

## Male-Male Sex and HIV/AIDS in Asia

HIV/AIDS interventions throughout Asia have maintained a deathly silence on the subject of sex between men. This has left many males who have sex with males (MSM) unaware of the need to protect themselves from HIV and ignorant of the practices that will lower their risk of being infected.

For many years, there was virtually no data collected about MSM and HIV in most Asian countries. Recent efforts to fill this gap have confirmed some people's fears — certain MSM populations have alarmingly high HIV prevalence rates. Studies are also

beginning to yield insights into the factors driving MSM HIV/AIDS epidemics.

The purpose of this booklet is twofold:

1. to summarize key findings about the epidemiology of HIV/AIDS among Asian MSM; and,
2. to discuss the programmatic implications of those findings.

The central epidemiological issues were presented in detail in *AIDS in Asia: Face the Facts*, a report issued by the Monitoring the AIDS Pandemic (MAP) Network in 2004. This publication follows up by highlighting main

issues that relate specifically to male-male sexual behaviour. It also describes how those points should inform HIV prevention strategies.

This is one of a series of three programming-themed booklets based on AIDS in Asia: *Face the Facts*. The other two are *MAP Report 2005: Drug Injection and HIV/AIDS in Asia* and *MAP Report 2005: Sex Work and HIV/AIDS in Asia*. Taken together, they provide insight into how to respond to the behaviours driving the spread of HIV in Asia's most at-risk populations.

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## Acknowledgments

The members of the Monitoring the AIDS Pandemic Network (The MAP Network), the grouping responsible for this report, are listed in Appendix 1. The MAP Network would like to thank several people who are not currently network members but who have contributed actively to this report. These people include: Jeanine Bardon, Philippe Girault, Parvez Sazzad Mallick, Elizabeth Pisani, Kelly Safreed Harmon, Ganrawi Winitdhama, and Nigoon Jitthai. The MAP Network would also like to thank the governments of Asia and their development partners for generously sharing national HIV and behavioural surveillance data for this report.

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### Notes about sources

Because this document refers to data with great frequency, the sourcing of each individual data point cited would be impractical. The sources for surveillance data are consolidated in a list in Appendix 2. Any data point that is not individually sourced, or that is sourced to “national surveillance records” or “behavioural surveillance,” comes from the sources on that list.

Data from stand-alone studies rather than from repeated surveillance efforts are individually referenced in endnotes that appear in Appendix 2.

Sources for all figures are provided in Appendix 2.

## Male-Male Sex and HIV/AIDS in Asia: a summary

Many of the first reported HIV cases in Asia were among males who have sex with males\* (MSM). As the heterosexual and injecting epidemics grew, male-male sex was largely ignored in HIV/AIDS interventions. This is in part because male-male sex is so difficult to characterize in many Asian countries. It encompasses a large spectrum of behaviours between people with various social and sexual identities. In recent years, renewed efforts to understand the risk of exposure to HIV in anal sex between men have yielded some alarming findings.

- In Bangkok, Thailand, a 2003 study found that 17 percent of men who have sex with other men were infected with HIV.
- By 2000, 15 percent of men who engage in male-male sex in Phnom Penh, Cambodia, tested positive for HIV.
- Among transgender sex workers in the Indonesian capital, Jakarta, HIV prevalence increased from 6 percent in 1997 to 22 percent in 2002, according to a survey.

As a result of the recruiting methods used, it is possible that these findings represent the segment of the MSM population that is most at risk, rather than the MSM population overall. However, they still give cause for alarm in the Asian countries that continue to neglect male-male sex in their prevention, care/support and treatment programmes.

Programme managers addressing male-male sex need to consider the following issues.

- **Condom use.** Most HIV/AIDS interventions have focused strongly on reducing unprotected commercial sex between men and women, and have done little to tackle risky sex between males or between males and transgenders. The result is that in most countries, males are far more likely to report condom use in sex with a female sex worker than with a male partner, even though the risk of HIV transmission in anal sex is higher than in vaginal sex.

- **Selling sex.** Males and transgenders who sell sex to other males are at particularly high risk, because their turnover of partners tends to be very high. Risky behaviour remains common in this part of the population. Simple risk reduction strategies involving the provision of condoms and water-based lubricants are little known in some countries. HIV risk reduction initiatives at an adequate scale are urgently needed for males engaging in high-risk behaviour with other males.
- **Sex and drugs.** When male-male sexual behaviour overlaps with drug use, including drugs that are injected and other drugs like amphetamines, the risk of HIV infection may increase. Prevention programmes need to take into account the possibly high potential for drug use among males who have sex with males and either integrate drug use reduction approaches into programming or establish linkages with other agencies working in this field.
- **Males who have sex with men and women.** In many parts of Asia, studies have revealed that men generally assumed to belong to the heterosexual mainstream report high levels of bisexual behaviour. These may include men who identify as heterosexual, even while buying sex from transgender sex workers. Also, males selling sex to men have reported being sexually active with women. These complex sexual networks all can potentially serve as pathways for the spread of HIV. The integration of information about the risks of male-male sex in prevention programs is critical.

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\* For the sake of brevity, this report will refer to people who engage in male-male sex, regardless of their motivations or their identity, as MSM (males who have sex with males, excluding transgenders) or transgenders, as appropriate.

## 1. Introduction

In most countries in Asia, the very first cases of AIDS and of HIV were identified in men who have sex with other men, and not infrequently they were people who lived abroad or were the sex partners of those people. It was not long however, before other risk factors became more prominent, and the uncomfortable issue of male-male sex was swept into the closet, even in countries such as Thailand, which took a generally pragmatic and non-judgemental approach to the epidemic. The generalized discomfort with male-male sex has meant that very few data have been collected among males who have sex with males. This has helped generate a familiar vicious circle: no data equals no problem, no problem equals no intervention, and no intervention equals no need to collect data. Inside that circle, HIV can spread undetected.

