

# MSM: a missing link in national responses to HIV/AIDS in Asia and the Pacific

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**For**

**UNAIDS, 2006**

Across Asia and the Pacific governments are putting more money and resources into prevention and treatment of HIV/AIDS, but few countries yet address the entirety of the challenge. A key link missing from virtually all national programmes is men who have sex with men (MSM). The omission, if it persists, can counteract government achievements on other fronts.

Asia-Pacific countries do not face a single HIV/AIDS epidemic but multiple, overlapping epidemics with a number of key drivers. Asia has experienced in the past 10-15 years how quickly these epidemics can accelerate through vulnerable populations, particularly sex workers, clients of sex workers, injecting drug users and men who have sex with men. To contain and ultimately defeat these epidemics countries will need action against all the components of the epidemic. But while Asia-Pacific countries have devoted increasing attention and investment to dealing with the epidemic among heterosexuals, most treat the epidemic among men who have sex with men, like the practice of male-male sex, as if it doesn't exist.



### Male-Male sex occurs in all countries and cultures

The reality is very different. At least 5% to 10% of all HIV cases in the world are transmitted in sex between men. The number of men who currently engage in sex with men is usually estimated at 2% to 5% worldwide. It occurs in every culture and country. Early Sanskrit writings describe same-sex relationships, as do ancient Chinese and Korean texts. In East Asia, studies estimate 3% to 5% of men have same sex relations at some point in their life and in South and South East Asia 6% to 12%.

Most studies are believed to underestimate the prevalence of male-male sex. That is partly because, of all the many sensitive issues of sex and gender raised by the HIV/AIDS epidemic, the issue of male-male sex remains most heavily shrouded in stigma and denial and the most difficult for people to discuss frankly and openly. It is also because of the sheer diversity of the people who engage in male-male sex and the social circumstances in which it occurs.

Men who have sex with men are not an isolated social minority with a single sexual preference. They come from all social classes. They range from men who maintain normal masculine identities and do not identify themselves as homosexual or gay or even bisexual, to transgenders -- men who do not accept their gender and identify as women, like India's *hijras*, Indonesia's *waria* and Thailand's *katoey*.



### Overlap between heterosexual and homosexual activity

Many married men also engage in male-male sex: 57% of the respondents in a survey of MSM in India were married. It is believed that most men who have sex with men have also had sex with women. A sample of 482 men who had sex with men in Beijing found that nearly two-thirds had had sex with a woman at some time, 28 % of them within the past six months. Many men who sell sex to men have a wife or female partner and do not consider themselves homosexual; others also sell it to, and buy it from, women. Sex between men often happens because it is what is immediately available, for example in prisons or to truck drivers and those who engage in it also may not think of themselves as homosexual and in other situations will have sex with women.

This overlap between heterosexual and homosexual activity matters in the fight against AIDS. First, there is a clear risk that MSM who become infected with HIV will pass it on to their wives or female partners. The epidemic among MSM, therefore, is not separate from the epidemics in the general community, so efforts to prevent the spread of HIV/AIDS among MSM are essential to prevent transmission of HIV to others outside this group. Secondly, although data is limited, the prevalence of HIV infection among men who have sex with men, wherever it has been measured, is often substantially higher than in the general population.

That applies to such diverse locations as Thailand, where national adult prevalence was 1.4% in 2005 and the infection rate among MSM in Bangkok was 28%, or Vietnam, where national prevalence is 0.5% and among a sample of MSM in Ho Chi Minh City HIV prevalence was 8%, or in India, where national adult prevalence was estimated at 0.9% in 2005 and a study in Mumbai in 2001 found 17% of MSM infected. MSM also report a much higher incidence of other sexually transmitted infections which significantly increase the risk of HIV transmission.

Another overlap important to HIV/AIDS prevention and treatment efforts is between men who have sex with men and injecting drug use. In Nepal, 4% of MSM in a 2004 survey injected drugs and in Indonesia 27% of MSM who did not sell sex and 47% of male sex workers in Indonesia reported taking drugs in the previous year. Injecting drug users have high rates of HIV infection and drug use increases high risk sexual behaviour.



### **MSM are a significant and growing component of the Asia-Pacific epidemic**

Clear evidence exists that the HIV epidemic among MSM in some countries is accelerating. The 28% infection rate reported in Bangkok in 2005 compared with 17% in 2003. In Ho Chi Minh City it accelerated from 5% in 2003 to 8% in 2005. Without prompt and effective action to address the issue, other Asia-Pacific countries are in danger of witnessing a similar acceleration in rates of MSM infection.

