

A REVIEW OF KNOWLEDGE ABOUT THE SEXUAL NETWORKS AND BEHAVIOURS OF MEN WHO HAVE SEX WITH MEN IN ASIA

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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 carry 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;
- Stigmatisation or criminalisation 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 stigmatised 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 create an Annotated Bibliography.
- Produce a report summarising the key findings of the literature, with a detailed analysis of documented sexual practice and sexual networks. Highlight gaps in knowledge.

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

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

- 5th and 6th International Congresses of AIDS in Asia and the Pacific (ICAAP).
- 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, SAATHI, Solidarity and Action Against The HIV Infection in India, Chennai, India. Dr Chakrapani was the in-country consultant, SAATHI. 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, SAATHI, 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); Tamil 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 Mada, 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 for 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 (on CD-ROM)

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).

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

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.

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.

Throughout the country reports, whenever referencing details are limited or ambiguous, a code is provided in brackets. This code (e.g. [IS3]) corresponds to the associated reference entry in the References section and to the entry for that item in the Annotated Bibliography.

These codes also allow for easy cross-referencing between the country reports, References section and Annotated Bibliography. Codes for Bangladesh begin with 'B' (e.g. [B12]), for India with 'ID' (e.g. [ID104]), for Thailand with 'T' (e.g. [T17]), and for Indonesia with 'IS' (e.g. [IS3]).

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 stratus 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 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 the 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 a 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. 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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ACRONYMS

AI	Anal intercourse	IMRB	Indian Market Research Bureau
AMIS	Research Asian Information, Marketing and Social Research, Ltd.	IOM	International Organisation for Migration
ANC	Anti Natal Clinic	ISW	Indirect female sex worker(s)
APAC	AIDS Prevention and Control Project	IVDU	Intravenous drug user(s)
ARV	Antiretroviral therapies	JAMA	<i>Journal of American Medicine</i>
ASA	Aski Stop AIDS	JSI	John Snow International
ASAP	AIDS Society of Asia and the Pacific	KABP	Knowledge, Attitude, Behavioural and Practices
BOSCO	Bangalore Oniyavara Seva Coota	KAPB	Knowledge, Attitude, Practice and Behaviour
BSS	Behavioural Surveillance Survey	LGBT	Lesbians, gay men, bisexuals and transgendered people
BSWS	Bandu Social Welfare Society	LSW	Location-based sex worker(s)
CAPACS	Chennai Corporation AIDS Prevention and Control Society	LTW	Local transport workers
CBO/NGO	Community Based Organisation/Non-Government Organisation	MARD	Male auto-rickshaw driver(s)
CDC	Centers for Disease Control	MC	Male client(s) of FSW
CSW	Commercial sex worker(s)	MCC	Madras Christian College
CT	Chlamydia	MCSW	Male commercial sex worker(s)
DfID	UK Department for International Development	MDIW	Male diamond industry worker(s)
DSW	Female direct sex worker(s)	MFW	Male factory worker(s)
ERC	Ethical Review Committee	MM	Male miner(s)
FCSW	Female commercial sex worker(s)	MMW	Male migrant worker(s)
FFW	Female factory worker(s)	MPW	Male plantation worker(s)
FGD	Focus group discussion	MSD	Male slum dweller(s)
FHI	Family Health International	MSM	Men who have sex with men
FSD	Working female slum dweller(s)	MSMF	Men who have sex with men and females
FSW	Female sex worker(s)	MSMW	Men who have sex with men and women
FSW-bb	Brothel-based female sex worker(s)	MSW	Male sex worker(s)
FSW-nbb	Non brothel-based female sex worker(s)	MUS	Male university student(s)
FVS	Female vocational student(s)	MVS	Male vocational student(s)
FW	Women in the fishing industry	MYS	Male youth living in slums
GOB	Government of Bangladesh	NA/NR	Not applicable/No response
HAART	Highly active anti-retroviral therapies	NACO	National AIDS Control Organization
HAPP	HIV/AIDS Prevention Project	NACP I	National AIDS Control Project Phase I
HBsAg	Hepatitis B	NACP II	National AIDS Control Project Phase II
HBV	Hepatitis B virus	NGO	Non-Government Organisation
HCV	Hepatitis C virus	NLSW	Non-location-based sex worker(s)
HDI	Human Development Index	NP	Non-penetrative sex
HMT	Hand moving technology	ODPU	Organization of Development Program for the Underprivileged
HPSP	Health and Population Sector Project	OS	Oral sex
HSV2	Genital herpes simplex virus type 2	PREPARE	Indian rural reconstruction disaster response service
ICAAP	International Congress on AIDS in the Asia and the Pacific	PUCL-K	People's Union for Civil Liberties – Karnata
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh	RRC	Research Review Committee
ICWO	Indian Community Welfare Organisation	S/SLS	Sailors and seaport labourers
IDU	Injecting drug user(s)	SIAAD	South Indian AIDS Program
IEC	Information, Education and Communication	STD	Sexually transmitted disease
IGAMA	Melang branch, Indonesian Gay Association	STI	Sexually transmitted infection/illness
		SWAM	Social Welfare Association for Men