In recent years, a few countries have started to collect information on male-male sex. After years of programming neglect, this has yielded some unpleasant surprises, as **Table 1** illustrates.

### Sexual Identities

Male-male sex is poorly understood in Asia, making it difficult to study, particularly for epidemiological purposes. Some countries have culturally sanctioned transgender communities. While it is widely recognized that members of these communities often work as sex workers, very little thought is given to their clients, male-identified men, who want to buy anal sex. In qualitative studies, clients of transgendered sex workers in Jakarta often say that they do not consider these encounters to be homosexual behaviour, but rather a variation on sex with female sex workers.<sup>1</sup>

Besides sex between men and transgenders, other forms of male-male sex are also common. While a “gay” social identity and norms are beginning to emerge in some Asian cities, a high proportion of men who have sex with other men do not consider themselves “homosexual,” and also have sex with women. This plethora of identities and behaviours illustrates the difficulty of even finding an appropriate term for the risk of anal sex between biological males in Asia. For the sake of brevity, this report will refer to people who engage in male-male sex as MSM (males who have sex with males, excluding transgenders) or transgenders, as appropriate.

**Table 1: Wake up call: Percentage of MSM and transgenders infected with HIV, various countries**

Surveillance/study location	Percent HIV-positive (Number tested)	
	MSM	Transgender
Bangladesh, Central A, 2004	0% (399)	0.2% (405)
Phnom Penh, Cambodia, 2000	12.8% (166)	36.7% (40)
Beijing, China, 2002	3.1% (481)	
Dili, East Timor, 2003	0.9% (110)	
Mumbai, India, 2003	18.8% (NA)	
Jakarta, Indonesia, 2002*	3.2% (529)	21.8% (250)
Bangkok, Thailand, 2003	17.3% (1,121)	
Thailand, 4 provinces, 2004*	9.6% (519)	
Ho Chi Minh City, Vietnam, 2004	8% (600)	
Pakistan, Karachi* / Lahore, 2004*	4% (409*) / 0.5% (400*)	2% (199) / 0.5% (204)
Nepal, Kathmandu, 2004 MSM/MSW**	4% (275) / 5% (83)	
Philippines, Manila / Baguio, 2004	0% (261) / 0% (261)	

\* Sample design includes only male sex workers \*\* MSW refers to male sex workers

It should be noted that most of the data shown in Table 1 represent HIV prevalence in samples chosen at sites where MSM go to meet one another, often looking for new sex partners. These prevalence figures are unlikely to represent HIV infection in the whole population of MSM. Still, they should act as a wake-up call to public health authorities, including those in countries that have not recorded any HIV epidemic among MSM simply because they have not tried to look for it.

### Out of Sight, Out of Mind

Access to populations of males who have sex with males remains a problem. Only a handful of HIV surveillance systems in the region include MSM—Bangladesh, India, Indonesia and the Philippines. But recent ad hoc surveys around the region have been finding extremely high levels of HIV infection: 16.1 percent in men attending gay saunas in Taiwan, 14.4 percent at a cruising area in Cambodia, 17 percent in a community sample in Thailand, and 2.5 percent to 22 percent in samples of different populations engaging in male-male sex in Indonesia.<sup>ii,iii,iv,v</sup>

These data make a compelling argument for the need to include MSM in national surveillance as well. Without more information about HIV incidence and prevalence trends, it will be extremely difficult to implement and monitor the most appropriate prevention initiatives in this population.

## 2. Why Asian HIV prevention efforts must target MSM

The question of how many males engage in high-risk anal sex is much debated. There are very few studies that record male-male sex in the general population. Those that exist suggest that between 3 percent and 5 percent of men have sex with other men on a regular basis.

- In a variety of surveys in Thailand, between 3 percent and 4 percent of males have reported recent sex with males.<sup>vi,vii</sup>
- Similarly, in the Philippines, 3 percent of over 1,200 males recruited at blood banks and medical facilities said they had had anal sex in the preceding six months.<sup>viii</sup>
- In a household-based survey in a low-income area of Chennai, India, 6 percent of males reported sex with other males. These males were over eight times more likely to be infected with HIV than other men in that population, and 60 percent more likely to be infected with other sexually transmitted infections.<sup>ix</sup>

Like HIV surveillance, behavioural surveillance among MSM is likely to capture the high end of the risk spectrum. In most cases, men are recruited for inclusion in surveillance from locations where social and sexual activities are common among MSM (and also between other populations with high-risk behaviours, such as female sex workers and injecting drug users). In these more sexually active sectors of the MSM community, high-risk behaviour is not uncommon in most Asian countries.

### Why Anal Sex is So Risky

HIV is more likely to be transmitted during anal sex than during vaginal sex, because the anus is not naturally lubricated, and small tears and lesions that allow HIV to pass from one partner to another can easily occur. This is especially true for the receptive partner, because sperm and other body fluids will remain in the anus after the insertive partner has withdrawn. Anal sex (both insertive and receptive) is also vastly more risky than oral sex. Anal sex is by far the most common sexual practice between men.

## Ignoring male-male sex has skewed risk perceptions

Although condom use in anal sex between males varies very widely across Asia, **Figure 1** on page 7 underscores an interesting reality. Almost everywhere it has been measured, condom use in commercial sex between males and females is consistently higher than condom use in commercial sex between males, even though male-male sex carries a far higher risk of HIV transmission. This is probably in part because HIV/AIDS interventions throughout Asia have focused attention on the issue of unprotected heterosexual sex, while maintaining a deathly silence on the subject of sex between males. This has left many people inadequately informed about the risks of male-male sexual behaviours.