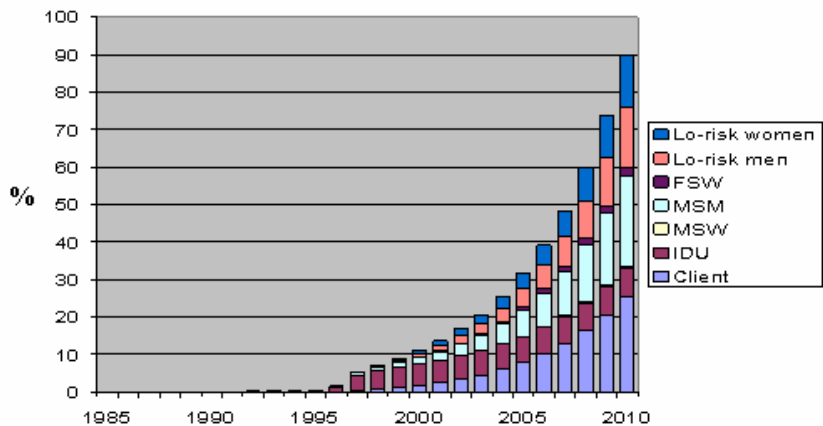
The extent of the risk needs to be kept in perspective. Projections derived from the Asian Epidemic Model (AEM) suggest that HIV infection among men who have sex with men is unlikely to become a primary driver of the region's heterosexual epidemics.

However, that does not mean that MSM transmission can be ignored. On the contrary, the AEM shows that by 2010 the annual new infection attributed to MSM are likely to overtake that from injecting drug use and commercial sex to become one of the largest contributors to the region's epidemics (see Figure 1). Indeed, the effectiveness of national programmes to deal with men who have sex with men together with sex workers and injecting drug users will be a key determinant of the size of countries' epidemics and the financial costs they will incur in tackling it.

Many factors are driving these trends. An important one is that men who have sex with men demonstrate little knowledge and many misconceptions about the risks associated with male-male sex. Among 423 MSM included in a recent survey in Myanmar, knowledge and awareness of HIV/AIDS was high, yet 90% believed they were not at risk. They believe HIV/AIDS is not transmitted by healthy-looking individuals is widespread.

The high levels of ignorance and misinformation are reflected in the high risk behaviours prevalent among men having sex with men. The average number of sexual partners is high and the use of protection is low – much lower than among women sex workers. They are particularly vulnerable to infection because anal sex (the most common practice between men) is much more likely to transmit HIV than vaginal sex, yet many MSM see it as safer.

Figure 1: Estimated number of new HIV infections per year among Asian adults



Source: Tim Brown et al. 2006

As many as half the participants in a survey of MSM in China reported unprotected anal sex in the preceding six months but only 15% saw themselves as at risk.

Behavioral surveillance by India's National AIDS Control Organization found that condom use among male sex workers was just 12% compared with 57% among clients of female sex workers. Indeed, some MSM see unsafe sex as a sign of commitment to their partners. In other circumstances, however, low condom use results from a range of factors: lack of availability, lack of awareness of their importance for protection, the expense of buying them, or because the furtive and hurried circumstances in which sex is performed does not allow negotiation of condom use.



## Stigma and discrimination help to drive the epidemic

Such findings also underline another driver in the growth of HIV/AIDS among men who have sex with men in Asia and the Pacific: the way that stigma, discrimination and laws criminalizing male-male sex act as a catalyst for unsafe practices and create conditions that encourage the spread of the epidemic.

**“It is homophobia, not homosexuality, that we should fear.”**

Mass media campaign message, Mexico, 2005

A 2006 survey found that in 16 of 20 Asia-Pacific countries sex between men was illegal. Not all countries with these laws seek to enforce them, but they still pose a serious handicap to interventions and outreach to men who have sex with men.

In India, some doctors have reportedly threatened to report MSM to police, while in Sri Lanka cases have occurred where medical staff revealed the identity of HIV-positive patients. High levels of rape and beatings of MSM are reported in Pakistan and Nepal. Even where sex between men is legal, the stigma associated with this behavior results in discrimination by authorities, health workers and employers.