TB	Tuberculosis
TD/A	Truck drivers and their assistants
TG	Male-female transgender
TH	Truck drivers and their helpers
TNS Mode	Taylor Nelson Sofres Mode
TPHA	Syphilis
TRIPS	World Trade Organisation's Agreement on Trade Related Aspects of Intellectual Property Rights
USAID	United States Agency for International Development
VDRL	Syphilis
VHS	Voluntary health services
VOICE	Voluntary Organisation Indulged in Community Enlightenment
WB	World Bank
YOUTH	Single male slum youth

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 and its porous borders allow 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. STI 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 plan

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 STI. In 1997, the AIDS Prevention and Control Programme issued a five-year national strategic plan. UNAIDS estimates that there are about 50 NGOs working with

HIV/AIDS related activities throughout Bangladesh, all working together in a national network of NGOs on STIs/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; STI 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; and
- **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 fourth surveillance round is underway at the time of writing.

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 may be clients of sex workers (rickshaw pullers, truck drivers, dock workers and STI 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 antibodies 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 (Government of Bangladesh, 2001). The report is, however, cautious, and argues that this situation may not be sustained unless rapid action is taken, particularly when: a) 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 b) 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 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 disquieting indicators.¹

The literature reviewed includes the three rounds of the BSS undertaken in Bangladesh published thus far. Overall, there is considerable inconsistency in the BSS data available to this review on all key markers. Suffice it 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 (AIDS and STD Control Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, 2000). Jenkins (1999), in the national surveillance data from BSS #1, reported highest levels of STI symptoms in those with stigmatised socio-sexual categories: MSW, hijra, IDU. For example, 21.5% of MSW reported 'ever' experiencing an STI, with 13.3% 'currently' having those symptoms. Among hijras the figures were 41% for 'ever' having had anal STI symptoms and 18% for 'currently'. However, Jenkins also notes 18% of non sex-working MSM reported 'previous' anal STI symptoms, with 4.5% having 'current' symptoms (and even 1.5% of truck drivers reported 'current' anal STI symptoms).

In BSS #2 (AIDS and STD Control Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, 2000), in a report on HIV prevalence among 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 STI symptoms were reported by 43.6% of MSW and 37.3% of rickshaw pullers. Again, and as other reports reviewed below will indicate, these data on 'high-risk group' categories require cautious interpretation before they are collapsed into any singular category of MSM. While BSS #3 (National AIDS Program, 2001) has no data on HIV prevalence available to this review, in the Central district (one of four sites in BSS #3) 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 & Rauyajin (1997) report on Dhaka clinic patients and all had STIs (not surprisingly). Khan (1997a), in a qualitative study of MSM (n=40), also recruited from a Dhaka skin/STI clinic, noted

¹ Use of the term 'commercial' to describe sex work is problematic and is avoided in this report.

that all participants reported STIs. In a later paper reporting on fifteen men (Khan, 2000), Khan again reports all the men were diagnosed with STIs. Similarly, Pasha (2002), in a qualitative study in Sylhet of twenty-five MSM, noted that 80–90% suffered from symptoms of STIs. Another paper (Bayzid, 2001) reported 100% of the sample of MSM reporting STIs, but there is doubt expressed by the in-country consultant as to the methodology used. So, many of the clinic-based studies offer no opportunity for assessing either HIV or STI prevalence among MSM.

