

A review of knowledge about the sexual networks and behaviours of men who have sex with men in Asia

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This work was supported by the U.S. Agency for International Development through Family Health International's Implementing AIDS Prevention and Care (IMPACT) Project, Cooperative Agreement HRN-A-00-97-00017-00.

The views expressed in this report by named authors are solely the responsibility of those authors and do not necessarily reflect the views of Family Health International or the United States Agency for International Development (USAID), the original funder of the work described.

This report was presented to Family Health International in September 2003.

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Australia, May 2006

Monograph Series Number **59**

ISBN **1920948104**

Suggested citation for the report:

Dowsett, G.W., Grierson, J. W., and McNally, S.P.,
A Review of Knowledge about the Sexual Networks and Behaviours of Men who have Sex with Men in Asia.

Australian Research Centre in Sex, Health and Society

La Trobe University, Melbourne, Australia. Monograph Series Number 59. 2006

Suggested citation for annotated bibliography:

Dowsett, G.W., Grierson, J. W., and McNally, S.P.,
A Review of Knowledge about the Sexual Networks and Behaviours of Men who have Sex with Men in Asia: Annotated Bibliography - Bangladesh

Australian Research Centre in Sex, Health and Society

La Trobe University, Melbourne, Australia. Monograph Series Number 59. 2006

This annotated bibliography citation can be altered for each country.

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Introduction to the Project

Background

Sex between men would appear to occur in all societies; yet, despite that and the recognition that sexual practices between men carries a high risk of HIV transmission, a serious lack of attention towards men who have sex with men (MSM) throughout the developing world still exists.

Denial, stigma, discrimination, poor quality data, or a lack of data, the absence of appropriate prevention programmes, and the inherent difficulties in reaching men who have sex with men remain as obstacles to developing and sustaining effective HIV prevention work. UNAIDS (2000), in its technical update report on *AIDS and Men Who Have Sex With Men*, identified the following barriers to effective HIV prevention programmes for men who have sex with men:

- Denial that sexual behaviour between men takes place;
- Stigmatization or criminalization of men who engage in sex with other men;
- Inadequate or unreliable epidemiological information on HIV transmission through male-to-male sex;
- The difficulty of reaching many MSM;
- Inadequate or inappropriate health facilities, including sexually transmitted disease (STD) clinics, and lack of awareness or sensitivity among STD clinic staff about the existence of anal, rectal and oral STDs;
- Lack of interest among donor agencies in supporting and sustaining prevention programmes among men who engage in same-sex behaviour, and a lack of programmes addressing male sex workers in particular; and
- Lack of attention in national AIDS programmes to the issue of MSM.

These issues are evident in the literature reviewed in this report. However, while there are similarities across the four countries under review, this report also shows that male-to-male sexual activity and interests are not always straightforward or singular. Sex between men is often stigmatized in many countries in different ways, including the four chosen for this review, India, Bangladesh, Indonesia and Thailand, and the visibility of such sexual interests varies considerably from one country to another. There is some variation in the level of commitment displayed by governments, organisations and individuals, in part due to cultural considerations, but in part due also to the financial, political and infrastructural exigencies. This in turn has an impact on the level and quality of research and prevention work. While there are many similarities across countries in sexual networking and risk behaviours of male-to-male sex, differences also exist.

Peter Aggleton noted in his report on Track D-Social Sciences at the 13th International AIDS Conference in Durban, that while there were 'markedly fewer presentations on homosexually active men...there was an encouraging increase in papers from developing

countries on this group.’ However, he went on to state that ‘there was a strong sense that less-than-optimal global sharing of good prevention practice among these populations was slowing progress.’ (Aggleton, 2002, 32)

The lack of attention given to MSM throughout the developing world has been documented by a number of studies, the most recent being the 1996 Panos report *On the Margins: men who have sex with men and HIV in the developing world*, (McKenna, 1996). This report examines the extent of knowledge of male-to-male sexual behaviour and the range of AIDS prevention activities in 133 developing countries. Most of the findings of the report are based on a survey of national AIDS programmes, AIDS service and other non-governmental organisations, gay organisations and key individuals in these countries. The aim of the Panos survey was to identify current knowledge, understanding and policy in relation to MSM and HIV. The major findings of the report are:

- Overwhelming absence of research on MSM and HIV transmission. In most developing countries MSM is not acknowledged and poorly understood;
- Support and information systems for MSM are rare or non-existent;
- Prevention programmes very rarely focus on MSM;
- Human rights of MSM are derided and abused which often creates a further obstacle to effective HIV/AIDS prevention;
- There are many different types of MSM and many do not identify themselves as homosexual, gay or bisexual;
- Funding for HIV prevention targeted at MSM is extremely limited and often does not exist;
- MSM do not form a homogeneous, easily reached group; and
- Many MSM also have sex with women.

The report reinforces the view that good HIV programmes addressing men who have sex with men have often been seriously neglected.

Project Brief

The objective of this study, commissioned by Family Health International (FHI) and undertaken by the Australian Research Centre in Sex, Health and Society (ARCSHS), based at La Trobe University, Melbourne, is to provide a thorough analysis of existing information about **MSM** and their **sexual networks** and **HIV transmission** in four Asian countries. While some developing countries have begun researching male-to-male sexual activities and interests, many gaps exist in the understanding of sexual networking within MSM populations, and between MSM populations and wider populations. The project brief includes the following tasks:

- To collate published data on sexual networks and sexual behaviours of MSM with a focus on four countries: Bangladesh, India, Thailand and Indonesia;
- Increase understanding of MSM by analysing all existing literature and data;
- Highlight gaps in knowledge; and

- Make recommendations for additional research needed to further the understanding of sexual networks and sexual behaviours of MSM.

Why these four countries?

Bangladesh, India, Thailand and Indonesia were selected by FHI for this review as each has demonstrated some commitment to the collection of data about MSM in relation to HIV/AIDS. These four countries represent a range of economic and infrastructural complexity and sophistication, and vary in their epidemiology and response to the HIV epidemic. It is also recognised that the differences between these four countries might assist in identifying potentially appropriate parameters on MSM for the developing Asian Epidemic Model.

What we set out to do:

- Perform an international literature review of all English language electronically indexed studies on MSM sexual networks.
- Identify in-country researchers to collect local material. Liaise with in-country researchers to collect material and analyse local language material.
- Review the material collected and created an Annotated Bibliography.
- Produce a report summarising the key findings of the literature, with a detailed analysis of documented sexual practice and sexual networks. Gaps in knowledge were also highlighted.

Methodology

A great deal of the available literature and data relating to sexual networks and sexual behaviours of men who have sex with men in Bangladesh, India, Thailand and Indonesia has been identified. Although there may still be some material we did not discover, we are confident about the extensive nature of the literature reviewed. The review covers published (and some unpublished) material and includes material published in local languages. Relevant quantitative material from local language material has been translated and included in the Annotated Bibliography. Published 'grey' material reviewed does not include newspaper, newsletter or magazine articles. However, every effort has been made to include evaluation reports, surveillance system reports, and government documents.

The collection of data involved (1) searching the on-line databases, and (2) in-country searches.

1. Searching the on-line data bases

International literature was identified through the standard academic process of using electronic citation search engines to scan the peer-reviewed literature. As the engines differ in the journals, monographs and dissertations they index, and in their disciplinary focus, the search was conducted with each of the following electronic databases:

- Medline,
- PsychoINFO,
- Sociofile,
- Sociological Abstracts,
- Healthline,
- Cinahl,
- AEGIS (AIDS Education Global Information System Search),
- Current Contents,
- Southeast Asian Serials Index,
- United States National Library of Medicine,
- Bibliography of Asian Studies.

In addition, the complete listing of abstracts from the following conferences were reviewed:

- 5th and 6th International Congresses of AIDS in Asia and the Pacific (ICAAP) conferences.
- 12th, 13th and 14th International AIDS Conferences.

The search terms used to interrogate the databases were:

- 'MSM'
- 'men who have sex with men'
- 'gay'
- 'male sex work'
- 'male prostitution'
- 'transvestite'
- 'bisexual'
- 'hijras'
- 'waria'
- 'kathoeys'
- 'sexuality',
- 'homosexuality'
- 'sex tourism'
- 'same sex'
- 'HIV' and 'AIDS' were excluded from the searches until the final round of searches

The journals represented in the literature review include: *International Journal of STD and AIDS*; *Preventative Medicine*; *Social Science and Medicine*; *Social Science International*; *AIDS*; *Journal of Homosexuality*; *Indian Journal of Social Work*; *Culture, Health and Sexuality*; *Journal of Gay and Lesbian Social Services*; *Sexually Transmitted Diseases*; *Journal of Men's Studies*; *The Australian Journal of Anthropology*; *Health Transition Review*; *AIDS CARE*; *AIDS and Behaviour*; *Crossroads*; *Social Text*; *Journal of the History of Sexuality*; *Archives of Sexual Behaviour*; *AIDS Education and Prevention*; *Amerasia Journal*; *IDS Bulletin*; *Sexual and Marital Therapy*; *SOJOURN*; *New England Journal of Medicine*; *Venereology*; *Medical Anthropology*; *Journal of the Medical Association of Thailand*; *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*; Dissertation – Abstracts – International

2. In-country search

A key component of this project was the collaboration of in-country consultants. These consultants brought to the project their local knowledge, familiarity with the institutions and individuals engaged in research work in this area, an ability to assess the content, quality and relevance of local language publications, and the means to access local sources of difficult to obtain material.

The following is a list of the in-country consultants who assisted in identifying, retrieving and assessing material.

Bangladesh: Dr. Md. Sharful Islam Khan, Research Fellow, Social and Behavioral Sciences Program, ICDDR,B, Dhaka, Bangladesh.

India: Dr Venkatesan Chakrapani, SAATHII, Solidarity and Action Against The HIV Infection in India, Chennai, India. Dr Chakrapani was the in-country consultant, SAATHII. Due to the size of India it was decided to employ five research assistants to cover different regions. The assistants were chosen on the basis of their knowledge in this area and their ability to access the literature from different organisations:

East - Mr Pawan Dhall, SAATHII, Calcutta

North – Mr Aditya Bandyopadhyay

West – Mr Ernest Noronha, The Humsafa Trust, Mumbai

South (excluding Tamil Nadu) - Mr Arvind Narrain, Alternative Law Forum, Bangalore

Tamil Nadu – Ms Monica Joseph, Social Welfare Association for Men (SWAM), Chennai.

Thailand: Dr Frits van Griensven and Mr Naorat Sathapana, US CDC Collaboration, Ministry of Public Health, Bangkok, Thailand

Indonesia: Dr Richard Howard, Director of Research, CastleAsia, Jakarta, Indonesia (Now with FHI, Jakarta)

Andri Manuwoto, Research Analyst, CastleAsia

Heryana Tri, Admin Assistant, CastleAsia

Special Assistance from:
Dede Oetomo, Gaya Nusantara Indonesia
Piper Crisovan, Yayasan Lentera

Organisations and individuals contacted by in-country consultants are listed below.

Bangladesh

Organisations

Bandhu Social Welfare Society (BSWS); The Social and Behavioural Sciences Unit of ICDDR,B; Organization of Development Program for Under Privileged (ODPUP), HIV/AIDS Alliance Bangladesh (HASAB), Family Health International (FHI), UNAIDS, Population Council, CARE Bangladesh, Marie Stopes Clinic Society, National AIDS/STD Program, Directorate General of Health Services, Government of Bangladesh (MOHFW).

India

Organisations

Tamil Nadu: Social Welfare Association for Men (SWAM); Thamil Nadu Aravanigal Association; Madras School of Social Work (MSSW); Chennai Department of Social Work, Stella Maria College, Chennai; Department of Social Work; Madras Christian College, Chennai; Department of Criminology; University of Madras, Chennai; Department of STD, Dr. MGR Medical University, Chennai

South India: Sangama Resource Centre, Alternative Law Forum, Sabrang; SAATHI, Hyderabad

West India: The Humsafar Trust; Naz Foundation International, Lucknow

North India: Naz (India), Delhi

East India: Palm Avenue Integration Society, Calcutta; Counsel Club, Calcutta; New Alipore Praajak Development Society; Vivekananda International Health Centre, Calcutta

Key Individuals

Mr Sherry Joseph, Visva-Bharati University Sriniketan; Mr Niloy Basu and Mr Ajay Majumdar, Bongaon; Mr Ashok Row Kavi, The Humsafar Trust; Mr Rajiv Dua, Naz Foundation International

Thailand

Organisations

Ministry of Public Health (several departments), Thai Red Cross Aids Research Centre. Also the Chulalongkorn, Thammasat and Mahidol Universities

Indonesia

Organisations

Lentera Foundation, Yogyakarta; University of Gadjah Madah, Yogyakarta; Centre for Health Research at University of Indonesia, Family Health Indonesia, Jakarta, AusAID, Jakarta.

Key Individuals

Dede Oetomo, Budi Utomo

We are very grateful to all these individuals and organisations of their assistance.

Note: Domestic Indonesian and Thai language research on MSM and AIDS is limited in scope and quality. The bulk of domestic Indonesian language research on MSM and AIDS is in the form of undergraduate and master level thesis work.¹

The Annotated Bibliography

A major component of the report is the Annotated Bibliography. This is a tabulated document where each publication is identified, sourced and evaluated on a number of key characteristics. The coding of the publications was done by ARCSHS project staff for the international literature and by in-country consultants for the local literature. An Annotated Bibliography is provided for each country.

The categories used in the Annotated Bibliography focus on risk behaviours of MSM and behaviour links between MSM and wider populations of women and men. The categories, which were agreed in consultation with FHI, are considered to be the most relevant and helpful as potential parameters for the Asian Epidemic Model on MSM.

The Annotated Bibliography is divided into four sections: (1) **Bibliographic Information**; (2) **Methods Used** (stated goals, research site, notes of methodology used, sample size); (3) **Sexuality** (terms/definitions used, frequency of sex, sexual practices, number of partners, condoms used, MSM who have sex with women, HIV/STI data,² characteristics of sex networks and other significant findings); and (4) **Comments** (problematic aspects of research, comments about quality of work).

¹ As we wished to be certain that the relatively small number of articles identified for Thailand (given the scale of the epidemic and the history of response) was exhaustive, a list of publications was sent to Dr Peter Jackson, Australian National University, Canberra, to confirm that we had undertaken a thorough search, and we especially thank him of that assistance.

² Both the terms STI and STD are used in this report. In developing countries diagnostic facilities that detect asymptomatic infections are often not available, and therefore these infections are only diagnosed when symptomatic, hence STDs. When the publication makes clear reference to STIs, and when discussing the issue more broadly, that term is used

Country Reports

The detailed analysis of MSM sexual behaviours and networks is contained in each of the four country reports. These have been divided into comparable sections covering: (1) background; (2) epidemiology; (3) methodology; (4) MSM population; (5) sexual practice; (6) sexual networks; and (7) conclusions.

Wherever possible, judgments about the quality of data summarised and findings reviewed have been included, including comments from our in-country consultants where appropriate. This is important because there are often conflicting accounts revealed in the studies and reports reviewed and at times considerable reliance on self-report and non-comparable items in surveys and interviews.

The broad argument suffusing the country reports, beyond the description of MSM populations studied, concerns the viability and coherence of MSM as a grouping to assist in understanding the nature of current and future HIV/STI transmission during sex between men in these countries. A key finding is the very lack of coherence in that term and the dangers in assumptions that are often made in many studies about easily accessed or familiar populations being *the* or the *main* MSM grouping. There was no singular MSM population in any of the four countries reviewed and nothing remotely approaching the possibility of being the major grouping that might mark the ‘tip’ of any single main MSM ‘iceberg’. While there are MSM who identify as ‘gay men’ in these countries to differing degrees, these men *cannot* be regarded as the core MSM grouping in any country. Also, even where certain MSM populations have received significant research and programme attention (e.g. the ‘kothis’ of India or Bangladesh), there is nothing in the literature reviewed that would support considering these populations as the key MSM grouping. This may provide additional difficulties in modelling the contribution that MSM populations might make to the HIV epidemics in these countries and point to future difficulties in the region in understanding MSM sexual cultures.

That said, the country reports offer a vivid picture of multiple MSM populations, some with links to others, some pointing to further as yet uninvestigated formations of MSM sexual activity and even possible subcultures. Essentially, developing an understanding of sex between men in these countries is still an endeavour in its infancy.

Broad Project Recommendations

It may be no surprise that a review such as this would recommend that further research needs to be conducted in this area, and we would like to highlight four key areas in which attention needs to be paid to the type of research conducted and the manner in which it is undertaken. These four areas are:

- (1) the use of the concept and terminology of MSM;
- (2) attention to the interplay, dynamism and fluidity of cultural definitions of same-sex sexual practice;
- (3) attention to the dynamic networks of same-sex male sexual practice, particularly where these can be seen as integral to broader social networks; and
- (4) the roles of gender and sexual economies as organising constructs for much of what is currently characterised as same-sex orientation.

MSM as a construct

The concept of MSM as a behavioural category masks the diversity and complexity of male-to-male sex in these countries, and may point to the possibility of similar diversity in other parts of the region. Often terms such as 'gay', 'homosexual' and 'bisexual' are used as unproblematic categories in some of the literature reviewed, and we note carefully the difficulties of such usage in the country reports. But using MSM as a category does not work either. Despite the fact that some research uses MSM as a specific group to study, it is clear from the material reviewed that there is not a clearly identifiable group of men who can be labelled MSM in any of the countries. The literature reveals that there are no socially or self-defined groups of men that fit into an overarching category of MSM. What the review shows is that there are just men!! Fishermen, students, factory workers, military recruits, truck drivers, and men who sell sex, and so on: all these categories of men are to be found in the studies and programmes reviewed. And were we to use reports from countries elsewhere to offer pointers to other MSM (e.g. sex between men in mining communities in South Africa), then clearly in these four countries there are other MSM still to be investigated.

There are two key issues here. The literature available is not exhaustive of the possibilities of same-sex-seeking cultures and patterns of sex between men in these four countries, and there is still too little evidence to be certain where many of the MSM populations investigated so far fit into the overall MSM picture.

The many practices of male-to-male sex

The sexual practices of men need to be put into cultural context. There are many meanings attached to various sexual practices. From the literature reviewed, it is not always possible to know what meanings are attached to various sexual practices. It is clear that both 'traditional' sexual relations produce many of the patterns seen in the studies reviewed. In some cases these patterns are recognised, for example, the hijra,

waria and kathoey all represent longstanding categories of men who are recognised to be available for and pursue sex with other men. Similarly, rickshaw pullers in South Asia could be seen to constitute another longstanding population of men who also have sex with men on occasion (and with women and sex workers of both sexes as well) and the sexual acts they engage in are quite varied because of this dispersal of sexual interests. There are also emerging patterns of sex between men resulting from modernisation and urbanisation, e.g. gay men in Indonesia, sex between males students or with sex workers in Bangladesh, which are yet to resolve into clear or singular patterns.

Similarly, cities are continually providing spaces for sex (parks, railway stations etc.) where younger and/or older men meet, and where prevention activity by NGOS is discursively re-shaping the populations they reach in ways that may or may not reflect logical clustering in terms of common sexual identification or any sense of being a group of like persons. The sexual practices facilitated by this quite substantial amount of sex with 'casual' partners (as it would be termed in the West) are varied. There is some evidence of a kind of gendered behaviour (kothis are thought to be receptive in anal intercourse – except this is not always the case in practice) that may be age-related, and some of it contextualised within deeper relational meanings (e.g. boyfriends).

But the key message once again is considerable variation that makes it difficult to categorise risky practice in relation to this group or that as such, or to any specific circumstances (e.g. young sex workers are always receptive [not so]).

Dynamic networks

Within this quite diverse and dispersed sexual activity there are, admittedly, denser networks of MSM. The dilemma is that these often have been subject to more research and appear more 'solid' as groupings than they should. We are convinced that positioning these more well-known populations as the key MSM grouping in any country is erroneous and we warn against that substitution.

There are certainly male sex workers (MSW) who sell sex quite regularly and are known as such. However, it would appear that these men cannot easily be sequestered into an MSW group as a discrete permanent category, because their sporadic sex selling does not make many MSW a form of commercial sex work analogous to female sex workers (FSW) in the way that could warrant the tag 'commercial sex worker (CSW)' – and for this reason we have not used this last term in this report. Therefore, categorising a man because he has sold sex yesterday as MSW for the purposes of assigning a risk status would be incorrect.

Even if MSM sexual networks exist –and there is evidence of denser, more continuous networks surrounding or facilitated by the AIDS service organisations serving MSM – these networks are not stable over time. There are variations related to seasonality, life stage (e.g. marriage), urban-rural migration, educational pursuits, and so on. Men move in and out of these networks. But the key issue appears to be the large number of men

who are not ‘networked’ in any conventional way. Here, there is dearth of research reports or data on such men, usually married, or in mid life, who have maintained a sexual interest in other men and pursued that over many years. We have little sense of that continuity from the research findings available. Nor do we have much sense of how these men see themselves and their risk in relation to HIV/AIDS. Considerably more exploration of these men – possibly the majority of men actually having sex with other men in these countries – is needed, and reveals a significant great gap in our knowledge and lays a trap for who is positioned as the MSM in epidemiological modelling.

Gender and sexual economies

The realities of sexual practices do not always fit popular beliefs. For example, cultural meanings and practices of men who identify as kathoey, waria or hijra are not that same. Classifying kathoey, waria and hijra as the 3rd sex or 3rd gender who are penetrated does not allow for a range of meanings and practices influenced by time and space. Indications are that modal preferences in sexual acts do exist but are far from firm or predictable, and there is some sense that there is a discursive *construction* occurring as a result of AIDS service organisations, researchers, and other NGOs utilising concepts (such a ‘gender role’) to configure and make sense of what they are observing.

Similarly, men classified as MSW in studies are a diverse group of men. They sell sex for many different reasons and perform different types of sex work, i.e. for money, exchange for food, accommodation and survival. Male sex workers in the West often identify as ‘heterosexual’; it is unclear from the reports reviewed how such distinctions or identifications might work in these Asian countries and how they would play themselves out in relation to sexual practice. There is evidence of those categorised as MSW having diverse sexual partners; whether that leads to identification as ‘heterosexual’, or its cultural equivalent, is unclear. As such, it is unwise to position such men as some equivalent to Western ‘bisexual’ men and position them as a potential bridge population between the homosexually active and those normatively heterosexual – precisely because these two sides of the Western sexuality binary are themselves neither stable nor readily applicable in these countries as well. Indeed, MSW may be more at risk of receiving HIV from the men who pay them or from the FSW they themselves also seek out.

Conclusion

These four issues by no means capture the full complexity of the difficulty emerging in any analysis of MSM in these four countries. These are explored in more detail in the four country reports. But they frame the key conceptual issues and point to major obstacles in the utilisation of the category MSM in any singular or simplistic way. What this review has revealed is very large amount of sex between men occurring within many diverse configurations, some more firmly within networks than others, but in the main very fluid and changeable. There is significant vulnerability to HIV infection among these populations, but the directions for transmission are not at all clear or easily predictable *on the current evidence*.

The research reviewed is also patchy in terms of quality at times, dominated by forced-choice survey method often with incompatible categories and items, and with poor sampling frames at times. Such findings are suggestive, highly so at times, but need to be approached cautiously. Large, better-designed studies exist and, in the main, point to and confirm the central tenet of the argument in this review – an acknowledgement of diversity and a warning against the convenience of convergence.

Clearly there is more to be done. Providing good conceptual and methodological leadership in producing some systematisation in further research would go a long way toward securing better data sets and more sophisticated findings. These are important to predict the movement of the epidemic in these countries, and in understanding the vulnerability of those populations of men whose sexual interests in other men have to date been neglected and forgotten in forging responses to HIV/AIDS in this region.

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September 2003

Acknowledgements

We would like to thank the Director and staff at the Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, for support and assistance in this undertaking; and also, Tobi Saidel from FHI for her patience and support, Tim Brown from the East-West Centre for his briefing of the team on the Asian Epidemic Model, and the Mailman School of Public Health, Columbia University in the City of New York for supporting one of the PIs during the project.

References

McKenna (1996) *On the Margins: men who have sex with men and HIV in the developing world*, Panos Report, Panos, London

BANGLADESH

1. Background

In 2001, Bangladesh's population reached 140 million with approximately 33% aged between 15 and 24 years. With a Human Development Index ranking of 145, Bangladesh is categorised by the United Nations as a Least Developed Country (UNDP, 2002).

The first case of HIV infection in Bangladesh was recorded in 1989. More than a decade on, Bangladesh continues to be classified as a low HIV prevalence country. HIV infection in the highest HIV-risk behaviour groups continues to be low, for example, about 4-5% of injecting drug users (IDU) and less than 1% of female sex workers (FSW) have been found to be infected with HIV (WHO, 2001).

