

Males Who Have Sex with Males (MSM) and HIV/AIDS in India: The Hidden Epidemic

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ABSTRACT

This article presents a discussion of the role that males who have sex with males (MSM) have in the HIV/AIDS epidemic in India. Among South Asian countries, India has the highest prevalence of HIV/AIDS, in which the proportion attributable to MSM may be under-reported, and not well understood by policy makers. A discussion of the social and cultural context in which males have sex with other males includes sexual behavior patterns, religion, socio-cultural factors, and legal considerations. The article also considers the implication of the reality of the lives of MSM for the HIV/AIDS control programs in the country, including measurement issues, behavior change, anonymous voluntary testing and counseling, the continuum of care, and human rights. The article concludes with recommendations: (1) a call to end the polarization between “MSM” and “gay” models for community work; (2) the need for better scientific research and linkages to policy regarding MSM; (3) the need to work toward a more open social discourse on sexuality in India; (4) recognition of the need for intersectoral work to support work with MSM; and (5) the importance of working toward the destigmatization of HIV/AIDS among policymakers and the lay public.

INTRODUCTION

HIV/AIDS EPIDEMIC IN INDIA

There were an estimated 3.5 million people living with HIV and AIDS in India in mid-1998.¹ Large variations in HIV prevalence have been noted between risk groups and regions of the country: the prevalence of HIV in truck drivers ranged from 4.98 percent to 8.2 percent,² and among pregnant women, rates have been estimated at between 0.69 percent and 3.4 percent.³ In some states, particularly in southern and western India, HIV has a significant grip on the urban population, with more than one pregnant woman in 50 testing positive. In the northeast, HIV infection has spread rapidly through networks of men who inject drugs and has spread to their wives.⁴ Yet other Indian states have only detected their first HIV infections in the last year or two. It is important to note that the health statistics for the population of India (currently estimated at over one billion) have global implications: a small percentage change in national infection rates in

India inevitably results in large changes in the total number of people infected worldwide. For example, a rise of just 0.1 percent prevalence among adults in India would add over half a million people to the world total of adults living with HIV.

HIV STATISTICS AND MSM

The contribution of MSM to the HIV/AIDS epidemic in India is officially set at 1 percent.⁵ However, these estimates may seriously underestimate the importance of MSM to the epidemic in India, especially since global estimates suggest that 5 percent to 10 percent of HIV prevalence is attributable to sexual transmission between men.⁶ Truck drivers are a group known to have higher levels of homosexual behavior than the general public.⁷ Therefore, the high rates of HIV infection among truck drivers may be an indicator of the importance of homosexual transmission in the India epidemic because homosexual behavior also takes place outside of this particular group.

There are a number of social factors that lead us to expect that MSM in India may not be recorded as either a risk group or even be recorded in current surveillance activities. Since many MSM are married to women, marital status cannot be used as a proxy for sexual activity with persons of the same sex. Unfortunately, figures relating to the prevalence of sexual practices in the Indian subcontinent are unavailable, rendering it difficult to project the contribution of MSM to the HIV epidemic. Sexual segregation and taboos around premarital sex create a climate in which MSM behavior is rarely discussed, but it is widely tolerated as long as it remains out of public view.⁸

International studies of same-sex desire demonstrate that proportions of populations in different places in the world and in different historical periods has been fairly constant.⁹ What varies in time and place is how this desire is expressed and how the dominant society responds to homosexual behaviors. Genetic explanations for such desire and resulting social and sexual behavior have been considered as well.¹⁰

SOURCES AND METHODS

The materials and perspectives synthesized in this article are drawn from the experiences of the authors with the HIV/AIDS epidemic in the United States and in South Asia. This experience includes clinical and community work, academic research, and public program leadership. In addition, some of the authors draw on personal experiences as gay men who have worked in movements to combat HIV/AIDS in U.S. and India. For the purposes of this article, the region of South Asia is considered to be the contiguous nations of Bangladesh, India, Nepal, and Pakistan. The region of South Asia (with the exception of Nepal) is also referred to as the "Indian subcontinent."

