

MSM, HIV/AIDS and Human Rights in South Asia

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It is my aspiration that health will finally be seen not as a blessing to be wished for, but as a human right to be fought for. *Kofi Anan, Secretary General United Nations*

Realisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS.

Declaration of Commitment on HIV/AIDS: United Nations General Assembly, Special Session on HIV/AIDS, 25-27 June 2001, United Nations

Sexual health is the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love. *WHO, 1975*

Denial, ignorance, illegality, myths, fears, violence, abuse, exclusion, and invisibility create a discourse that denies much of male-to-male sexual behaviours in society.

At the same time, current discourses on sexual identity, sexual orientation, and “sexual minorities”, also increases the invisibility of much male-to-male sex.

Who is “MSM”?

- “MSM” is not an exclusive category or “target group”
- It reflects a category of behaviour not an identity
- It involves any male who has any sexual contact with another male, regularly or irregularly
- It includes those males with specific sexual identities, such as gay men, as well as those with feminised and gendered identities (i.e. kothis) and their manly partners
- But not all MSM are at risk of HIV infection - this would depend upon their specific sexual practices

Who is “MSM”?

- **Based on evidence, male-to-male sex across South Asia appears to be primarily structured around sex/gender roles - the penetrated and the penetrator, not on sexual orientation or identity**
- **Here the penetrator perceives himself involved in a manly activity - he does not perceive himself, nor is he perceived, as a homosexual, nor does he perceive himself as a man who has sex with a man**
- **His penetrated partner is perceived (and most often perceives himself) as NOT-MAN, nor does he perceive himself as a man who has sex with a man**

Stigma, Discrimination and MSM

We all know about stigma, discrimination, and human rights abuse regarding those living with HIV/AIDS

But what about sexual practice, gendered identities or sexual identities!

Stigma and Discrimination

- **Kothis, hijras and some other MSM are doubly stigmatised, because of their feminisation and sexual penetration, which reinforces the stigmatisation and leads to exclusion and denial of services**
- **Already stigmatised, this is reinforced when living with HIV/AIDS**
- **Self-stigmatised because of their gendered identities, social exclusion and sense of worthlessness**

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A study NFI conducted in Bangladesh regarding feminised males and abuse showed:

- 33% reported assault of a sexual nature or rape at the hands of 'friends'**
- 48% reported that they had been sexually assaulted or raped by policemen**
- 64% reported facing harassment of one kind or the other at the hands of the police**

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- **71% stated that they had faced some or the other form of harassment from *goondas*. Other than rape, these are, extortion [38%], beatings [45%], threats and blackmail [31%]**
- **87% stated that they had been subjected to sexual assault or rape simply because they are effeminate**
- **41% of those who had faced some form of harassment at the hands of the police say that the police guessed that they were MSM from their feminised behaviours**

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- **55%** of those who had faced harassment from *goondas* also reported that the *goondas* guessed they were MSM from their feminised behaviour
- **77%** stated that they know of others who have also faced harassment
- **48%** stated that fellow students or teachers had harassed them in school or college because they were effeminate
- **33%** reported that they have either thought of or tried to commit suicide at some point in their lives

The socio-behavioural dynamics in Bangladesh are the similar in the other countries of South Asia.

Sufficient anecdotal evidence exists that similar levels of abuse, harassment and violence exists in India.

(Our thanks to Aditya Bondyopadhyay who conducted the study)

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Unless we address the social, judicial and legal impediments to effective sexual health interventions for marginalised and socially excluded populations, then the ‘fight’ against AIDS will be lost.

Such a rights-based approach to HIV/AIDS and sexual health must also include consensual behavioural and gendered, and identity choices, as well as integrate the WHO definition of sexual health.

Sexual health is a right for all.