or most at risk populations that are easier to identify, such as female sex workers, their clients and, to a lesser extent, injecting drug users.

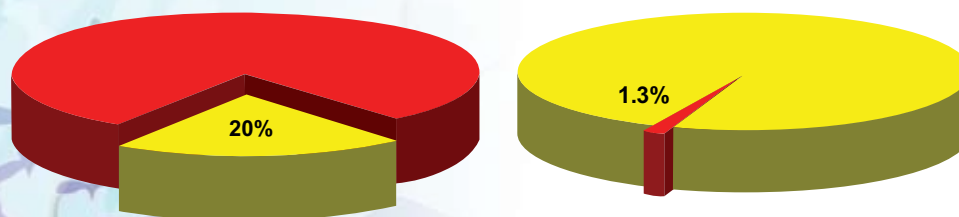
The reach of MSM targeted programmes was small. A 2006 survey of the coverage of HIV interventions in 15 Asia-Pacific countries estimated that targeted prevention programmes reached less than 8% of men who have sex with men (Stover et al., 2006).

The problem often starts with data. National programmes are only as effective as the evidence on which they are based. However, a recent survey of 20 Asia-Pacific countries identified only eight countries had any form of surveillance specific to MSM, while only five reported the inclusion of MSM in Behavioral Surveillance Surveys (BSS) (UNAIDS response survey, 2006). Where surveillance has occurred, the extent of the epidemic linked to male-male sex can still be disguised by the preference of individuals to attribute HIV infection to more socially acceptable risk factors.

Expenditure on interventions aimed at MSM inevitably makes up only a small part of spending on HIV prevention and bears no relation to the estimated proportion of people living with HIV who are MSM, or of MSM living with HIV. Data from selected countries showed spending on MSM typically ranges from zero to 1-2% in Thailand. In Ho Chi Minh City, where MSM accounted for 8% of the HIV infections, spending on MSM interventions amounted to less than

1% of the HIV prevention budget (Martin et al., 2006). Programmes aimed at men who have sex with men in Asia and the Pacific are left almost entirely to NGOs, local community based MSM organizations (CBOs) and to foreign donor financing. However, many NGOs and particularly the CBOs lack sufficient personnel, funding or the enabling environment to undertake more than local interventions.

Figure 3: Where does the Money go?



Although MSM is one of the five priority groups most at risk, in Asia and the Pacific, spending on MSM-specific programme and interventions is less than 1% of the National spending on AIDS in most countries in the region.

In Thailand MSM is estimated to contribute over 20 per cent of all new infections, while MSM-specific spending accounts for slightly over 1 per cent of the total national budget for AIDS.

Source: Martin G. et al., 2006

Effective national responses should be the results of broad partnerships between governments, MSM groups and civil society organizations

Developing effective responses to the wide diversity of social classes and groups, gender identities, marginalized and hidden populations and behaviours encompassed by the term MSM presents policy makers with a complex challenge. Only a few effective interventions have been launched in Asia and the Pacific region that achieve wide coverage, start from an epidemiological baseline and make any investment in monitoring and evaluation. Yet experience gained in this and other regions already points to a number of principles that should guide design and implementation of interventions aimed at MSM.

A broad-brush, one-programme-fits-all strategy will prove ineffectual in reaching the diverse groups of Asian and Pacific MSM and transgenders. HIV prevalence and behavioural surveillance among MSM is essential to enable national policy makers to tailor programmes to different groups of MSM in different socio-economic and cultural environments.

Types of interventions that have been effective in reaching MSM include peer outreach education, MSM friendly clinics for STI treatments, delivery of condom and lubricants, local advocacy, involvement of the MSM community and access to VCT and anti retroviral treatment services (UNAIDS best practice collection, 2006). The high incidence of sexually transmitted infections among MSM underlines the need for greater access to STI prevention, care and treatment. Services should aim to increase availability of condoms and water-based lubricants and improve access to voluntary counseling and testing. Experience shows interventions can also be more effective if MSM participate in programme design and implementation. For example, counseling by MSM has proved particularly effective in building knowledge of condom and lubricant use and awareness of the risk of drug abuse.

National health plans and budgets need to include costed programmes to increase delivery of essential services aiming to rapidly scale up services for MSM (UNAIDS, 2006).

What works: Indonesian innovative approaches

The Aksi Stop AIDS (ASA) project in Indonesia shows how evidence-based interventions with high coverage can influence behaviour change. The programme has two different agencies in both Jakarta and Surabaya (and others in other cities), one in each city to deal with waria (transgenders), the other to work with male sex workers and other men who have sex with men

Starting in 2003, ASA put together 'safer sex packs' with a condom and lube sachet (and waria cover picture) for distribution free to MSM including waria. In addition, it provided access to educational materials and peer educators and, in Jakarta, funded clinics focused on treating waria and other MSM

Among waria the programme achieved 65% coverage, and the number of people seeking voluntary counseling and testing rose from 0% to 21%. The programme also recorded a sharp increase in condom use in most recent anal sex among waria between 2002 and 2004 and a sharp fall in the incidence of unprotected anal sex from 66% to 48%. Condom use with commercial and non-commercial partners increased dramatically in all groups; in 2004, male sex workers reported 83% condom use in most recent anal sex with clients; for MSM, the percentage of condom use in most recent anal sex went up from 31% in 2002 to 63% in 2004. However, the use of condoms was inconsistent across partner types, and water-based lubricant use remained low. Between 2002 and 2004, a huge increase across the three groups was found in the uptake of HIV testing


(MOH Indonesia 2002 and 2004 (unpublished)).