In Vietnam's Ho Chi Minh City, for example, fewer than one-third of MSM questioned in a 2001 survey said they thought MSM were at higher risk of HIV infection than other people.<sup>x</sup> Just 6 percent said they felt at risk of HIV infection, despite very high levels of multiple partnerships and unprotected sex. This is a pattern repeated in China, Pakistan, the Philippines and Nepal.

This skewed risk perception translates into ongoing risk behaviour. While 70 percent of Vietnamese MSM who had casual female partners used a condom at last sex with a woman, only 55 percent used a condom at last casual sex with a man. Similarly, in Cambodia, 79 percent of MSM reported always using a condom if they had casual sex with women, while only 33 percent always used a condom in casual anal sex with men.

## Male and transgender sex workers

When sex workers are discussed in Asia, people usually think of women who sell sex to men. But Asian men also buy sex from male and transgender sex workers. For example:

- 20 percent of MSM in Sichuan, China, said they bought sex from another man in the last six months.<sup>xv</sup>
- 22 percent of MSM in Vietnam, bought sex from a man in the preceding year and 31 percent sold sex.<sup>xvi</sup>
- Over one-third of MSM in five cities in India bought or sold sex in the month before surveillance in 2002, and, in the cities of Chennai and Delhi, more than one MSM in two was involved in a commercial sex transaction with another man.

## Sexually Transmitted Infections

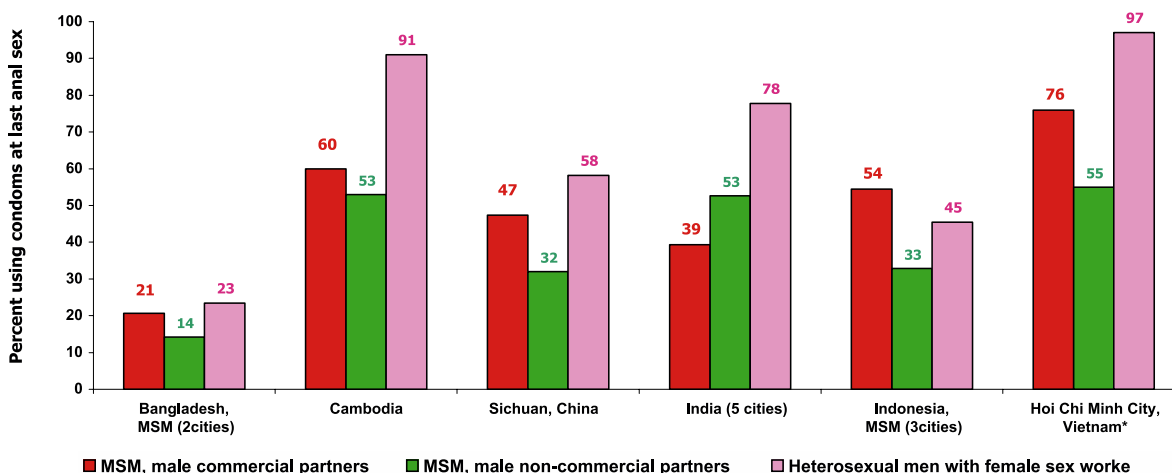
It is widely known that sexually transmitted infections (STIs) other than HIV increase the likelihood of HIV passing from one person to another during sexual encounters. STIs constitute a neglected epidemic even among males, in whom infections are more likely to be symptomatic. This is particularly so among women, in whom asymptomatic infections are common. But infections that are transmitted in anal sex are not just overlooked, they are almost completely invisible. So much so, that there are very few data available about this serious problem. The information that does exist is not encouraging.

- In East Timor, 14 percent of MSM were infected with gonorrhoea compared with just 0.5 percent of soldiers and taxi drivers. All but one of the infections was rectal. Chlamydia infection among MSM was similarly high, and all of the infections detected were rectal.
- In the Philippines, 34 percent of MSM in Manila and 30 percent of MSM in Baguio tested positive for at least one STI.<sup>xi</sup>
- In Nepal, 19 percent of MSM and 54 percent of MSW tested positive for at least one STI.<sup>xii</sup>
- In Karachi, Pakistan, 60 percent of hijras (transgenders) and 36 percent of MSWs tested positive for current or previous syphilis infection.<sup>xiii</sup>
- In Cambodia, urethral infections among MSM were much higher than rectal infections, but overall 27 percent of MSM were currently infected with at least one STI. Infected males shared one important characteristic: many did not recognize that they might be infected with an STI.<sup>xiv</sup> But even many of the MSM who reported symptoms of STIs did not seek treatment.

It appears that appropriate sexual health services for MSM should be a crucial strategy in HIV/AIDS interventions for Asian males, but currently this issue is overlooked.

- Close to three-quarters of Cambodian MSM approached in public meeting areas in the capital, Phnom Penh, said they had sold sex to another man in the previous six months.<sup>xvii</sup>
- The high rates of commercial sex between males reported in surveys do not represent the habits

## MSM are more likely to use condoms in commercial than in casual sex, but condom use in male-male sex is still lower than with female sex workers



**Figure 1 Percentage of MSM using condoms at last sex with commercial and non-commercial partners, and comparison with condom use reported by clients of female sex workers in the same locations.**

\*Always or frequent condom use in commercial sex over last month

of all MSM. Those included in surveillance are generally approached at sites known to be “hot spots” for seeking new sex partners, including commercial partners. But those rates serve to draw attention to the forgotten population of male sex workers.

**Figure 1** shows that MSM are generally more likely to use condoms in commercial sex than in unpaid sex, but consistent condom use in commercial sex is low, even in places where HIV/AIDS interventions exist. Not surprisingly, male sex workers report higher numbers of partners than other MSM, and the consequence is often higher rates of HIV infection. Higher rates of other STIs also have been found in these populations.