Much of the material presented in this article was developed at a historic conference held in Calcutta, India, in March 1999, which brought together non-governmental organizations (NGOs) who work with MSM and HIV/AIDS in South Asia.¹¹ The meeting was organized by the Naz Foundation International, a U.K.-based NGO, and its partner agencies in India. The 84 mostly MSM participants came from Bangladesh, India, Pakistan, and Sri Lanka and included international observers. Workshops touched on aspects of MSM life as they relate specifically to HIV/AIDS, such as problems with police and government, religious issues, relations with family and women, living with AIDS, and male sex workers. A significant proportion of the workshop was devoted to disseminating information on modification of risk for HIV.

The term MSM as it is used in this article refers to "males who have sex with males." It has also been used to describe "men who have sex with men;" however, since many males do not conform to a particular minimum age that defines them as "men," we propose the uniform use of "males" rather than "men" in the term. While MSM is used descriptively to refer to behaviors, without any presumption as to sexual identity, the word "gay" as it is used here has connotations of social and sexual identity. "Homosexual" is used to describe behaviors taking place as part of a sexual act or series of acts between two individuals of the same gender. While it would seem that "MSM," "gay," and "homosexual" are interchangeable terms, the reality in India and elsewhere is that "MSM" has also developed independent social connotations relating purely to homosexual behavior within a variety of social contexts, and is equally applicable to married men as well as

those who define themselves as gay.¹² For the purposes of this discussion, the word “homosexual” will be used as a neutral term, referring to gay and MSM sexual behavior.

OUTLINE

In the second section of this article, the social and cultural realities of MSM as they relate to HIV/AIDS are discussed. In the third section, we present the implications of the reality of the lives of MSM for public health programs that address HIV/AIDS. The concluding section makes specific recommendations for research and policy that can facilitate progress towards control of the HIV/AIDS epidemic in India.

MSM IN INDIA: SOCIAL AND CULTURAL ISSUES RELEVANT TO HIV/AIDS

In this section, the social and cultural circumstances which, in many cases, define the lives of MSM in India are discussed as they relate to the HIV/AIDS epidemic. It is difficult to generalize about a region as large and as diverse as South Asia, a region generally agreed to comprise the nations of Bangladesh, Bhutan, India, Nepal, Maldives, Sri Lanka, and Pakistan, with well over a billion people and, in many cases, porous borders that lead to a constant flow of people across national boundaries. Such a study must consider the numerous linguistic, religious, socioeconomic, and cultural groups that comprise the region.

Some commonalities do exist, however, especially with regard to social taboos and some societal norms and values. One commonality that is useful in understanding male relationships in South Asia is the “homophilic” nature of those relations. Life in South Asia tends to be gender-segregated. The tone of relations between men is expressive with regards to touch, and expressions of physical tenderness between men are commonplace.¹³ It is not rare for men to walk hand in hand in the street, nor for male friends to share a bed. All-male settings are common in India and in its neighboring countries and include hostels, guest-houses, teashops, and sleeping quarters. Migrant men in cities frequently live in hostels or with other migrant men, and this provides the opportunity for sexual relations to occur. In addition, women are discouraged from visiting certain public places, including bars, in India, which effectively renders them all-male. Therefore, the issue raised here is not about sexual relations, but the very distinct social context in which men find themselves. Sexual relations between men in India need to be understood within this more general context of homosocial relations.

HIDDEN BEHAVIOR AND STIGMA

MSM behavior in India is both stigmatized and hidden, and a distinction must be made between the two concepts. The stigmatization of homosexual behavior in India derives from images that have been seen in the international media. Fear and hatred of what is received from abroad results in an Indian homophobia that is attached to anti-Western sentiments.¹⁴ Public discussion of homosexuality elicits strong reactions of disgust in public discourse.¹⁵ This disgust frequently includes distaste for the perceived decadence and immorality of American and European society. Anti-colonial and anti-imperialist traditions in Indian culture reinforce the homophobic elements incipient in the culture of the subcontinent. In addition, a widely perceived religious prohibition against homosexual behavior also results in stigma, and is discussed below.