While Bangladesh is in what is considered to be the early stages of an HIV epidemic, there are a number of worrying signs. Sex between men and sex work in Bangladesh are illegal, which has a significant impact upon prevention work. Sex workers, both brothel and street-based, report high client turnover, by Asian standards. Consistent condom use is among the lowest in the region, with only 0.2% of brothel-based sex workers consistently using condoms during paid sex. Needle-sharing among injecting drug users is common. Blood supply is mostly unscreened and donors are paid. Legislation on safe blood was passed in 2002. There is limited knowledge among the population about HIV and AIDS and how it is transmitted. Bangladesh is surrounded by countries that are experiencing significant HIV epidemics. Its porous borders allows for easy border crossings. The International Organisation for Migration (IOM) estimates that currently between 200,000 and 250,000 Bangladeshis leave the country each year to work abroad. STD prevalence in sex workers and hepatitis C prevalence in IDU are very high as are risk behaviours, and these are comparable to rates in other countries in the region that are experiencing a concentrated epidemic.

Estimates at end of 2001 by WHO/UNAIDS

- 13,000 adults (<0.1%) aged 15-49 were living with HIV/AIDS
- 3,100 women aged 15-49 were living with HIV/AIDS
- 310 children under 15 were living with HIV/AIDS (UNAIDS, 2002)

National Strategic Framework

The National AIDS Committee, formed in 1995 and coordinated by the Ministry of Health and Family Welfare, consists of representatives from twelve ministries and NGOs and a few parliamentarians. In 1996, the Directorate of Health Services under the Ministry of Health and Family Welfare issued a National Policy on HIV/AIDS and STD. In 1997, the AIDS Prevention and Control Programme issued a five-year National Strategic Plan. UNAIDS estimates about 50 NGOs working with HIV/AIDS related activities throughout Bangladesh, who work together in a national network of NGOs on STDs/HIV/AIDS. A strong commitment from the government for HIV prevention also exists, with a particular focus on young people.

In December 2000, the World Bank approved a US\$40 million HIV/AIDS Prevention Project. The Bank and other donor agencies have supported advocacy and policy dialogue regarding the control of HIV/AIDS in the context of the Health and Population Sector Project (HPSP). This project is strengthening the delivery of essential health and family planning services for the general population. Other agencies, such as Department for International Development (UK), International HIV/AIDS Alliance, and USAID have financed a number of HIV/AIDS control activities, including: a social marketing program; peer education and condom promotion activities; information, education and communication efforts; STD treatment; surveillance and operational research; and the provision of capacity building to NGOs. The Global Fund has also recently provided Bangladesh with funds.

The World Bank (2002) has identified the following priority areas for Bangladesh:

- **Scale up the behavioural change activities and health promotion interventions** for high risk behaviours and vulnerable groups, seeking to achieve a high coverage;
- **Expand advocacy and awareness efforts for the population at large**, seeking to attain a satisfactory level of public awareness on HIV transmission and prevention;
- **Promote the social acceptability of condom use** and ensure adequate supply and access;
- **Reduce discrimination** of those infected with HIV, or groups engaging in high risk behaviours, by creating and enabling environment through implementation of appropriate advocacy, policies and related measures;
- **Strengthen Government of Bangladesh capacity** for program planning, implementation, monitoring and evaluation;
- **Promote NGO capacity** for program planning, implementation, monitoring and evaluation
- **Strengthen mechanisms for collaboration and coordination** within and between Government, the non-government sector, development partner agencies, and other stakeholders.

Sero and Behavioural Surveillance System

Bangladesh has an established second generation HIV/AIDS surveillance system, conducted among vulnerable population groups. Serosurveillance is undertaken by the Centre for Population and Health (formerly the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B)), currently funded by the Government of Bangladesh, using World Bank /Department For International Development (DfID) funding. Family Health International (FHI) provides technical assistance for behavioural surveillance studies (BSS), and BSS reports have been produced for 1998-1999, 1999-2000 and 2000-2001. The 4th surveillance round is currently underway.

Sero and behavioural surveillance for HIV has been conducted among the most vulnerable population groups and what are understood to be bridging population groups. These groups include: men who maybe clients of sex workers (rickshaw pullers, truck drivers, dock workers and STD patients), male and female sex workers and hijras, men who have sex with men (MSM), and IDU.

Treatments for HIV

There are very few testing facilities in Bangladesh. There are only seven government diagnostic centres for confirmatory ELISA tests for detection of HIV antibody in blood. There are no treatments for HIV in Bangladesh and anti-retroviral drugs are beyond the reach of most Bangladeshis.

2. Epidemiology

Bangladesh currently enjoys low prevalence in HIV infection, at least that is what the third and latest published National HIV and Behavioural Surveillance report indicates.³ The report is, however, cautious and argues that this situation may not be sustained unless rapid action is taken, particularly when: (1) behavioural surveillance indicates that Bangladeshi sex workers have, on average, higher partner numbers and lower condom use than other Asian countries, and other Asia countries, including Islamic ones, have seen dramatic rises in HIV incidence among sex workers; and (2) the epidemic among IDU is rising elsewhere in Asia, and Bangladesh's IDU share needles more frequently than in other countries. No comparable statements are made for MSM. The key indicators table from that report (p. 6f) lists 0% HIV infection among MSM, truck drivers and rickshaw pullers, with 0.5% among street-based sex workers, 0.3-0.5% among brothel-based sex workers, and 1.7% among out-of-treatment IDU.

Other behavioural data indicating assessed levels of risk-taking are worrying, but care needs to be taken in relation to such data, e.g. 41.6% of MSM in the northeast region sold

³ HIV In Bangladesh: Where is it going? (2001), Government of Bangladesh, Dhaka, p. 5.

sex last month and 61.6 % bought sex; 0% of MSM in the central region (which includes Dhaka) sold sex last month, while 91% of them bought sex last month (from whom then?). These are not credible data. Low levels of condom use in 'commercial' sex and low levels of drug injection, however, are worrying indicators.⁴

The literature reviewed includes the three rounds of the BSS undertaken in Bangladesh so far published. Overall, there is considerable inconsistency in the BSS data available to this review on all key markers. Suffice to say that there is considerable risk-taking occurring in a context of very low prevalence of HIV among the classical categories of high-risk groups being used for research, but a large number of MSM outside these classical categories of risk are not being surveyed, studied or reached by prevention activities, and they constitute the great unknown in likely HIV transmission patterns in Bangladesh.

Details

BSS #1 reported very low HIV prevalence among male sex workers (MSW) (in Dhaka) at 0.4%, with 12% syphilis prevalence (B1). Jenkins (B12), in the national surveillance data from BSS #1, reported highest levels of STD symptoms in those with stigmatised socio-sexual categories: MSW, hijras, IDU. For example, 21.5% of MSW reported 'ever' experiencing an STD, with 13.3% 'currently' having those symptoms, and among hijras the figures were 41% 'ever' for anal symptoms and 18% 'currently'. However, Jenkins also notes 18% of non sex-working MSM reported 'previous' anal STD symptoms, with 4.5% having 'current' symptoms (and even 1.5% of truck drivers reported 'current' anal symptoms).

In the BSS #2 (B2), in a HIV prevalence report on 388 MSW, only one case was noted, and HIV prevalence was termed 'indeterminate' at 0-0.9% (with a 95% confidence interval). However, syphilis was reported among 12.6% of MSM, and STD symptoms were reported by 43.6% of MSW and 37.3% of rickshaw pullers. Again, these data on 'high-risk group' categories require cautious interpretation before they are collapsed into any singular category of MSM, as other reports reviewed below indicate. While BSS #3 (B3) has no data on HIV prevalence available to this review, in the Central district (one of four sites in the BSS) syphilis was reported in 18% of MSW and 5.3% of MSM, i.e. quite a discrepancy compared with BSS #2, providing further warning that MSW and MSM may not readily be combined into a single category.

Khan and Rauiyjin (B35) report on Dhaka clinic patients and all had STDs (not surprisingly). Khan, in a qualitative study of MSM (n=40) also recruited from a Dhaka skin/STD clinic (B20), noted that all participants reported STDs. In a later paper reporting on fifteen men (B61), Khan again reports all the men were diagnosed with STDs. Similarly, Pasha, in a qualitative study in Sylhet of twenty-five MSM (B21), noted that 80-90% suffered from symptoms of STDs. Another paper (B43) reported 100% of the sample of MSM reporting STDs, but there is doubt expressed by the in-country

⁴ Use of the term 'commercial' to describe sex work is problematic and is avoided in this report.

consultant as to the methodology. So, many of the clinic-based studies offer no opportunity for assessing either HIV or STD prevalence among MSM.

In contrast, in a clinic-based study in Chittagong, in which 13% of the men reported being 'homosexual', Khokan et al. (B36) reported 0.5% prevalence of HIV and 4.5% prevalence of syphilis, but this is for the whole sample not just MSM. Another report of clinical services (B40) noted only 23% of clinic attendees with STD symptoms—but one wonders why this figure is so low? However, Ahmed and Arafat (B51) reported only between 4% and 11% STD prevalence among clinic attendees at Bandhu's services.⁵ As this service does not specifically recruit with only existing STD-infected men in mind, this figure might be a useful pointer to STD prevalence among a somewhat select population of MSM, i.e. those to whom Bandhu provides outreach, as distinct from STD clinic attendees in studies above. Yet, Uddin and Rashid (B59) in a report of an intervention among of 1,454 MSM in Chittagong note that 65% were referred to STD clinic services, but this is not explained and may also be a product of targeted yet differently focused outreach. Hossain (B23) in a follow-up study of MSM who had participated in an HIV/STD education program, noted 6-7% reporting symptoms, but no pre-intervention data are reported.

Khan, in an investigative study in Dhaka, utilising workshops with 32 MSM and then a survey of 530 MSM respondents recruited through the networks of the workshop participants (B6), reported that 12 workshop participants and 35% of survey respondents reported having STD symptoms in the previous two years. Symptoms reported by the later included bleeding from anus (40%), burning around anus (24%), itching in the pubic area (21%), pain or burning sensation during urination (15%) rashes in the pubic area (15%), lesions around anus (15%), discharge from penis (11%), warts on penis (3%), and lesions on penis (12%). In other reports from programs, the Naz Foundation South Asia study of MSM (B8) reported for Sylhet between 1-16% of men having symptoms of STDs, with higher figures (20-60%) reporting in pain on urinating, defecating or while having sex (no further specification provided). Khan and Bhuiya (B13) rely on self-report also, noting 32% of MSW perceived 'current' STD symptoms as did 20% of their clients.

Finally, Masud et al. (B18), in a study of child prostitutes in Dhaka, report that 60% of the boys reports itching and penile discharge (which would mean that these boys are insertive as well, not just receptive). And in contrast to BSS #1 (B1) and Jenkins (B12) discussed above, Nahar and Ahmed (B39) found only 18% of hijras in that study reporting 'current' anal STD symptoms.

Many of these studies and program reports rely on self-report and, sometimes, syndromic diagnoses in the clinic reports. It is very hard to treat these figures as reliable and, therefore, none of these studies can provide surety as a useful *single* indicator of HIV/STD prevalence among MSM, despite otherwise useful material on masculine sexuality and sexual networks. The main conclusion is that MSM does not constitute a

⁵ Bandhu Social Welfare Society—one of the main MSM HIV and sexual health organisations operating in a number of cities in Bangladesh.

single ecology for STD infection, but that prevalence patterns so far found indicate dispersed sexual economies among men providing a number of potential scenarios for male-to-male transmission of HIV in Bangladesh.

3. Methodology

Sixty-three reports were included in the final review of Bangladesh, including some unpublished material and conference presentations. A key component of the review included the three rounds of behavioural surveillance that used FHI's BSS survey instrument as their basis. Each used different parts of the country and different regions, although Dhaka is represented in all (and at times is the only site). In some cases, MSM, MSW and hijra are all included. At other times, MSM are broken into two comparison groups focused on MSW and other MSM. At still other times, specific categories of MSM such as truck drivers were added. On the whole, selected high risk groups were the focus of the BSSs, and we concentrate here on only the MSM categories, only mentioning women and female sex workers where appropriate comparisons are made. In BSS #2 (B2) men who were bled for prevalence data were not always the same men from whom behavioural data were sought. Comparisons between the BSSs are, therefore, difficult as the MSM samples are not equivalent each time, and there is overlap in subsamples in BSS #2. In addition, the boundaries between categories are not clear; nor do they necessarily hold fast—the distinction between a man who sells sex today (MSW) and a non-selling MSM tomorrow is not at all dependable.

Other reports in the review also subdivide MSM into special categories, such as truck drivers and rickshaw pullers notably, but some of these studies are difficult to compare. The BSS#1 (B1) included a subsample of 411 truck drivers in Dhaka. In B12, in a re-analysis of those data, 12-15% of truck drivers were considered bisexually active (with men, women and or hijra), with about 10% doing so in the last year. Compare this with the 388 truck drivers in B4, which noted 21% reported 'some physical release' with another man (but only 7% in the last year). B25 offers highly suggestive qualitative data on male-to-male sexual activity among foreign and local sailors, fisherman, dock workers, rickshaw pullers and MSW—quite a range of MSM, but all from one particular city, the largest port.

There are, however, no reports that contain other categories of men known to be sexually active with other men, such as students, police, mastans (ruffians, thugs) and the military, or of intrafamilial or institutional sexual activity, well known from exploratory qualitative work undertaken in Bangladesh (B11). These are rarely mentioned or accorded a category in MSM activity. This makes comparisons of behavioural findings hard to synthesise into a single MSM category with any confidence.

Only one study attempts to contextualise its MSM findings in a more general population group (B26), reporting 4% of the sample as actively MSM. But the sample researched were those clustered around a truck stand in Dhaka and cannot (and does not) claim any general population representativeness.

Many of the local reports sought samples through various mapping and networking techniques, some better than others, e.g. the cluster samples utilising time location strategies (B3) or two-tier cross-sectional studies (B4). Most, however, used *convenience* samples. Sample sizes are at times large, in the BSSs particularly, but as the samples are not the same each time, it is difficult to trust comparisons over the three times for which data are available. Many other reports rely on focus groups and interviewing techniques (e.g. B6, B8), where the sampling frames are not defined and, as a consequence, we cannot distinguish between *purposive* or *convenience* recruitment of respondents. Despite the sometimes large numbers (even in surveys, e.g. B6), it is usual that existing networks were used and/or program outreach techniques were employed to gain the respondents, producing biases that are not declared (or even recognised). The size of some of the samples (B30, B6 again) certainly allows for highly suggestive findings. However, representativeness cannot be imputed in such samples (nor do the authors claim this, it must be noted) and, therefore, generalising from these findings where quantified data are reported is to be approached cautiously.

Even the qualitative studies and reports of programs on, for example, clinic attendances or MSM in interventions, utilise local categories, e.g. *kothis*, but mostly MSM is undifferentiated and not disaggregated. The qualitative data (reviewed in B5) are suggestive, however, of complex and multiple homoerotic cultural forms, urban and rural, secretive and openly acknowledged, rapidly changing and traditional (if under pressure), for which little quantitative data are available.

What is clear in the West is that, because defining a sample of 'gay men' has proven impossible during this epidemic, most of the best behavioural research there has relied on cross-sectional studies with varying degrees of energy in networking of samples. In other words, the blurred sexual boundary between 'gay men' and 'other homosexually active men' has been hard to define in the West, even when there is an available and firm socio-sexual category called 'gay'. In Bangladesh, the idea of a single socio-sexual MSM category would appear illogical, and it is not surprising that often the sampling has concentrated on the most easily reached, more socially defined categories of MSW and MSM (and their partners or friends). The gaps in the data on other categories of MSM, e.g. those mentioned above or married men who seek the services of MSW, are only beginning to be addressed (see later in report).

Much of the categorical work has resulted from a set of consultations and reports in Bangladesh among NGOs working with MSM within a larger ambit of work with MSM in South Asia. There is little investigation of exactly how these initiatives have influenced the categories of MSM noted, defined, developed and focused on; and even whether such initiatives may have considerable discursive effect in re-framing the very object they seek to support. This may, to some extent, explain the dominance of the '*kothi*' in the studies and reports rather than demonstrate that this dominance is empirically supported. As a result, for example, in B23 and B31 the 'systematic random sampling' reported on men selected from the (successful) programs of the organisation itself is not reliable, and it is impossible to relate this sample even to a population of *kothis*, leaving aside MSM as a

broader group. Similar problems occur with clinic-based convenience samples (B36). Also, in B38, noted as the first quantitative study of hijras attempted in Bangladesh, the sampling frame is indistinct. While data on the 150 hijras offer a useful beginning, they cannot represent the estimated 2000+ hijras in Dhaka alone (key informants' estimate).

The reliance on self-report is problematic not just for the usual reasons noted in the literature, but because there is usually little explanation of how self-reports are elicited. Where more complex methodologies have been tried (e.g. B13), they are often of single cities or regions and provide no nationally applicable data. There is also a shortage of experienced Bangladeshi social and behavioural researchers working on these issues, and the recency of most of the work might also point to biases in focus and explain gaps noted in this report.

Finally, the in-country consultant in his report noted the absence of human subjects research ethics approval processes for many studies and this is an important observation.

4. MSM Population

The caution concerning methodology notwithstanding, it is clear that Bangladesh has quite a variety of evidence of MSM activity, which may position such activity as especially vulnerable to HIV. First, the studies and program reports reveal MSM activity throughout country, i.e. it is not confined to Dhaka or large cities but also occurs in rural areas, although the evidence on rural areas is admittedly thin. There is no overall estimate of the proportion of Bangladeshi men who have sex with other men—at any given time or over a lifetime—and there is no evidence on the situational nature of that activity: is it more likely to happen in Dhaka or Chittagong (the major port) than in regional centres, rural settings or resorts? The age ranges reported indicate sex between men happens at most ages: although the studies focus mainly on younger men, the qualitative evidence notes partners of many ages.

The second feature is the existence of socially and self-defined MSM groupings, with traditional characteristics or cultural origins, and a growing discourse that utilises at times the Western term *sexual identity*. The kothis and the hijra dominate these accounts. Little cultural incursion has been achieved (unlike India, Indonesia or Thailand to some extent) by the Western category 'gay men'; indeed, there is significant resistance to its usage in Bangladesh. It is hard to deduce whether this kothi/hijra dominance is a discursive rather than empirically confirmed one (as noted above), as many other categories of MSM exist beyond these most noted ones. The studies that tried to nominate these other categories at least named possibilities for locational or situational sex between men as well as other non kothi/hijra categories: truck drivers, fisherman, dock workers, rickshaw pullers, panthis (partners of kothis and hijra), students, 'civil kothis' (MSM with a standard or conventional masculine public presentation), police, hoodlums and students were those named.

There would appear to be at least three complementary ways to configure the cultural forms of MSM activity:

- (1) sex between men negotiated on the basis of *exchange*, e.g. in sex work (i.e. sex for money), within emotional relationships (e.g. with ‘parik’ or boyfriend in relationships), and via coercion (i.e. to gain freedom from bullying or violence at the hands of police or mastans)—i.e. exchange does not necessarily or always involve money;
- (2) sex framed by *familial, institutional and traditional relations*, e.g. intrafamilial and intergenerational sex in family homes and neighbourhoods, in brothels or schools and related to other educational processes (e.g. among university students), or with hijra (in their role as sexual performers and dancers derived from earlier forms of South Asian gendered spiritual forms); and there is some evidence of workplace-related sex (while we know nothing of prisons in Bangladesh);
- (3) *occasional* or ‘casual’ sex facilitated in part by a widespread cultural practice of night time walking in parks, by rivers, in cool open spaces, in markets, in a culture without large-scale mass entertainment infrastructure, i.e. where the structuring of the sexual encounter is any of the above and about opportunity and possibility, and where any of the categories mentioned above might engage each other in variety of ways—e.g. a kothi seeking sex might accept payment, an older man seeking a younger one without payment, a student seeking a casual partner etc.

And these are not mutually exclusive categories.

The research reviewed, however, concentrates on two conventional divisions: (1) between MSM who sell sex and their non sex-selling partners (and the distinction is not as clear as that); or (2) on the division between socially categorised groupings (kothis and hijra to name the major ones) and their variously termed but more usually non-termed partners. These divisions are dangerously easy to adopt, because the largest amount of material reviewed also adopts these divisions when it suits the study, program or report. There is no evidence that each or any of these categories is constituted by sufficient numbers to warrant becoming *the* locus of MSM activity in Bangladesh (and, indeed, the estimate of 12,000 hijra in Bangladesh (B38) would guarantee that *they* are definitely a tiny minority).

Also, the majority of studies and reports featuring kothis utilised recruitment methods from within the range of local MSM NGOs’ existing networks or knowledge of cruising sites etc., a technique that generated large samples in some cases, but one which already builds in the proclivity of such organisations to work to their strengths and through their existing networks. In other words, there are sampling biases here built into these studies and reports right from inception. The only studies that attempt broader (and somewhat more rigorous) approaches are those very studies that then list a larger variety of MSM (e.g. the BSS #2 study [B2] which lists MSW, MSM, rickshaw pullers and hijras, but in a design that already limited the sample to these groups anyway).

The often-used division between MSW and MSM is not a sturdy one, as there are no studies that document the ‘career’ of MSW and suggest with any confidence that it

conforms to similar sex worker careers in Western data. Similarly, there are no life history studies that offer a picture of the sexual careers of kothis, as most of the MSM NGOs concentrate on younger age groupings, and there is little evidence of what happens to older kothis (i.e. about 40 years and older). The same is true of any other named category so far described. Also, many of the other categories of MSM used actually describe preferred sexual mode rather than social category, i.e. insertive and/or receptive in anal or oral sex, e.g. ‘doparatha’ or ‘panthi’ (and qualitative data undermine the certainty of these modal preferences in practice). Finally, the categories of partners who are not kothis or hijra, and men who do not sex sell sex, the relatives, or those who seek casual sex with men only, e.g. fisherman, truck drivers or other men in parks, are hardly researched at all. We also know little of the sexual practices of professional men (who might have had sex in their youth with other men, but who marry and build careers not centred on sex work or on being kothi) and what they might do sexually in relation to other men. Just who the panthis are is an unanswered question.

What is missing is a population-based study of men’s sexual activity and that is an expensive and difficult thing to do. Also, more sexual career studies and life history work investigating sexual initiation, migration to cities, heterosexual marriage as a sexual relationship, retrospective institutional accounts of schools, the military and police, and work on the partners of the existing socially or self-labelled groups of MSM are needed.

5. Sexual practice

BSS #1 (B1) reported 99% of MSW practised anal intercourse (AI) in the previous week and 20% were engaged in group sex in the last month. BSS #2 (B2) confirmed the 99% figure but added that this AI was receptive, noting that only 32% reported insertive AI as well, 22% reported insertive oral sex (OS), and 35% of men reported other non-penetrative practices (NP). Jenkins (B12) reports from BSS #1 that among MSW 95% engaged in receptive AI and 25% insertive AI in the previous week, compared with other MSM (41% receptive AI, 72% insertive AI) and hijra (92% receptive AI and 1% insertive AI). Only one study reports on other high risk groups: Gibney et al. (B4) report that of the 80 truck drivers (21% of a sample of 388) who reported sex with men 95% reported AI and 4% OS (no mode reported), and 26% mutual masturbation (i.e. NP).

The Naz Foundation situational analyses of MSM in India and one Bangladeshi site (B8) reported that in Sylhet 78% of AI was modally receptive. So the receptive modality is not directly or only a product of being paid for sex. Of those paid for sex in the previous month, 18% practised insertive AI, 52% receptive AI, 5% insertive OS, 19% receptive OS, and 6% NP. In its investigative project of Dhaka MSM (B6), the Khan reported that all workshop participants (32) stated that they had experienced OS, while among the 530 survey respondents current sexual practices included: body rubbing (71%), AI insertive (42%), AI receptive (75%), masturbating partner (91%), being masturbated (90%), receptive OS (72%), insertive OS (45%), thigh sex (71%)

The Chittagong situation assessment (B13) reports higher overall levels of anal sex: 99.6% among MSW and 98.5% among ‘clients’. The interesting similarity here is the modal preference: among MSW 0% reported exclusive insertive AI, 52% reported exclusive receptive AI, but 48% reported doing both. The largely American gay notion of being exclusively a ‘top’ (always insertive) or a ‘bottom’ (always receptive) would seem less relevant in Bangladesh; so while there are modal emphases, there is a dispersal of potential HIV transmission risk in anal intercourse between men.

Reports from programs (B14/B43) reaching largely kothis (and a few reports on hijra) record high levels of receptive AI reported by the men, but it is very unclear how these assessments were made. Others note both receptive and insertive AI and OS in the similar populations (B15) and among other MSM (B19).

Leaving aside the non-penetrative sex practices also noted in various reports, the level of AI contrasts significantly with figures from gay communities in the West where behavioural studies consistently report lower levels of AI than in Bangladesh and higher levels of OS. The key problem lies in interpreting the seeming modal preference of some groups. The data are not consistent where some care is taken. Certainly, the populations of MSM mostly researched and currently reached by most programs (kothis in particular) report a preference for the receptive mode, linked to a cultural understanding of their position vis-à-vis their partners, who are men. Therefore, the kothis are *like* women (NB: not *as* women—this is reserved for the hijra). But behavioural data and qualitative reports note significant modal shifts even among kothis and for other MSM groupings. So, it is hard to conclude that, in the absence of solid data on the other MSM populations, this reported modal preference is as firm as often claimed. If it is, then we must reckon with the fact that for every receptive act reported, there was an insertive partner; and, therefore, the bias in the available data toward receptive AI could imply there is a large population of other MSM (i.e. those who prefer to insert) out there still unreached and unresearched.

