Comments on MSM, visibility and sexual health

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In the socio-cultural frameworks of South Asia, the issue of male to male sexual behaviours and their impact upon the reproductive and sexual health for both males and females has profound implications for any effective control and management of STDs and HIV infections. But because of cultural, religious and social reasons, these behaviours are to a great extent invisible, often difficult to access, and not framed within heterosexual and/or homosexual dichotomised constructions. Male sexual behaviours in South Asia appears to be much more polymorphous than the simplified reductionisms of heterosexual/homosexual identities would indicate, whilst anal sex between males and females and between males and males is much more common than has been assumed.

Anecdotal and direct research by Naz Foundation and its partner agencies in a number of South Asian countries, as well as newspaper reports and magazine articles and surveys, and work done by a number of gay identified groups/organisations in India, indicate significant levels of males who have sex with males in both urban and rural areas, as well as the existence of substantial levels of male commercial sex workers in urban areas. With this are the high levels of sexual activity, and multiple sexual partners by these males, significant levels of sexual access to females by many of these males including their wives, low levels of condom use and safer sex practices, with the concomitant high risks for HIV and STD transmission from these males to their sexual partners. Further many young males (both pre-adolescent and adolescent) are also involved in these activities. These behaviours are exacerbated by gender segregation, economic and age and gender power differentials, adult male ownership of social spaces, low levels of knowledge of STDs/HIV, and adult male sexual privileges.

At the same time male to male transmission of STDs and HIV will be largely invisible because of the low levels of testing by males, the lack of anal and oral STD testing in many clinics, and because such behaviours are denied by the males and females themselves.

This invisibility of much of male sexual behaviours is further exacerbated by the claim that transmission of HIV in South Asia is based on ÒheterosexualÓ intercourse, i.e. vaginal sex, which allows government, non-government, international and donor agencies to ignore the possibilities of wide-spread anal transmission. Whilst it is recognised that substantial levels of STD/HIV infections in South Asia are caused by vaginal sex, it also needs to be clearly and openly recognised that with the public and social denial of anal sex behaviours between males and between males and females,

its significant role in STI/HIV transmission is grossly underplayed, if not denied completely. Such focusing on vaginal sex as the sole (almost) route often ends up victimising females (particularly female sex workers) as the source of infection and disease, whilst it also often denies the male role in STD/HIV transmission. At the same time such a process by invisibilising the role that anal sex plays in transmitting STDs/HIV ensures that significant levels of sexually active males sees such a sexual behaviour as a safer option. "They have never said that unprotected anal sex can be dangerous, so I have always thought of it as a safer option," as one person reported to Naz Foundation.

All current research into constructions of male to male sexual behaviours in South Asia indicate that they do not fit the patterns of heterosexual/homosexual behaviours so common in HIV literature. There is no such clear cut dividing line. Sexual identities of South Asian males do not fit this Western pattern, and this creates further invisibility of sexual behaviour patterns. Many males who have anal sex with other males also have vaginal and anal sex with females. Many males who have sex with males are married. Early sexual encounters by many males are often with another male. But a major consequence of a heterosexual/homosexual labelling of the AIDS epidemic has meant that if there is any discussion on sexual transmission, males who have sex with m ales become subsumed within a category of "gay" or homosexual". This further marginalised and invisibilises the behaviour. Of course there are gay-identified males in South Asia. But they are overwhelmingly outnumbered by non-gay identified males who have sex with males, whether such males define themselves as *kothi*, *panthi*/*giriya*, *hijras* (who often are defined as " a third- gender", a male body with a women's soul, a hermaphrodite, a eunuch, a castrated male, a transvestite, a transsexual, or some such label- but it should be remembered that for the large part, hijras are biologically male and before they are castrated are functionally sexually males) *double-deckers*, or just have sex with other males for *maasti* or discharge. It becomes an urgent necessity to discover the true patterns of male sexual behaviours, as well as to recognise that anal sexual behaviours is a very common phenomena, if any effective approaches to HIV management and control is to be conducted in South Asia. After all unprotected anal sex is the most risky form of sexual behaviour in terms of transmission of STDs and HIV!

The consequences of unrecognised epidemiological patterns of STI/HIV transmission, whether through denial or invisibility, regarding the management and control of the epidemic should be clearly understood. The impact upon the epidemiological, social and economic frameworks need not be overstated where these have been discussed in other forums over the last 10 years. Clearly at the family level, such behaviours, should they lead to STD/HIV infections, have a devastating impact upon its economic

welfare. At the social level, the economic impact upon the country is also clearly recognised.