While “gay” identity is stigmatized in India, MSM can be more accurately described as hidden. Historians of sexuality have commented that modern European culture is not as “tolerant” of sexual diversity as it has developed a distinct discourse around it.¹⁶ In India, conversely, there is a lack of public discourse about same-sex experiences that further inhibits constructive actions based upon it.

MSM BEHAVIORS AND IDENTITIES

Kothis, Panthis, and Double-Deckers

Despite the hidden nature of MSM in India, a distinct “underground” culture flourishes.¹⁷ This culture has distinct linguistic and behavioral patterns among groups of men. While these patterns appear to be shared across broad areas of the subcontinent, consultations and group meetings reveal that open communities of MSM do not exist in any region.¹⁸

MSM tend to be categorized as either *panthis* or *kothis*.¹⁹ *Panthis* consider themselves the masculine partners and are the insertive partners in the context of sexual intercourse. They tend to be stereotypically masculine in appearance and behavior. *Kothis* tend to be sexually receptive and display effeminate mannerisms and appearance, including gestures and details of clothing.

Similar to the use of the English word “queen,” the Hindi word for queen, *rani*, is also used to designate MSM. Local variants of these terms are in use in different parts of India. In Cochin, the equivalent terms for *kothi* is *menika*, while the equivalent term for *panthi* is *sridha*. In Delhi, the equivalent term for *panthi* is *giriya*; however, the term *kothi* remains in use and is not generally replaced with another term. Similarly, in Calcutta, while *kothi* and *panthi* are in use, common synonyms for both are, respectively, *durani* and *parik*.²⁰

These terms are prominently used among *kothis*, but the masculine partners, that is, the *panthis*, do not necessarily categorize themselves according to this terminology. That is, *kothis* tend to categorize some of their partners as *panthis*. In addition, the distinction between *kothis* and *panthis* is more based on cultural meaning than on sexual behavior: many MSM will admit that sexual actions cross the strict lines of these stereotypes, and many MSM have experienced both insertive and receptive sex.²¹ It is unknown whether identifying as a *kothi* or a *panthi* in a social context actually predicts exclusive sexual role of the individual.

The term “double decker” or similar local variants are used to denote men who are both sexually active and passive. The equivalent Hindi term is *do paratha*, which is the name of a popular two-layered bread. Little is known beyond anecdotal reports regarding the prevalence of sexual acts or their proportions in the MSM context.²²

Behavior and codes of communication are well known and are recognized among MSM throughout the subcontinent: flirtation and sexual advances are recognized by other MSM but might not be understood by heterosexual, non-MSM men or heterosexual women. The world of the MSM is hidden by choice, so as to avoid the stigma inflicted upon exposure. The stereotypical behavior of *kothis* and *panthis* is therefore usually reserved for safe spaces, such as social gatherings of MSM, and for other non-threatening locations.

Manliness and Musti

Another important aspect of MSM in the subcontinent is the meaning of manliness. Many men consider it a display of sexual prowess for an older, sexually dominant man to have sex with a young and/or submissive man or boy. Jokes and folk knowledge regarding sex incorporate this theme and create some flexibility for socially acceptable MSM behavior in an otherwise repressive environment.²³ The notion of *musti* also provides an open space for sexual behavior. *Musti* is translated as “fun or mischief” in Hindi and Urdu; the word is understood by most to describe sexual release through ejaculation and non-penetrative sex. In that sense, oral sex or mutual masturbation is not considered to be “sex,” which affords for wider license to be given to *musti* between men. A phrase commonly heard is that a particular liaison was “just *musti*,” connoting that it is not to be taken seriously, and therefore below the level at which it would draw moral opprobrium. *Musti* is also tacitly acknowledged as a common part of boyhood experience: it is considered of little consequence, and it is believed that boys grow out of this behavior.²⁴