China does not have laws specifically criminalizing male-male sex but MSM are difficult to reach because of fear of police raids. In Thailand and Vietnam, police sometimes target the carrying or distribution of condoms as evidence of commercial sex, thus discouraging the availability and use of a key resource for reducing risk and curbing the spread of AIDS. The effect of such stigma and oppression thus results in high risk behaviour.

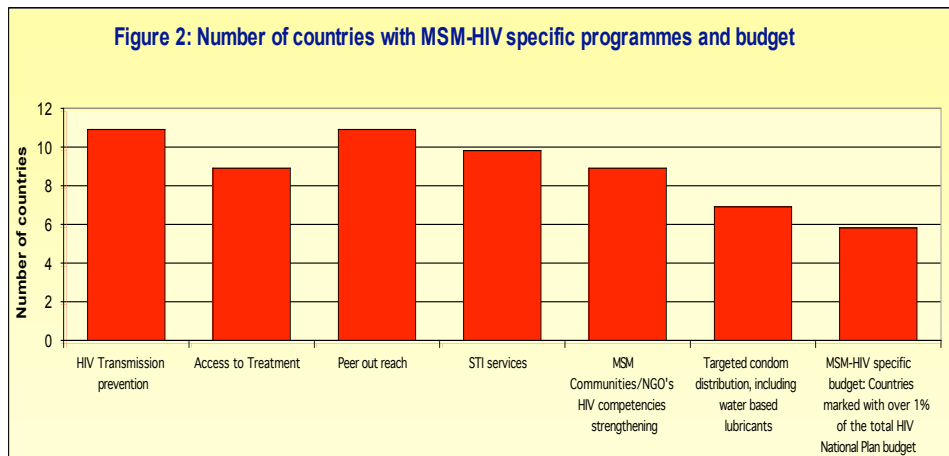
Discrimination discourages men who have sex with men from identifying their sexual orientation, applying for health services or providing information that can inform national policy and thus promote public health. In many Asian countries, men who have sex with men but maintain masculine identities may not identify themselves as MSM and are hidden to the general community. The number of MSM is thus almost certainly generally under-reported and the extent of the HIV epidemic associated with male-male sex is also disguised.

Stigma and discrimination also discourage policy makers from finding out what is needed to curb this important component of their national epidemics or acting on it. Until 2000, academic journals in China were banned from addressing MSM issues. Lack of information feeds denial about the extent and significance of the MSM epidemic. That helps governments to avoid committing funds for the services and resources crucially needed to tackle it.



## MSM in national plans: conspicuous by their absence

In some countries the environment is changing. In 2005, China's Vice Minister of Health, Wang Longde said the government must admit the existence of MSM in its efforts to tackle HIV/AIDS and the Ministry of Health instructed its disease control institutions to carry out interventions for men who have sex with men. In February 2006, a major report on MSM written by a



Chinese gay writer was released. Its sponsors included the Beijing Gender Health Education Institute, China's first homosexual counseling agency. Soon after, China's State Council issued the first comprehensive regulations on HIV/AIDS prevention. One of these regulations outlaws discrimination against people infected with HIV.

Still, national plans for tackling the HIV/AIDS epidemic in the region largely ignore men who have sex with men. Although Asia's HIV/AIDS pandemic first appeared among MSM, most governments have focused AIDS prevention and treatment strategies to date on the general public or groups that are easier to identify such as female sex workers, their clients and, to a lesser extent, injecting drug users. Among 20 Asia-Pacific countries surveyed in 2006, all countries had a

National Strategic Plan on AIDS but only nine had NSP's which included MSM and HIV specific Programmes or interventions.

**“The generalized discomfort with male-male sex...has helped generate a familiar vicious cycle: No data equals no problem; no problem equals no intervention; and no intervention equals no need to collect data.”**