In contrast, in a clinic-based study in Chittagong, in which 13% of the men reported being 'homosexual', Khokan et al. (1997) reported 0.5% prevalence of HIV and 4.5% prevalence of syphilis, but this is for the whole sample and not just MSM. Another report of clinical services (Arafat et al., 1999) noted only 23% of clinic attendees with STI symptoms, but one wonders why this figure is so low. However, Ahmed & Arafat (2000) reported only between 4% and 11% STI prevalence among clinic attendees at Bandhu's services.² As this service does not specifically recruit with only existing STI-infected men in mind, this figure might be a useful pointer to STI prevalence among a somewhat select population of MSM, i.e. those to whom Bandhu provides outreach, as distinct from STI clinic attendees in the studies discussed above. Yet, Uddin & Rashid (2002), in a report of an intervention among of 1,454 MSM in Chittagong, note that 65% were referred to STI clinic services, but this is not explained and may also be a product of targeted yet differently focused outreach. Hossain (2002), in a follow-up study of MSM who had participated in an HIV/STI education program, noted 6–7% reporting symptoms. However, no pre-intervention data are reported.

Khan (1997), in an investigative study in Dhaka utilising workshops with 32 MSM, followed by a survey of 530 MSM respondents recruited through the networks of the workshop participants, reported that 12 workshop participants and 35% of survey respondents reported having STI symptoms in the previous two years. Symptoms reported by the later included bleeding from the anus (40%), burning around the anus (24%), itching in the pubic area (21%), pain or burning sensations during urination (15%) rashes in the pubic area (15%), lesions around the anus (15%), discharge from the penis (11%), warts on the penis (3%), and lesions on the penis (12%). In other reports from programs, the Naz Foundation South Asia study (2000) of MSM reported for Sylhet between 1–16% of men having symptoms of STIs, with higher figures (20–60%) reporting pain during urination, defecation, or sex (no further specifications provided). Khan & Bhuiya (2001) rely on self-report also, noting that 32% of MSW – and 20% of their clients – reported 'current' STI symptoms.

Finally, Masud et al. (1997), in a study of child prostitutes in Dhaka, report that 60% of the boys report itching and penile discharge (which would mean that these boys are insertive as well, not just receptive). And in contrast to BSS #1 and Jenkins (1999), both discussed above, Nahar & Ahmed (1999) found only 18% of hijras in their study reporting 'current' anal STI symptoms.

Many of these study and program reports rely on self-report and, sometimes in the clinic reports, syndromic diagnoses. It is very hard to treat such figures as reliable and, therefore, none of these studies can provide surety as a useful *single* indicator of HIV/STI prevalence among MSM; this despite otherwise useful material on masculine sexuality and sexual networks. The main conclusion is that 'MSM' does not constitute a single ecology for STI infection, but that prevalence patterns found to date 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 hijras 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, mentioning women and female sex workers (FSW) only where appropriate comparisons are made. In BSS #2, men who gave blood samples 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 sub-samples 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 (e.g. truck drivers, rickshaw pullers) but some of these studies are difficult to compare. The BSS #1 included a sub-sample of 411 truck drivers from Dhaka. In Jenkins (1999),

² Bandhu Social Welfare Society is one of the main MSM, HIV and sexual health organisations operating in a number of cities in Bangladesh.