“Gay” and “MSM” Models in India

Because of the hidden nature of MSM in India, the issue of gay identity has become problematic, which has caused the model for gay identity and the MSM model to develop along somewhat separate paths. The gay identity model advocates, in addition to homosexual behavior, an acceptance of the “gay lifestyle” as understood from international example. The MSM model starts with existing patterns and focuses on self-acceptance and integration of MSM into the existing societal context, and into current individual relationships. A rancorous debate between those working with different models has occurred at meetings and via the Internet.²⁵

The focus of the gay identity movement in India is in Mumbai (Bombay).²⁶ Bombay Dost (*dost* is a Hindi term meaning “friend”) is a Mumbai-based NGO forming the focal point for those working with the gay identity model. It includes a community center and a periodical publication with an international circulation. Much of the early work drawing attention to the HIV epidemic in

India was conducted by Bombay Dost. However, while the Bombay Dost experience is historic in the subcontinent, we perceive the gay identity movement as having certain limitations.

The MSM model represents a serious alternative to “gay identity” as a vehicle for work to curb the HIV/AIDS epidemic in India. The MSM model is well-represented in NGOs such as Sahodaran, Prakriti, Praajak, and others. MSM work in the community with the dual aim of curbing HIV/AIDS and promoting male sexual health; however, MSM may not even be mentioned in publicly available materials. The MSM-related interventions, while a core mission of these groups, remains a private matter, discussed between staff members and in confidence with clients. While many of the leaders of these MSM-oriented groups might indeed consider themselves to be “gay” when put in a European or North American setting, they prefer to talk about MSM as a behavior rather than as an identity. MSM workers also stress the class-bias of “gay”-oriented work in India: the perception exists among these workers that those within the gay identity model belong to a higher socio-economic strata, and, with greater access to Western media and culture, embrace what is inherently a Western construct.²⁷

Hijra: The Limiting Case

Hijras are the most well-studied type of homosexual in the subcontinent.²⁸ *Hijras* have a lengthy recorded history, including mention during the Mughal Period, when some worked in royal courts as entertainers and artists. *Hijras* are males who adopt female dress and identity and typically live in groups led by a *guru* (older leader); some *hijras* self-castrate to complete a process of separation from male identity. They do not marry or take part in mainstream social functions; they exist in Hindu and Muslim societies in all the countries of the subcontinent in a similar form.²⁹ Typically, *hijras* work as singers and dancers in social functions such as weddings and feasts. While this tradition continues, some *hijras* also support themselves through prostitution. Even though it is a widely-held perception that *hijras* are only sexually receptive, in reality they also are asked to be sexually insertive by some of their clients.³⁰ *Hijras* represent a limiting case of male homosexuality that is separate and distinct from most MSM. Despite their long history, *hijras* are generally a socially marginalized community; they do not identify with the *panthis* or *kothis* described above. Their secluded lifestyle and risk factors predispose them to HIV/AIDS, sexually transmitted diseases (STDs), and a variety of other physical and mental health issues. As such, they are one of the populations most in need of services related to the above.

RISK BEHAVIORS

Places

MSM sexual acts take place in a variety of places, while sexual intercourse takes place in private places (rooms, hostels, hotels, and restaurants), and public places (public toilets, bus stops, alleys, cinema halls, temples, railway/bus stations, and construction sites).³¹ Such places become well known among a particular group of MSM and are frequently utilized until the police or some other factor forces a change of venue. Some bars or restaurants may be tolerant of homo-affectionate behavior, but sexual advances must be more discreet. There are no bars or restaurants in India that could be called openly “gay” as are found in many other, particularly Western, societies.³² Private parties are less common than might be expected: many in India live in communal or extended household settings that do not accept MSM-oriented socializing.