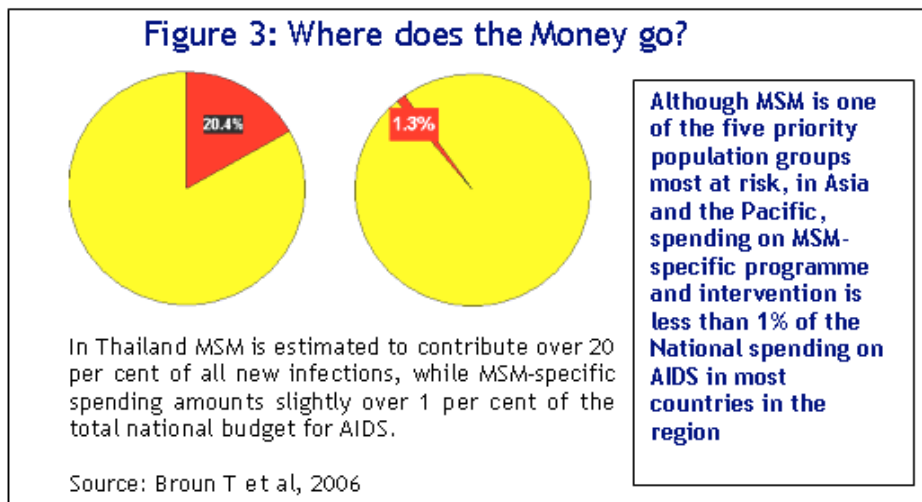
MAP (Monitoring the AIDS Pandemic Report, July 2005)

The impact of these programmes was predictably small. A 2005 coverage survey of 15 Asia-Pacific countries estimated that targeted prevention programmes reached less than 8% of men who have sex with men.

The problem often starts with data. National programmes are only as effective as the evidence on which they are based. However, a recent survey of 20 Asia-Pacific countries identified only eight countries had any form of surveillance specific to MSM, while only five reported the inclusion of BSS. Where surveillance has occurred, the extent of the epidemic linked to male-male sex can still be disguised by the preference of individuals to attribute infection to more socially acceptable risk factors.

Public information which could inform men engaging in male-male sex and encourage safe behaviour is equally rare. Many of the region's governments and organizations simply remain silent on the subject. A report in Vietnam on the epidemiology of AIDS only mentions MSM in the list of acronyms. A 112-page Cambodian report on AIDS limits reference to MSM to one footnote. In Nepal, MSM-focused public messages are banned.

Expenditure on interventions aimed at MSM inevitably makes up only a small part of spending on



prevention and bears no relation to the estimated proportion of MSM in HIV infections. In Latin America and the Caribbean, which have among the best funding data, expenditure on MSM typically amounts to between just 0.01% and 6.5% of total prevention expenditure. In Asia, data from selected countries showed spending on

MSM typically ranges from zero to a high of 4% in Thailand. In Ho Chi Minh City, where MSM accounted for 8% of the HIV infections, spending on MSM interventions amounted to less than 1% of the HIV/AIDS prevention budget. Programmes aimed at men who have sex with men in Asia and the Pacific are left almost entirely to NGOs, local community based MSM organizations (CBOs) and to foreign donor financing. However, many NGO's and particularly the CBOs lack sufficient manpower, funding or resources to undertake more than narrowly focused local interventions.



## How the status of MSM interventions can change

Developing a response to the wide diversity of social classes and groups, gender identities, marginalized and hidden populations and behaviours encompassed by the term MSM presents policy makers with a complex challenge. Only a few effective interventions have been launched in Asia and the Pacific that achieve wide coverage, start from an epidemiological baseline and make any investment in monitoring and evaluation. Yet experience gained in the Asia-Pacific region and other areas already points to a number of principles that should guide design and implementation of interventions aimed at men who have sex with men.

A broad-brush, one-programme-fits-all strategy will prove ineffectual in reaching the diverse groups of Asian MSM and transgenders. Social and sexual networks often do not overlap and sub-groups made up of different sexual identities do not respond well to shared interventions. HIV prevalence and behavioural surveillance among MSM is essential to enable national policy makers to tailor programmes to different groups of men who have sex with men in different socio-economic and cultural environments.

Other interventions that are key requirements in any MSM setting include peer outreach education, MSM friendly clinics for STI treatments, delivery of condom and lubricants, local advocacy, involvement of the MSM community and access to VCT and Anti retroviral treatment services.

Experience shows interventions can also be more effective if MSM participate in programme design and implementation. For example, counseling by men who have sex with men has proved particularly effective in building knowledge of condom and lubricant use and awareness of the risk of drug abuse.

National health plans and budgets need to include costed programmes to increase delivery of essential services aiming to raise coverage of services to 80% of MSM. The high incidence of sexually transmitted infections among men who have sex with men in particular underlines the need for greater access to care and treatment that addresses behaviours causing most infections. Services should aim to increase availability of condoms and water-based lubricants and improve access to voluntary counseling and testing.