- In Thailand’s capital, Bangkok, 32 percent of MSM who reported ever selling sex were infected with HIV, nearly twice the level of those who did not sell sex.<sup>xviii</sup>
- In Nepal, 65 percent of male sex workers were infected with at least one STI (including HIV), compared with 21 percent of other MSM. Rectal STI infection rates were higher, at 29 percent compared to 5 percent.<sup>xix</sup>
- In Jakarta, Indonesia, 4 percent of male sex workers tested HIV-positive compared with 2.5 percent of other MSM, a difference that was not statistically significant. HIV infection among transgender sex workers, however, was dramatically higher, at 22 percent. This level, which represents a tripling since HIV was last measured in this group in the mid-1990s,

places transgender sex workers second only to drug injectors in terms of HIV prevalence in Indonesia.<sup>xx</sup>

### Oral Sex as a Risk Reduction Strategy?

While 79 percent of transgender sex workers had provided both oral and anal sex services to clients in the past week in three cities in Indonesia, 12 percent had provided oral sex services only. In qualitative research, transgender sex workers reported getting paid the same or more for oral sex as for anal sex. While oral sex may not be entirely without risk, unprotected oral sex is much, much safer than unprotected anal sex.

A shift from anal to oral sex services in commercial sex may therefore be considered as one possible risk reduction strategy for male and transgender sex workers who cannot negotiate condom use in anal sex. However, it is important to bear in mind that there is still a chance of HIV being transmitted from an infected person to an uninfected person during unprotected oral sex.

Because the number of transgender sex workers is relatively small, their impact on the epidemic will not be as great as that of injectors. But transgender sex workers sell sex to heterosexual males, many of whom, in qualitative studies, also report being regular clients of female sex workers. This potentially creates a chain of HIV

transmission: from transgender sex workers to heterosexual males; from heterosexual males to female sex workers; and, from female sex workers to their other clients. Therefore, high HIV infection rates among transgender sex workers can have a “booster effect” on the spread of HIV through heterosexual commercial sex networks.

Some 40 percent of transgender sex workers in Jakarta who were infected with HIV were also infected with current, active syphilis.<sup>xxi</sup> This is further confirmation that they are continuing to have unprotected sex, but it is also worrisome since syphilis infection will speed up HIV transmission to clients and other sex partners.

### Are Clients Foreigners or Natives?

In some settings, it is commonly assumed that male sex workers serve only or mainly foreign clients. That assumption has been upended in East Timor, for example, where the presence of international peacekeepers and United Nations staff coincided with social liberalization that led to more openness about homosexual activity. One survey found that only one-third of males who had sold sex in the previous month had foreign partners, the rest of the demand came from locals.

Qualitative research in Hanoi, Vietnam, mirrors these findings. While men selling sex in the increasingly active commercial sex scene provide services to foreign partners, they report that the majority of their clients are Vietnamese.<sup>xxii</sup>

Interestingly, both the Hanoi and the East Timor studies reported that overseas clients were more likely to use condoms than local clients.

### Sex and drugs

The epidemics driven by male-male sex and by drug injection overlap in notable ways.

- 3 percent of MSM in a 2004 Nepal survey reported injecting drugs in the past year.<sup>xxiii</sup>
- About 3 percent of MSM in Manila (the Philippines) said that they had used injection drugs at least once.<sup>xxiv</sup>
- 2 percent of MSM in central Bangladesh and 4 percent of male sex workers in the southeast reported injecting drugs in the past year.
- Cambodia is a country generally thought to have escaped the burdens of drug injection, but as early as 2000 in a survey of MSM (mostly

male sex workers) 3 percent had injected drugs in the preceding 12 months.<sup>xxv</sup>

- In Indonesia, rates of drug injection among male sex workers were higher than among other population groups. In all likelihood, these people were selling sex to finance their drug use.

Drugs, and particularly amphetamines, may also increase the risk of transmission during unprotected anal sex. Anecdotal reports among MSM suggest that crystal methamphetamine delays ejaculation and dampens discomfort or pain for the receptive partner. Both those factors may contribute to sexual practices that increase rectal trauma.

It should be cause for concern, therefore, that about one-third of MSM in the Philippines reported ever having taken recreational drugs.<sup>xxvi</sup> Also, 24 percent of MSM in Nepal reported recreational drug use in the previous year.<sup>xxvii</sup>

Some 47 percent of male sex workers in Indonesia reported taking drugs in the previous year, compared with 27 percent of MSM who did not sell sex. Data on specific drugs are not available, but amphetamines are the most commonly seized drugs in all three Indonesian cities where surveillance took place, according to police reports.

In Thailand, about 4 percent of IDUs recruited at Chiang Mai drug treatment centres reported male-male sex behaviour. In addition, it was found that these MSM had significantly higher HIV rates compared to the men who reported only female partners, and they were more likely to have been paid for sex.<sup>xxviii</sup>

### Men who have sex with men and women

In many industrialized countries, a majority of people classify themselves relatively easily into one of three behavioural categories: homosexual, heterosexual or bisexual. But in Asia, people's sexual behaviours, occasional sex with male or transgender sex workers, for example, may not match their overt social identities (such as heterosexual family men).

A high proportion of males reporting same-sex behaviour also have reported having heterosexual sex. Some examples follow.

- In a household study in India, 57 percent of men reporting sex with other males were married.<sup>xxix</sup>

- In a similar survey in central Thailand, one in three of the men who reported sex with other men also bought sex from women, and almost half had non-regular female partners.<sup>xxx</sup>
- One in five of the respondents in a survey of truck drivers in Bangladesh reported sex with both men and women. Interestingly, men who had recent sex with men were four times more likely to report recent sex with female sex workers. This suggests that the availability of sex outweighs many people's sexual identities or preferences.
- In surveillance among clients of female sex workers in India, 11 percent said they had ever had sex with a male, and 3 percent had done so in the previous year. These behaviourally bisexual men were far less likely to use condoms with men than with female sex workers. Indeed, only 15 percent of the men said they always used condoms with male partners, compared with 57 percent with female sex workers.