Acts

Large-scale survey-based information on MSM sexual acts does not exist. However, some limited survey-based information on MSM sexual acts has been collected in several cities in India and in neighboring Pakistan and Bangladesh.³³ A large part of what is known comes from ethnographic sources. Anal sex, oral sex, frottage, and mutual masturbation are all considered common.³⁴ There is, however, little quantitative evidence for the prevalence of these behaviors among MSM beyond anecdotal reports. Condom use is reported to be uncommon. In addition, condoms are thought of primarily as a family planning method in India,³⁵ therefore, the MSM population in general does not identify them as a protective method for same-sex acts. Sterile lubricants intended for use during sexual intercourse are rarely available in places where sex occurs: hair oil, cooking oil, and spit are the most commonly used form of lubricant. At present,

commercial lubricants in pocket-sized sachets or containers are not made available in the subcontinent.

Social Context of Sexual Relations

While male commercial sex workers (CSW) are common in the subcontinent, most of MSM is embedded in complex social relations. To exchange money for sex as a part of earning a living by other means is common.³⁶ MSM brothels do exist in the subcontinent but are a rarity. Requests for money are a variable part of the activity in the parks, public toilets, and other places described above. Men who provide massage are also frequently willing to provide sex for money; this can happen in a hotel room, a health club, or a house. A range of sexual services are typically offered and usually involve giving oral sex or masturbation. Sex is also provided in return for favors such as help to find a job or housing. In summary, there is a continuum of relations between men from financial to social in which sexual relations can occur.³⁷

CULTURE, SOCIETY, AND MSM

Family and Wives

Family is central to the lives of many in South Asia, to an extent sometimes not appreciated by many in the West. In many cases, marriages are arranged by parents, and the newly married couple lives with the family of the groom. Having children is strongly encouraged, beginning soon after marriage. In such an arranged marriage, where particular likes and dislikes may not be considered by the family elders making the match, issues of sexual preference are usually not an area of consideration.

It is frequently observed that MSM in India marry and have children.³⁸ The intense social pressure of the family is not conducive to the formation of either a gay identity or long-term, exclusive sexual relationships between men. Even in an urban environment, which has historically provided anonymity for men to create gay communities, as in Western societies, such opportunities are overshadowed by family ties.

Religion

The diversity of religious beliefs in the subcontinent adds another dimension of complexity. Despite the fluidity in the beliefs and practices of Hinduism (the predominant religion in the country), India is a conservative society, and the contemporary interpretation and practice of the major religions in the subcontinent (Hinduism, Islam, and Christianity) ban or shun homosexuality. Muslims have very specific dictums and punishments for male homosexuality. Sodomy is a severely punishable offense, according to interpretations of Shariat law, the basis of religious law in Islam:³⁹ depending on the setting and interpretation, sodomy can be considered punishable by decapitation, by throwing the guilty off a cliff, or by pushing a brick wall on top of the offender. While Shariat law has no formal legal status in India, it sets a cultural norm for the 120 million Muslims living in India. With respect to Hinduism, the status of homosexuality is less clear-cut: Hinduism offers many models for homosexual love in the extensive set of stories about gods, goddesses, and demons; however, in terms of contemporary mores and norms, the overall conservatism does not tolerate homosexuality, as evidenced by recent backlash against homosexuals.⁴⁰ Christianity, as practiced on the Indian subcontinent, follows European and American trends, which interpret Biblical references as prohibition.⁴¹ Buddhism, Jainism, and other regional religions represent an important area in which the issues around religion, MSM, and HIV/AIDS need further study.

Civil Society, the Law, and Police

In India, homosexuality is governed by Section 377 of the Penal Code, which prohibits sex between men.⁴² The law forbidding “carnal intercourse against the order of nature” was enacted during British rule and dates from 1861: As a result, homosexual sex is framed as an “unnatural act” in India as well as in Bangladesh, Pakistan, and Sri Lanka, countries that share the legacy of British colonial law. While prosecutions under Section 377 are rare, fear of the law is a tool used by the Indian police and can result in threats or blackmail.⁴³ The distribution of condoms in public can precipitate police action, and Section 377 is used as a general tool to break up any perceived

MSM public gathering. Rapes and assaults, especially of the feminized *kothis*, by police in local jails are reported as frequent. This climate of fear adds another challenge to public health work, particularly within the context of outreach intervention.