Concrete interventions and tools are available now to combat stigma and discrimination (ICRW, 2004; International HIV/AIDS Alliance 2003). Working with local police, law enforcement authorities and opinion leaders will require much more effort and attention from national authorities than it has received so far.

Community-based organizations or NGOs programmes that include drop-in centres or similar safe areas for discussion and services have proved particularly effective, and may open up access to MSM peer networks, often reluctant to attend public services. In Australia, government and policy makers provided the legal framework and budgets for MSM programming; for the execution of campaigns they developed a partnership with civil society and private and public health personnel. National programmes should also include interventions targeting MSM who are especially vulnerable to HIV infection, including sex workers, injecting drug users and those in settings such as prisons or the military where they are also exposed to a greater risk of sexual coercion.

The work of designing, mobilising resources for, and implementing effective strategies for men who have sex with men presents a critical test of political will for governments and policy makers. The UNAIDS Annual Report 2006 comments that Asian governments should and could afford to spend more on HIV but have yet to recognize HIV in general, let alone the issues of men who have sex with men, as a problem that is sufficiently urgent to require more attention. Failure to act promptly and comprehensively on MSM interventions will allow the AIDS epidemic to grow in scale and complexity.

Moreover, programme responses will remain inadequate in reach and impact unless governments create a more sympathetic and enabling environment that allows implementing agencies to deliver essential services. This requires sustained effort to tackle the deep-rooted stigma and prejudice in society and to promote respect for the rights of men who engage in male-male sex.



This may entail removing or amending laws that criminalize sex in private between consenting male adults (UNAIDS, 2006). In Asia, many of these laws remain as a legacy of colonial rule. An exception is Hong Kong, which repealed its law in 1991. It may also involve proactive measures to fight discrimination, whether within government institutions, the workplace or health care centres, by introducing and enforcing anti-discrimination laws. It is in governments' own interest to ensure that national law enforcement agencies understand, and act in ways consistent with, the strategies of AIDS interventions undertaken either by public institutions or NGOs. Interventions aimed at delivering services to men who have sex with men cannot succeed if the intended beneficiaries are fugitives from the law.

The governments of Asia and the Pacific already subscribe to these principles on paper. In the 2001 UN General Assembly Special Session's declaration on HIV/AIDS, all UN members accepted the importance of addressing "the needs of those at the greatest risk of, and most vulnerable to, new infection as indicated by such factors as...sexual preference." In 2006, at the High Level Meeting on AIDS, all UN member

“An AIDS response that is not as embedded in advancing social justice as in advancing science is doomed to failure.”

Dr. Peter Piot, Executive Director, UNAIDS, August 2006

states agreed to the need for “the full and active participation of vulnerable groups” and to eliminate discrimination.

“We must address the fundamental drivers of the crisis, including low status of women, sexual violence, homophobia, and AIDS-related stigma and discrimination.”

Dr. Peter Piot, UNAIDS Executive Director, Statement at the UN General Assembly high-level meeting on AIDS, New York 2nd June 2006