What about people who are approached for inclusion in surveys because they are associated with venues or services that cater to people who are more openly identified with homosexual behaviour? These might include, individuals sampled at gay bars, cruising areas and in internet chat rooms aimed at gay men, for example.

As **Figure 2** shows, at least one in five males who were included in surveys across the region because they reported sex with other males also reported recent sex with women. Particularly noteworthy

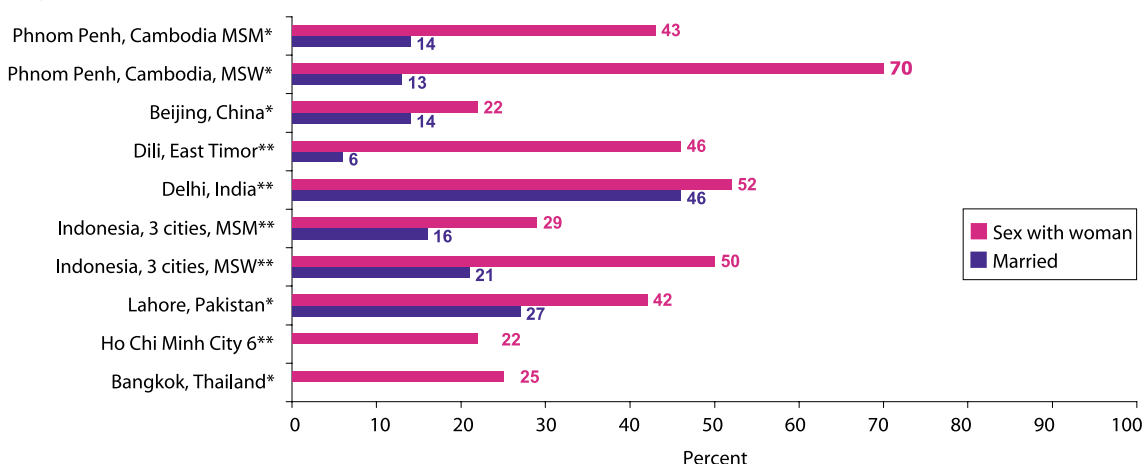
were the high rates of bisexual behaviour among males who sold sex (the darker sets of bars in Figure 2). In Indonesia, high proportions of male sex workers had sex with other males chiefly to earn money. All their unpaid sexual partnerships were with women.

### HIV Prevention for Clients of Transgender Sex Workers

Missing from Figure 2 is an important subset of males with bisexual behaviour: the clients of transgender sex workers. No quantitative behavioural data on this group exist, to our knowledge. However, qualitative research in Indonesia shows that almost all males who buy sex from transgender sex workers consider themselves heterosexual. Most are active clients of female sex workers, and have sex with transgender sex workers for an occasional "change of scene." Transgender sex workers, for their part, are proud of the "macho" qualities of their clients, and dislike providing sex to effeminate or gay-identified males.

The Indonesian health ministry estimates that one-quarter of a million Indonesian men buy sex from transgender sex workers each year. One in five transgender sex workers are living with HIV in some parts of the country, so their clients clearly risk being exposed to the virus. If clients become infected in anal sex with transgender sex workers, they may in turn expose female sex workers and other female partners to HIV.

### At least one MSM in five reports sex with women; among male sex workers, the rate is much higher



**Figure 2 Percentage of active MSM who are married or report recent sex with women, various countries.**

Notes: \*Last six months \*\*Last 12 months. China: unprotected sex with woman. MSM refers to males who have sex with males. MSW refers to male sex workers.

### 3. Facing the facts: translating the evidence into strategies for reducing HIV transmission among MSM

#### Starting with the prevention basics: condoms and lubricants

Throughout Asia, males who have sex with males need more information about the risks involved in anal sex. Risk avoidance, including abstinence, mutual fidelity and partner reduction, should be encouraged. But information alone is never enough. MSM are far more likely than heterosexual men to cite limited access to condoms as a reason for not using them. In many countries in Asia, access to condoms is low. In Nepal, for example, only 28 percent of MSM reported being able to get condoms when they needed them.<sup>xxxii</sup>

Lubricants are another basic prevention technology that can help cut HIV transmission in anal sex. The anus, unlike the vagina, does not produce natural lubricants, so abrasive anal sex easily produces rectal trauma, and that in turn makes it easier for HIV to pass from an infected to an uninfected person. Condoms are generally lubricated, but many men prefer to use additional lubricant even when using a condom. The problem is that many of the creams and lotions that are often used in anal sex are oil-based, and can damage the latex from which condoms are made. The safest lubricants are water-based lubricants (such as the well-known brand KY™). However, data from around Asia show that water-based lubricants are rarely used, and many MSM have never even heard of them. Where they are known, water-based lubricants are considered expensive and inconvenient (they are often packaged in large tubes like toothpaste containers, which don't fit easily into a pocket during a night's cruising).

In Nepal, 22 percent of MSM reported using water-based lubricant with a condom the last time they had anal sex.<sup>xxxiii</sup> In East Timor only one MSM in 10 had ever used water-based lubricant, and in Cambodia only one in 100 had used it.<sup>xxxiv</sup> In Vietnam, 75 percent of respondents had never heard of water-based lubricants; and, 41 percent mentioned saliva as an appropriate lubricant.<sup>xxxv</sup>

MSM in a number of countries, including Cambodia, East Timor, India and Indonesia, frequently mention being embarrassed to buy condoms. This may be associated with a fear that buying condoms will identify a person as "gay"; a somewhat irrational fear in countries

where condoms are heavily promoted for use between men and women. Whatever the reason, efforts to reach out to MSM and provide them with easier access to condoms are an important step toward promoting greater use. Water-based lubricants should be promoted to MSM at the same time. Some HIV prevention programmes may need to supplement traditional distribution strategies with new approaches, as the following box describes.