Because of social stigmatisation, invisibility and denial, there are almost no STD/HIV services in South Asia focused on the issues of males who have sex with males and/or anal sex behaviours. Sexual health information and services are focused on so-called ÒheterosexualÓ behaviours, i.e. vaginal sex, and ignore the high levels of anal sex, irrespective of the gender of the sexual partner.

At the same time there has been almost no effective and appropriate research conducted on the sexual health issues of male to male sexual behaviours, nor on any risk and needs assessments amongst such males, nor any effective and appropriate education and awareness programmes, or sexual health promotion campaigns targeting male to male behaviours, the situation needs urgent clarification, if South Asia is to have any realistic hope in enabling the control and prevention of STDS and HIV, and reduce the risks of increasing numbers of people living with AIDS in the region.

What does exist? Humsafer Trust in Bombay working primarily amongst gay identified men and their partners under the sterling leadership of Ashok Row Kavi. CAN in Madras which works primarily amongst male commercial sex workers, Naz Foundation (India) Trust which is now working amongst gay-identified men, male commercial sex workers, street males who are sexually active with other males, and other networks of males who have sex with males, Praajak (Naz Calcutta) which is working amongst males who have sex with males, Bandhu Social Welfare Society in Dhaka working amongst civil and professional *kothi*, *panthis* and also rickshaw drivers, hotel boys and truck drivers who also have sex with other males, and Association for Health and Social Development, also in Dhaka working with gay-identified men and those with emerging gay identities. There is work evolving through Friends India in Lucknow with increasing support from Naz Foundation, GAY in Bangalore, and other groups in a number of other cities in India. In Sri Lanka, Companions on a Journey have begun developing a sexual health and advocacy programme primarily amongst gay identified males.

These few projects in a population level of over 1 billion people in South Asia. And apart from the number of gay groups trying to develop a framework of sexual health promotion amongst their constituents, Humsafar Trust and CAN, all the others have evolved out the work of Naz Foundation. What about Pakistan and Nepal? What about male sex workers? Street males? Male domestic servants? Hostels, male only institutions? Males who have sex with males and are intravenous drug users? Sexual abuse of males in families and by neighbours? Male dorms? Male Gulf workers from

South and West Asia? Male refugees who have sex with males? Male to male sexual behaviours arising from traditional ad religious beliefs? Male gift sex amongst tea shop boys, hotel boys, rickshaw drivers, truck drivers, construction workers, businessmen who travel, business men who don't trave, male factory workers, male teachers, tutors, ...

Vulnerable Groups

The majority of males who have sex with males will also have sex with females, many of them their wives. Because the level of unprotected sex in the male to male sexual networks is very high, such behaviours increase the vulnerability of females, in particular married women, in terms of their reproductive and sexual health Further, social and cultural structures such as homoaffectionalism amongst males in South Asian societies, the ÒapprenticeshipÓ models in working environments, gender segregation, delayed marriages, and the high levels of poverty and unemployment, indicate the vulnerability of young males to STD and HIV transmission from sexual encounters with other males.

The Need

There is a clear need to understand the dynamics of male sexual behaviour patterns, both in the urban and rural settings to provide effective information towards developing appropriate strategies for reducing the levels of risky sexual practices amongst them. This not only includes sexual behaviour research amongst males who have sex with males, but also exploring methodologies for encouraging safer sex practices amongst them, as well as ensuring that appropriate sexual health services and products are easily accessible to them.

However, it is clear that because of the issues of denial, invisibility and stigmatisation, the frameworks utilised in such work would have to include the beneficiaries of such work. This means that the development of research, the production and distribution of sexual health products and the availability of sexual health services must be peer-led.

There is an urgent need to educate people about the risks of unprotected anal sex as much as has been given to vaginal sex. There needs linguistically appropriate education materials about STDs and HIV where anal sex is the route of transmission. There needs to be greater accessibility to appropriate condoms suitable for anal sex and appropriately packaged sachets of water-base lubricant, readily and easily available. There needs to be education and sensitising work done amongst STD clinicians and doctors. There needs to be a greater recognition amongst government and nongovernment agencies working in the field of reproductive and sexual health,

STDs and HIV about the levels of anal sex behaviours and they should be encouraged and empowered to include such issues into their work and education materials.