Undoubtedly, those practising unprotected AI are at risk of HIV infection, were the prevalence of HIV already greater than is currently assessed or assessable in Bangladesh. And those more likely to be receptive more often are at greater risk, especially with the (admittedly variable) levels of STDs reported. This would place the kothis and hijra at enhanced risk of being infected by their insertive partners, i.e. those other still largely unknown categories of MSM. It may be then, that populations of kothis and hijras are potentially more vulnerable to HIV infection than a major source of it. Rather than constituting a *core group*, kothis’ vulnerability might be more akin to the wives of men who are sexually active outside marriage, whether with other women, sex workers of either sex, other MSM or hijra.

Partner numbers

Partner numbers is a second way to assess risk-taking, although the number of partners is not an actual risk factor for HIV infection *per se*. Most of the data in the studies and reports reviewed listing high partner numbers refers to the MSW (and occasionally hijra)

subsection of the MSM populations. In BSS #1 (B1), MSW reported a mean of 3 clients per week, while other MSM reported a mean of 46.6 in the previous year (or <1 per week). In BSS #2 (B2), the average number of clients in the previous week was reported as 6.19 (with a range from 1 to 45). In BSS #3 (B3), MSW and hijra reported between 8 and 11 clients of per week; the majority (90%) of other MSM reported only 20+ sex partners in the previous year. These discrepancies can be accounted for in part by the different samples used in each BSS, *but* the same populations were being sampled and the rough doubling of the numbers each year (3→6.19→8-11) suggests different questioning or different subsamples and/or sites. Note also: one study of 150 hijra (B38) noted a mean of 7 clients per week, with a range of 2-12 (cf. the mean of 13.3 per week in BSS #1[B1]).

The Chittagong situational assessment (B13) of MSW reported an average of 4.4 partners in the last week, with a range of 0-14, whereas Jenkins' Chittagong study (B25) of MSW reported 10 clients per week. A small study in two parts of Dhaka (B14/B43) also reported 10 clients per week.

The Naz Foundation (B8) 4-site study of kothis provides a range for numbers of partners in Sylhet in the previous month:

Table B1: No. of Partners for kothis in Sylhet in Previous Month (Naz Foundation [B8])

No of partners	% of kothis
1-3	1
4-6	6
7-10	15
11-15	20
16-20	19
21-30	12
31-50	6
50+	21

Therefore, 73% of the kothis have one partner a day or fewer, with nearly ¼ having 10 or fewer partners per month.

The frequency of sex events is not so different in the Naz Foundation's investigative Dhaka study (B6), with sex over the previous six months among survey respondents ranging from 'no sex' (4%), '1-5 times' (15%), '6-14 times' (31%), '15-30 times' (31%) to '>30 times' (20%). Yet, (in B23) the kothi population of Mymensing and Saver reported 73% having only a single sex partner (but there is no time period specified). The existence of 'parik'-based relationships (i.e. boyfriends) among kothis, reported in the qualitative studies, may offer further support for seeing a proportion of this population as not necessarily engaged in sex with numbers of men each week; and while 'group sex' and 'multiple partners' were mentioned in some reports, no numbers are available, nor are there explanations of how group sex is sexually and socially constituted.

The absence of data on the non sex-worker and non socially identified MSM is an important gap in these data. The sex worker data cannot be credited to those not selling sex; yet sex work by men in Bangladesh is not a 'profession' and men move in and out of exchange-based sex (see above).

Women partners

Some studies and reports note that sex with women occurs among this population of men, but its exact dimensions are quite unclear (B32, B20, B21, B35, B37, B47, B54, B56, B61, B62 and B63).⁶ The categories of women referred to are wives, girlfriends, female sex workers (noted as FSW or CSW [sic]) and relatives. This diversity of relational possibilities with women cautions against any simplistic or singular definition of HIV risk for women and even a single category 'women' in considering HIV infection trajectories in Bangladesh. One could also decide where to place the hijra within this category, further complicating the picture.

BSS #3 (B3) noted 40% of MSW reported buying sex from both men and women in the previous month, while in BSS #2 (B2) only 11% of MSW had bought sex from FSW on average 1.5 times in the previous month (only 11.2 % had 'ever' bought sex from FSW). Khan and Bhuiya's Chittagong study (B13) reported on the average number of *new* female sex partners in the previous week 0.8 (range 0-2), the average number of *known* female sex partners 0.13 (range 0-4), and the average total for past month 0.5 (0-6). These female sex partners could be FSW, relatives, wives or girlfriends. But with 86% of the MSW sample and 48% of the client group 'never married', and the average age of the MSW at 22 years and the client group at 33 years, these low numbers of female sex partners can thereby be partly explained in a country where most men are expected to and do marry. However, note that Khan et al. report (B56) that 50% of MSM (i.e. MSW and clients) engaged in unprotected AI with their female partners.

A small Dhaka two-site study (B14/B43) notes 22% of kothis were engaged in sex with their wives. In contrast, in a Sylhet study of 200 MSM (B30), only 8 men reported vaginal intercourse with women. Yet, the Naz Foundation (B8) reported 22% of kothis in Sylhet were married. But then in B6, Naz reports that 37% of the survey respondents in Sylhet were married and 28% of those have had sex with other women, primarily FSW. Of all workshop participants in the same study who had had sex with women, a large proportion had had anal sex with the women. Meanwhile, just to confuse things a little more, in a qualitative study of MSM in Chittagong (B34), all men reported sex with women, including anal intercourse (mentioned also in B15).

In one of the few studies outside socially or self-recognised MSM categories (B4), in this case 388 truck drivers and their helpers in Dhaka, of the 28 men who had sex with men in the previous year (7.2% of the whole sample) 23 also reported sex with FSW, i.e. 6% of

⁶ Some of these overlap as they were conference papers extracted from reports or studies elsewhere reviewed.

the whole sample. Yet, Jenkins' study of Dhaka truck drivers (B12), drawing on BSS #1 data (B1), reported 12-15% could be considered behaviourally bisexual with 10% reporting sex with hijras and women in the previous year, 2% with men and women, and 1.5% with all three genders.

These data are quite difficult to assess. Reports of high levels of marriage among MSM in Bangladesh occur largely in the qualitative studies, and the comparative youthfulness of the population focused upon in Bangladeshi research so far may contribute importantly to an underassessment of sex between MSM of various categories and women partners. For one, the notion that all men eventually marry in Bangladesh needs empirical elaboration and confirmation before we can begin to assess the potential difference between these data and the reality.

Condom use

Condom use provides the third key component. A clinic-based sample of men (B36) reported 79% condom non-use, but there are no figures for MSM within that sample. For MSM, a number of studies and reports provide general statements only, mostly noting low levels of condom use (B15, B18, B20, B25, B32, B34, B35, B44, B46, B61, B62).

In BSS #1 (B1), 25% of MSW reported using a condom last time they had sex, with 26% of 'commercial' sex acts involving condom use, as did 19% of 'non-commercial' sex acts. Similarly, 26% of MSW were able to show researchers a condom, i.e. they were carrying them.

In BSS #2 (B2), 34.9% of MSW asked all their clients to use condoms in the previous week, but the percentage of men reporting unprotected AI was 81.6%. The proportion of all acts of AI in the previous week was: protected 44%, unprotected 56%. Only 2.7% of MSW reported consistent condom use in the previous week. When condom use with last client was asked, 41.6% reported 'all', 11.9% reported 'some' and 46.5% 'none'.⁷ Oral sex was much less protected, with only 30% of OS involving a condom when MSW was the insertive partner (70% non use) and 23% using condoms for receptive OS (77% non use).

In BSS #3 (B3), 23.7% of MSW reported 'never' using condoms, while 69.3 % reported 'occasional' use; for MSW clients the figures were 67.3% and 27.9% respectively. This discrepancy is interesting and suggests that targeted interventions to date are working but limited. The report also commented that almost all MSW reported using condoms at times while selling anal sex, but almost none used them all the time. Other sex worker studies (B39) reported 26% condom use on the previous week, but this sample included female and male sex workers.

⁷ This may not be a trustworthy figure and may have a considerable social desirability factor in it when compared with results from other questions.

The Naz Foundation four-site study (B8) reported for Sylhet: condom use for insertive acts 33% and receptive acts 31%; MSW condom use with previous 5 clients—9% all times, 39% sometimes, 52% never; lubricant use—56% used saliva, 56% vaseline, 35% oil products, 11% soap, and 0% KY jelly. Khan's investigative Dhaka study (B6) reported that 94% of the survey respondents either did not use condoms at all or used them inconsistently, while the workshop participants reported higher levels of use. The discrepancy between the two cities is noteworthy, and might be only partly explained by differences in questions asked.

In the Chittagong study of MSM (B13), condom use 'always' during the last week for insertive AI was reported by 6.5% and for receptive AI the figure was 2.7%. These figures are notably lower than the BSS figures, which concentrate on those nominated as MSW, not all MSM, and may reflect in the BSSs the participating NGOs' outreach limits, respondent recruitment patterns and/or the sampling focus of these studies.

One small Dhaka study (B14/B43) noted 11% of kothis had 'ever' used a condom, with only 4% reported 'current or occasional' use, which might confirm this sampling bias. Another Dhaka report (B38) noted 4% of all penetrative acts involved condom use, but no time period was reported. However, the study of 425 kothis in Mymensing and Saver (B23) reported 12% 'always' used condoms and 23% 'mostly' used condoms, but again this may reflect a population reached by the specific organisation itself and, if so (ironically, for the purposes of this review), may reflect some success in HIV prevention education rather than an underlying condom use level. B31 reports even higher levels (35-37% condom use) and must be regarded with some doubt according to the in-country consultant. Yet, in one conference abstract (B45) Bandhu reported on assessed increases in condom use directly related to prevention interventions from 6% at baseline lifting to 40-50% assessed six months later. An earlier report from the same organisation (B50) noted the increase from 6% to 30-39% over a six-month period about a year earlier. So there is some evidence emerging that such interventions are working, but these high figures cannot be assumed to be generalisable to all MSM.

Finally, in the truck drivers/helpers study (B4), only one MSM in the 28 who had had sex with another man in the previous year reported 'ever' using a condom in that previous year and only 13.7% of all 388 respondents were aware that condoms could prevent AIDS. For hijra, the figures on condom use in BSS #3 (B3) are 89% 'never' use and 7.4% 'sometimes' use condoms—worrying low. Condom use with women was rarely reported (it was rarely asked), but one study (B26) reported 13% condom use with spouse and 13% condom use in the last commercial sex with FSW.

6. Sexual networks

In (B5)—an early overview of work done to that date on Bangladeshi MSM—Dowsett reported that such work had achieved the identification of numerous and more than expected patterns of male-to-male sexual activity that must be regarded as vulnerable to HIV infection. Also, this report noted that the patterning of male-to-male sexual activity

in Bangladesh is multiform and there is a great diversity of male sexual expression. Some of the categories of male-to-male sexual practice in Bangladesh pertain to identifiable and self-identifying social groups (kothis and hijra). But it is also clear that other MSM have no common pattern or process of socio-sexual identification. There was evidence in qualitative studies of considerable intrafamilial male-to-male sexual relations in both natal and extended families, and within neighbourhoods and in workplace-related sexual activity. There is strong evidence of the predominance of anal intercourse among the sex acts men engage in with each other. Finally, the boundary between those engaged in male-to-male sexual activity and those who are engaged in male-to-female sexual activity is anything but firm or predictable. A second important factor that structures sex acts and relations between men was the existence of large numbers of (now-called) 'cruising sites' (using a North American term), which facilitate MSM activity. BSS #1 noted the use of maps collected by NGOs had revealed 81 sites in Dhaka alone at which MSM activity could be assessed (B1).

This framework, when tested in BSS #2 (B2), noted that among the named and accessible MSM groupings, many men go in groups to hire sex workers. MSWs also join in groups for sex among friends, i.e. not for money, and 38.8% participated in these groups on average 2.5 times in the previous month. In the previous year, 83.2% of MSW reported being involved in group sex on an average of 8.6 times. The last time, 488 men reported on events that included a total of 251 men, 33 women and eleven hijras. Group sex was also reported in B6 by over 25% of survey respondents. Among rickshaw pullers in the previous month, 20.4% stated they had sex with males on average 1.6 times, while for the previous year these figures were 43.5% on average 3.3 times (with a maximum of 18). Of these events, about 63% (or an average of 2.4) were 'commercial' sex. Hijras were also popular among rickshaw pullers: in the previous month, 13.2% went to an average of 1.4 hijras and in the previous year 26.0% had sex with an average of 7.4% hijra partners. Meanwhile, 16% of long-distance truck drivers had sex with a man or hijra last year (B4). BSS #3 (B3) reported over one rickshaw puller in ten in south-eastern Bangladesh and one in seven in central Bangladesh reported he had had sex with a hijra or other man in the previous month, and among truck drivers it was close to one in five.

The Naz Foundation study (B8) mapped the four cities in the study in regard to public sex sites for MSM—Sylhet was reported as having 28+ sites. Kothis reported meeting sex partners from a broad range of social, occupational and neighbourhood environments, with 63% meeting in public spaces, 27% in private homes, 8% in hotels/guest houses, and 2% in other spaces. Sex partners were reported to be: friends (27%), strangers (21%), paying clients (19%), MSW (14%), neighbours (13%), relatives (2%), and others (4%). Places where sex actually took place included: public spaces (49%), private homes (20%), entertainment venues (11%), hotels/guest hostels (2%), others (18%). This low level of 'entertainment venues' reflects that lack of an equivalent to 'gay bars' or a 'gay scene' etc., in Bangladesh.

Even more varied sites of sexual activity were reported in Khan's investigative Dhaka study for the Naz Foundation (B6): all workshop participants reported visiting a total of 22 sites including a number of parks, streets, religious sites, neighbourhoods known

among MSM networks, their homes, friends' homes, guest houses, hotels, side streets, construction sites, dark alleyways, inside cars, trucks, and behind bushes were sex can take place unobtrusively, public/private toilets, and in restaurants and tea shops with owners/staff. The study's survey respondents listed among their sexual partners: strangers (72.5%), friends (36.8%), relatives (30.3%), neighbours (28.7%), MSW (10%), domestic servants (9.2%), and paying clients (5.1%); note, 5% of respondents were paid for sex but did not consider themselves MSW. Meeting places for sex (12 are listed) included: parks (77%), cruising areas (not parks) (70%), neighbourhoods (60%), bazaars (29%), personal home (26%), cinemas (25%), hotels (23%), street (22%), friends' homes (21%), railway/bus station (7%), and toilets (5%). Clearly, sex with men is widely available in Dhaka.

This study (B6) also suggest that higher educational levels delays entry to male-to-male sex. Jenkins' early qualitative work (B11) with a very similar populations revealed initiation into male-to-male sex happens relatively young among those who go on to become MSW, kothis or both (*and this is an important caveat about these data, i.e. these specific populations of MSM only were studied*). Initiation was earliest in rural areas at the age 8-9 years, but most occurred around 13-15 years of age with partners around 17-24 years; and it often happened among relatives (see also B19 for confirmation of rural male-to-male sexual activity). There were also reports of rape by groups of older boys. 'Gender roles' varied, suggesting that modal preference may not necessarily be age-related. Sex with other youth was seen as a safe substitute for sex with women (issues of virginity, pregnancy) and prostitutes. Nearly all these informants were married and the rest claimed they would get married. B23 notes ages at sexual initiation ranging from 7-20 with a mean of 12, and these data are from a predominantly kothi grouping in two smaller cities (not including Dhaka), possibly indicating only a little difference between city and country. Another study (B58) reported that 67% of kothis (respondents chosen from an intervention) were involved in selling sex for their livelihood, and the mean age of first male sex activity was 12 years (but the in-country consultant notes significant bias in sample selection in this study).

Clearly, numbers of young men do become paid sex workers (again B11), but other forms of sex for exchange (see framework above) were not investigated and the notion of 'paid' sex work lacks clarity. For example, Khan (B34) noted that among MSW the sexual network was quite big. They were having sex at the 'commercial' settings (sites) both with MSWs and FSWs, girlfriends, and with relatives of both sexes. Therefore, 'professional' MSW may be sexually active in any numbers of arenas outside their male 'commercial' transactions.

Jenkins (in B25) estimated 37,000 clients engaged sex workers each week in Chittagong, with 1,000 MSW in the sex workforce, although it is hard to confirm this estimate as the study was based on qualitative interviews. So the proportion that 'commercial' sex between men contributes to the full amount to male-to-male 'sexual outlet' in Bangladesh is impossible to estimate.⁸

⁸ Following the measure developed in Kinsey AC et al. (1948) *Sexual Behavior in the Human Male*, Philadelphia & London: WB Saunders.

As noted earlier, the focus of much research and many programs reviewed here has been on kothis, and this suggests a bias in the overall shaping of the current understanding of how MSM sex acts and relations are structured in Bangladesh. For example, in B14/B43 the sampling was clearly biased with 80% MSMs under the age of 30 years (whereas the majority of hijras were over 30) and 26% of the kothis were exclusively engaged in sex work. In the same study, 46% of kothis were reported as working as MSW, while 20% live with their 'pariks' (boyfriends), and 22% have sex with their wives. Meanwhile (in B39), MSW were reported to engage in less 'commercial' sex activity than FSW, and (in B54) 30% of men reached in outreach programs were married.

Where the focus has not been on kothis or MSW, the findings are equally unclear: male sex partners of the 80 truck drivers who had sex with men, studied in B4, included a friend (47.5%), a neighbour (28.8%), a MSW (15%), and a family member (5%)—i.e. very localised and network-dependent. Yet among respondents at a STD clinic (B20), sex with other men was reported to be largely opportunistic or situational.

Women figure in a number of studies as sex partners, not just as wives (B35, B14/B43), but also in various categories of girlfriends, relatives, FSW, extra-marital partners (B13, B15, B34, B35, B37, B47, B54, B56, B61, B62, B63) and female clients (B18). In their study of Chittagong MSW and clients (B56), Khan et al. report 10% MSWs and 50% clients were married, and 12% of MSWs and 67% of their clients were fathers. They also noted that unmarried kothis, 'giriya', MSW and clients rarely wanted to remain unmarried, and 100% clients and 50% of MSW had unprotected sex with women in the previous month. Ninety percent of MSM (i.e. MSW and clients) claimed their female partners did not know about their male sexual relations.

Other significant findings

In BSS #2 (B2), MSW were reported to have been in sex work for an average of 8.9 years, but no other studies corroborate this figure and this figure would certainly need verification. BSS #3 (B3) reported MSW twice as likely to inject drugs as FSW—again with no corroborative data elsewhere available and verification needed.

The data on hijra in B38 indicate high levels of risk: 13% had engaged in group sex in the previous month; most had engaged in sex work at some time, 98% in the previous week; 69% had engaged in non-'commercial' sex in the previous week (a very important finding as is evidence of 'parik' relations for some hijra). Rape by police was reported by 41% of hijra and 46% reported rape by 'mastans'. Combined with the evidence above, clearly hijra cannot simply be included in MSM as a subset; nor are they necessarily easily included with FSW. They constitute quite a different category (culturally and behaviourally) and given what is known so far about their partners and almost exclusive receptive AI, they are very vulnerable to HIV infection.

7. Conclusions

The evidence on MSM in Bangladesh is far from conclusive in any simple terms. There is clearly no singular category of value that the acronym ‘MSM’ describes, except as a convenient term for a set of sexual acts collected together as such because only men are engaged in them. Once these ‘behaviours’ are regarded as ‘practices’, i.e. socially contextualised activities whose character derives from their contexts not merely the acts, then HIV vulnerability among MSM disperses from any assumed singular category of risk to multiple possibilities for infection. There is quite a deal of such sexual activity occurring and those so engaged have escaped HIV so far as we can tell because of Bangladesh’s low HIV prevalence and probably also because of this highly dispersed MSM activity. Lacking the dense sexual ecologies of Western gay communities that were so central to the transmission of HIV in the early days of the epidemic, MSM activity in Bangladesh provides few clues as to the potential impact of the virus on men.

The word ‘men’ is deliberately chosen in the previous sentence, because one picture that emerges from this review of the available literature is of a multiform men’s sexual economy, in which FSW, MSW, boys, other men, kothis, hijras, girlfriends, boyfriends, family members, workplace colleagues, wives and institutional partners all feature. This economy is not singular either, but partitioned (as far as we can tell so far) by at least some certain structural determinants, such as work (e.g. truck drivers, rickshaw pullers, police), age (e.g. sexual debut, intrafamilial sexual activity), social class (e.g. university students), the cultural place of marriage, the social role of sex work, traditional gender categories (e.g. hijra), emerging economic trends (e.g. urbanisation, transportation), and the impact of HIV/AIDS activism and interventions themselves (e.g. a codifying focus on kothis etc.). And there is evidence of considerable overlap between any categories produced so far, begging the question: what is a MSM (and similarly a MSW) really?

All of which leaves a significant empirical and conceptual gap in the middle of the work done to date: just who are the ‘men’ who are the partners of all the above? Whoever they are, they are not the elusive MSM who might provide certainty to any idea of a *core group*, for they are too dispersed to be singularly implicated, revealing the inadequacy of the conceptualisation behind that shorthand term. If anything, these men perform more like a ‘bridging group’, except that they are more likely to be transmitting HIV *to* the more vulnerable subcategories identified above of other men engaged in sex with men and women engaged in sex with men who also have sex with men. Understanding these penetrators is a key challenge, compounded by the fact that we know that modal singularity among men is not certain either in Bangladesh.

Finally, factoring in *time* as a variable will add further complexity, as a young boy sexually debuting at 15 with a family member, might sell sex at 18, have a boyfriend at 20, marry at 25, seek sex with other men in the parks at 30, and do some of these things concurrently. Given the time span of the pandemic elsewhere, time is going to be a central factor in shaping the Bangladeshi epidemic and its effects on men who have sex with men and with both men and women.

References

Government of Bangladesh (2001), *HIV in Bangladesh: where is it going?* AIDS and STD Control Programme, Directorate General of Health Services, Ministry of Health, Govt. of Bangladesh.

UNAIDS Epidemiological Fact Sheets 2002

UNAIDS, <http://www.unaids.org/nationalresponse/result.asp>

UNDP (2002) Human Development Report, United Nations Development Programme

World Bank (2002)

<http://lnweb18.worldbank.org/sar/sa.nsf/8b211d2239d56913852567d7005d8e54/ba0cdbb55ccef28785256a9b0056d414?OpenDocument>

World Health Organization (WHO) (2001) HIV/AIDS in Asia and the Pacific Region, Regional Office for South-East Asia, New Delhi, India.

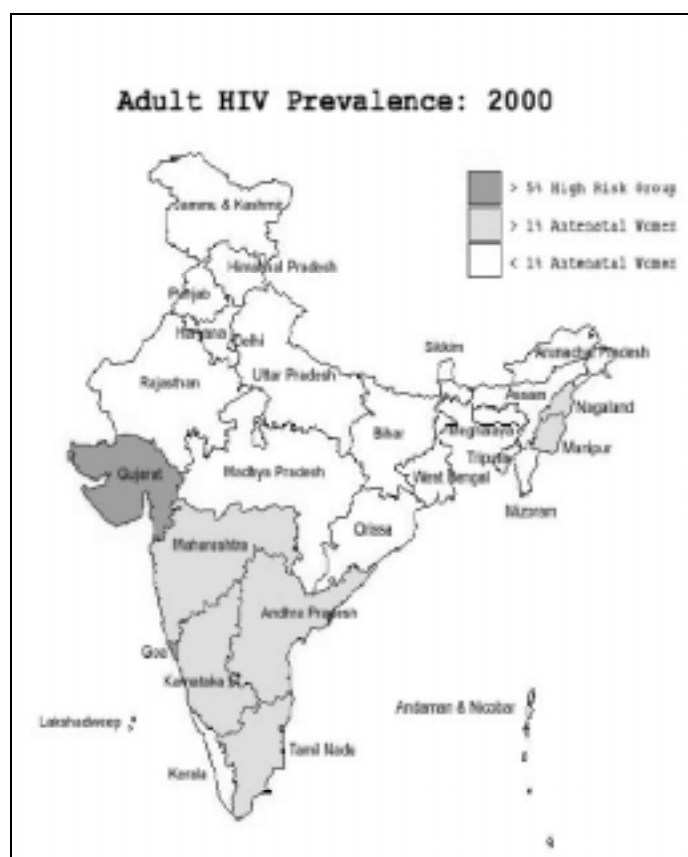
INDIA

1. Background

India's population reached 1.027 billion in 2001, with approximately 19% of the population between 15 and 24 years. India ranks 124 on the Human Development Index, with 35% living below the poverty line (UNDP, 2002).

The first case of HIV was reported in India in 1986. By the end of 2001, an estimated 3.97 million people (0.7%) were living with HIV/AIDS; only South Africa has more people living with HIV/AIDS. Although HIV prevalence is low in a majority of States, the numbers of HIV infections are high. WHO has classified India as a moderate HIV prevalence country and has classified the States and Union Territories into three groups (refer Map 1).