#### Promoting Condoms and Lubricants

Unwillingness to access condoms and lubricants may not be difficult to overcome in some settings. Indonesian researchers found that only 14 percent of MSM and male sex workers and 15 percent of transgender sex workers (waria) had ever used water-based lubricant. Furthermore, 68 percent of those who didn't always use condoms in both groups said it was because they were embarrassed to buy condoms, or condoms were just too inconvenient to access. In response, an HIV prevention programme began producing "safe sex packs".

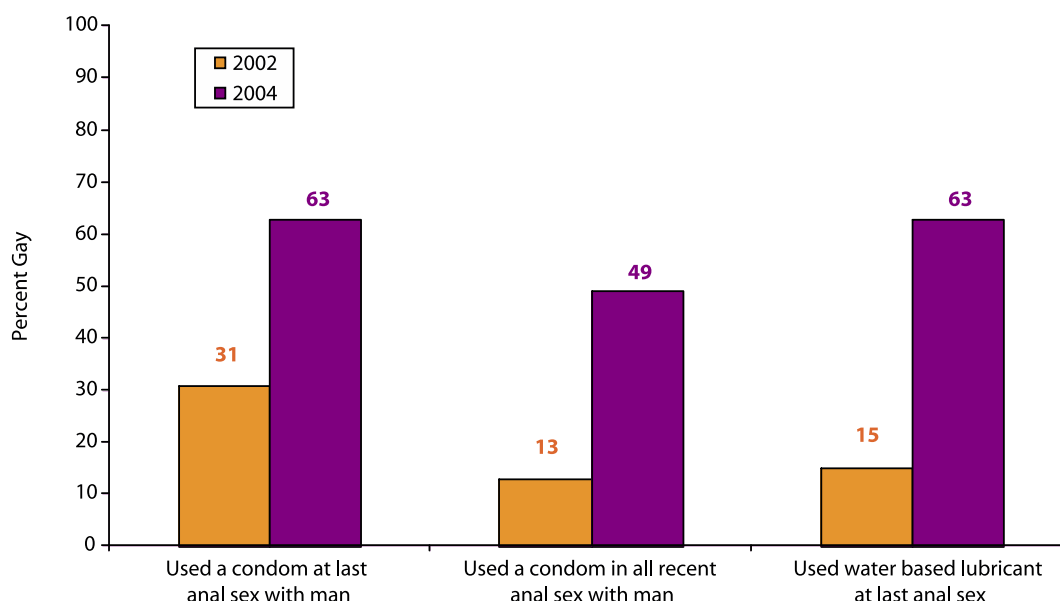
These slickly designed little packs, picturing a gay man on one and a waria on the other, contained a condom, a sachet of lubricant and instructions on their correct use in anal sex. Close to 70 000 of the packs were handed out in four cities in just two months. The result was that lubricant use doubled among MSM and rose nearly two and half times among waria. Around 90 percent of both groups said they would be willing to buy the packs and plans to make a socially-marketed version available are now underway.<sup>xxxvii</sup>

Evidence-based interventions can make a difference and may have an impact on the future of the epidemic in Asia. This is the case of Indonesia, as **Figure 3** shows.

#### Services for males who have sex with males

The high levels of HIV and STIs in many MSM populations point to the need for MSM to have better access to STI services and to HIV voluntary counselling and testing (VCT). There are also important opportunities to promote HIV prevention practices to HIV-infected MSM receiving care, support and treatment, including antiretroviral treatment. But while Asian populations in general and some high-risk groups in particular have acquired greater access to HIV

**Data from Indonesia suggest that high coverage with the right interventions can have an impact on the behaviour of MSM.**



**Figure 3 Percentage of MSM using condoms and lubricant, 2002 and 2004.**

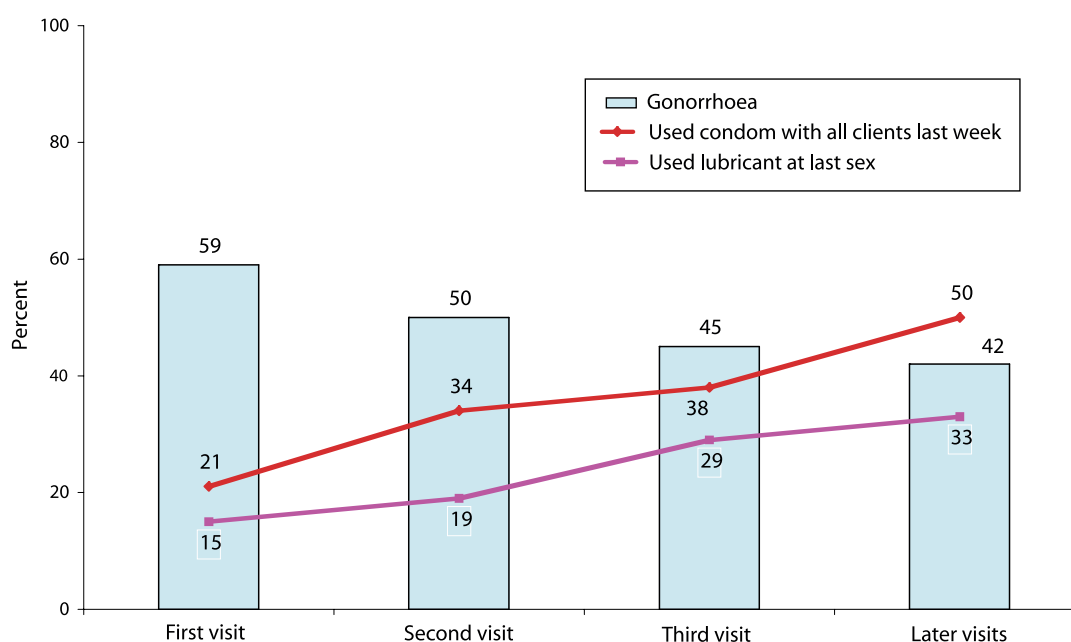
prevention-related services, there is still a gap to fill for MSM. Even if they have the option of utilizing the currently existing services, there are significant deterrents to doing so.