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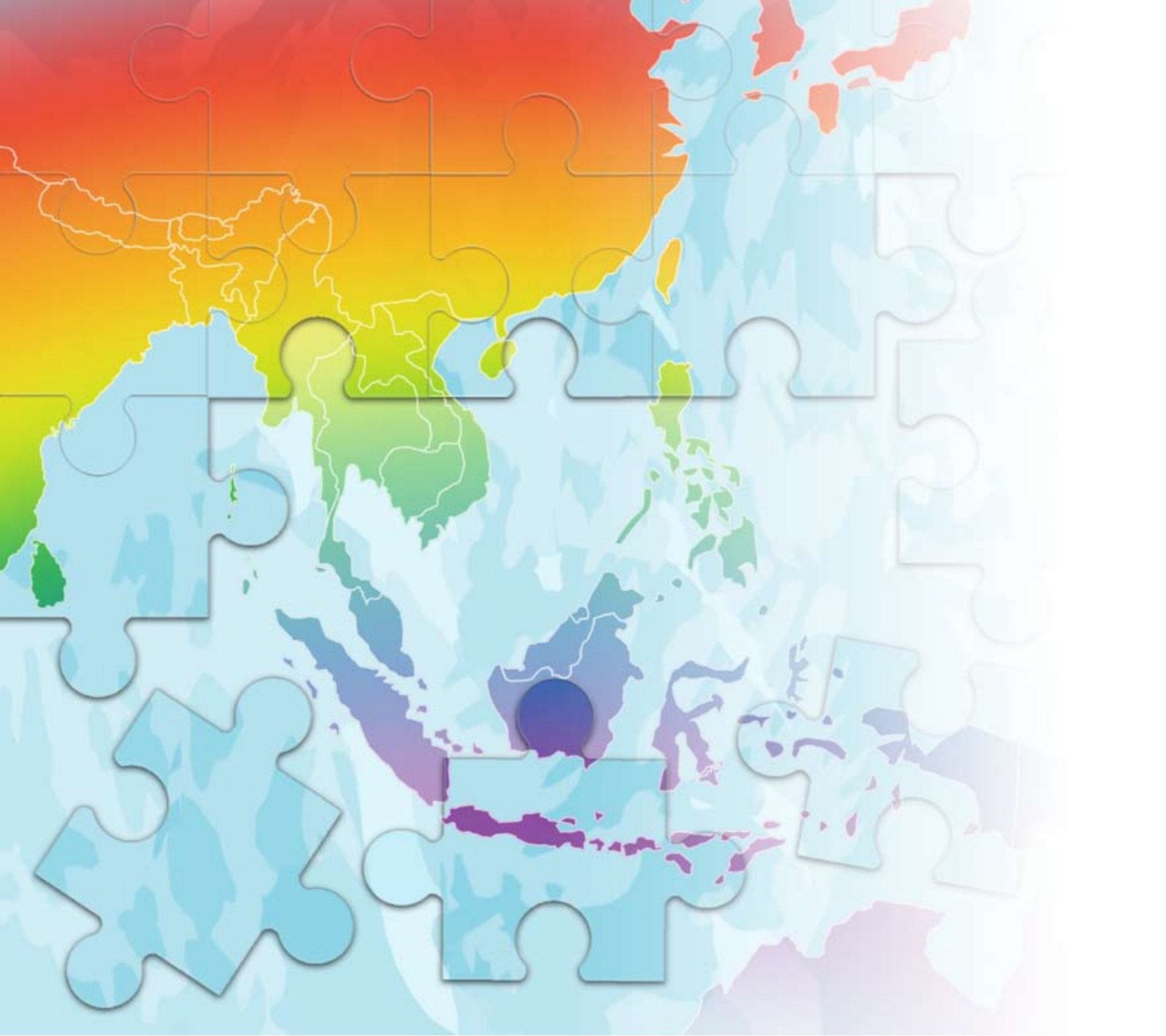


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"We struggled against apartheid in South Africa, supported by people the world over; because black people were made to suffer for something we could do nothing about: the colour of our skin. Sexual orientation is also a biological given; homophobia is as unjust as was apartheid."

Reverend Desmond Tutu, *Inaugural message at the official opening of the Male Sexual Health and HIV in Asia and the Pacific International Consultation: "Risks and Responsibilities."* - 23rd September 2006.

"You can be assured of the support of the United Nations Family in our common endeavour to win the battle against HIV amongst the MSM and transgender communities. If nobody else is there for you – we are here!"

Nafis Sadik: *Special Adviser to the UN SG and Special Envoy for HIV and AIDS in Asia and the Pacific. Inaugural message at the official opening of the Male Sexual Health and HIV in Asia and the Pacific International Consultation: "Risks and Responsibilities."* - 23rd September 2006.

"...for the very first time in 25 years, we have the resources, the political commitment and the public concern needed to begin turning the tide on this epidemic. We must collectively use this opportunity to end, once and for all, the killing failure to make the AIDS response work for gay and other men who have sex with men."

Dr. Peter Piot, Executive Director: UNAIDS Geneva, *video message at the closing of the Male Sexual Health and HIV in Asia and the Pacific International Consultation: Risks and Responsibilities – 26th September 2006.*

'My son Arif was detained for 47 days and 47 nights in an Indian jailI am a practising Muslim, a wife and mother with strong religious beliefs. I believe in compassion, justice and fairness. Section 377 of the Indian Penal Code is neither just nor fair. The pain of this discriminatory section is with me every day. And so are my fears and anger that Arif, and many, many others are not protected by the laws of my India. What a paradox!'

Fatima Annes (Mother of Arif Jafar, NGO worker arrested in India in 2005)

Why should we work with MSM and HIV prevention, care and support? Because it is the right thing to do on humanitarian grounds; it is the right thing to do epidemiologically; and it is the right thing to do from a public health perspective. Males who have sex with males, whether their self-identity is linked to their same sex behaviour or not, have the right to be free from violence and harassment; the right to be treated with dignity and respect; the right to be treated as full citizens in their country; the right to be free from HIV and AIDS; and MSM who are already infected with HIV have the right to access appropriate care and treatment equally with everyone, regardless if how the virus was transmitted to them.

Shivananda Khan, Chief Executive: Naz Foundation International