Map 1: States grouped by high, moderate and low HIV prevalence



(Source: WHO, 2001, 25)

- **Group I** – High HIV prevalence States: includes Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh and Manipur, where HIV prevalence rates were 1% or greater in antenatal women.
- **Group II** – Moderate HIV prevalence States: includes five States – Gujarat, Goa, Kerala, West Bengal and Nagaland, where HIV prevalence rates were 5% or more among high HIV-risk behaviour groups but below 1% in antenatal women.
- **Group III** – Low HIV prevalence States: includes the remaining States, where HIV prevalence rates in any of the high-risk behaviour groups were still less than 5%.

The epidemics are focused very sharply in a few States, with most of India having exceptionally low rates of infection. An overwhelming majority of the total reported national AIDS cases – 96% – were reported by only 10 of the 31 States. The major impact is being felt in Maharashtra in the west, Tamil Nadu in the south with adjacent Pondicherry and Manipur in the northeast. The epidemics vary between States, with heterosexually transmitted infections predominating in Maharashtra and Tamil Nadu, while infections concentrated among injecting drug users (IDU) and their partners predominate in Manipur (21 of the 31 States only report 4% of the total reported national AIDS cases).

India has more cases of tuberculosis (TB) than any other country in the world. Given the high prevalence of TB infections in India, the problem of TB related to HIV infection also poses a major health problem, as HIV+ persons are at greater risk of TB. The HIV epidemic could greatly increase the incidence of TB.

Legislation on safe blood was passed in 2002 to facilitate the enforcement of blood banking improvements, closure of unlicensed blood banks, and prohibition of paid blood donations. Homosexuality is illegal in India. In January 2003 the High Court of India responded to a petition by the Naz Foundation, seeking the legalisation of homosexuality, and the court has asked the government to respond to a request for explanation.

Estimates at end of 2001 by WHO/UNAIDS

- 3,800,000 adults (0.8%) ages 15-49 were living with HIV/AIDS
- 1,500,000 women aged 15-49 were living with HIV/AIDS
- 170,000 children under 15 were living with HIV/AIDS

National Strategic Framework

In 1986, the Government of India established a National AIDS Control Program under the Ministry of Health and Family Welfare.

In 1992, the Ministry of Health established the National AIDS Control Organization (NACO) to coordinate an enhanced program of preventive activities. NACO provides

national leadership and facilitates the development of State AIDS Control Societies in all States across India in order to strengthen national and state level responses.

The NACO is now running the second phase of the National AIDS Control Project (NACP-II). The first phase (NACP-I) ended in March 1999. The duration of NACP-II is from December 1999 to March 2004. Lack of resources hinders full-scale implementation of the plan. Current available resources are US\$60 million per year. Additional resource requirement is US\$200 million over 5 years at current financial absorption capacity.

The fourth Board Meeting of the Global Fund to Fight AIDS, Tuberculosis and Malaria, which concluded in Geneva on 31 January 2003, approved US\$ 130 million to fight HIV/AIDS and TB in India. The grant assigns US\$ 100 million for HIV/AIDS, and US\$ 30 million for TB, and commits up to US\$ 38.8 million over the first two years. This is the largest single country grant within Asia in the Second Round of Global Fund Awards.

UNAIDS has established a Theme Group and Technical Working Group on HIV/AIDS to coordinate the response of UN agencies to the epidemic and assist the government's activities. Countries providing significant bilateral assistance in the area of HIV/AIDS include: the United States and the United Kingdom. Some support is also provided by Australia, the European Union, Japan, the Netherlands, Sweden, and Canada.

The World Bank (2002) identified the following priority areas for India:

- **Enhanced policy and support** to build capacity at state, district, and municipal levels;
- **Scale up the behavioural change activities and targeted interventions** among risk behaviours and vulnerable groups, seeking to achieve high coverage;
- **Increased community-based approaches** to prevent new infections, in particular with high-risk groups and youth;
- **Promoting low-cost community-based care** without stigmatisation for those living with HIV and AIDS;
- **Increased mobilization** of other parts of society including the private sector, government ministries (such as education), and civil society.

Sero and Behavioural Surveillance System

Both seroprevalence and behavioural surveillance are conducted. HIV surveillance at a consistent level in each state did not begin until 1998. In 1998, the number of HIV Sentinel Surveillance sites increased from 55 to 180: 83 STI, 89 ANC and 8 IDU. Table 1 (see appendix) gives a breakdown of prevalence level for each State for 2000.

India has an established second generation HIV/AIDS surveillance system conducted among 'general', 'bridge' and 'high-risk' population groups. A nationwide (35 States

and Union Territories) behavioural surveillance survey (BSS) was conducted in 2001 by NACO in partnership with ORG-Centre for Social Research (ID19).

BSSs have been carried out in Tamil Nadu since 1996, with successive surveys in 1997 through to 1999. The Tamil Nadu BSSs were conducted by the AIDS Prevention Control Project (APAC) of Tamil Nadu, administered by the Voluntary Health Services (VHS) Chennai and funded by The United States Agency for International Development (USAID).

The UK Department for International Development (DfID) in 1998 funded Family Health International (FHI) to design a project for assessing the impact of sexual health and HIV/STI prevention programs in States supported by DfID: Kerala, Orissa, Andhra Pradesh, Gujarat and West Bengal (ID102-ID110). The focus areas also included national highways on which DfID supported a pan-Indian HIV prevention project called the Healthy Highways Project. This project was aimed at long-distance truck drivers and others working in the trucking industry most vulnerable to HIV infection and their sexual partners. The methodologies designed by FHI complemented the NACO-supported HIV sentinel surveillance and consisted of HIV risk behaviour surveillance surveys, STI prevalence surveys and surveys of health care providers on STI case management.

Treatments for HIV

Although anti-retroviral (ARV) therapy in India has become much more affordable in the last two years, it still remains out of reach for most Indians. India signed TRIPS as a member of the World Trade Organization in 1994. Patent laws in India will change from 31 December 2004.

2. Epidemiology

A large number of studies have been undertaken in India over the last five to eight years, of widely varying quality, many of which have not been published through processes of peer review. One hundred and ten reports or studies are included in this review, including some late reports that arrived just at the time of writing were added.

A small number of 'baseline' studies came to light, few of which report HIV prevalence or incidence figures, offering only some evidence mostly on self-reported STI infection. For example, in 2001, the AIDS Prevention and Control Program reported on the sixth wave of its BSS (ID37) conducted in Tamil Nadu (twelve sites) and Pondicherry (two sites). High-risk categories were: truck drivers and helpers, male injecting drug users, male factory workers, male students, and male youth in slums (these categories are commonly used, with some variation, and not without merit, in most BSS studies, but without explanation on their assumed pertinence in India). However, in ID37, urethritis

was reported by 15% of the men. And that is all we know. Commonly, no BSS studies contain HIV incidence or prevalence figures (even self-report) for the populations studied.

HIV infection

One study (ID1) took 63 blood samples from homosexually active men in two STI clinics in Mumbai over a six-month period. All had a history of unprotected sex with men. Ten samples were positive to HIV1 and three to HIV 2 (in all, 20.6%). However, we have no other characteristics of the sample other than mean age, 31.6 years. In addition, there were 22 cases of condylomata, 20 of herpes, 15 of gonorrhoea, 3 each of candidiasis and syphilis. In a Delhi study of 19,840 male and female clinic attendees (ID99), 96 (0.5%) were found to be HIV+ and only 2 men reported sex with other men.

In a Humsafar Trust clinical sample of 150 MSM and 28 transgender (TG) so far enrolled in a study in Mumbai, and reported on at the XIV International AIDS Conference in Barcelona in 2002 (ID76), Kumta et al. found that:

- 17% of MSM and 68% of TG were HIV+;
- STI prevalence rates were for MSM and TG respectively—syphilis (17% and 57%), hepatitis B (10% and 57%), hepatitis C (8% and 22%), herpes simplex virus 2 (40% and 71%), and chlamydia (11% and 0%);
- only 4% presented with active genital ulcers, urethritis, or proctitis;
- HIV was significantly associated with syphilis, hepatitis C, herpes simplex virus 2 in TG and MSM;
- HIV prevalence was 48% in syphilis+ MSM and 88% in syphilis+ TG, 62% in hepatitis C+ MSM and 100% in hepatitis C+ TG; and 38% in herpes simplex virus 2+ MSM and 80% in herpes simplex virus 2+ TG.

This is one of only two MSM sentinel surveillance sites in India but we must note how small the samples are in this study, and for the finding for TG, it must be noted that that percentage represents 19 out of 28 persons—caution is needed in using this result.

An earlier Humsafar Trust clinic-based report on 242 men by Kumta et al. (ID89), in a poster exhibition at 6th International Congress on AIDS in Asia and the Pacific (6ICAAP) in Melbourne in 2001, noted that 20% of 69 MSM reported being HIV positive, as were 19% of the 31 bisexuals (gonorrhoea was reported by 6% of MSM and 10% of bisexuals). Earlier again, a poster exhibition at the XIII International AIDS Conference in Durban in 2000 (ID72) reported from a sample of 100 MSM attending the Humsafar Trust clinic in Mumbai that prevalence of HIV in this population was 15%, positivity to syphilis was 16%, and 14% had rectal complaints, with smaller percentages for other STI symptoms (see India annotated bibliography for details). A study presented in Barcelona in 2002 noted similar levels of HIV infection: Mathur et al. (ID78) report on 1,276 men and 124 TG in a tertiary care centre in Mumbai where HIV infection rates were 20% among homosexual men, 11% among heterosexual men and 10.5% among bisexual men, while syphilis positivity was 13%, 5% and 7.4 % respectively. But we need to be really careful of the use of the terms ‘homosexual’, ‘heterosexual’ and ‘bisexual’ here. The rates

for TG were: 41% tested positive for HIV and 25% tested positive for syphilis. These are all Humsafar Trust studies and the relationship between the samples in ID72, ID76, ID78 and ID89 is not clear and the small numbers must be again noted with caution.

An unpublished study of STI clinic attendees at the Government General Hospital in Chennai (ID40) noted 42% of the homosexual and bisexual men reported STI/HIV infection; however, no clear distinction was made between the infections. Yet, another Chennai CBO clinic-based sample of 51 MSM (ID96) noted that 14% self-reported as HIV+ and 26% were clinically diagnosed with an STI.

An earlier multi-country review of HIV and MSM (ID57) noted that two clinics in Mumbai over a six-month period in 1992 reported finding HIV prevalence among 'gay-identified' men at 20.67%. However, in 1994, Nag (ID23), reviewing the literature, cited a study by Parasuraman et al. (1992) of 2,293 male patients in the Institute of Venereology (Madras) conducted in 1990-92 (in which 73 or 3% were homosexual), which reported 62% of the subjects had an STI (mainly syphilis), and an ELISA test among the homosexual subgroup found only 4-5% of them HIV positive, but given the sampling this figure is not surprising.

Aher (ID83), reporting on a KAPB study of >230 MSM recruited in railway stations in Mumbai, found that 17% reported being positive to syphilis and 14% to an ELISA test for HIV. An unpublished dissertation from Mumbai of 50 MSM (ID35) noted that 12% reported being HIV-infected. A similar dissertation (ID41), noted among 50 hijra in Chennai noted 6% reported being HIV infected—a strong contrast to the much higher levels reported in the Humsafar Trust studies above. Lastly, a study of 240 gaol inmates in Ghaziabad (near Delhi) found three male inmates were HIV positive and 28 were positive to HBsAg (hepatitis B) (ID25/65).

The wide variability in these figures for HIV and the reliance in many cases on small samples or self-report suggest that any generalisation must be approached with caution. Small samples, particularly those recruited through clinics or CBOs, may consistently overestimate HIV prevalence, while self-report, given the exigencies of HIV testing in India, may consistently underestimate. For example, in contrast to the Humsafar Trust figures for TGs, Timothy, in an socio-economic and sexual behaviour study of hijras (ID41), found that only 6% of the respondents reported being infected with HIV.

Sexually transmissible infections

In relation to STIs, it should be noted at the outset that many studies report respondents' own opinions as to their STI histories, often in the absence of reliable testing or clinical diagnosis. This is particularly true for community-based surveys that were attached to no clinical programs that might provide confirmation. In these circumstances, such respondents' memories of, and accuracy about, disease experiences provide somewhat shaky evidence on incidence and prevalence. However, we summarise the evidence

presented in the reports as written; but would warn against regarding many of these figures as definitive.

That said, in 2002, the national baseline study conducted by NACO noted among 1,387 MSM in Delhi, Kolkata, Mumbai, Chennai and Bangalore that 16% reported a genital discharge the previous month, with 44% reporting having accessed treatment for the same condition (ID19). In the Maharashtra BSS (ID53), nearly 19% of MSM in Mumbai and Thane reported anal ulcers and sores, 11% reported genital discharge and 10% reported genital ulcers in the previous six months. The Healthy Highways BSS (ID104) undertaken in six regions in India, reported on the incidence of genital discharge/ulcer in the previous 12 months for truck drivers (5%), helpers (5%), related 'stationary' workers (3%).

Kumar and Ross (ID7) notes in a study of four STI clinics in northwest India that, unsurprisingly, all reported being infected with an STI. The Humsafar Trust in an undated survey (ID15) of 80 diverse MSM (from 1000 questionnaires posted) noted 20% reported ever having an STI. In another study for the Humsafar Trust, conducted in 2001 (ID52), 35% of MSM have reported STIs in the last six months, with redness and swelling in the groin reported by about 42% of the MSM. Very few (3%) reported multiple symptoms. Of the 327 respondents, 68% have had a HIV test, but no results were provided.

In West Bengal, the ORG Centre for Social Research included 400 MSM in its 1999 baseline behavioural study of high risk groups (ID20) and found that only 5% reported genital discharge or ulcer in the previous year. Also, the Chennai Corporation AIDS Prevention and Control Society (CAPACS) found in 70 men (ID38) the following STI problems in the previous twelve months: 20% had pain in the genitalia while passing urine; 14% had genital ulcer; and 6% had inguinal swelling near their genitalia. Of the 28 respondents who reported having experienced STI problems in that period, twenty-four belong to the 'commercial circuit' (i.e. male sex workers [MSW]) and four from the 'pleasure circuit' (presumably, non-commercial recreational sex is meant by this).

A situational assessment (ID29) of 800 MSM conducted by the Naz Foundation in Hyderabad, Bangalore, Pondicherry and Sylhet (for the last, see Bangladesh report) found the following reported levels of STI symptoms:

- in Hyderabad—37% pain during sex, 30% itching/burning around anus, 29% pain while urinating, 28% pain when defecating, 25% rash on genitals, 22% bleeding when defecating, 16% genital sores, 16% sores/blisters inside mouth, 13% pus/discharge from penis, 7% pus/discharge in stools, and 2% other;
- in Bangalore—10% pain while urinating, 9% Itching/burning around anus 9% pain during sex, 7% pain when defecating, 5% rash on genitals, 3% sores/blisters inside mouth, 2% bleeding when defecating, 2% pus/discharge from penis, 1% genital sores, 0% pus/discharge in stools, and 1% other;
- in Pondicherry—31% pain while urinating, 28% itching/burning around anus, 16% bleeding when defecating, 13% rash on genitals, 9% genital sores, 3% sores/blisters inside mouth, 0% pus/discharge in stools, pus/discharge from penis, pain when defecating, pain during sex, and other.

The much lower rates for Bangalore are noteworthy here and the much higher rates for the other cities compared with many other studies need to be noted.

Other reports of STI infections among MSM (as a broad undefined category) reported: 32% (ID80) in Mumbai; 24% among MSW and male masseurs in the last six months (ID81), also from Mumbai; others reported STI infections but without figures (ID7, ID92).

Finally, a survey of long distance truck drivers (ID22)—published in 1994, it should be noted, and of which only 5% reported regular sex with men—found that 35% had a history of urethral discharge and three of the 302 (1%) truck drivers tested for HIV were positive. Bamne (ID70) at Durban in 2000 reported from a study reaching out to 800 truck drivers (including 350 cleaners) via a mobile clinic noted that 21% had STI at the time of examination, with 67% reporting having a STI in the past (no specific information was available for MSM truck drivers). In contrast, in ID104, a large study of truck drivers, helpers, female sex workers (FSW) and related ‘stationary’ workers from highways in six regions, STI levels in the previous 12 months were: truck drivers 5%, helpers 5%, stationary workers 3%. Low figures indeed.

These are, at times, generally high rates of STIs or symptoms suggesting STIs, but prevalence is uneven across the populations of men having sex with other men. The possibility of high levels of HIV related to these levels of STIs clearly exists in places and might be confirmed were HIV testing and surveillance available at levels needed for such confirmation. The difficulty is gaining certainty on STI infection levels arises in part because these are not literally underlying levels or ‘baseline’ assessments, but in many places figures gained after interventions were already in place. This is particularly so of some CBO-based assessments.

3. Methodology

The studies reported here (and in more detail in the annotated bibliographies) reflect the complexity and uncertainty surrounding data on MSM from India. Many reports are based on small samples (and this is not just the qualitative studies) and unclear sampling frames, particularly clinical samples where representativeness of the population being reported on is usually impossible to assess. There are some BSS surveys available and these are regional and never really national, and generally offer little, if any, comparable data. Only one (non-BSS) study (ID11) attempts to situate MSM within a more general population framework for one city, Orissa; and one Madras (Chennai) study attempts to estimate the volume of MSM activity (ID13) overall.

The clinic-based studies at times report on samples of men (in general) and then subsection MSM, and occasionally MSW, for the purposes of ascertaining risk behaviour, condom use, partner numbers etc. Unfortunately, they rarely document the same items in the same way. Although anal intercourse (AI) is clearly a focus, rarely is it assessed over the same forms of measurement (time periods, sexual mode, categories of partners etc.).

The clinic-based samples are very useful in revealing the instability and diversity in the category MSM in India. There are few data sets analysed by age, caste/class/SES (an exception is ID4), or by religion/ethnic minority grouping. Most of the reports are from the big cities, particularly Chennai and Mumbai, with Delhi, Kolkata, Pondicherry and Bangalore occasionally mentioned. Little regional or rural data were available at a general level. BSS studies often select special local 'at-risk' groups (e.g. miners and migratory workers in one, diamond industry workers in another, slum dwelling young men in most), but there is a lack of rationale for these selections; and while data for these groups might be valid, generalisation beyond is not.

Many of the largest reports rely on CBO/NGO situational assessments or surveys of men in known cruising sites. These are generally revealing about the multi-layered and contextual nature of much MSM activity, but they are less revealing about the nature of sexual cultures that support this activity and do not always confirm the existence of subcultures (in the sense that 'gay community' is a subculture in the West) that might offer confidence in any notion of 'core groups' at enhanced risk of HIV infection. There is certainly strong argument in these reports that sexual behaviour often has little to do with anything like a 'sexual identity' in the true sense of the construct (as distinct from self- or group-labelling activity). Indeed, except where 'gay' has made some inroads and 'kothi' is gaining ground as the leading indigenous category, sexual identity is looking as shaky a category as it is in Bangladesh.

Many of these cruising sites studies do reveal the widespread nature of same-sex seeking among men and, while there are 'hot spots' (railway stations, parks), there are few locations for activity akin to the gay precincts with which the West is familiar, like the Castro in San Francisco, or Darlinghurst in Sydney, or the Marais in Paris. This has implications for any geographically local (and therefore containable) transmission of HIV/STI and intervention possibilities. A few intervention studies reveal behaviour change occurring, but it is difficult to generalise from these beyond the target groups of the programs, their locational specificities and scale of program.

ID20 is one of the few to employ a more rigorous sampling frame, but had a 21% non-response rate among MSM and this makes its findings less certain. But we note that the in-country consultant reported a number of methodologically poor quality studies, not just in the design, but often in the lack of adequate reporting that would allow a confident judgement to be made about the quality of the study or report. We have excised those that appeared completely unreliable, but retain some studies with highly suggestive, replicated or interesting findings even though we note being somewhat uncertain as to their methodological rigour and veracity of interpretation.

4. MSM as a category

The tension between the traditional and the modernising is pervasive in a number of studies reviewed. ID47 is a good example where modernisation has valorised the nuclear family and challenged social places for same-sex intimacy, particularly that organised by

various cults, such as Ayappa, which foster male sexual intimacy. Similarly, ID56 notes that the history of same-sex love in India is conveyed in the context of India's rich cultural heritage. Same-sex love is an integral part of both Hindu and Islamic traditions. From the history mapped by the editors, it is clear that the diversity and complexity of same-sex desire in India cannot be easily categorized within the labels of 'homosexual' or 'heterosexual'. The authors also map the rise of homophobia as a specifically Western discourse, although it is difficult to tell whether they are commenting on actual increasing levels of violence, abuse or discrimination etc., or the adoption of a Western codification of more dispersed acts against MSM.

As in Bangladesh, it would appear there are large numbers of married men who are sexually active with men, with men and women, and/or with both male and female sex workers as well as 'non-commercial' partners. Taxi drivers (cf. rickshaw pullers in Bangladesh), truck drivers and their helpers, other situation-specific workers (e.g. miners) college students, prisoners, and young impoverished men feature in the studies reviewed, in addition to the more common samples of men recruited from cruising sites for whom categorisation criteria are often omitted or assumed. There are, however, startling examples of diversity among MSM, e.g. 37% of men in a survey of educated business executives reported homosexual relations (ID4), and 15% of truck drivers admitted previous homosexual experience (ID23). In contrast to this last figure, a recent report on 4,811 truck drivers, 1,200 of their helpers, 1,504 FSW, and 1,201 related 'stationary' workers from highways in six regions of India (ID104) found quite low levels of sex with other men: 2% of truck drivers, 2% of helpers and only 1% of stationary workers. Similar regional studies (ID105, ID106) add little to this picture, except that 10.3% of truck drivers at 'dhabas' ('halt points') in northern India (ID107) reported 'ever' having sex with another man, compared with 3.4% of truck drivers overall—which may point either to the situational and opportunistic nature of such activity or a local cultural variant or proclivity.

Defining risk levels by occupational category a priori would seem somewhat problematic, whereas situational and locational analyses might prove more useful. For example, one study of college students (ID97) reveals 15% of men had had sex with another man, 75% had had multiple partners and, interestingly, half the male partners were friends, with sex often taking place at home. This exemplifies the particular institutional character of sex between some men. Finally, interconnected patterns of risk were reflected in only one study (ID25), where 28.8% of male IDU reported sex with men or men and women, and 25% had a history of AI with other men.

There are studies that amplify the indigenous categories used to describe same-sex erotic interests (see ID2), some of which refer to attributed or preferred sexual mode, some to gendered behaviours, some to age, and some reflecting both the impact of the modern Western gay communities and the globalising effects of HIV/AIDS mobilisation. This amplification goes well beyond the 'kothi'/'panthi' distinction dominant in Bangladesh. There is a deployment of the terms 'homosexual' and 'bisexual' in a small number of studies, mainly reflecting a proto-medical use of the terms without reflection. Indeed, ID28 summarises part of the definitional dilemma, arguing that heterosexual and

homosexual identity-based frameworks do not exist in India in the sense in which they are understood in the West. Furthermore, sexual experience and behaviour are more fluid as a consequence of many factors, i.e. gender segregation, Indian ‘homosociality’, the male ownership of public space, cultures of shame, communities of ‘izzat’ (an Urdu term for ‘honour’), the existence of compulsory and arranged marriages, the influence of joint and extended families, etc. Definitions that exist for male-to-male sex, terms such as ‘hijra’ and ‘homosexual’, act as frames that hide multifaceted sexual activities.

Similarly, Gayatri Reddy (ID46) maps out a broader ‘homosocial’ universe in Hyderabad as spanning the realms of tradition and modernity. There are traditional identification such as hijra and kothi, as well as modern identities such as ‘gay’, but Reddy argues that the two are not mutually exclusive and the line between them is fluid (cf. ID51). While acknowledging the particular position of hijras, the receptive/insertive sexual distinction, common in Asia, tends to be elided. It is argued that a new ‘class’ of individuals appears to have been created for whom sexuality seems to have replaced gendered practice as the mark of self-identification, an important theoretical consideration congruent with post-Foucauldian thinking. This fluidity is reflected in the more noticeable presence of ‘gay’ as an organising feature among some NGOs/CBOs in India (e.g. ID61) in contrast to its noticeable absence in Bangladesh. However, Purkayastha disagrees (ID55) and re-asserts that gender remains the pervasive organising feature of sex between men in India.

Theoretically, this conundrum supports the idea offered by Nair and John (ID49), drawn in relation to mainstream sexuality, that what is occurring in India is a proliferation of discourses on sexuality, built on already extant, multiple frameworks (unlike the West with its reliance on the binary opposition ‘heterosexual/homosexual’)—and this would include gender as well. HIV/AIDS mobilisation is entering this dynamic process and needs to be keenly aware of the poverty of its simplistic tools, i.e. the very concept of MSM as a behavioural category masks great diversity and complexity in the structure of HIV risk and vulnerability in India. This is true for gender as well, as women’s position in relation to HIV in India is neither uniform nor singular.