HIV/AIDS CONTROL PROGRAMS AND MSM

MEASUREMENT ISSUES

Current methods for collecting data on the dynamics of HIV/AIDS in India have proven limited. Clinical reporting of disease as a source of data is dependent on the willingness of providers and patients to provide data collection agencies with detailed and accurate information. Survey-based approaches have also not accurately captured the role of MSM in the epidemiology of HIV/AIDS in India: questionnaires that use the variable of “marital status” in the absence of other variables relating to sexual preference will not capture useful information regarding MSM. Similar problems are encountered with non-examination-based information regarding anal and oral manifestations of STDs.⁴⁴

Special interventions that work through confidential networks may be a useful tool to study this dimension of the epidemic.⁴⁵ Groups working with MSM have access to networks in which behaviors and diseases can be studied, but these groups have not been made a part of official government AIDS control programs yet. For example, successful models exist in the subcontinent that can be used to increase our understanding of highly stigmatized behavior and the spread of STDs: these include interpersonal communication, creating networks of at-risk MSM, and community-based outreach efforts.⁴⁶ In addition, current epidemiological methods exist that do not require names of persons tested for HIV/AIDS; confidentiality can therefore be maintained without compromising data quality.⁴⁷ However, one of the major barriers to implementation remains the lack of recognition of MSM as a high-risk group in India.

BEHAVIORAL CHANGE

A great deal has been learned around the world about behavior change in relationship to HIV risk.⁴⁸ The application in India and elsewhere of behavior-change interventions has been most effective when appropriate modifications were made to suit the unique construction of homosexual behavior as well as the local cultural norms.⁴⁹ Specific interventions around particular places and behaviors should be favored over generic behavior-change approaches. Promotion of safer sex and condom use must take into account the discomfort many men feel while buying condoms in a public commercial setting. Encouragement of non-penetrative sex requires open discussion of sexuality in safe settings; therefore, identification of appropriate settings for such activities is vital. As part of information, education and communication (IEC) efforts to promote behavior change, condom distribution, and related education and outreach in public places (such as parks) have been successful.⁵⁰ However, such work is currently restricted by police practices that do not allow public distribution of condoms in some parks.⁵¹ As mentioned earlier, there is a lack of acceptance of condoms as an STD prevention method, since condoms are strongly associated with heterosexual sex and with family planning, a trend observed elsewhere as well.⁵² An atmosphere of extremely limited discussion around anal STDs and HIV/AIDS among MSM compounds problems associated with low use of condoms and lubricants.

IEC methods that utilize a variety of media, such as radio and television (mass media) and peer outreach (community-based media), have served as cornerstones of behavior change in countries that have had success in curbing STDs and HIV/AIDS.⁵³ In particular, the promotion of anonymous and voluntary counseling and testing (ACT) are means of prevention that hold significant promise in the Indian context. In developed nations, testing is linked closely to treatment such as protease inhibitors and highly active antiretroviral therapy (HAART). However, the utility of testing and counseling as a method of behavior change in and of itself must not be neglected.⁵⁴ The next two sections of this article discuss the implications of these programs for work with MSM.

