

Mainstreaming male-to-male sex and HIV prevention, treatment, care and support services

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All across the Asia and Pacific region there are a number of concentrated HIV epidemics among males who have sex with males (MSM¹), but spending on HIV prevention, treatment, care and support, or service coverage, match the urgent need to reduce prevalence.

Thus, in Thailand, which reported an enormous growth of HIV infection among MSM from 17% in 2003 to 28% in 2005,² investment in MSM HIV programming was just over 1% of the total national plan spending.³ This disparity is common across the countries of Asia and the Pacific.

This gross mismatch between need and reality is a clear indication of the denial, 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.⁴ A sample of 482 men who had sex with men in Beijing⁵ 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, sex between males may often happen because it is what is immediately available, for example in prisons or among truck drivers.⁶ 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). And what about male-to-male sex among refugees, mobile populations, in conflict zones, cross border movements, adolescents, and so on? And what about males who have anal sex with females?

Male-to-male sex is does not involve a separated and isolated sub-population, one that can be easily identified and targeted. It involves a broad spectrum of males of differing ages, gender and sexual identities, gender performances, risks and vulnerabilities. These males are an integral part of the citizenship of each country, and what they do is not isolated from the general pattern of male sexual behaviours. It involves males/men who practice a range of same-sex activities who do not have a framework of sexual orientation based on same-sex desires, as well as those who do have non-normative sexual/gender orientation.

There is growing evidence to indicate that male-to-male sex outside of those categories of sexual and gender identities is not as uncommon as we would like to believe, and that anal sex is a relatively common phenomenon whether it is between males or between males and females.

This lack of recognition of the diversity of male sex behaviours outside the reductionist categories of desire that have framed the sexual health discourse has been exacerbated by the misuse and misunderstanding of the term 'men who have sex with men' which was originally invented in the early 1980's as an epidemiological phrase to identify a group of males/men who practiced same-sex behaviours but did not identify with the category gay. But this construction forgot the vast diversity of same-sex behaviours/desire categories in the Asia and Pacific that were also different from the gay framework, and the extent of anal sex as a part of the recreational sex repertoire of many males in the region. The term MSM became pervasive, and began to be confused with an identity framework (hence many use the term MSMs!), and thus increased the invisibilisation of male-to-male sex and anal sex as a male sexual practice.

The reality is that shame, 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.

Naz Foundation International believes that in order to comprehensively address the issue of male-to-male sex, as well as the risk of unprotected anal sex has for both receptive males and females, a two-pronged parallel approach is essential.

Firstly, we need to ensure that those males who identify with their sexual behaviours and same-sex desires through a sexual/gender identity, whether they label themselves kothis, hijras, katoeys, waria, metis, zenanas, apwint, apone, long hairs, short hairs, fa'fa'fini, bisexuals, homosexuals, or gay men (and the list of identities can go on and on), have specialised HIV prevention, treatment, care and support services specific to their physical, mental, psychological, and social needs and well-being to reduce risk and vulnerability.

But in order to reach their male sexual partners, as well as women who have anal sex, we also need to ensure that unprotected anal sex is included in all HIV and sexual and reproductive health programmes in terms of education, HIV prevention and treatment for sexually transmitted infection programmes.

This means mainstreaming the issue and the fact of male-to-male sex and anal sex.

This is much more than just mainstreaming MSM, which would involve ensuring that all HIV and sexual health services are also appropriate to the needs of differing sub-populations of MSM irrespective of their sexual/gender identities or sexual practices. It is much more than just sensitising HIV and sexual health service providers to differing sexual and gender identities and behaviours. It involves much more than involvement of self-identified "MSM" in policy making, planning and implementation of direct sexual health services appropriate to the needs of MSM.

It actually challenges the practice of compartmentalisation (as well as the whole epidemiological construct) that confronts HIV programming, i.e. separated and isolated programmes and measurement for injecting drug users, female sex workers, adolescents and youth, education, MSM, trafficking, refugees, prison populations, the uniformed services, cross-border mobility, migration, and so on, need to urgently recognise the diversity of male-male sexualities and male sexual practices and incorporate the reality of such practices and risks within all of their programming and services.

Some female sex workers also have anal sex, and sell sex to women. Some male injecting drug users also have sex with other males, and some even sell sex to other males or females. Some males in prisons have sex with other males, while some males in uniform also have sex with other males, and some may even sell sex to other males. Some male youth will also have sex with other males and some may well be involved in commercial sex with other males and/or females.

A reduction and exclusivist approach to HIV and sexual health can actually increase risk and vulnerability since such approaches can add to stigma and discrimination and social marginalisation.

What is needed is a combination of specialised services that provide for specialised needs for specific sub-populations, while developing combined services where crosscutting issues are involved. Thus projects providing services for self-identified 'MSM' should also work with those projects providing services for injecting drug users, or sex workers (often the clients of male sex workers may well be clients of female sex workers), or with youth programmes, and so on.

Of course developing effective responses to the wide diversity of social classes and groups, gender identities, marginalized and hidden populations and sexual behaviours encompassed by the term MSM or male-to-male sex will present governments, policy makers and donors with an enormously complex challenge. It will mean visibilising the whole issue of male-to-male sex, or normalising and destigmatising anal sex, of addressing sexual pleasure and recreational sex, of exploring the sexual compulsions that arise from gender segregation, and of addressing laws, policies and attitudes that stigmatise a range of adult consensual sexual activities.

In a comment made at a conference on sexual and reproductive health in Europe a couple of years ago made by the author, I had suggested that the focus on sexual and reproductive health was based on outdated 19th century discourses on sexuality and reproduction which ignored (or denied) the broad diversity of sexualities, masculinities, femininities and, sexual desires and practices. I asked why the anus and the mouth were not seen as sexual organs, and why the focus was only on reproductive sex, where women to a large extent were seen as producers of babies and so little attention placed on recreational sex. After all every act of sex between a male and female does not, and cannot, lead to reproduction. And certainly males who have sex with males are involved in what can only be termed as recreational sex. And in a global picture such males would number in the many millions. There was no answer.

Truly mainstreaming MSM arises from honestly addressing the nature of human sexualities and sexual practices at its core, and the recognition that human beings enjoy sex beyond just a reproductive necessity, and they do so because essentially, for the most part, it is fun. Until we reject the concept that sex is dirty, sinful, shameful and nasty, and somehow less than human, we can never fully achieve the goal of an AIDS free world.

¹ Males who have sex with males/men who have sex with men (or MSM) is an inclusive, public health term to define the sexual behaviour of males having sex with other males, and does not refer to an identifiable community or gender identification. Within this context it is understood that the word 'man'/'men' is socially constructed; as well, within the framework of male-to-male sex, there are a range of masculinities along with diverse sexual, gender and transgender identities, communities and networks.

² 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.),

³ HIV expenditure on MSM programming in the Asia-Pacific region, *Constella Futures*, 2006, *Constella Futures*

⁴ Dandona et al, 2005

⁵ Gibson et al., 2004

⁶ Khan and Hyder, 1998