Levels of marriage and female partners (sex worker and otherwise) are high and there is clear evidence that husbands’ male sexual partners are not only MSW. Yet, there are large numbers of MSW in the studies, but perhaps again this reflects the emphases many NGOs/CBOs place on those populations and the origins of the development of interest in MSM activity in HIV/AIDS and activist mobilisation in India. There are certainly different forms of MSW activity (e.g. those who sell to truck drivers reported in ID22) that involves cruising sites, somewhat ambiguous evidence of sex work among college students, and plenty of evidence on MSM who will pay for sex. What is less clear is the extent of MSW activity all up, its place(s) in individual sexual lives, its density as sexual cultures, and its underpinning of enhanced vulnerability among MSW, i.e. do men live on these earnings entirely in ways similar to brothel-based FSW? Indeed, there is no mention of male brothels at all in any study; yet, anecdotal evidence suggests they exist. This dispersal of MSW activity, noted also in ID88, suggests varying vulnerabilities to infection (and the experience of violence is noted in this regard [ID63]). At least one report on boy prostitution (ID43) indicates that prevention efforts must assume that

exchange-based sex is not just an adult activity; nor is vulnerability to HIV infection lodged largely within the clients of sex workers, but equally within the sex workers themselves. The fact that the boys identified up to sixty sex sites in Bangalore also indicates yet again a widespread and fluid sexual economy that may disperse HIV rather than localise it in identifiable or stable ‘groups’ of MSM (see also ID64, ID65 and ID44 for further details, including the boys’ sexual activity with women).

Those studies that survey a range of sexual practices (e.g. ID7) reveal a full repertoire, and this indicates considerable MSM activity is not only related to quick satisfaction (‘discharge’ ID29), but also can often possess considerable relational meaning for large numbers of men. This stands in some contrast to discourses of discharge in some reports and in the semen-loss literature. Such variety in sex acts also suggests that the concept of ‘sexual cultures’ may be useful point for developing and contextualising interventions. Similarly, the diverse ways in which MSW operate suggest that investigating the different ‘sexual economies’ that shape sex work (in which men and women are clearly operating often with the same client base) might fruitfully suggest innovative modes of intervention.

This is especially important in regard to hijra. Nanda (ID33) discusses the hijra role as an institutionalised third gender in India, as ‘neither male nor female’, containing cultural and embodied elements of both. Hijra are commonly believed by the larger society to be intersexed, impotent men, or those who undergo emasculation in which all or part of the genitals are removed (does anyone really know?). Therefore, the core of the hijra role culturally would appear linked to a negation of sexual desire. However, the reality is that many hijras do engage in sexual activities. Such sexual behaviour is contrary to the definition of the social role of the hijra, and causes conflict for both the individuals and the community. Individual hijras deal with the conflict in different ways, while the community as a whole resorts to various mechanisms of social control. Nanda argues that, in contemporary India, hijras extensively engage in sexual relations with men (a phenomenon that is not entirely modern), mostly receptive AI (but not exclusively). Increased prostitution is due to declining opportunities to earn a living in their traditional manner. It is also important to note that hijras will engage in forms of sexual behaviour in which Indian women might normally not engage.

See also ‘sexual networks’ below.

5. Sex Practices

The overarching impression is that AI is widely practised by Indian MSM, but the patterning of the practice is far from uniform or simple, and the sexual repertoire of male-to-male sex is as diverse as found elsewhere in the world (e.g. see Kumar and Ross (ID7) below). Note, for example, ID2 (n=30), in which 24 reported body rubbing, 27 masturbating partner, 27 being masturbated by partner, 12 undertaking anal penetration, 22 being penetrated anally, 19 giving oral sex, 12 receiving oral sex, 7 doing thigh sex, 12 deep kissing, and 24 kissing on lips/cheeks—clearly, a varied repertoire.

Many reports just note AI or oral sex (OS) occurs, with no estimates or quantification (ID1, ID24, ID43, ID60, ID74). Many are small studies with accidental or purposive sampling, often not clearly defined. Others have particular samples that are difficult to compare with MSM as a general category. For example, note again Narain et al. in a review of literature published in *AIDS* (ID4), who report *inter alia* that 37% of educated business executives surveyed reported having homosexual relationships.

One study comes close to offering a general population-based picture of male sexual practice (ID11): in a structured survey of a random sample of 2,087 (men and women) with additional data from key informants, health practitioners, and some case studies, Collumbien et al. report nearly 5% of single men and 6.4% of married men have had sex with other men, with 2.3% of single men and 4.7% of married men reporting AI, with 0.9% of both groups doing so in the previous twelve months. Higher levels were reported in the district of Puri: 8.6% of single men there reported sex with other men and 1.6% had experienced AI compared with 21.4% of married men reporting sex with other men and 14.5% experiencing AI, with 3% of married men reporting AI in the previous twelve months. This is not the only report reviewed where local differences are noteworthy, suggesting again situational or locational sexual cultures or economies.

A magazine survey of readers (ID59) of ‘Debonair’—an expensive and erotic English-language magazine with 85,000 readers, of whom 1,424 returned questionnaires—found 29.4% reported engaging in ‘homosexual intercourse’, with 17% participating in ‘group’ homosexual activity. Among college students (IN97), of the 15% of men who had sex with men, 27% had had AI with male partners. Yet, a report from an intervention in Lucknow among young men (ID14) reporting on 377 men in an intervention group and 343 in a control group, noted that 76% and 80% respectively had had no sexual activity at all, and only a total of 20 men reported OS or AI with men—so this figure of 2.7% of the sample experiencing male-to-male sex may not be very useful as a guide as to what young Indian men are doing sexually.

Regional BSS data was recently released for Gujarat (ID108), Orissa (ID109) and Kerala (ID 110) from multi-site surveys of classic ‘high-risk groups’ (although somewhat different in each site). In Gujarat (ID108), 2.4% of male clients of FSW and a small proportion of other male sub groups reported anal sex with a male partner in the last year (male diamond industry workers 5%, male slum dwellers 0.2%, and male university students 0.3%). In Orissa (ID109), 2% of male clients of FSW and a very small proportion of other male sub groups (male migrant workers 0.3%, and male miners 0.1%) also reported anal sex with a male partner in the previous year. Finally, in Kerala (ID110), 7% of male clients of FSW and 2% of male university students reported anal sex with a male partner during the preceding year. These figures are low, in contrast to studies reported below, but point to the dispersed nature of sex between men and, again, suggest a situational basis for such sexual activity. It would appear that sex between men is not necessarily always regarded as in contravention of masculine or gendered expectations of men as such.

Clinic-based samples offer a different picture. Kumar and Ross, in a comparative study of Indian and Australian MSM (ID7), reported for the Indian men recruited in four STI clinics in the northwest that the most frequent sexual act reported was ‘dry’ and then ‘wet kissing’, followed by AI insertive and then OS insertive sex.

Table ID 1: Frequency of Sex Practices by MSM in Northwest India
(Kumar & Ross ID7)

SEX PRACTICE	ALWAYS	MOSTLY	SOMETIMES	NEVER
Wet kissing	19.6	34.8	19.6	0
Dry kissing	23.7	28.9	31.6	15.8
Solo masturbation	41.7	25.0	27.1	6.3
Mutual masturbation	4.8	4.8	42.9	47.6
Oral receptive	4.1	10.2	42.9	42.9
Ejaculate in mouth	2.4	4.8	14.3	78.6
Oral insertive	12.2	22.4	36.7	28.6
Anal insertive	18.4	22.4	26.5	32.7
AI/insertive/withdrawal	14.6	2.4	9.8	73.2
Anal receptive	10.2	8.2	26.5	55.1

Like ID2, these are interesting figures and reveal less AI than might be expected. The very low ‘OS with ejaculate’ percentage is also interesting.

Data from another clinic-based study from Mumbai (ID82) presented in Barcelona in 2002 by Linden et al., revealed that of the 386 men so far enrolled in the study, 24% reported receptive or insertive AI with men in the past. And, in a clinic-based sample from Chennai (ID40) of 117 male patients attending Government General Hospital, who were either homosexual (52) or self-identified as bisexual (65), 27% of homosexual men stated that AI was their most common practice, 8% nominated OS, and 65% chose both; while 17% of bisexual men chose AI, 15% nominated OS, and 68% chose both. Of interest in this study were the respondents’ reports on mode. Homosexual men reported 23% active, 52% passive, and 25% both; bisexual men reported 64% active, 5% passive and 31% both. Yet, data collected in community-based clinic in Chennai (ID96) from 51 MSM and Nirvan kothis/Alis (M→F post-operative transsexuals) reported a much larger 60% engaged in AI with another male in the previous six months.

When potentially higher-risk populations are identified, levels of male-to-male sex are still not high. For example, an early 1990s study of truck drivers (ID22) noted that 5% admitted to regular sex with men, mostly with MSW. More recent BSS data from Tamil Nadu (ID36) confirm this 5% figure for truck drivers, and adds that 28% of these were engaged in anal sex. In the same study, the figure for anal sex was 13% for male factory workers who had sex with men. More worrying was 58.8% of young men living in slums having AI when they have sex with men; however, only 12% of the young men living in slums surveyed had actually engaged in sex with men at all. The subsequent 2001 BSS study in Tamil Nadu and Pondicherry (ID37) found the 68% of MSM had engaged in anal sex in the previous month, but the levels of male-to-male sexual activity among the

various groups was similarly low: 12% of young men living in slums, 8% of male factory workers, and 5% of truck drivers. Hausner et al. (ID93), reporting on college students in southern India, note that 32% of the study population reported previous sexual activity (sex of partners unspecified), with 53% of these sexually active men 'ever' having male sexual partners (i.e. just on 17% of the men). Of these MSM, 35% reported ever engaging in either receptive or insertive AI, 44% OS, and 80% non-penetrative sex. In other words, only 5.9% and 7.5% of these college students were engaged in AI and OS with men respectively. Finally, one prison based study (ID25), noted 28.8% of inmates under 50 years of age reported sex with men or sex with men and women, and 25% had a history of AI with another male.

When locally defined subpopulations of MSM are involved, the figures are different once again. A study of 300 MSM recruited in railway stations in Mumbai (ID52) found 15% had engaged in AI in the previous month (79% had engaged in OS), with 52% and 61% of these practising insertive AI and receptive AI respectively. However, in an intervention among MSM in Mumbai railway stations, presented by Aher (ID83) in Barcelona in 2002, 53% reported receptive AI. In West Bengal, a study of 400 MSM from twenty sites found 65% reporting AI in the previous year (ID20). Similarly, Row-Kavi et al., in a Mumbai survey of MSM (ID94), note that 64% reported insertive AI and 73% receptive AI. The Humsafar Trust surveyed readers of 'Bombay Dost' (ID15, ID58), eighty replied (out of 1000 questionnaires sent out) with 45% reporting AI, 43.5% OS (with 15% reporting vaginal sex, and 58.8% reporting non-penetrative sex). These are generally higher levels of AI compared with those figures reported earlier or in a small Chennai study (ID35) where only 26% report practising AI and OS (an unpublished dissertation). The higher figures suggest that a focus on the locally defined subpopulations of MSM who are more likely to be associated with, or be sexually active in the context of, specifically MSM-defined NGOs might partly explain the elevated levels of AI. Indeed, NGOs working in the MSM field may recruit such specific subpopulations, unwittingly or deliberately. While these findings do point to the existence of sexual networks operating according to a particular sexual or situational dynamic, these populations may not be a good or general indicator of MSM as a wider at-risk population.

Where sex with MSW is concerned, the picture changes again. One study (ID53/ID95) that attempted to develop a 'baseline' of high-risk populations by interviewing, among others, 626 MSM in four sites (Mumbai and Thane, Pune and Sangli), noted that MSM were highly sexually active, with 92% reporting multiple AI activity with men in the previous month and 27% had sex with MSW. A four-site Naz Foundation situational assessment in Hyderabad, Bangalore and Pondicherry (ID29) noted:

- For Hyderabad—
 - AI in previous month (total number of sex acts = 7,029), insertive 24%, receptive 76%. Of the 42% of respondents who were paid for sex during the previous month, 3% practised insertive AI, 54% receptive anal, 4% OS insertive, 33% OS receptive, and 6% non-penetrative. Total number of paid sex acts in during last month was 2,355 (from 62 people involved);

- For Bangalore—
 - AI in previous month (total number of sex acts = 3,754), insertive 35%, receptive 65%. Of the 40% of respondents who were paid for sex during the previous month, 4% practised insertive AI, 53% receptive AI, 4% OS insertive, 31% OS receptive, and 8% non-penetrative. Total number of paid sex acts during last month was 1,122 (from 60 people involved);
- For Pondacherry—
 - AI sex in previous month (total number of sex acts = 2,182), insertive 23%, receptive 77%. Of the 44% of respondents who were paid for sex during the previous month, 4% practised insertive AI, 53% receptive AI, 4% OS insertive, 31% OS receptive, and 8% non-penetrative. Total number of paid sex acts during last month was 1,168 (from 72 people involved).

The vulnerability of those who sell sex is clear here. A second report from Naz on the Bangalore data alone (ID50) gives different figures (total number of sex acts = 4,746), but reveals among the kothis and ‘double deckers’ (those who engage in both modes of AI) a preponderance of AI compared with OS (for kothis 1,544 vs 641; for DD 1,390 vs 596), while among those who were labelled ‘gay’ the proportion was less marked (233 vs 139). An interesting difference.

In one study of 120 MSW and masseurs (ID81) in Mumbai, Thakur reported 92% of the sample engaging in AI. Yet, a ‘baseline’ in Chennai (ID38), mainly of MSW with some MSM, found just 58% of MSW practised AI in the previous month. But we do not know the mode for these very high figures. From information gathered from twenty ‘room boys’ in hotels in Pune and New Delhi (ID32), eight reported anal sex with male guests, with a further five reporting non-penetrative acts. Of those eight engaged in anal sex, six were penetrated and all were the penetrators. One qualitative study (ID10), focusing on 121 street boys in Bangalore, found 14.9% has sex ‘regularly’, 45% ‘sometimes’ and 29.9% ‘rarely’. Sex included a variety of practices, with 46 boys practising anal sex, 42 vaginal sex, and only 8 boys reported both anal and vaginal sex.

Finally, ID103 reports all 28 TG (in a study which included 122 men) reported receptive AI and had >10 sexual partners in the previous 6 months (there are no data on the rest of the men), but 24% of MSM claimed to have used condoms sometimes for receptive AI. A second hijra study in Chennai (ID41) reported only 26% practising receptive anal sex, while 64% reported practicing receptive OS. One small baseline study of transsexuals (‘Aravanni’) in Chennai (ID39) found 78% involved in sex work, with 22% reporting OS, 33% ‘hand moving technology (HMT)’ (presumably masturbation), 9% AI, 16% both OS and HMT, 7% thigh sex, and 2% both AI and OS. Importantly, it is noted in ID102 that three-quarters of hijra were not castrated (we have no sample size or methodological information to verify this judgement), so the possibilities of insertive sex cannot be disregarded either, even though it may be that the cultural concept of hijra cannot allow for an insertive mode, irrespective of practice (much as kothis claim receptivity but many insert).

Sexual partners

ID1 reports from a clinic-based study of 63 MSM in Mumbai that the men averaged 2-3 partners per week. In the study of MSM in Mumbai railway stations (ID52), 76% reported to casual male partners, with an average of 7 per month. In Mumbai, in the 'Bombay Dost' readers' survey (n=80), the mean number of partners in the previous six months was 6.12, while the median was 3 (ID15). Also, 174 MSM in Mumbai surveyed by Row-Kavi et al. (ID94) reported an average number of 11 partners in the previous month. However, Asthana and Oostvogel (ID13) report from a qualitative study of several hundred MSM in Madras (Chennai) that the men average 1-2 partners per day. Indeed, they extrapolate from their interviews and observations in 25 'cruising sites' that there are 1,400 men seeking sex with other men each day. In Bangalore and Chennai respectively, NACO's 2002 BSS (ID19) reported means of 6.1 and 13.7 with MSW partners, and 5.1 and 8.3 with non sex-working male partners in the previous month. Clearly, these Chennai data suggest a distinctly active MSM sexual economy there. Note again Kumar and Ross' finding (ID7) in their four-clinic study undertaken in Northwest India of an average of only 2.13+/- 1.21 partners in the previous two months.

The West Bengal Sentinel Surveillance Study (ID20) in its subsample of 400 MSM, found in the previous month that 34% of men had no partners, 11% had one partner, 54% had 2-7 partners and 24% had >7 partners (note: these figures refer to male anal sex partners specifically). The Tamil Nadu and Pondicherry BSS, conducted by APAC (ID37), found 58% of MSM had regular partners, 40% paid partners, and 38.4% had casual partners. But this figure is not disaggregated for the various subpopulations studied, i.e. truck drivers, IDU etc. However, the six-region study of truck drivers, their helpers and related 'stationary' workers (ID104) reported quite low average partner numbers in the previous year: truck drivers 1.7, helpers 1.6, stationary workers 1.2. Other BSS-derived data from:

- Gujarat (ID108) reported the average *number* of male anal sex partners in the previous 12 months for those small number of men who reported a male partner was: male clients of FSW (2), male diamond industry workers (1), male slum dwellers (4), and male university students (1);
- Orissa (ID109) found that the average number was 0;
- Kerala (ID110) noted the average number was 3 for male clients of sex workers and 5 for male university students.

Low figures indeed.

In contrast, Khan provided the following averages for the previous year from qualitative studies (ID24):

Table ID 2 – Number of Sex Events in Previous Year (ID24)

Number of sex events	%
1-5	4
6-14	17
15-30	25
31-45	36
46+	18

And in ID31, based largely on the same data, Khan reported for various age groups: for 14-16 years (n=50) then average number of different sexual partners for the current year was 2; for 17-21 years (n=120) it was 5; for 22-35 years (n=355) it was 42; for 36-45 years (n=234) it was 35; for 46-60 years (n=105) it was 8; and for >60 (n=24) it was 5.

The Naz four-city situational assessment (ID29) reported:

Table ID 3 – Number of Sex Partners for Three Cities
(Naz Foundation situational assessment (ID29))

Number of partners	Hyderabad %	Bangalore %	Pondicherry %
1-3	4	22	22
4-6	6	18	20
7-10	6	13	26
11-15	5	12	14
16-20	15	13	10
21-30	25	13	7
31-50	19	7	1
>50	20	2	60

Similarly, a community clinic-based sample of 100 MSM (ID72) reported 6% having regular partners, while the rest had casual partners. From the same clinic, in a study of 17 men of whom 14 were HIV+ (ID85), 50% also reported 11-30 partners per year. The much higher levels reported in these studies, compared with earlier BSS samples, would seem to suggest particular sampling strategies in play, similar to those reported above from other CBO-based reports. This is not to suggest that these findings are not useful, but that both research strategies (the CBO outreach-based and the BSS high-risk populations-based) may produce their own specific emphases.

One study collected data on *lifetime* partners (male and female) among a clinic-based sample of homosexual and bisexual men (ID40), noting for the homosexual men that 48% have had up to 10 partners, 27% from 11-100 and 25% had >100 partners. For bisexual men the figures were 68% up to 10 partners, 24% from 11-100 and 8% >100 partners. In answer to the question: 'How many regular sexual partners do you have at

present?’ 45% stated ‘nil’ 42% states ‘only one’ and 13% stated ‘more than one’. Of the 49 persons who have a single regular partner, 22 are with their wives, and among 15 persons having more than one regular partner, 4 included their wives. The rest are mainly male partners. The frequency of sex with men was for ‘homosexuals’—11 (21%) stated daily, 12 (39%) weekly, 12 (23%) monthly, and 9 (17%) occasionally; for ‘bisexuals’—nil stated daily, 14 (21.5%) weekly, 34 (52%) monthly, and 17 (26%) occasionally, suggesting somewhat lower levels of activity. These data are particularly important for they reveal the complex nature of male to-male sex beyond the easily reached and more readily recognised subpopulations that are captured in many of the community-based NGO reports.

Male sex workers reveal quite varied numbers of partners. ID81 notes an average of 11 partners (but no time scale was given). One street boy study (ID10) found 41.9 % had ‘few’ partners and 31.1% had ‘several’. Finally, hijra in one report (ID101) presented at the XII International AIDS Conference in Geneva in 1998 were noted to have 15 times more sexual partners than FSW (although how this calculation was reached is not clear).

Female partners

Setia et al., in a study of MSM and TG clients of the Humsfar Trust (ID103), found that 44% of 122 MSM studied had visited FSWs, 22% of MSM were married and 20% live with their wives. In the study of MSM in four clinics in NW India (ID7), Kumar and Ross found that the proportion of men who had had sex with women and men in the previous two months was 65.3%. Indeed, 55.3% of respondents were married. Another STI clinic-based sample (of whom 30% reported MSM behaviour) found most men were married (see also ID76 for a similar general finding). In contrast, in a Mumbai clinic offering services to men in general (ID82), only 12% of those who were married had engaged in sex with men in the previous three months.

In a study of North Indian slum-dwelling young men (ID14), roughly one third of the young men (8 out of 22) who visited FSWs also reported having sex with another male. Young men in the sample who visited FSWs were approximately 33 times more likely to engage in sex with a male than were other young men (but the numbers here are too small to make such a ‘proportional’ comment trustworthy.) The ‘Bombay Dost’ survey of 80 of its readers (ID15/58) reported only an average number of 0.25 female partners in previous six months.

In an unpublished qualitative study based on focus groups with MSM with female partners (ID16), the Naz Foundation noted that very few participants were willing to inform their wives of their sero-status, and informing their female partners and wives of either their sexuality/identity/behaviour, or of their STI/HIV status arising from male-to-male sexual encounters, was clearly not an option for the majority of discussants. None of the discussants believed that they could stop their MSM behaviour or even desired to, even though a few stated that they tried. Related work (ID87) noted that 78% of MSM were married, while 46% had sex with other women. Khan also noted in his account of

hotel room boys (ID32) that seven of the men only have sex with women (and of these, three have a regular girlfriend) and 14 men visit female sex workers on average once a month after payday, with 6 men having anal sex with women also. The Naz Foundation four-site MSM study (ID29), with one site in Bangladesh, noted that in 25% of Hyderabad, 26% of Pondicherry and 30% of Bangalore respondents reported being married. In addition, ID50 also reports that 9% of MSM respondents in Bangalore reported sex with females other than their wife.

The 2002 National Baseline High Risk and Bridge Population-Behavioural Surveillance Survey (ID19) reported that just on 33% of the 1,387 MSM respondents reported sexual experience around the age of 20 years with a female partner, while 31% of the respondents (of which 52% were from Delhi) reported sexual intercourse with a female partner in the previous six months.

In one Chennai study of MSM and MSW (ID38), 31% of the respondents reported of having sex with female partners. Meanwhile, also in Chennai in a STI clinic sample of men (ID40), 65 of 117 respondents self-identified as 'bisexual', (with all the caveats that term implies). Another Chennai study (ID96) of 51 MSM enrolled in a CBO clinic reported the majority (64%) as having had sex with women.

The Humsafar Trust study of various cruising sites in Mumbai (ID52) noted 52% MSM had had sex with female partners, 20% on a regular basis, with 38% having had vaginal intercourse. The average number of female partners in a month was two. 28% of MSM are married, but only 22% stay with their spouse. Another Mumbai study of cruising sites (ID80) reported 89% of men as 'bisexual', while 56% of MSW and masseurs in one Mumbai study had had sex with female partner (ID81). Meanwhile, the Mumbai-based 'Debonair' magazine survey (ID59) found that 32% of their readers who were married have had sex with another man. Another survey of 174 MSM in Mumbai (ID94) noted 50% of self-identified MSM reported having had sex with women during the previous month. Indeed, only 5% reported never having sex with a woman at all. Even among hijra in one study (ID41), 24% reported to have had their first sexual experience with a female.

These are very difficult figures to generalise from in terms of female partners, with marriage rates among MSM ranging at times from 28% to 78%, and rates of sex with women ranging from 31% to 65.3%.

Condom Use

In the national baseline study of 'high-risk' and 'bridge' populations (ID19), 39% of 1,387 MSM reported using condoms in their last sexual encounter with MSW, but we have no data on use with other partners. The fifth wave of Tamil Nadu BSS (ID36) found 63.3% of truck drivers and their helpers used condoms for anal sex, while 40% of the slum dwelling young men did so (but very small numbers of men in these categories were sexually active with other men—see above). The sixth wave (ID37) also included Pondicherry and found that 44.7 per cent of over 11,000 MSM having sex with men in

the previous six months reported using condoms in the latest anal sexual encounter. In addition, condom use among MSM was 54.3% with MSW, 41.3% with regular male partners and 30.8% with casual partners. Also, 25% reported using condoms with casual female partners and 62.5% with FSW. These are very encouraging figures, supported by some other studies; yet much lower usage is reported elsewhere, so it is doubtful that these can be taken as any kind of 'norm' for MSM as a whole.

Other BSS data from regional studies note lower usage:

- in Gujarat (ID108), condom use for last anal sex with male partner for male clients of FSW was 20%, while all other categories of MSM surveyed reported no condom use in their last anal sexual experience, and only 20% of male clients of FSW reported consistent condom use with male partner during anal sex in the previous 12 months (note: n=2 out of 10);
- in Orissa (ID109), none of the male respondents had reported condom use during the last AI with a male partner;
- in Kerala (ID110), condom use at last anal sex with male partner among male clients of FSW was 14% and 31% for male university students, while 14% of male clients of FSW and 15% of male university students reported consistent condom use with male partner during anal sex in the previous twelve 12 months.