Public Education

Widespread IEC interventions in India have already led to an increase in understanding among the general population as to how the disease is spread.⁵⁵ The next steps in such efforts need to address issues of destigmatization of HIV/AIDS; this is especially necessary among the MSM population that suffers already from considerable stigma. While models from a number of countries already exist, specific public education around issues of MSM is of doubtful utility in India at present. The intervention needs to weigh the potential benefit against the damage wrought by public backlash and insensitively handled education efforts. Although the increasing tolerance for sexually oriented public discussion may help foster constructive IEC efforts, it is the belief of the authors that direct public discussion of MSM may be premature in most areas of the subcontinent. MSM-oriented interventions need to be conducted cautiously and in confidential, safe settings. At present, the most successful model has been to frame the discussion as concerning risk behaviors associated with HIV/AIDS and men's sexual health. This provides an adequate context within which MSM-oriented interventions can be conducted. There is widespread consensus within the MSM community on this issue, which provides validity to investigators working in this area.⁵⁶

ACT

ACT is an essential aspect of many HIV/AIDS prevention activities; it needs to become a norm for MSM-related HIV/AIDS interventions as well.⁵⁷ The lack of knowledge of one's HIV status allows the virus to continue to spread without recognition or response. Those who test HIV positive tend to adopt safer-sex practices, and ACT has been understood as a crucial part of changing social norms, which has slowed the spread of the disease in many countries.⁵⁸ Since public knowledge of how the disease spreads has not in and of itself been proven to change behavior, more focused approaches, such as aggressive ACT, may therefore be important strategies to be undertaken in India.

Due largely to the hidden nature of the behaviors and the stigmatized nature of HIV/AIDS in India, MSM will generally not come forward for counseling and testing unless anonymity is ensured.⁵⁹ Therefore, the distinction between "confidential," when anonymity is attempted but not ensured, and true "anonymity," when no recording of names is made, needs to be clarified to the audience targeted for such services. Modification of clinical practice in large public clinics is essential if the clinics are to play a positive role in the control of the epidemic. NGO and private-sector healthcare have for a long time played a major role in the treatment of STDs in India: all social classes rely on the private sector for a large proportion of their care.⁶⁰ The government and international development agencies can play a role by encouraging the private sector with education programs for healthcare professionals, providing quality control criteria to private laboratories, and assisting in the development of best practices for counseling and outreach. These ends can be reached by setting examples and by setting standards of practice for the private sector. Public sector investment should seek to leverage private sector activity without displacing large amounts of public sector investments. Existing models for these partnerships in other settings, as well as the authors' experiences and consultations with colleagues in the government sector, indicate a growing willingness to participate in such collaborative activities.⁶¹

THE CONTINUUM OF CARE FOR HIV/AIDS PATIENTS

The continuum of care for HIV/AIDS has been advanced mostly in developed countries, mostly due to the prolonging of life and an improved prognosis for those testing HIV-positive due to the advent of triple therapy and HAART.⁶² This continuum has come to include a set of modalities including prevention, treatment of opportunistic infections, HIV syndrome treatment, antiviral drugs, social/psychological care, and palliative care. Using this methodology, work has begun on the care of the persons living with HIV/AIDS in India, undertaken largely by the NGO sector.⁶³ However, sensitivity to the needs of HIV-positive MSM living with HIV/AIDS has not been dealt with. This may be due to the relative invisibility of MSM, which makes tailored care difficult to address, and because it is not known whether MSM in India have a unique clinical or psychosocial presentation of HIV/AIDS.

Anal STDs may have special relevance to MSM with regards to medical care: anal warts, anal gonorrhea, and other sexually transmitted infections are, according to NGO-based clinics and the authors' experiences, common among MSM and represent special treatment needs in the context of HIV/AIDS.⁶⁴ However, knowledge among medical professionals regarding anal STDs (whether in men or women) is generally lacking.⁶⁵ In addition, it is unlikely that patients who are MSM will offer this information to doctors except in safe settings.

The provision of care for MSM in India is therefore problematic because of the hidden nature of MSM as well as the inadequate information among public health medical professionals. While it is likely that a resource limitation also exists with regards to such care, the basic foundation of the care continuum is so underdeveloped that issues of healthcare financing have not yet been approached or discussed to any significant degree.