Even when these are available, fear of discrimination and lack of confidentiality can deter MSM from making use of such services, underlining the importance of having health service providers are trained to deal in a non-judgemental way with men who have sex with men. By the same token, the stigma around male-male sex is so strong in Asia that programme staff can be reluctant for their work to be too well-known, hampering delivery of products and services. Working with local police, law enforcement authorities, opinion leaders will require much more effort and attention from national authorities than they have received so far.

### What works: an Indonesian lead

The Aksi Stop AIDS (ASA) project in Indonesia shows how evidence-based interventions with high coverage can achieve behaviour change. The programme has two different agencies in both Jakarta and Surabaya (and others in other cities), one in each city to deal with *waria* (transgenders), the other to work with male sex workers and other men who have sex with men

Starting in 2003, ASA put together ‘safer sex packs’ with a condom and lube sachet (and *waria* cover picture) for distribution free to *waria* and MSM. In addition it provided access to educational materials and peer educators and, in Jakarta, funded clinics focused on treating *waria* and other MSM

Among *waria* the programme achieved 65% coverage, and the number of people seeking voluntary counseling and testing rose from 0% to 21%. The programme also recorded a sharp increase in condom use among *waria* between 2002 and 2004 and a sharp fall in the incidence of unprotected anal sex among from 66% to 48%. Less success was achieved in coverage or outcomes of the programme aimed at male sex workers and gay-identified MSM

Community-based programmes that include drop-in centres or similar providing safe areas for discussion and services have proved particularly effective, and may open up access to MSM peer networks inaccessible to government organizations or NGOs. National programmes should also include interventions targeting MSM who are especially vulnerable to infection, including sex workers, injecting drug users and those in settings such as prisons or the military where they are also exposed to a greater risk of sexual coercion.

The work of designing, mobilising resources for, and implementing effective strategies for men who have sex with men presents a critical test of political will for governments and policy makers. The UNAIDS Annual Report 2006 comments that Asian governments should and could afford to spend more on HIV but have yet to recognize HIV in general, let alone the issues of men who have sex with men, as a problem that is sufficiently urgent to require more attention. Failure to act promptly and comprehensively on MSM interventions will allow the HIV/AIDS epidemic to grow in scale and complexity.

**“An AIDS response that is not as embedded in advancing social justice as in advancing science is doomed to failure.”**

Peter Piot, Executive Director, UNAIDS, August 2006

Moreover, programme responses will remain inadequate in reach and impact unless governments create a more sympathetic and enabling environment that allows implementing agencies to deliver

essential services without having to fight for the right to do so. That requires sustained effort to tackle the deep-rooted stigma and prejudice in society and to promote respect for the rights of men who engage in male-male sex.

This can entail removing or amending laws that criminalize sex in private between consenting male adults. In Asia, many of these laws remain as a legacy of British colonial rule. An exception is Hong Kong, which repealed its law in 1991. It may also involve proactive measures to fight discrimination, whether within government institutions, the workplace or health care services, by introducing and enforcing anti-discrimination laws. It is in governments own interest to ensure that national law enforcement agencies understand, and act in ways consistent with, the strategies of HIV/AIDS interventions undertaken either by public institutions or NGOs. Interventions aimed at delivering services to men who have sex with men cannot succeed if the intended beneficiaries are fugitives from the law.

The governments of Asia and the Pacific already subscribe to these principles on paper. In the 2001 UN General Assembly Special Session's declaration on HIV/AIDS, all UN members accepted the importance of addressing "the needs of those at the greatest risk of, and most vulnerable to, new infection as indicated by such factors as...sexual preference." In 2006, at the High Level Meeting on AIDS, all UN member states agreed to the need for "the full and active participation of vulnerable groups" and to eliminate discrimination.

"It is time that we get serious about protecting and promoting human rights," Peter Piot, UNAIDS Executive Director, commented in August, "and reflect it in our budget allocations."

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\* **Note:** Several facts and conclusions are drawn from the unpublished background papers commissioned by Naz Foundation International for the Male Sexual Health and HIV in Asia and the Pacific International Consultation: "Risks and Responsibilities," to be held in New Delhi, India, 22<sup>nd</sup> -26<sup>th</sup> September 2006. Risks and Responsibilities, in support with UNAIDS.