General comments are available in some studies: ID2 and ID98 report low usage but no figures; ID11 reported no use for AI among its respondents; similarly in ID13; 1% 'sometimes' in ID 73; no consistent use with male or female partners (ID74); condom use is rare among Mumbai MSM (ID94) (and see below for other findings).

In the Chennai-Tamil Nadu clinic-based study of male attendees (ID40), condom use among the 'homosexual' men was 4% 'always', 42% 'occasionally', 54% 'never' and among the 'bisexuals' 54% 'occasionally', and 46% 'never'. Kumar and Ross' four-clinic study in NW India (ID7) found very low levels of condom use of OS ('sometimes' — 4.5% for receptive OS, 4.3% for insertive OS), and very low use 'always' for insertive AI (2.4%, 'sometimes' 11.4%) and receptive AI (0%, 'sometimes' 5.6%). In other clinic-based reports from Mumbai (ID79), 80% of MSM had 'never' used condoms. A Humsafar Mumbai clinic-based report (n=100) presented at Durban in 2000 (ID72) noted only 5% of men used condoms 'regularly', 20% 'sometimes' and the rest 'never'; while a similar Humsafar clinic-based report presented at 6ICAAP (ID89) noted 28% 'consistent' condom use among MSM and 10% among bisexually active men. Finally, in ID 96 in Chennai, among 51 SWAM (CBO) clinic attendees, all the married MSM reported 'never' using condoms with their wives, inconsistent use with other female partners and only 40% use with other MSM in the most recent AI event.

These low levels of condom use in clinic-based studies are consistent with special population studies. Among young men in an intervention in Lucknow (ID14), in which only 20 of the 567 were sexually active, 10 had 'ever' used a condom for oral/anal sex, with some reporting experience of condom use with women—but these numbers are too small to be seen as definitive for young men as a whole. A study of young male college students in southern India (ID93) found that condom use varied with partners (male or

female) and sex acts (vaginal sex, or anal sex with either male or female partner): e.g. only 12% of the men whose sexual initiation involved anal sex with another man used condoms.

Meanwhile, in a Delhi taxi driver intervention study (ID68), only 19% used condoms for sex with men, but 47% were having unprotected incidental sex with men. Another intervention study with truck drivers in Mumbai (ID70), some of whom were sexually active with men, reported 4% of homosexually active men used condoms regularly compared with 12% of the heterosexually active. Reasons for not using condoms included: 46% 'no pleasure', 32% 'non-availability', 20% 'doubts about condoms as preventive measure', 2% 'fear of developing impotency'. The six region study of highways (ID104) revealed condom use with last male partner for truck drivers at 26%, for helpers 15%, and for stationary workers 17%; consistent use in the previous twelve months was lower at 15.3%, 5.2% and 5.8% respectively. Another intervention among 6,885 MSM in 72 cruising sites in Chennai reported in Durban in 2000 that at baseline 27% reported condom use, rising to 40% after the first year of intervention, offering some hope of rising levels of condom use (ID71).

In Chennai, of 50 MSM interviewed for an unpublished dissertation (ID35), 35% reported using condoms. In another Chennai study (ID38), intended as 'baseline' on 70 MSM and 10 MSW, 50% (n=5) of MSM reported condom use 'always', 30% 'rarely' and 20% 'never' in the previous 3 months, with 34% of MSW reporting 'always', 8% 'rarely' and 58% 'never' using condoms for the same time period.

Of the 122 MSM and 28 TG enrolled in the Humsafar Trust study reported by Setia et al. in Barcelona in 2002 (ID5), only 24% of MSM and 11% of TG reported using condoms for receptive AI. Interestingly, 82% of MSM and 75% of TG reported that their partners would be 'angry' if condoms were insisted upon. The Humsafar Trust survey through 'Bombay Dost' (ID15, n=80) offered similar findings: 18% reported using condoms 'always', 39% 'sometimes', 34% 'never', with 9% 'NA/NR'. There were also reports of tears in condoms (18.8%) and water-based lubricant use (17.5%). Yet, another Humsafar study of railway station cruising sites (ID52) for MSM (n=300), reported 87% have easy access to condoms. Of the 52% who engaged in insertive AI sex in the previous month, 89% used condoms and 82% did so on a consistent basis; while, of the 61% who were engaged in receptive AI in the previous month, 91% used condoms and 84% did so on a consistent basis. For receptive OS, only 36% used condoms (70% 'always' and 30% 'sometimes'), while for insertive OS, 33% used condoms (58% 'always', 40 'sometimes' and 2% 'rarely'). It is not clear whether this encouraging difference is simply an artefact of recruitment, and effect of social desirability, or a real distinction between populations of MSM available to clinic-based research and outreach methods.

The West Bengal sentinel surveillance study of 400 men in 20 sites noted 60% condom use in last AI with regular partners, 72% with non-regular, and 79% with MSW. 'Consistent use' figures were respectively 30%, 54% and 66%, indicating important levels of condom use uptake among these MSM there. Other reports from Mumbai presented in Barcelona in 2002 from NGOs/CBOs note: 65% usage (ID80); non-

availability for masseurs and MSW (60%) and client resistance (68%) (ID81); 58% usage with only 34% consistent usage (ID83). These studies all relate to intervention/program sites and may achieve such heightened levels of condom use with clients, but we have no indication of the 'representativeness' or extent of their client base.

The Naz Foundation four-city situational assessment (ID29) reported for:

- Hyderabad: condom use for insertive acts 35%, for receptive acts 29%; for lubricant 87% used saliva, 55% oil products, 35% Vaseline, 26% KY jelly and 9% used soap; and among MSW, condom use with previous 5 clients was 12% every time, 48% sometimes, 40% never.
- Bangalore: condom use for insertive acts 45%, for receptive acts 45%; for lubricant 61% used saliva, 60% oil products, 4% Vaseline, 21% KY jelly and 5% used soap; and among MSW, condom use with previous 5 clients was 27% every time, 39% sometimes, 34% never (see also ID50).
- Pondicherry: condom use for insertive acts 34%, receptive acts 36%; for lubricant 53% used saliva, 41% oil products, 2% Vaseline, 2% KY jelly and 2% used soap; among MSW, condom use with previous 5 clients was 1% every time, 7% sometimes, 92% never.

Bangalore emerges again as a site of higher condom use, which suggests that interventions there may be working better; the data from Hyderabad is less encouraging. But the high levels of 'never' used among MSW are worrying, particularly in Pondicherry. And these findings on breakage and lubrication indicate that interventions on condom use alone are not sufficient, and measures of increased condom usage on their own might not be as helpful at judging risk reduction as we would like.

The qualitative studies reveal varying levels of condom use: of the 20 room service boys in ID32, only 1 man used condoms 'regularly', 3 'irregularly'. A hijra study (ID41) noted that of the 50 respondents 86% insisted on condom use with their clients, but 58% of the respondents did not reject the clients who did not use condoms.

These findings on sexual practice, partners and condom use offer a very complex and varied picture of sex between men and the female sex partners of such men in India. There is definitely a lot of sex between men occurring in India, but not necessarily where it is looked for (the low frequencies for sex with men in the truck driver studies are interesting). The widely varying number of partners and differing frequencies of sex (AI in particular) suggest that situational and contextual forces are at work producing the opportunities, patterns and meanings within which sex between men is taking place—and these are multiform and quite unpredictable. The cultural analyses (see below, and in the section 3 above) suggest any singular notion of an 'Indian' MSM culture (or even a 'South Asian' one for that matter) seriously underestimates the variability and the diversity of social, historical and cultural forces that produce the kinds of findings reviewed here and would mistakenly conflate significant differences in the many MSM sex cultures noted here.

6. Networks

In ID31, Khan reported on information from successive investigations of MSM cultures in South Asia and rated the following practices in terms of sexual enjoyment, which offers significant possibilities of focusing on safe practices in prevention education, as well as signalling the diversity of the sexual repertoire again, i.e. sex between men is not simply about ‘release’ but is also a matter of relationality. To the question ‘At the current moment, what type of sexual act do you enjoy the most in order of preference?’, 1,200 men gave the following answers: masturbation (60%), interfemoral sex (40%), oral sex (35%), receiving oral sex (35%), giving oral sex (26%), frottage (25%), mutual oral sex (23%), anal sex (40%) giving anal sex (24%), receiving anal sex (28%) , both (11%). This range of sex practices suggests a deeper relational quality to sexual activity between men than the more predominant ‘cruising site’ frame. These practices also suggest a certain *choreography of sex* (Dowsett 1996) that requires more than a tree or shrub to hide behind; maybe requiring a room, bed or more private place for a longer encounter. They also suggest an affectional/intimate quality to such encounters that amounts to more than mere ‘discharge’. These findings also to some extent de-centre AI from the heart of male-to-male sex in India.

The Naz Foundation (ID5) notes that there are no ‘communities’ as such among MSM, but networks connected to, and developed through, these sites (which can offer the possibility of building stronger links between MSM). These sites are varied, e.g. in ID15 places where sex occurs included: 11% toilets, 75% hotels, 4% brothels (this could be female brothels – it is difficult to assess), and 11% public places. Moreover, as reported above, partners were: 33% strangers, 2.5% MSW, 2.5% FSW, 64% friends, 6% blood relatives, 16% spouses. And 18.8% had paid for sex and 7.5% had been paid. Other studies (see also ID2, ID29, ID31, ID40, ID50, ID52 [notes the WWWeb], ID58) report similar varieties of cruising site and partner selection processes, suggesting quite varied and heterogeneous MSM patterns of association, rather than supporting any suggestion of one homogeneous MSM subculture. However, ‘cruising sites’ substitute for networks in many studies and these two should not be confused—they are not the same thing. The key phrase to describe this pattern of sex seeking might be ‘deliberate incidental sex’. The density of social (or sexual) networks is not revealed by any convergent notion of ‘cruising sites’.

Another problem is the misuse of ‘commercial’ to describe sex sold by men/boys to other men. The phrase has come under increasing pressure because of what it masks: various transactions and forms of exchange that bear little resemblance to the commercial sex work industry that dominates (as far we know) the way in which Western sex workers are positioned in HIV/STI epidemiological and social/behavioural research. This too-easy adoption of the term makes it difficult to judge the difference between tokens of gratitude and gift-giving (cf. ‘Sugar Daddies’ in East Africa), sex in exchange for accommodation or protection or in sporadic moments of economic need (among street boys), sex in exchange for money on an irregular basis as supplementary income (possibly students) or

as the main or only income, and sex work in brothel-based or other sex industries as a primary ‘occupation’ etc. (e.g. the bar boys in Thailand). We cannot tell from the reports that classify MSW as a category the structure of the sexual relations they engage in as a form of exchange—MSW also will not hold as a single category (ID88 concurs). The distinction made in one paper (ID38) between a ‘pleasure’ circuit and a ‘commercial’ circuit cannot be seriously sustained.

We also cannot tell from the cruising sites studies or the few studies where MSM report paying for sex exactly what these mean in terms of comprehending any density in the patternings of association that might also mean a concomitant density of potential HIV transmission and/or infection vulnerability. The various terminology discussions throw little extra light on this dilemma. For example, while we know that ‘panthi’ approximates at times what the sex industry in the West might call a ‘punter’ or a ‘john’, in South Asian usage it mainly means a ‘masculine’ insertive partner (although there are significant exceptions here), sometimes a peer (a boyfriend), sometime older, often married (it seems), sometimes paying; and from the clinic-based studies it appears that such men can often have wives, girlfriends, even boyfriends, and visit MSW and FSW. But, clearly, not all do and, therefore, this category has no real centre, no real value for us. ID13 also notes that transient nature of ‘panthi’ participation in cruising sites and suggests a social class differential in play, but provides no detail. Whatever we do know, it is clear that ‘panthi’ is a term those very men themselves do not use, and they form no pattern of association among themselves, do not seek to form social relations or a network among their kind, and share no common sexual subjectivity.

Elsewhere, social class differences are hinted at—slum-dwelling young men (e.g. ID36, ID37), street boys (ID 10, ID43, ID44), business executives (ID4)—but no real analyses of sexual networking that might be associated with ethnic, religious, racial, age or generation, or class-based differences are available. In relation to young men, we must note the report (ID11) of onset of sexual activity as 18.2 years for single men, 22 years if first sex was within marriage. However, among street children (ID64) Sharma et al. report older boys forcing AI on younger ones, and ID35 reports 52% of 50 largely effeminate MSM interviewed had been practising homosexual sex since 10-15 years of age. Similarly, in ID38, 83% of respondents had their first sexual experience between at the ages of 10 and 19. (See also ID43.)

Secrecy is noted (ID17) and violence (ID63, ID86) as well, indicating that MSM activity sits somewhat askance Indian society. But it is very difficult to make such a singular statement, given the enormous diversity in, and variety of, Indian cultures. A number of studies (e.g. ID9, ID28) pleaded the need for understanding Indian MSM activities as sites of historically formed but changing cultural production, i.e. as multi-contextualised practice, not as standardised categories of reified human behaviour. Only one study attempts to head in this direction (ID45), but it offers no findings of use to this review in its attempt to re-categorise MSM on secrecy/cluster axes.

ID11 notes that it excluded labour migrants and students who stay away from home. This raises an interesting gap in the studies/reports on the former, and reminds us of the

sketchy material available on the latter. We also have no reports from India on the armed forces, seafarers, wharf workers or farmers. More research is needed here. But we do see the structuring of some MSM sexual activity around certain industries and these findings are consistent with Bangladesh: truckers and their helpers (whatever ‘helper’ means—i.e. are they truck boys who are sex partners of the drivers, cf. the *Panos* Nigeria study, or work peers who as friends seek sex with third parties?), taxi drivers, factory workers, hotel room boys (ID32), and prisoners (scant but noted in ID48).

The gender/sexuality distinction, particularly invoked in relation to ‘kothis’, is very problematic. Its association with passivity in sex (i.e. being the receptive partner in AI) and the notion that this is congruent with a sense of being the ‘female’ in sex with a ‘real man’ is not only undercut by considerable evidence that kothis often are insertive in AI (a kind of kothi as ‘top’), but also, as the Naz Foundation notes in ID42, kothis often dominate the sex act even if they are being penetrated (a kind of kothi ‘on top’ rather than ‘as top’). We urge great caution in mistaking this evolving social form as equivalent to, or stand-in for, MSM in the absence of a firm centre to the MSM category. We must not mistake the greater level of reported effort undertaken in working with ‘kothis’ (particularly by NGOs and a few key researchers) for a rigorous scientific assessment of their ostensible centrality to the constitution of MSM as a category. (See also ID55 on this issue.)

7. Conclusions

The data from India are very mixed, in quality, variety of findings, terms of measurement, and conclusions drawn. But they are also very revealing. There is no doubt as to the variety of scenarios in which men have sex with other men. There is a larger range of those opportunities and situations for men to pursue sex with men than noted for Bangladesh, with the exception of intrafamilial sexual activity of which there were no reports.

The issue of *sexual identity* does emerge in some papers from a few CBO-based reports and a few academic articles. The former by no means provides a consensus on the meaning, utility and application of the concept, with some writers noting the growing use of ‘gay’ as a term to describe same-sex desire (or at least as a self-labelling action), while others claiming traditional (and often deeper) sources of meaning, more akin to designated social ‘roles’ or a derivative thereof. The academic usage is mainly untheorised, used either in an unthinking adoption of conventional Western scientific or behavioural terms (‘homosexual’, ‘bisexual’, ‘heterosexual’), or to offer a way to capture some sense of psychological resolution to that social dilemma that same sex desire engenders. No doubt that dilemma has increased within a globalising framework for sex, and is also driven also by biomedical and psycho-social HIV/AIDS paradigms. But, these deployments mask more than they reveal when it comes to understanding the social networks and the cultural dynamics that underpin so much of the same-sex activity noted in this review.

The epidemiological data offer little certainty. Many clinical studies use opportunistic samples (those attending clinics), in which one might assume higher levels of STI/HIV infection anyway. Many 'behavioural' studies rely on self-report, rather than clinical diagnosis, and the great variety of prevalence levels in these studies cannot automatically be regarded as reliable, particularly for TGs. Yet, there is a rough clustering of figures from approximately 14% to 26% and if any of these prevalence levels are even vaguely indicative of those MSM more vulnerable to HIV infection, then these particular populations are in need of better research to assist in focusing programs of prevention and voluntary testing and counselling. (Note: there are no HIV prevalence data on MSW, possibly revealing again the poverty of that term as any distinct subset of MSM.)

The behavioural data are contradictory in a number of ways. As in Bangladesh, higher levels of AI seem to occur among those MSM populations more closely associated with or reached by CBOs. The 'kothi' dominance in Bangladesh is less clear in India, but the ongoing 'social construction' dynamic noted in that report is in evidence. The early and extended work among this population; the extent of programs focused on their needs; the discursive framing of these populations within the globalising HIV/AIDS category of MSM; the imperative to 'prove' vulnerability to obtain funds; the confusion of sexual practice with risk-taking behaviours; the particular strategies of recruitment: these all play with dangers of overemphasis and misconstrued convergence of thought about the category of MSM itself.

The evidence on varieties of MSM activity is, perhaps, even more pervasive than in Bangladesh, if empirically only suggestive rather than proved. More physical places and social space for male-to-male sex are available. Indigenous categories of MSM are multiplying, indicating more varied symbolic sources of meaning and cultural support. However, the BSS studies, in general, report much lower levels of male-to-male sex among the non-categorised MSM (particularly, for example, truck drivers) than in Bangladesh. But these are very new studies and are still only suggestive rather than definitive.

There is evidence of denser networks of MSM found particularly in the CBO-based studies. The importance of cruising sites to the structure of these networks and of the sexual practice they produce is not clear from these studies, as these tend to mask potentially different sexual economies situated in the same settings. What is also more difficult in India to assess is the inter-relatedness of sex between men, masculine sexuality itself, and the place of male erotics in any sexual and gender orders. The diversity of sexual expression between men, marriage levels, sex with female partners, exchange-based sexual practices, and the potential diversification of such practices through a range of sociodemographic descriptors (age, ethnicity, religion, sect, location, situation, occupation etc.) all confound the possibility and utility of category of MSM itself.

Appendix to the India Report

Table 1: HIV Prevalence levels by State – Round 2000

S.No	Name of State/UT	Number of sites	HIV Prevalence (%)
1.	Andhra Pradesh	STD 3 ANC 6	30.00 2.60
2.	Arunachal Pradesh	STD 2 ANC 1	0.10 0.00
3.	Assam	STD 2 ANC 2	0.61 0.00
4.	Bihar	STD 8 ANC 3	0.50 0.10
5.	Delhi	STD 3 ANC 3 IVDU 1	3.26 0.25 5.00
6.	Goa	STD 2 ANC 2 CSW 1	12.02 1.17 53.20
7.	Gujarat	STD 6 ANC 6	4.65 0.50
8.	Haryana	STD 4 ANC 3	2.75 0.00
9.	Himachal pradesh	STD 5 ANC 4	0.40 0.89
10.	Jammu & Kashmir	STD 2 ANC 3	0.40 0.12
11.	Karnataka	STD 7 ANC 6 IVDU 1	12.80 1.68 4.23
12.	Kerala	STD 3 ANC 3	5.20 0.00
13.	Madhya pradesh	STD 8 ANC 6	1.60 0.12
14.	Maharashtra	STD 7 ANC 11	18.40 1.12
	Mumbai	STD 2 ANC 5 IDU 1 MSM 1 CSW 1	33.33 2.00 23.68 23.94 58.67
15.	Manipur	IDU 3 STD 2 ANC 5	64.34 11.60 0.75

16.	Meghalaya	IVDU 1 STD 2 ANC 2	1.41 0.00 0.00
17.	Mizoram	STD 1 ANC 2 IDU 1	2.00 0.37 9.61
18.	Nagaland	IVDU 1 STD 1 ANC 4	7.03 6.90 1.35
19.	Orissa	STD 4 ANC 2	2.60 0.27
20.	Punjab	STD 2 ANC 2	0.80 0.00
21.	Rajasthan	STD 4 ANC 4	2.84 0.25
22.	Sikkim	STD 1 ANC 2	0.00 0.00
23.	Tamil Nadu	STD 3 ANC 6 IVDU-1 MSM -1	16.80 1.00 26.70 4.00
24.	Tripura	STD 1 ANC -	1.34 -
25.	Uttar Pradesh	STD 7 ANC 6	1.80 0.12
26.	West Bengal	STD 5 ANC 4 IDU 1	1.96 0.50 -
27.	A & N Islands	STD 1 ANC 3	1.20 0.25
28.	Chandigarh	STD 2 ANC 1	3.35 0.80
29.	D & N Haveli	STD - ANC 1	- 0.00
30.	Daman & Diu	STD - ANC 2	- 0.00
31.	Lakshdweep	STD - 1 ANC 2	0.00 0.00
32.	Pondicherry	STD 3 ANC 1	4.1 0.25

HIV Prevalence levels in States with 3 or more sites are median values, while in States/UTs with less than 3 sites the values are mean values. (Source: NACO, <http://www.naco.nic.in/indianscene/country.htm>)

References:

Dowsett, Gary W. (1996) Practicing Desire: Homosexual Sex in the Era of AIDS, Stanford Calif: Stanford University Press.

National AIDS Control Organisation (NACO), <http://www.naco.nic.in/indianscene/country.htm>

UNDP (2002) Human Development Report, United Nations Development Programme

UNAIDS Epidemiological Fact Sheets 2002

UNAIDS, <http://www.unaids.org/nationalresponse/result.asp>

World Health Organization (WHO) (2001) HIV/AIDS in Asia and the Pacific Region, Regional Office for South-East Asia, New Delhi, India

On SS, ID20 needs changing from 'West Bangal' to 'West Bengal' in two places.

THAILAND

1. Background

In 2001, Thailand's population reached 63.3 million, with approximately 19% of the population aged 15-24 years. Thailand is ranked 70 on the Human Development Index (HDI) and is categorised by WHO as one of the three high HIV prevalence countries in the Asia and Pacific region along with Cambodia and Myanmar (WHO, 2001).

HIV was first detected in Thailand in 1984. While the number of annual HIV infections has dramatically reduced from 143,000 in 1991 to 29,000 in 2001, the number of people infected with the virus is one in 60. AIDS is Thailand's leading cause of death, with estimates until the end of 2006 at over 50,000 dying annually from AIDS-related causes. Over 90% of these deaths will occur in the age group 20-24. Estimates from 2000 indicate that approximately 2% of men and 1% of women are living with HIV; infection levels among adult males will remain about 1.5% until the end of 2006 (UNAIDS, 2002).

Seroprevalence data available since 1985 illustrate two independent epidemics, one among injecting drug users and the other among female sex workers (FSW). There has been a change in the composition of new infections.

- **The incidence of HIV among sex workers** has fallen (surveillance data indicate that HIV prevalence peaked among female sex workers and their clients in 1995 and 1996 and has since begun to decline, for example; HIV prevalence among sex workers in the Central and Northern regions fell from 24 to 30% in 1993-1994 to 13% in 1999).
- **The incidence among military conscripts** has also come down, falling from its peak of 4% in 1993 to 1% in 1999.
- **Injecting drug users (IDU)** have not benefited from prevention campaigns. In Bangkok, 1% of IDU were HIV-positive in late 1987, increasing to 30% by the end of 1998; since then, HIV prevalence among IDUs tested has remained between 20% - 50% both inside and outside Bangkok. Half of Thailand's IDUs are infected with HIV. Although the number of IDUs is generally declining for several reasons, it remains a problem in the five southernmost provinces close to Malaysia.

There are no laws in Thailand against male-to-male sex. Both male and female sex work is illegal in Thailand. Although prostitution remains illegal in Thailand, the government began working with brothel owners in the late 1980s to enforce 100 percent condom use in all commercial sex establishments. The 100 percent brothel-based condom use policy was implemented as a pilot study in 1989 in the North, requiring condoms to be used in

all sex acts in commercial settings. Under the scheme, condoms are distributed free to brothels, and sex workers are told to insist on condom use by all clients.

Estimates at end of 2001 by WHO/UNAIDS

- 650,000 adults (1.8%) aged 15-49 were living with HIV/AIDS
- 220,000 women aged 15-49 were living with HIV/AIDS
- 21,000 children under 15 were living with HIV/AIDS
- 55,000 estimated deaths due to AIDS (UNAIDS, 2002)

National Strategic Framework

In 1985, a National Advisory Committee on AIDS was established within the Ministry of Health. In 1987, Thailand launched a National AIDS Programme, along with a Centre for Prevention and Control of AIDS. In 1992 the 100 Percent Condom Use” policy was adopted at the national level, following the enactment of the first National AIDS Policy.

From 1992 to 1996, the National AIDS Program received dramatic increases in funding. The Ministry of Public Health budget for HIV decreased following the crisis in 1997. Many of the international donors who left Thailand during the economic boom years have not returned. By 1996 the government was spending US\$80 million a year on education, prevention and care.