The greatest barriers are fear of being discriminated against by health care providers and a lack of privacy and confidentiality at some clinics. Further issues relating to service providers include insufficient training on male sexual issues and a poor understanding of what gender and

sexuality mean to the MSM who are seeking treatment. Another obstacle is the absence of clinical guidelines relating to MSM, particularly clinical guidelines on rectal STI diagnosis and management.

Resources need to be channelled into addressing all of these concerns. Large-scale training initiatives may be called for to adequately prepare service providers to respond sensitively to MSM, including HIV-infected MSM receiving

**Regular visits to STI services have made a difference for MSM in Indonesia**



**Figure 4 Providing quality STI services will help decrease STI rates and help increase protective behaviours.**

care, support and treatment. HIV prevention programmes involving HIV-positive MSM need to be established. Improving the full spectrum of health care services for MSM is both an appropriate goal in its own right and an HIV prevention strategy. Many existing interventions could be broadened to include HIV prevention components that address male-male sexual risks. Data from Indonesia demonstrate the potential benefits of this approach (Figure 4).

### The role of the community in MSM HIV prevention efforts

The stigma often attached to male-male sexual behaviour can encourage MSM to be secretive about this aspect of their lives. In most Asian countries, there is an unfavourable social and political climate for discussing issues related to MSM, and it is even more unfavourable for organizing communities to respond to the HIV/AIDS epidemic. As a result, MSM populations can remain hidden in many Asian settings, making it difficult for service providers to reach them. MSM may be more accessible to their peers, which means that the MSM community has a vital role to play in promoting HIV prevention measures within their community.

By going through community channels, HIV prevention programme managers have the opportunity to utilize MSM peer networks that otherwise would be impossible for governmental or nongovernmental organizations to locate. These peer networks have the potential to influence group norms regarding safer sex and

other HIV risk reduction strategies. They also can provide a means of mobilizing community members to advocate for the rights of MSM, decreasing this population's vulnerability to circumstances that might contribute to risky behaviours.

In cities that have active peer distribution networks supporting safer sex for MSM, overall levels of condom use are far higher than in cities that rely largely on pharmacies and other traditional outlets. The experience of India, illustrated in Figure 5, is instructive in this regard.

### The need for supportive government policies and programmes

A social environment that stigmatizes sex between males creates unfavourable circumstances for the behavioural changes that are necessary to reduce HIV infection rates among MSM. Fear of stigma and discrimination may encourage MSM to remain hidden and therefore disconnected from the information and services that would enable them to practice safer behaviours. This increases their vulnerability to HIV and to other health risks.

Advocating for more supportive government policies and programmes is therefore a necessary component of HIV prevention campaigns targeting MSM. In many Asian countries, there is a need for advocacy at both the national and local level. In their words and actions, government representatives and institutions can communicate views that will encourage the

### More peer distribution turns into more condom use

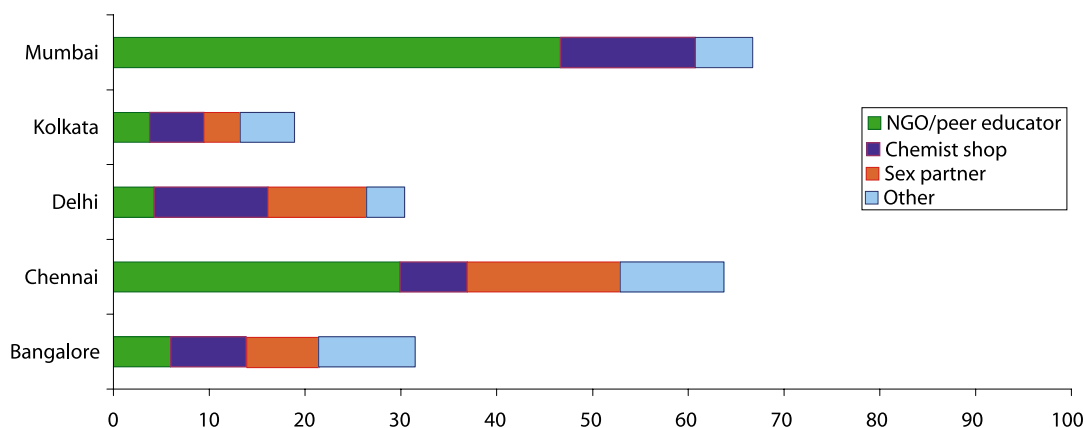


Figure 5 Percentage of men using condom at last commercial sex, according to source of condom used at last sex, five cities, India.

implementation of services for MSM and decrease violence and discrimination against MSM. At the national level, the needs of MSM should be acknowledged in national strategic HIV/AIDS plans. At the local level, it is important that key players such as police and religious leaders receive encouragement and support to help strengthen MSM HIV prevention efforts.

