

Conspicuous by our absence

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As the 8th International Congress on AIDS and the Pacific looms ever closer, where some 3000 people will gather together in Colombo Sri Lanka to share, discuss and learn from each other's experiences in confronting the challenge of HIV in the region, one stark fact stands out. Male-to-male sex, risk and vulnerability often seems to be conspicuous by its absence in national AIDS plans, an invisible population, where we are facing an often unacknowledged public health crisis. A soon to be published report from UNAIDS (Men who have sex with men – the missing piece in national responses to AIDS in Asia and the Pacific, Joint United National Programme on HIV/AIDS, 2007) points out that, while it is conservatively estimated that there are at least 10 million males having sex with males (usually identified by the acronym MSM which includes gay identified men, other men and feminised males who are involved in male-male sex, and transgendered male-to-female persons who have sex with men) in the Asia and the Pacific, and despite having higher infection rates than the general adult population, investment in supporting HIV prevention, care and support services focusing on the health needs of MSM is usually abysmally low in national AIDS programmes is usually between 0% to 4%. Further, the report goes on to say that only about one in ten MSM in the region, have access to any sort of HIV services.

All across the Asia and the Pacific region there are a number of concentrated HIV epidemics among MSM, but spending on HIV prevention care and support does not match need. Thus, in Thailand, which reported an enormous growth of HIV infection among MSM from 17% in 2003 to 28% in 2005 (Van Griensven F, Thanprasertsuk S, Jommaroeng R, Mansergh G, Naorat S, Jenkins RA, Ungchusak K, Phanuphak P, Tappero JW and Bangkok MSM Study Group., Evidence of a previously undocumented epidemic of HIV infection among men who have sex with men in Bangkok, Thailand. *AIDS* 2005, 19:521-526.), investment in MSM HIV programming was just over 1% of the total national plan spending (HIV expenditure on MSM programming in the Asia-Pacific region, *Constella Futures*, 2006, *Constella Futures*).

If anything this mismatch between need and reality is a clear indication of the stigma, discrimination and social exclusion, confounded by the often harsh victimisation by the state and individuals that are meted out to those visible MSM, particularly so when many countries have laws that make adult consensual same sex behaviours illegal creating social environments that not only impede the development of appropriate HIV services for MSM, but also impede access to them. For example, in India, in 2001, four people were arrested for 'promoting homosexuality' when in fact they were involved in providing HIV prevention services for MSM. This conflict between public health needs and the law enforcement agencies is common throughout the Asia and the Pacific.

At the same time many males who have sex with males are married, while many also access female commercial sex workers. 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 MSM also sell sex to, and buy it from, women, and may well be married also.

To add to the complexity of the whole issue of male-to-male sex and HIV, further sex between males 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, or even MSM, and in other situations will have sex with women. Along with this are males who are injecting drug users and also have sex with other males (a double jeopardy here).

The reality is that denial, invisibility, stigma, discrimination, social exclusion and illegality create an environment where there is little public acknowledgment of the issues, which feeds into a framework of a lack of understanding of the diversity of male-to-male sex, risks and vulnerability, and the lack of data, both epidemiological as well as ethnographic, on which effective programmes can be developed, funded and implemented.

But if the situation is left as it is, then any hope of addressing the challenge that HIV presents to the health of the nations in the Asia and the Pacific region is lost. MSM are not a separated and isolated sub-population from the general population. They are an integral part of the citizenship of each country. What they do is not isolated from the general pattern of male sexual behaviours in these countries, it is integral a part of the general male sexual behaviours, and creates increasing risks of a spreading epidemic.

Of course 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 will present policy makers and donors with a complex challenge.

A special consultation meeting focusing this specific question was held in New Delhi, India in September 2006, called Risks and Responsibilities: Male Sexual Health and HIV in Asia and the Pacific which brought together some 380 people representing government national AIDS programmes, donors, and MSM themselves from 30 countries, where agreements were reached on collaboration, principles of good practice, and forming an advocacy coalition between government, donors and MSM working on HIV.

The principles of good practice developed at this meeting included a proactive approach to address the societal, cultural and legal impediments towards implementing, and accessing, HIV services for males who have sex with males, such as reviewing, repealing, or amending laws that criminalise adult consensual same-sex behaviours towards addressing the constant discrimination and harassment that many MSM have to face. Along with this would be a rapid scaling up of investment in supporting a range of HIV risk-reduction strategies among MSM, that include outreach education programmes, MSM friendly STI clinics, distribution of condoms and water based lubricant, access to safe spaces where MSM can meet and socialise without undue harassment, and access to voluntary counselling and testing, support, care and treatment services for MSM who are HIV positive based on experience that shown that HIV interventions can also be more effective if MSM fully participate in programme design and implementation.

While HIV epidemics continue to grow among MSM, and for many countries may too late to prevent such epidemics, it is time to act to ensure that these epidemics do not continue to spiral upwards, and where epidemics are just beginning, and where MSM populations are extremely vulnerable to HIV infection, there is an urgent need for governments, donors and non-government organisations working in the field of HIV to clearly recognise the need to ensure that all MSM can have access to quality HIV

prevention, treatment, care and support services, if we are to fulfil the laudable goals of Universal Access that is being spoken of at then highest levels.

Governments across the region need to recognise the critical role that they play in addressing social, cultural and legal impediments while donors need to recognise that increasing investment in MSM is critical to successful HIV programming in the region. At the same time, if there is good will to work together in ensuring that more MSM do not need to become ill and die, and that a social and HIV service environment encourages MSM to address their own health concerns, then MSM themselves can be supported to join in this effort taking responsibility for their own lives. But to ask for such responsibility without addressing their own rights, we stand no hope to reverse the current trend of higher HIV affecting and infecting MSM populations across Asia and the Pacific.