The World Bank (2000) identified the following as the top three priorities for the Thai Government:

- **Sustaining and expanding condom use beyond commercial sex.** Targeting condom and behaviour change programs to other high-risk groups like: indirect sex workers;
- **A major initiative to prevent transmission by injecting drug use.** Injecting drug users have not been addressed in government programs even though this type of transmission has been an important feature of the epidemic in almost all countries of the region;
- **Ensuring access for people with HIV/AIDS to cost-effective prevention and treatment of opportunistic infections.**

Sero and Behavioural Surveillance System

Thailand has a comprehensive HIV surveillance system that has mapped HIV trends in selected sentinel populations throughout the country. The HIV surveillance system was established in 1989 in 14 provinces. By 1990, the system was operational in all 76 provinces. The system includes blood donors, antenatal clinic attendees, IDU, male STI

clinic patients and FSW, both brothels (direct) and in massage parlours and other places (indirect) (WHO, 2001).

Military recruits have also been used as a source of epidemiological information, whereby anonymous testing of 60,000 21 year old men chosen each year. Thailand was one of the first countries to implement Behavioural Surveillance Surveys (BSS). The BSS were carried out between 1993 and 1996. The sub-populations included direct female sex workers (DSW), indirect female sex workers (ISW) male factory workers (MFW), female factory workers (FFW), male vocational students (MVS) and female vocational students (FVS).

Treatment for HIV

Estimated that by the end of 2002 the Ministry of Health will be supplying ARV treatment to up to 23,000 people. The Global Fund to fight AIDS, TB and Malaria has promised funding to Thailand, which is supposed to increase the provision of highly active antiretroviral therapy (HAART) from 3,000 people to 70,000 over the next five years. The Thai government (through the Ministry of Public Health) is also providing free ARV to all HIV+ pregnant women during the last month of pregnancy so as to reduce perinatal transmission. The Ministry of Health has established guidelines and plans to develop the capacities of health care providers to serve 50,000-60,000 HIV positive people who need ARVs by the end of the year 2004. Inclusion of antiretroviral treatment into the health insurance scheme is currently being considered.

2. Epidemiology

Within the available published material, information on the incidence of HIV within MSM populations in Thailand comes mainly from studies of military conscripts. In these studies, HIV incidence among MSM ranges from 4.6% to 12.3%. While the cohorts themselves are quite large, the number of MSM identified within the samples is quite small. For example, in Beyrer et al. (T1), the sample is of 2,047 men with 134 MSM identified (any lifetime same-sex partners); in Nopkesorn et al. (T29), there were 1,115 men with 126 MSM identified.

In the Beyrer et al. (1995) study (T1), conducted in northern Thailand, an HIV incidence among 20-22 year-old men (n=2047) of 12.1% is reported. The study sample consisted of two cohorts of conscripts and one of recently discharged conscripts. Lifetime history of same-sex behaviors had an odds ratio of 0.78 for HIV infection, while the HIV prevalence among MSM in the recently discharged cohort was 27.3%. The authors report that MSM with more than one lifetime same-sex partner were more likely to be HIV positive than those with only one such partner. One other important finding in this study was that of those men reporting no lifetime sexual intercourse, 4.6% (six men) were HIV positive; yet only one of these men had any other risk factor for HIV. This suggests a

systematic under-reporting of sexual behaviour, possibly more so for same-sex practices. In addition, the cohort reporting the highest incidence of same-sex practices was the recently discharged cohort (9.3%, compared with 6.5% of the remainder).

In Nelson et al.'s study of five cohorts of military conscripts from six provinces of northern Thailand (T2), HIV incidence among these men ranges from 10.4% to 12.5%. In May 1991 the HIV incidence is 10.4%; in Nov 1991–12%; May 1993–12.3%; Nov 1993–11.5%; May 1995–6.7%; and in Nov 1995–6.8%. The authors note an increase in the 1995 cohort of HIV prevalence among men reporting sex with a male partner. In a multiple logistic regression reported in this paper, the adjusted odds ratio for HIV infection for those reporting sex with a male partner rises from 1.16 in 1991 and 1.65 in 1993 to 3.27 in 1995 (when history of an STI is *not* included in the analysis). This suggests that, at least within the constraints of this study, same-sex sexual practice is playing an increasing role in HIV transmission in Thailand. Importantly, this paper also reports an increase in the proportion of men reporting same-sex partners from 2.8% in 1991 and 3.8% in 1993 to 4.8% in 1995, although the paper fails to indicate whether this was lifetime or in the previous year (data on both were collected).

In Nopkersorn et al.'s (1993) paper (T29), 10% (8/80) of men who reported only insertive AI (no receptive) with other men were HIV-positive, while none of the 46 men who reported receptive AI tested HIV-positive. In Celentano et al. (1996), 4.6% of MSM were HIV positive (T31).

HIV incidence among MSW is rarely reported. Kunawararak et al. (T6) and Beyrer et al. (T21) in studies of MSW in Chiang Mai found a HIV incidence of 16.6% (27/219) and 16.5% (17/103) respectively.

Information on other STI incidence among MSM is very scarce. Kunawararak et al. (T6) report the incidence of syphilis among MSM at 7.6% (Chiang Mai); while Beyrer et al. (T1) noted that MSM were significantly more likely to report STI than other men. In 1992, Sitattrai et al. (T26) noted 7.7% of MSM had reported an STI in preceding 12 months.

The paucity of reliable HIV incidence data in MSM populations continues to be a significant barrier to understanding the Thai epidemic. The UNAIDS synthesis document (T38) notes that 'continuing high incidences [of HIV] have been seen in one cohort of gay bar workers, but no samples of the more general population of men having sex with men are available' (p. 12). Without such data, the situation of Thai MSM vis-à-vis HIV remains at best speculative, at worst invisible.

3. Methodology

A significant limitation to any analysis of MSM in Thailand is the absence of any BSS. The material reviewed relies on a small number of studies where the stated aim is epidemiological or focused on prevention. The remainder of the material is drawn from research where the stated aims are framed within other, more tangential academic

discourses, or from research where the MSM population is not the focus, but rather a by-product, as in the conscript studies. Overall, the material reviewed can be seen to fall into five discursive categories:

1. Research by non-Thai academics (alone or in collaboration with Thai researchers) published in English language format, with a focus on sexual practices within particular sub-populations of MSM;
2. Research by non-Thai academics (alone or in collaboration with Thai researchers) published in English language format, seeking to represent or problematize cultures of male same-sex practice;
3. Research by Thai and non-Thai researchers on HIV/AIDS and sexual practice that includes MSM issues peripherally;
4. Research by Thai academics, generally published in Thai, that seek to identify the causative factors for homosexuality and gender non-normativity and propose cultural interventions to limit its development;
5. Research by Thai academics, generally published in Thai, that seeks to manage the social well-being of *kathoey* or homosexual men within a tolerance and control ethic.

The bulk of published research has been conducted on three distinct (but not mutually exclusive) populations: *kathoey*; military conscripts; and male sex workers (MSW). Each of these groupings brings its own strengths and limitations. The cumulative effect of this pattern of research, however, particularly given the position of male same-sex practice in Thailand, is to create a significant silence on what may be the bulk of same-sex behaviour in the country.

Research on kathoey

(T14, T19)

Kathoey is a gender category, historically consisting of both men and women, but in recent times applying almost exclusively to men. The current use of *kathoey* denotes men who breach biological and/or cultural norms of masculinity, and in different contexts can mean either hermaphrodite, transvestite, transsexual, or an effeminate homosexual man” (Jackson [1997] p. 53 (T12)). Importantly, the status of *kathoey* as a separate gender category allows ‘100% men’ (i.e. heterosexual men) to engage in sex with them without endangering their masculinity. *Kathoey* are understood to be the receptive partners in anal intercourse within both popular and academic discourse, although this may not reflect the reality of their sexual practice. Much of the research on *kathoey* pre-dates the HIV epidemic and operates within a project of social control and the amelioration of social disadvantage.

Research on military conscripts

(T1, 2, 20, 23, 29, 30, 31, 36, 37, 42)

Military conscripts offer a captive population of young male Thai citizens amenable to both social and bio-epidemiological research. On the surface, the apparent randomness of

these samples (conscripts are selected by lottery, and military service is compulsory) and the capacity to elicit detailed sexual histories suggest that this is an ideal sentinel population. This material must be treated cautiously on two main grounds. First, the apparent randomness of the samples is weakened by the ability of more affluent men to avoid military service. Beyrer et al. (T1) note that '[d]eferments are given for men in higher education, limiting the conscript base to a less educated sample of the general population' (p. 174). Given the suggestion in a number of papers that the practices under discussion, or the reporting of them, may be mediated by class variables, this is an important consideration. Second, the stigma or loss of face associated with receptive anal intercourse or sex with non-*kathoey* men may lead to under-reporting of both these activities, particularly within a military environment.

The methodologies used include both interviewer-administered surveys and self-completed surveys, adding to the difficulties in comparing findings.

Research on commercial sex workers

(T3, T4, T5, T6, T7, T16, T17, T18, T21, T25, T33, T35, T42, T43, T44, T45, T46, 47)

Given the nature of the Thai HIV/AIDS epidemic, and the focus of prevention work (and funding) within the commercial sex industry, it is not surprising that the bulk of empirical work on MSM behaviour has also been focused on sex work. Twelve publications in this review have MSW as their primary focus. These include examinations of the sexual practice and condom use of workers (T3, T4, T35), sexual networks and sexual geographies (T5), HIV incidence (T6, T7, T21), discourses of identity (T16, T25), social support (T17, T18), and workplace safety (T33). There were no studies with a primary focus on clients of MSW.

Theoretical work

(T8, 9, 10, 11, 12, 13, 15, 19, 24, 27, 28, 32)

A body of theoretical or conceptual work, primarily by non-Thai academics is included in this review. Largely, this work examines the relevance of Western constructs of MSM identity for Thai contexts, or examines the cultures and categorization systems of Thai MSM and their socio-sexual networks.

Other research

In addition to the major groupings described above, there are a small number of publications that have a different focus. These include four publications situated within defined (generally self-defined) gay or homosexually active communities (T16, T19, T26, T34). There are two general population studies (non-military) that make some reference to MSM (T23, T37), and one study using medical students (T22) that includes a sub-sample of MSM.

4. MSM Population

Estimates of the size of the population of MSM, or incidence of MSM sexual practice in the literature, come mainly from the studies of military conscripts. These publications use, variously, lifetime sexual experience, current sexual practice, sexual partners/sexual practice in the last twelve months, and/or sexual identity as measures of the MSM population. In Beyer et al. (T1), 6.5% of the conscripts reported one or more lifetime male sexual partners. In T2, recruits across three years (1991, 1993, 1995) reported 2.8%, 3.8%, 4.8% respectively on sex with male partners. In T20, 16.3% reported AI/OS with a male partner. In T29, 11.3% reported AI with a male partner (10% insertive, 4.1% receptive).

Borthwick in her paper on models of community development and service delivery among MSM in Northern Thailand (T19) argues that the use of the term 'gay' is problematic in the Thai context. She suggests that among 'gay-identified' men the term is used to distinguish 'masculine' homosexually active men from both *kathoey* and heterosexually identified MSM. However, she argues, the term 'gay' is used in the general population and among *kathoey* to mean any homosexually active men. One of the projects discussed in this paper, based in a village of 2000 people, includes reference to 3.0-3.5% of the population that self-define as 'gay'. The use of this terminology in a rural village, very much in opposition to other categorizations suggests that the incursion of Western discourses is far reaching.

The study of medical students (T22) elicited information on sexual behaviour and 'sexual orientation' and used the Kinsey scale to ascertain that 17.6% of the students could be classified as 'homosexuals'. It should be noted that the in-country reviewers considered this paper to be of poor quality. The study is primarily concerned with comparative analyses of 'homosexual' and 'heterosexual' students 'sexual outlets' (i.e. sexual behaviours). The findings include such revelations as 'more homosexuals males engaged in homosexual contact than heterosexual males.'

Similarly, studies of MSW sometimes classify participants by 'identity' or sexual practice outside the sex work. In T3, 82% of MSW reported only male partners in the previous year. In the clinical study of MSW (T6), 57% of MSW described themselves as 'heterosexual'. In McCamish (T17), 20% of MSW self-identified as 'gay'. In Beyrer (T21), 58% of Chiang Mai MSW reported a 'heterosexual' orientation and 34% were married.

5. Sexual practice

Estimates of the prevalence of specific sexual practices vary considerably within the literature. In part this is due to definitional inconsistencies, where in some studies the MSM sample is defined *ipso facto* by the presence of same sex partners, in others the sample is derived from identity characteristics, and in others there is no categorical

distinction made. Therefore studies may report the incidence of sexual acts among all men, among men with any same sex partners, or among men defined by some other criteria as 'homosexual'. There is, however, a consistent finding that reported rates of penetrative AI with other men are greater than reported rates of receptive AI. This may reflect a reporting bias that would be consistent with the system of values proposed by Jackson (T11).

Within the conscript studies, sexual practice is generally reported with reference only to the sex of the partners involved and is not related to identity categories. While this avoids some of the pitfalls associated with *a priori* identity-based categorization (for example failing to elicit information on same-sex behaviour among heterosexually identified men), it does not allow us to reconcile these findings with other identity-based research. An additional difficulty in these studies is the circularity of categorisational process, whereby MSM are defined as those who have any sex with other men and then examined as a *de facto* social category, something that becomes particularly problematic when these findings form the basis for educational interventions. T1 with a sample of 2,047, extracts those who have had lifetime sexual experience with men and then reports that for these 134 MSM 61.9% have had insertive AI with a male, while only 5.9% have had receptive AI with a male. T29 reports that 11.3% of all male conscripts have had AI with a male, 10.0% insertive AI and 4.1% receptive AI. Also, T20 with 512 conscripts reports 16.3% of all male conscripts have had anal or oral sex with another male. T30 is particularly informative in understanding these findings as it includes partner type: 13.6% of the 157 men had insertive AI with a *kathoe*y, while 3.2% had had insertive AI with a non-*kathoe*y and 3.3% had had receptive AI.

The study using self-defined MSM populations in North-Eastern Thailand (T3/T26), with 157 men, reports a lifetime experience of receptive AI of 74% and a lifetime experience of insertive AI of 60.6%. In the previous year, 82% reported male partners only and 12.7% male and female partners. Lifetime incidence of sex with a MSW was 70% and with a FSW 16%. Partner numbers were reported in this study, with 40% reporting 10 or more male partners in the previous year (mean=28.8, mdn=8). Interestingly, condom use was highest with sex worker partners (30.6% with MSW, 60% with FSW) compared with male 'lovers' (15%).

Within the studies of MSW, the focus tends to be on condom usage (generally with clients). In T35, with 141 MSW, 72% reported an experience of receptive or insertive AI with males. Condom use on last occasion was 47% when insertive and 37% when receptive. In addition, 8.5% had never used a condom. In T6, 42% reported inconsistent condom use with clients and 58% always used a condom with clients. In T21, with 103 MSW, 72.1% reported inconsistent condom use.

The UNAIDS synthesis document (T38) notes that 'Behavioural trends in men having sex with men are difficult to assess because there is [sic] little serial data. However, existing studies do indicate high levels of behavioural risk with low levels of protective behaviour' (p. 25). This document also highlights the multiplicative effects of the higher

numbers of lifetime sexual partners, lower levels of protective practice and higher use of sex workers among MSM.

6. Sexual networks

Several studies provide limited analysis of the structure and, to a lesser extent, fluidity of sexual networks. This evidence, as with the material discussed above, is mostly constrained to particular categories of MSM.

The material on MSW is primarily focused on two issues: the overlap between men working in different sites; and the extent to which MSW also have sex with women (including wives, girlfriends and FSW). Conceptually, these studies presuppose MSW as a distinct population of MSM, largely on the basis of identity constructs and behavioural bisexuality. The supposition is problematic given the critique of sexuality categorizations offered by Jackson (T10, T11, T12, T32), Storer (T16, T25, T27) and Murray (T15). While, arguably, *kathoey* may occupy a distinct social position and cultural role within Thai society, the relative rarity of 'gay'-identified homosexually active men (generally restricted to urban settings and particular class structures) and the construction of penetrative sex as fundamentally heterosexual, the distinction based on the transactional quality of the sexual practice may be of limited value.

McCamish et al. (T5) in their analysis of the geographies of MSW in Pattaya, Chiang Mai, and Bangkok note the overlap between 'commercial' and 'non-commercial' MSM sexual networks and the intersections these have with heterosexual networks. Elsewhere, McCamish (T17) noted the difference between MSM networks in Bangkok and Pattaya. In Bangkok, there is considerable mobility between bars with lower social bonding between workers; whereas, in Pattaya, the workers remain in the same bars for long periods with high social bonding.

In an examination of the male sex work industry in Chiang Mai, de Lind van Wijngaarden (T34) notes the distinction between bars and *ban*, (houses, or word-of-mouth brothels) and examines the flow of MSW between these and public sex-work sites such as parks. There is also considerable discussion of the way in which identity constructs intersect with the geographies of MSW.

The publications based on research with military conscripts also contain information on the extent to which MSM have sex with women and/or identify as heterosexual.

What is clearly absent in the Thai material is any substantive investigation of the social and sexual networks of MSM *per se*. Networks are the dynamic systems of social and sexual relationality that not only facilitate and/or constrain transmission of HIV, but also define the pathways of social and educational influence. While some of the theoretical material discussed may provide clues as to the structure and fluidity of the social categories employed, the lack of systematic investigation of networks prevents us from meaningfully integrating these analyses with the behavioural data from other research.

The material discussed above does suggest that the majority of MSM sexual practice does not take place within a population delimited by sexual identity. The sexual relationality of MSM is intrinsically embedded in broader social systems that include *kathoey* and women. Understanding these systems is critical if any understanding of the place of MSM within the Thai epidemic is to move forward.

7. Other Significant Findings

The issue raised by Jackson (T10, T11, T12) of the nomenclature of same-sex male sexual practice is critical in interpreting these publications. The distinction between academic constructs of MSM (particularly in Thai language material) and popular usage, and the shifts in meaning over the past 40 years, suggest that particular caution should be exercised in any summative or comparative analysis of this material.

Additionally, taking together the construction of penetrative AI (at least with a *kathoey* as fundamentally ‘heterosexual’), the loss of face associated with receptive AI, and some evidence that non-penetrative sexual practice is not classified as sex *per se*, there may well be a systematic under-reporting of constellations of same-sex sexual practice that is not considered same-sex or even sex.

The absences in the available data also sound a note of caution. Information on the clients of MSW would play a significant role in fleshing out this analysis, as would more general population data (other than conscript-based studies). As noted, there is little information on STI incidence or prevalence among MSM, which makes the assessment of the veracity HIV incidence estimates difficult.

8. Conclusions

Overall, there is a paucity of reliable and generalisable data on the current incidence of HIV in MSM in Thailand. The data that are available suggest that, at least for certain populations of Thai men who regularly or occasionally have sex with other men, either in the context of sex work, affectional or opportunistic relationships, there may be a higher incidence of HIV infection than in the remainder of the population. It may seem axiomatically banal to suggest that more research needs to be done in this area, but is nonetheless the most compelling conclusion to be drawn from this review. There is a danger of yielding to the seductiveness of the conscript studies, given that on the surface they appear to offer a random sample of Thai men, interviewed in controlled circumstances. The danger is made apparent when one examines the literature that problematizes the place of same sex activity in Thai cultures. Sensitivity to the multiplicity of meanings associated with same-sex practices and sexual relations with transgendered individuals, and to the stigmatization of such practices leads us to treat

many of these findings with considerable caution. In addition, the geographical and population specificity of much of the research points more to the gaps in our understanding of the position of MSM in Thailand than to our comprehension of it.

Another caution that must be highlighted is the temptation to make trans-Asian generalizations about the characterization of transgendered communities. What should be clear when these reports are read in consort is that discursive position of the transgendered is not unitary or stable within countries, let alone between them.

We can say little about the patterning of sexual relations in Thailand with any certainty. Were analyses available, even at the level of the detail found in the Indian and Bangladeshi material, of the systems of relationality and sexual networks that include male-to-male sex, we might be able to situate the cross-sectional findings within meaningful contexts. As it is, we are constrained by the categories created by research effort and the funding of interventions. While Thailand has, as a whole, been the subject of intense academic and health organizational gaze, and the site of intensive interventional effort throughout the history of the HIV/AIDS epidemic, MSM as a 'group' and MSM sexual practice has been intensively marginalized. The recency of much of the research effort that includes, even peripherally, MSM speaks strongly of this phenomenon, and offers some hope for the future.

References

UNDP (2001) Human Development Report

UNAIDS Epidemiological Fact Sheets 2002

UNAIDS, <http://www.unaids.org/nationalresponse/result.asp>

The World Bank, 2000, Press Release, Strategic Priorities Essential to Confronting the Changing Face of AIDS in Thailand, Bangkok, November 3, 2000, News Release No. 2000/1103/EAP

World Health Organisation (WHO) (2001) HIV/AIDS in Asia and the Pacific Region, Regional Office for South-East Asia, New Delhi, India

INDONESIA

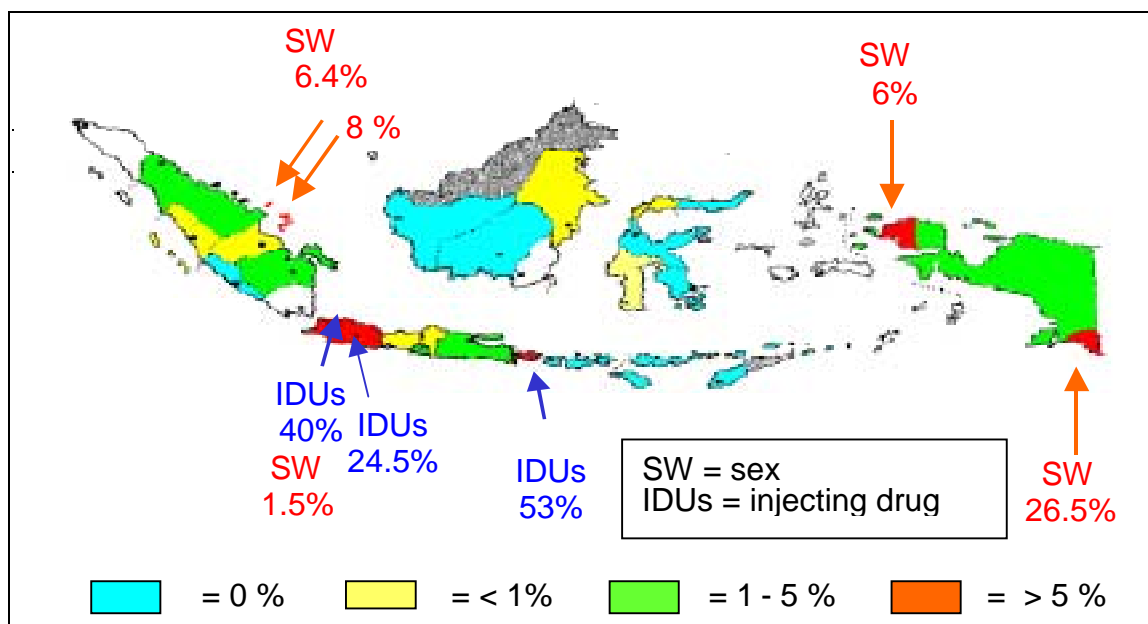
1. Background

The population of Indonesia was estimated to be 228 million in 2001, with approximately 19.8% of the population between 15-24 years. Indonesia ranks 110 on the Human Development Index and is classified as a low prevalence country, with a concentrated HIV epidemic primarily among its injecting drug user (IDU) population.

HIV was first detected in Indonesia in 1987. After more than a decade of negligible HIV prevalence rates, Indonesia is now experiencing infection rates increasing rapidly among injecting drug users and sex workers. The economic, political and social upheaval of recent years has provided an opportunity for HIV to spread rapidly. The most recent MAP Report (2001) states that Indonesia is now experiencing an explosive epidemic.

The most notable increases in HIV infection level are in Jakarta at 18% in 2000 for female sex workers and 47% for intravenous drug users in 2002. There has also been an exponential rise in infection among blood donors with a 10-fold rise in HIV prevalence from 1998 to 2000 (MAP, 2001, 8). According to the Government of Indonesia, cumulative HIV/AIDS cases jumped 60% from 2000 to 2001. Compounding the problem of HIV is the fact that Indonesia has the third highest tuberculosis burden in the world, with an estimated 500,000 new cases and 175,000 deaths per year (Synergy Project, 2001).

Map 1 below shows provinces with high rates of infection recorded in sex workers and injecting drug users for 2000-2001. The occurrence of drug injecting was little known until recently. HIV infection among injectors were not measured until 1999/2000, when it had already reached 15%. A year later, 40% of injectors in treatment in Jakarta were already infected. In Bogor, a West Java province, one quarter of injectors tested were HIV-infected, while among drug users tested in prison in Bali prevalence was 53%. (MAP, 2001, 3)



(Source: MAP 2001, 9)

Indonesia has tested sex workers anonymously for HIV infection since 1988, expanding from two cities to cover 15 provinces. Very few female sex workers tested positive for HIV. By 1999 several HIV sentinel surveillance sites for FSW began to detect increasing numbers of HIV infections, and prevalence rates from 1-5% were found in several areas. For example, infection rates of 26.5% were recorded among female sex workers in Merauke, Irian Jaya.