### **Strategies for MSM Interventions/Services in Greater Mekong Region (GMR)**

“... After reviewing and discussing the issues in providing HIV services to men who have sex with men, existing services and lessons that have been learned in the GMR, participants set two objectives: 1) decrease the prevalence of HIV; and, 2) mitigate the impact of HIV and AIDS among MSM in the Greater Mekong Region. The workshop described a minimum package of interventions that could fulfil the objectives, through the implementation of activities and dynamics such as those suggested in the Minimum Package of MSM Interventions of the GMR produced by the workshop. Three priority needs were identified by the participants of the workshop: 1) strengthening of existing or newly created community organizations, MSM and non-MSM, so that they can facilitate access to prevention, care, support and treatments services by MSM; 2) improvement of existing clinical services through the adoption of clinical guidelines and training in the health care sector in the GMR; and, 3) engage with regional governments to recognize the need for HIV prevention, care, support and treatments services by MSM and establish relevant, supportive policies and programs.”

*Source: Strategizing Interventions among MSM in the Greater Mekong Sub-Region (GMR) Report. CDC-GAP/USAID/FHI-ARP. March 2005. Bangkok, Thailand.*

A comprehensive series of initiatives is called for to mobilize governments, policymakers and donors at the regional and national levels. The box above describes how interventions targeting MSM and transgenders might be developed and scaled up; while the report that is cited has a geographical focus on the Greater Mekong Sub-Region, it raises issues that are relevant to a large number of Asian countries.

## **4. Conclusion**

In Asia, general discomfort among civil society, governments and the leadership of national AIDS programmes in regard to MSM and transgenders has been a factor contributing to high-risk behaviours among these populations. As a result, there have been unpleasant surprises such as high levels of HIV and STIs. These findings are a wake-up call for everybody!

However, despite some progress in designing and implementing HIV/AIDS interventions in the region, there is no agreement or clear guidance about the type or the methodology of interventions or services for MSM and transgenders. In fact, no study or evaluation has so far clearly provided proof of any short-term impacts of current interventions, or has started to derive a model for interventions targeting MSM and transgenders in the region.

Some studies to evaluate outcomes of the targeted HIV/AIDS interventions for MSM and transgenders are currently in progress in selected countries in Asia. Lessons learned can help programme managers strengthen current interventions and can inform the development of more targeted interventions for MSM and transgenders. Meanwhile, the experiences of Asian countries thus far suggest the need to adopt certain key principles when designing and implementing interventions. These are summarised below.

### **Key Principles**

- 1) Address the specific behaviours that are causing most infections and provide specific services and commodities to reduce the risks associated with those behaviours.** Encouraging risk avoidance including: abstinence, mutual fidelity and partner reduction, along with better access to condoms and water-based lubricants is essential. Equally important, is access to high-quality STI screening and treatment services which take into account the needs of MSM and transgenders.
- 2) Provide access to information and to services on a scale large enough to make an impact on HIV transmission.** Asia is a continent on the move, which greatly increases the interaction of people who are taking risks in regard to sexual or injecting practices. Small demonstration projects in one district may protect the few people who live in that district

and do not interact with anyone from an area with no prevention programme, but they will not make a difference to a national or regional epidemic. Prevention efforts are successful if they change behaviour on a national or regional scale. This often means using multiple channels of communication rather than simply trying to contact at-risk individuals.

**3) Ensure that the social, political and security environment supports the provision of appropriate HIV/AIDS services to those most at risk, allowing them to adopt safer behaviours.** People will not use HIV/AIDS services if using those services puts them at risk in other ways, such as, being arrested or being stigmatised in ways that threaten their livelihoods. Successful HIV/AIDS interventions have worked with law enforcement, legal and social services, sex industry power-brokers and others to ensure that those in need of services are supported in protecting themselves and others from HIV.

Ignoring MSM and transgenders in Asia will not make their needs go away. Providing good prevention, care and treatment programming on a large scale will make their lives safer and will reduce the risk of HIV infection in the broader community. There is nothing inevitable about the spread of HIV — the right prevention services for the right people can change the course of HIV epidemics in Asia.

## Appendix 1: Members of the Monitoring the AIDS Pandemic Network

The members of the MAP Network are listed below. Special thanks to those who appear in bold for their active participation in the preparation of this report.

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Stefano Bertozzi	Mitsuhiro Kamakura	Bernhard Schwartlander
Stephen Blount	Claudes Kamenga	Mohammed Shaukat
Tim Brown	Masahiro Kihara	Qu Shuquan
Hor Bun Leng	Ann Marie Kimball	Weerasit Sittitrai
Anne Buve	Irena Klavs	Karen Stanecki
Carlos F. Caceres	Maria Laga	Robert Stein
Ricardo Calderon	<b>Peter Lamptey</b>	Rand Stoneburner
Bilali Camara	Stefano Lazzari	Steffanie Strathdee
Michel Carael	<b>Sophie Le Coeur</b>	Donald Sutherland
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Kevin de Cock	Angus Nicoll	Myint Zaw
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Carlos Del Rio	Mead Over	Debrework Zwedie
Helene Gayle	Tia Phalla	
Peter Ghys	Chansy Phimpachanh	
Ron Gray	Peter Piot	
Sofia Gruskin		

## Appendix 2: Sources used in this report

### Surveillance Data

The majority of the data in this publication is taken from national surveillance systems. This publication is based on the best available data. Its authors have, as far as possible, ascertained that the data used were collected following reliable protocols and standard procedures. The MAP Network wishes fully to acknowledge the sources for all of the data used. However because the report refers to data with very great frequency, the sourcing of each individual data point cited would be impractical. For that reason, the sources for surveillance data are consolidated in this list.

Any data point that is not individually sourced, or that is sourced to “national surveillance records” or “behavioural surveillance”, comes from the sources on this list. Unless otherwise stated, a cited data point refers to the most recent year for which data are available, as stated on this list. Note that this list refers to the year of data collection, not the year of publication. Data from stand-alone studies rather than from repeated surveillance efforts are individually referenced using endnotes. (See the next section of this Appendix.)

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