WORKING WITH WOMEN

Given the current reality of the lives that MSM live in India, in that many are married or involved in heterosexual relationships, working with the female partners of MSM is a crucial recommendation for HIV/AIDS prevention. Current models for counseling involve educating MSM about the risk they impose on their wives. There are some particular problems with the range of recommendations, however. Abstaining from sex with wives is not always practical, and using condoms with the female partner/wife when birth control is not desired can be problematic. This aspect of MSM intervention is at an early, formative stage, since the need to maintain confidentiality must be balanced against the desire to prevent additional morbidity and mortality in the female partners. Contact tracing may not be useful for work with MSM as it would discourage participation of the people the program is trying to reach. Along with strong recommendations for condom use (and, in some cases, provision of free condoms), counseling of MSM to begin to an open, if limited, dialogue with their wives about their male sexual partners is currently an active recommendation in most counseling settings.⁶⁶ At present, however, even MSM who are themselves public health workers involved with HIV/AIDS prevention suggest that no discussion of their work takes place with their wives and family, and that the possibility of any discussion regarding personal sexual preference is even more remote.⁶⁷

As discussed above, MSM interventions are conducted in the context of HIV/AIDS and male sexual health. The relationship of the presenting disease entity to the behavioral aspects of MSM is introduced to the client following the establishment of trust on the part of the provider. A possible next step is to develop models for working within the context of families of MSM.

CONCLUSIONS AND SUMMARY RECOMMENDATIONS

The material in this article has been presented in a dispassionate and perhaps clinical fashion that does not adequately convey the oppressed nature of the lives of MSM in India: injustice and intolerance are routine, creating tragic circumstances for many MSM, with the potential for fulfillment and happiness available to very few. While the authors are deeply concerned about the broad social conditions that frame the lives of MSM in India, the recommendations in this section are modest and represent what may be feasible next steps. These realizable changes may help control the spread of HIV/AIDS; they are recommended based on successful models used in India and elsewhere, current projects that are underway, and an understanding of interventions that are realistic within the social context of Indian society. It should be made clear that this article is not promoting any particular social agenda; the issues raised herein are informed by the principles of epidemiology and medical anthropology, and focus on public health measures that can help curb the HIV/AIDS epidemic in India.

First, we recommend an end to the hostility between those working with the two predominant models relating to homosexuality in India, that is, the "gay identity" and "MSM" models: the two models should be considered as complementary and not contradictory. India is a diverse nation within a subcontinent of even greater diversity and porous borders. A biomedically and socially complex syndrome such as AIDS cannot be expected to be addressed with a single perspective.

Second, there is a need for scientifically rigorous and systematic study of MSM behavior in India to measure the extent, distribution, and diversity of risk behavior and its contribution to the HIV/AIDS epidemic. Existence of the appropriate methodological underpinnings and public health imperative make it essential for current epidemiological studies to take into account the MSM population, and for researchers working on the social aspects of MSM behavior to include examination of HIV/AIDS and related health issues.

Third, the communities that are concerned with MSM interventions must include as a common goal the destigmatization of sexuality. The forging of a culture that can more explicitly and constructively deal with sexuality is necessary if HIV/AIDS is to be controlled. The authors believe that direct public discussion of homosexuality and MSM may be premature in most of the subcontinent. For now, public discussion of risk behavior associated with HIV/AIDS and the promotion of male sexual health provide an adequate context for MSM-related outreach, counseling, and care.

Fourth, the issues raised by MSM in India make it clear that work on HIV/AIDS must be intersectoral. In particular, public health workers must be protected from interference from law enforcement. Careful negotiations between parts of government should coordinate efforts to ensure that prevention work can proceed in all relevant settings.

Fifth, HIV/AIDS as a disease syndrome must be destigmatized in India. During the early years of the HIV/AIDS epidemic in the U.S., many communities worked to increase awareness and decrease the fear of HIV/AIDS.⁶⁸ These early steps were critical in curbing the spread of HIV/AIDS by breaking the silence around a deadly disease. This work has begun in India and must grow in communities all over the country. In India, frank and open discussion of AIDS will help people change behaviors that can stem the spread of the epidemic.

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