There are no laws against sodomy or homosexuality. There is currently no law that categorically prohibits commercial sex work.

Estimates for end of 2001 by WHO/UNAIDS

- 120,000 adults (0.1%) aged 15-49 were living with HIV/AIDS
- 27,000 women aged 15-49 were living with HIV/AIDS
- 1,300 children under 15 were living with HIV/AIDS [UNAIDS, 2002]

National Strategic Framework

In 1987, the Government of Indonesia established a National AIDS Control Commission (NACC) and began HIV surveillance activities. In 1994 a Presidential Decree No. 36 established an International AIDS Prevention and Control Commission under the direction of the Coordinating Minister for People's Welfare.

Since 1996 the government of Indonesia has collaborated with Family Health International (FHI), USAID, and non-governmental organizations in seaport cities of

Indonesia (notably, North Jakarta, Surabaya, and Manado) to implement the HIV/AIDS Prevention Project (HAPP).

Challenges identified by FHI:

- Inadequacy of appropriate testing and treatment commodities
- Legal curbs to effective harm reduction interventions
- Urgency to initiate and scale up efforts in many different sites amid the challenges of instability and violence.

Sero and Behavioural Surveillance System

The Indonesian BSS have been carried out since 1996, with follow-ups in 1997, 1998, 1999, 2000 and 2002. The population bases are as follows: location-based sex workers (LSW) non location-based sex workers (NLSW) sailors and seaport labourers (S/SL) truckers (TD/A) male factory workers (MFW) male students and female students. North Jakarta, Surabaya, and Manado, were selected as the sites for the BSS due to each of the sites having cosmopolitan and urban characteristics, major ports and active sex industries. North Jakarta, Surabaya, and Manado were selected as the sites for the BSS. Besides being major entry ports for the country, these three cities have cosmopolitan and urban characteristics, with active sex industries.

Treatment for HIV

February 2003, Indonesia signed a deal to buy low cost generic antiretroviral drugs over the next three years from Thailand.

2. Epidemiology

Overall, there is a paucity of information on men who have sex with men (MSM) in Indonesia in comparison with the other countries included in this review. There are three main groups of empirical researchers who account for the bulk of published material (Lentara Sahabat Remaja; Ford, Wirrawan et al.; and Utomo, Dharmaputra et al.), and two cultural theorists (Oetomo and Boellstroff), with the remainder of the material reviewed being one-off publications and undergraduate or postgraduate dissertations.

In addition, the empirical work by two of these groups concentrates on a particular population group within a particular geographical setting. The work by the organization Lentara Sahabat Remaja (IS17, IS18 & IS20) is based in Yogyakarta with gay-identified men and *waria* (transvestites). The material from Ford, Wirrawan et al. (IS26, IS27 & IS28) is based in Kuta, Bali, and is concerned with commercial sex workers and their clients. The behavioural surveillance surveys (BSS) from Utomo, Dharmaputra et al. (IS40, IS41 & IS43) cover a range of localities and probably provide the most comprehensive, although limited, data.

The terms used to define subpopulations of MSM in Indonesia vary considerably between the papers reviewed. In part this is because usage is localized, occupies different public and private domains, and is structured by class. The term 'transvestite' is used in several studies as catchall for a range of groups with a transgender identity. This is a not unreasonable response to the different local meanings of terms like *waria*, *banci* and *wadam*. In this report the term 'transvestite' will be used when the authors have not specified the social category. The remainder of the publications that include reference to transgendered groups refer to *waria*, the most broadly understood term in Indonesia, and for these we will use that term. The choice of terminology reflects a set of underlying assumptions. The term 'transvestite' is effectively a behavioural category, while the more locally understood *waria* is a gender identity. The former is therefore a male engaging in certain gender practices, while the latter is within a gender category that is distinctly not male. An important consequence of this is that men who have sex with a *waria* are not having sex with a man, and would therefore not consider themselves MSM. The terminology for non-transvestite MSM is similarly complex and contextual. Oetomo (IS25) suggests that the discursive power of the HIV/AIDS epidemic has increased the use of the term 'gay' and of variants of 'homosexual'; including 'homosekss,' 'homoseksual,' 'homoseksualitas' and the increasingly common 'homo' (not pejorative). Both Oetomo (IS24 & IS25⁹) and Boellstroff (IS21, IS22) argue that 'gay' is a term that

⁹ Oetomo has also written about the 'warok/gemblak' relationships in Ponorogo, Java, in publications not included in this review (mainly in electronic format or in community publications; see for example www.she.murdoch.edu.au/intersections/issue2/Oetomo.html). This is a locally specific and historically longstanding system of relationships between 'older men called *warok* who, instead of having sex with their wives, have sex with younger boys - eight to fourteen, fifteen ... They don't call themselves homosexuals; they don't identify themselves as homosexuals, such as one finds in the West or in modern Indonesia. They would call themselves *warok-gemblakan*. It is a tradition of prowess, and of performing arts. This is where Reyog Ponorogo comes in. ... The older performers in the Reyog Ponorogo dance are usually the *waroks* and traditionally the younger boys, the hobby horse dancers - nowadays some of them

is primarily used in privileged ‘Westernized’ contexts and within academico-political discourses. We will, for preference, use the term MSM in this document, but will note the use of ‘gay’ by specific publications where the use of this term denotes such a specific group.

There are no data available in the material, reports and studies reviewed on HIV prevalence or incidence rates among MSM. One report from the Indonesian National AIDS commission in 2001 (IS39) gives HIV prevalence rates among *waria* as 3.1% in 1996 and 6.0% in 1997, and refers to a study of 300 *waria* in 1999 with approximately half testing positive for syphilis and 27% having some other sexually transmissible infection (STI). And that is all we know of HIV.

The material from Lentara Sahabat Remaja, an NGO that conducts outreach, is based on small samples, but contains considerable detail on sexual practices and STIs. The surveys conducted by this organization were part of an AIDS awareness program. In IS17 with 64 participants (gay men), 17% reported having visited a doctor for an STI, and 6% had been diagnosed with an STI (5% with gonorrhoea, 1% uncertain). Similarly, in IS18 with a sample of 43 transvestites, 30% had visited a doctor, and 21% were diagnosed with an STI (2% gonorrhoea, and the remainder uncertain). [Note: in-country reviewers gave a low quality rating to this material.]

The publications from Ford, Wirrawan et al. (e.g. IS28) detail the HIV/STI knowledge, behaviours and condom use of male sex workers (MSW) and their clients in the Kuta area of Bali. In IS28 (1993) with 20 MSW and 19 tourist clients, they report that 50% of MSW reported ‘ever’ having an STI, and of these, 90% had had an STI two or more times. Similarly, of the clients, 44% had ever had an STI and 21% had seen a doctor for an STI in the last 12 months. In IS26 (1995) with 80 MSW and 100 clients, the only STI information reported was that some of the MSW ‘reported STD symptoms or experience with STD’ since they had started sex work.

The BSS (Utomo, Dharmaputra et al.) provide information from a number of sites on STI treatment seeking and self-treatment. The table below summarizes the findings from IS41 and IS43.

Table IS1: STI treatment seeking and self-treatment

IS#	Population	Site	STI treatment seeking		STI self-treatment	
			1998	2000	1998	2000
IS41	Men (N=2101)	Bali	92%	50%	25%	50%
		Makassar	33%	25%	53%	83%
IS43	‘Homosexuals’ (N=170)	Bali, Kupand & Ujung Pandang	50%			
	‘Transvestites’ (N=180)	Bali, Kupand & Ujung Pandang	28%			

are women - are the *gemblakan*’ (from website above). Yuwana (IS10) reports on the sexual practices in these relationships, which consist exclusively of thigh sex and masturbation.

In addition, the 2000 BSS on transvestites (IS40) reports that only 1% of ‘transvestites’ in Jakarta reported having an STI in the previous 12 months.

3. Methodology

The bulk of the studies included in this review have small sample sizes, use convenience samples, lack a structured and informed sampling frame, and are geographically constrained. These problems are exacerbated when two of the three major contributors to the empirical data have both population and geographic foci—that is, we do not have comparable data on MSW outside the Kuta area, nor do we have the detailed (if possibly flawed) material on homosexually identified men outside Yogyakarta. The operationalization of social categories such as ‘transvestite/waria’, ‘MSM’ and ‘gay men’ is inconsistent across studies and often pays little heed to the, admittedly limited, conceptual work in this area. The poor quality of much of the material in terms of methodological clarity, inclusion of time frames for sexual practices, and meaningful denomination of findings adds considerably to the difficulties of interpreting these data.

4. Sexual practice

As noted, the studies from Lentara Sahabat Remaja (IS17 & IS18, but see also IS20 which is the program evaluation) report considerable detail on sexual practice. However, the in-country reviewers have expressed caution regarding the quality of this research, and have noted the limited information available about the research process. Even so, the data provided does raise some interesting questions around the different patterns of sexual practice among homosexually identified men and transvestites. These data on *waria*/transvestites also differ from that in the other countries reviewed, and are consistent with the discussions provided by Otemo and Boellstroff, which suggests that *waria* are often the penetrative partners in anal sex with both paying and non-paying partners. The table below summarizes the two studies from this organization.

Table IS2: percentage of participants reporting specific sexual practices

Sexual practice	IS17: MSM N=64	IS18: ‘Transvestites’ N=43
Receptive anal: no condom	30	93
Receptive anal: condom	41	86
Insertive anal: no condom	30	72
Insertive anal: condom	47	42
Receptive oral: no condom	60	79
Receptive oral: condom	30	37
Insertive oral: no condom	70	86
Insertive oral: condom	30	47
Genital rubbing	78	58

Receptive thigh sex	64	81
Insertive thigh sex	55	65
Masturbating partner	52	93
Being masturbated	55	42
Mutual masturbation	31	31
Chest sex (receptive) ¹⁰	-	14
Kissing	85	100

The studies of MSW and their clients conducted by Ford, Wirrawan et al. (IS26, IS27 & IS28) offer some insight into the contextual patterns of sexual practice. These studies are based in the Kuta area of Bali. The data collection among clients was restricted to tourist clients, although MSW report a broad range of clients. For example in IS28, 100% of the MSW reported having clients who were Japanese, 90% clients who were Indonesian tourists and 80% who were Indonesian businessmen. The table below gives the findings from IS26 where the most detail is reported. The other publications (IS27 & IS28) offer similar findings.

Table IS3: IS26—Percentage of MSW and tourist clients with paying/paid and non-paid partners (80 male MSW and 100 male tourist clients) engaging in various sexual practices in previous week

Sexual practice	MSW with clients	MSW with non-clients	Clients with MSW	Clients with non MSW
Anal receptive	47	33	44	5
Anal insertive	41	19	33	6
Oral receptive	61	26	77	15
Oral insertive	57	29	77	12

These differing patterns of sexual activity with clients and non-clients are also evident in the data on condom use. For example in IS26, condom use for anal sex with clients was given as 48% for receptive AI and 55% for insertive AI, while with non-paying partners it was 19% for receptive AI and 33% for insertive AI. These studies also include some information on the decision-making processes, or rationalizations, on condom use. Interestingly, in IS28, 24% of MSW asked all clients to use condoms, while 24% asked only clients they did not know or who 'looked suspicious' to use condoms, and 35% asked all foreign clients to use them. Clearly, there are systems of risk assessment in play that guide sexual practice.

The BSS (IS40, IS41, IS42, IS43 & IS49) give limited data on sexual practice among MSM, concentrating on condom use. The BSS use the term 'gays,' 'homosexuals' and 'MSM' interchangeably. This appears to be a behavioural definition with respondents reporting no same sex activity classified as 'adult males' and the remainder as MSM. This is particularly evident in the findings reported on most recent sexual event, where

¹⁰ Rubbing of the penis against the partner's chest/breasts

‘57% of the respondents reported their last sex with their current boyfriend. About 32% reported their last sex with a heterosexual ‘boyfriend’. A few reported their last sex with their wife, girlfriend or CSW’ (IS44, p25). The 2000 BSS on transvestites in Jakarta (IS40) includes information on the number of clients provided with anal sex in the day before survey (2 on average) and reports that 60% of paying clients in the week before the survey used a condom. Supporting the material discussed above, 24% reported using a condom with non-paying partners in the week before the survey.

The summary document of the 1998 and 2000 BSS (IS44) details the sexual behaviour and condom use of ‘transvestites’ and MSM. The authors note that there ‘seems to be increased cases of unsuccessful condom use’ among ‘transvestites’, with about half reporting some condom failure. Initiation of condom use among MSM, the report notes, ‘is still one-sided, either [by] the respondent (44%) or the partner (54%), and occasionally as a common decision (18%)’ (p. 25).

In the other material reviewed, findings on sexual practice and condom use were generally scarce. In an undergraduate research project (IS3) Adhi reports that, of the 37 ‘gay-identified’ men interviewed, 20% had anal sex, 20% oral sex, 16% interfemoral or thigh sex, 8% rimming, and 36% a combination of these. In a 1994 unpublished MA thesis, Yuwana (IS10) reports on the sexual practices of seven *gemblak* participants noting that they only engage in interfemoral/thigh sex or masturbation.

5. Sexual networks

The critical issues for sexual networks that are evident from the limited material available seem to be similar to those discussed in the other country reports. We note here the fluidity of sexual networks, the importance of marriage and family, and the social expectations of (particularly young) men’s engagement with sex workers, particularly *warias*. The extent to which MSM also have sex with women is evident in a number of documents. As mentioned above, the BSS include information on last sexual partner. The Lentara Sahabat Remaja material (IS17 & IS18) reports that 44% of participants had had sex with women (32% with one woman, 32% with two, 36% with more than two). The Ford et al. studies with MSW report comparable rates of sex with women: in IS26 4% had had sex with a woman in the last week, in IS28 59% had ever had sex with a woman..

When one considers *waria* as a gender category, rather than a category of MSM, the patterns of sexual mixing become more informative. One configuration of sexual relationships in Indonesia that is critical to note is the patterning of transactional sexual relationships. There is some evidence that ‘gay men’ (*homos* in this case) are paying for sex with *laki-laki asli* (real men), and the *laki-laki asli* are paying for sex with *waria* (IS24, IS25). When one considers the available data on the sexual practices of *waria* with clients (i.e. *waria* will often be the penetrative partner in anal sex) and *homos* with MSW, the usual notions of bridging populations do not apply. There are clearly complex systems of sexual patterning here that do not operate within Western sexuality/gender configurations.

There is very limited information on the geography of sexual networks, with few papers citing *cruising sites* with no further elaboration. IS24 lists ‘publicly known gay hang-outs’ as parks, street beats, shopping malls, hotel lobbies, amusement parks, swimming pools and gyms. The draft report for the Male Sexual Health Project (IS45), interestingly, describes sites in Jakarta as dual purpose, i.e. where MSM can find partners for ‘commercial’ and ‘non-commercial’ sex. These include salons, massage parlors, brothels, pubs, parks, streets and discothèques. More detail is available on the geography of MSW in Blowfield’s ethnography of MSW in Surabaya (IS31). The most notable aspect of this paper is the diversity of the sites, suggesting micro-geographies of sex work, even within the one city. These sites range from organized brothels to salons, ‘fashion houses,’ streets and word of mouth. Beazley (IS29) presents an ethnography of street children in Yogyakarta with particular reference to sexual networks (both paid and unpaid). This paper, again, points up the complexities of sexual mixing, and the importance of local gender categories. The boys in the study have sex with peers, acquaintances, *banci*, *renden* (street girls), girlfriends, adult men, tourists and sex workers (male and female). The boys are both paying for and being paid for sex, and will often visit a sex worker or *banci* with friends to split the cost. The sexual practices with men, boys and *banci* are not necessarily regarded as ‘homosexual’ sex as much depends on the motivation and relationship.

6. Conclusions

The contribution of MSM activity to the Indonesian HIV/AIDS epidemic is very hard to judge on the available evidence. With no HIV incidence or prevalence data available on MSM other than one *waria* group, and only sketchy STI data available, there is no way of even seeing the beginnings of a pattern to the epidemic related to MSM activity yet. To extrapolate on the available data would be foolhardy. The few studies done so far offer some ideas on MSM sexual cultures operating within several culturally and locally specific, fluid, and, importantly, permeable contexts. What is clear from the material reviewed, is that MSM in Indonesia do not sit as a culture *apart*, but a culture intrinsically embedded in Indonesian social and sexual life. Indonesia is a vast country of many distinct populations and cultures, and this makes any characterization of *an* Indonesian MSM population impossible. Indeed, the ways in which MSM activity is characterized in public and private forums, by class and by location, makes this an impossible task. The anthropological evidence on the great diversity of male-to-male sexual cultures among Melanesians alone (including West Papua) prohibits any premature foreclosure of a singular MSM category or even related MSM categories.

Condom use levels at this point merely indicate some effect of specific and localised interventions. The co-location of research and intervention presents its own conundrum. Given the gaps in the research, particularly geographically, it is unclear whether the research followed by funding and intervention creates a cycle of evidence where the discursive power of the HIV/AIDS epidemic both masks and creates understandings of MSM cultures. The specificity of available data is of little help in estimating patterns of condom uptake or regularity of use for male-to-male sex for Indonesia as a whole.

The structure of the research initiative within Indonesia so far has created three ‘cultures’ of MSM: (1) male sex workers (but the evidence is scant); (2) transvestites of various kinds (but these findings are geographically very specific and may need considerable work before any generalisations to the whole archipelago can be asserted with confidence (as can be done for the Hijra category in India and Bangladesh); and (3) various clusters of men who seek male sexual partners, sometimes loosely called ‘gay men’, sometimes as clients—local and foreign—of MSW (with no categorisation possible—not even as inserters in AI) and/or of *waria*, and the ‘real men’ partners of *homos* and *waria*. None of this can be regarded as definitive of MSM activity in Indonesia on the available evidence. An obvious, yet important, problem with this categorization is that the categories are by no means mutually exclusive, nor are they stable over time. ‘Transvestites’ are sometimes sex workers, MSW are also clients of sex workers and ‘transvestites.’ Although there is as yet little empirical evidence, one can assume that, across a lifetime, an individual may shift between these categories. While there is a clear and present need for an expansion of the research effort in Indonesia in order to situate MSM meaningfully within the HIV/AIDS epidemic, a simple expansion of the current model may only serve to reinforce the cycle of evidence.

References

MAP Report, (2001) The Status and Trends of HIV/AIDS/STI epidemics in Asia and the Pacific, Melbourne, Australia

Synergy Project (2001) HIV/AIDS in Indonesia and USAID Involvement
http://www.synergyaids.com/documents/3303_Indonesia_brief_rev1_accessible.pdf

UNAIDS Epidemiological Fact Sheets 2002

UNAIDS, <http://www.unaids.org/nationalresponse/result.asp>

World Health Organisation (WHO) (2001) HIV/AIDS in Asia and the Pacific Region, Regional Office for South-East Asia, New Delhi, India

Acronyms used in the report

Bangladesh Report

STD	Sexually transmitted disease
IOM	International Organisation for Migration
HPSP	Health and Population Sector Project
NGOs	Non-Government Organisations
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
GOB	Government of Bangladesh
WB	World Bank
DfID	Department for International Development (UK)
FHI	Family Health International
IDU	Injecting drug users
MSM	Men who have sex with men
BSS	Behavioural Surveillance Surveys
FSW	Female sex workers
MSW	Male sex worker
STI	Sexually transmitted illnesses

Bangladesh Annotated Bibliography

BSS	Behavioural Surveillance Surveys
STD	Sexually transmitted disease
MSM	Men who have sex with men
NGOs	Non-Government Organisations
MSW	Male sex workers
CSW	Commercial sex worker
BSWS p.16	Bandu Social Welfare Society
STI	Sexually transmitted illnesses
JSI	John Snow International
IDUs	Injecting drug users
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
RRC	Research Review Committee
ERC	Ethical Review Committee
ODPUP	Organization of Development Program for Underprivileged
FSWs	Female sex workers
FHI	Family Health International

India Report

IDU	Injecting Drug User
TB	Tuberculosis
NACO	National AIDS Control Organization
NACP-I	National AIDS Control Project Phase I
NACP-II	National AIDS Control Project Phase II
STI	Sexually Transmitted Infection
ANC	Anti Natal Clinic
APAC	AIDS prevention Control Project
VHS	Voluntary Health Services
USAID	United States Agency for International Development
DfID	UK Department for International Development
ARV	Antiretroviral therapies
TRIPS	World Trade Organisation's agreement on Trade Related Aspects of Intellectual Property Rights
TG	Transgender
MSM	Men who have sex with men
VDRL	Syphilis
CBO's	Community Based Organisations
CAPACS	Chennai Corporation AIDS Prevention and Control Society
MSW	Male sex workers
FSW	Female sex workers
CBO/NGO	Community Based Organisation/Non-Government Organisation
AI	Anal intercourse
OS	Oral sex
NP	Non-penetrative sex
NA/NR	Not applicable/ No response

India Annotated Bibliography

STD	Sexually transmitted diseases
MSM	Men who have sex with men
BOSCO	Bangalore Oniyavara Seva Coota
STI	Sexually transmitted illnesses
MCSW	Male commercial sex workers
FCSW	Female commercial sex workers
IDU	Injecting drug users
CSW	Commercial sex workers
VDRL	Syphilis
ICWO	Indian Community Welfare Organisation
MCC	Madras Christian College
APAC	AIDS Prevention and Control Project

BSS	Behavioural Surveillance Surveys
MYS	Male youth living in slums
VHS	Voluntary health services
TH	Trucker and helpers
MFW	Male factory workers
IDU	Injecting drug users
FGDs	Focus group discussions
KABP	Knowledge, Attitude, Behavioural and Practices see KAPB
CAPACS	Chennai Corporation AIDS Prevention and Control Society
HMT	Hand moving technology
FSWs-bb	Brothel based female sex workers
FSWs-nbb	Non-brothel based female sex workers
LTW	Local transport workers
YOUTH	Single male slum youth
LGBT	Lesbian, gay men, bisexuals and transgendered people
SIAAD	South Indian AIDS Program
PUCL-K	People's Union for Civil Liberties- Karnata
IEC	Information, Education and Communication
MSMW	Men who have sex with men and women
SWAM	Social Welfare Association for Men
TG	Male-female transgender
TPHA	Syphilis
HBsAg	Hepatitis B
HSV2	genital herpes simplex virus type 2
CT	Chlamydia
HCV	Hepatitis C virus
KAPB	Knowledge, Attitude, Practice and Behaviour
MSMF	Men who have sex with men and females
IMRB	Indian Market Research Bureau
PREPARE	Indian rural reconstruction disaster response service
VOICE	Voluntary organisation indulged in community enlightenment
AMIS	Research Asian Information, Marketing and Social Research LTD
TNS Mode	Taylor Nelson Sofres Mode
FSW	Female sex workers
MC	Male clients of FSW
MMW	Male migrant workers
MM	Male miners
FW	Women in the fishing industry
MDIW	Male diamond industry workers
MSD	Male slum dwellers
FSD	Working female slum dwellers

MUS	Male university students
MC	Male clients of FSW
MMW	Male migrant workers
MM	Male miners
MPW	Male plantation workers
MARD	Male auto-rickshaw drivers

Thailand Report

HDI	Human Development Index
FSW	Female sex workers
IDU	Injecting drug users
BBS	Behavioural Surveillance Reports
DSW	Female direct sex workers
ISW	Indirect female sex workers
FFW	Female factory workers
MVS	Male vocational students
FVS	Female vocational students
ARV	Antiretroviral therapies
TB	Tuberculosis
HAART	Highly active anti retroviral therapies
MSM	Men who have sex with men
STI	Sexually transmitted infections
AI	Anal intercourse
MSW	Male sex workers

Thailand Annotated Bibliography

STD	Sexually Transmitted Diseases
MSM	Men who have sex with men
CSW	Commercial sex workers
MSW	Male sex workers
FSW	Female sex workers
IVDUs	Intravenous drug users
JAMA	Journal of American Medicine
ICAAP	International Congress on AIDS in the Asia and the Pacific
HCV	Hepatitis C virus
HBV	Hepatitis B virus
CDC	Centers for Disease Control

Indonesia Report

IDU	Injecting drug users
FSW	Female sex workers
FHI	Family health international
HAPP	HIV/AIDS Prevention Project
BBS	Behavioural Surveillance Surveys
LSWs	Location-based sex workers
NLSWS	Non-location-based sex workers
S/SLS	Sailors and seaport labourers
TD/As	Truckers
MFWs	Male factory workers
MSM	Men who have sex with men
STI	Sexually transmitted diseases
STD	Sexually transmitted disease
AI	Anal intercourse

Indonesia Annotated Bibliography

IGAMA	Melang branch, Indonesian Gay Association
STD	Sexually transmitted diseases
ASA	Aski Stop AIDS
HAPP	HIV/AIDS Prevention Project
CSW	Commercial sex workers
FCSW	Female commercial sex workers
MCSW	Male commercial sex workers
ASAP	AIDS Society of Asia and the Pacific
FHI	Family Health International
BSS	Behavioural Surveillance Survey
KAPB	Knowledge, Attitude, Practice and Behaviour
ICAAP	International Congress on AIDS in the Asia and the Pacific