in a reanalysis of those data, 12–15% of truck drivers were considered bisexually active (with men, women and/or hijras), with about 10% reporting activity in the last year. This contrasts with the reports of the 388 truck drivers in Gibney et al. (2002), 21% of whom reported 'some physical release' with another man (but only 7% in the last year). Jenkins (1998) 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 men, such as students, police, 'mastans' (ruffians or thugs) and the military, or of intra-familial and institutional sexual activity which is well documented in exploratory qualitative work undertaken in Bangladesh (Jenkins, 1998c). These are rarely mentioned or accorded a category in MSM activity. This makes comparisons of behavioural findings and synthesis into a single 'MSM' category difficult. Only one study (Alam et al., 2002) attempts to contextualise its MSM findings in a more general population group, reporting 4% of the sample as actively MSM. But the sample researched was 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 in National AIDS Program, 2001; the two-tier cross-sectional studies in Gibney et al., 2002). Most, however, used convenience samples. Sample sizes are at times large, particularly in the BSSs, but as the samples are not the same each time it is difficult to trust comparisons between the three data sets. Many other reports rely on focus groups and interviewing techniques (e.g. Khan, 1997a; Naz Foundation, 2000) 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 like Khan, 1997a), it is common that existing networks were used and/or program outreach techniques were employed to engage respondents, producing biases that are not declared (or even recognised). The size of some of the samples (e.g. in Khan, 1997a) 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 done with great caution.

Even the qualitative studies and reports of programs on, for example, clinic attendees or MSM in interventions utilise local categories (e.g. 'kothis'), but MSM is mostly undifferentiated and

not disaggregated. The qualitative data (reviewed in Dowsett, 1999) 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 West's best behavioural research 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 sampling has oft concentrated on the most easily reachable, most socially defined, categories of MSW and MSM (and their partners or friends). The gaps in the data on other categories of MSM (such as those mentioned above or married men who seek the services of MSW) are only beginning to be addressed. This will be discussed later.

Much of the categorical work has resulted from a set of consultations and reports in Bangladesh among NGOs working with MSM, all 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, or of whether such initiatives may have considerable discursive effect in re-framing the very objects they seek to support. To some extent, this may explain the dominance of the 'kothi' in the studies and reports, rather than demonstrate that this dominance is empirically supported. As a result, in Hossain (2002) and Neogi (2002) for example, 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 (Khokan et al., 1997). Also, Nahar & Ahmed (1999), 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. Khan & Bhuiya, 2001), 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, while explaining 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 – 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 risky with respect to HIV. First, the studies and program reports reveal MSM activity throughout the country; it is not confined to Dhaka or large cities but also occurs in rural areas (although evidence from rural areas is thin). There is no overall estimate of the proportion of Bangladeshi men who have sex with other men – at any given time or over their 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 the Western term ‘sexual identity’. The kothis and the hijras dominate these accounts. Little cultural incursion has been achieved (unlike, to some extent, in India, Indonesia or Thailand) 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 the most frequently 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, fishermen, dock workers, rickshaw pullers, panthis (partners of kothis and hijras), students, ‘civil kothis’ (MSM with a standard or conventionally masculine public presentation), police, hoodlums, etc.

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**, such as within sex work involving the exchange of money, within emotional relationships (e.g. with a ‘parik’ – or boyfriend), and via coercion (e.g. to gain freedom from bullying or violence at the hands of police or mastans). Exchange, of course, does not necessarily or always involve money.
2. **Sex framed by familial, institutional and traditional relations**, such as intra-familial 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 hijras in their role as sexual performers and dancers (derived from earlier forms of gendered South Asian spirituality). There is some evidence of workplace-related sex and we know nothing of prisons in Bangladesh.
3. **Occasional or casual sex**, facilitated in part by widespread practices of night-time walking in parks, by rivers, in cool open spaces and in markets – in a culture without large-scale mass entertainment infrastructures. Here, the structuring of sexual encounters is about opportunity and possibility, and any of the categories mentioned above might engage each other in a variety of ways (e.g. kothi seeking sex and payment, older men seeking younger men for unpaid sex, students seeking casual partners).

These are, it must be noted, not mutually exclusive categories.

The research reviewed concentrates on two types of conventional divisions. First, divisions between MSM who sell sex and their non sex-selling partners (although the distinction is not always as clear as this). Second, on divisions between socially categorised groupings (kothis and hijras, to name major ones) and their variously termed, but more regularly unlabelled, 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. Indeed, the estimate of 12,000 hijras in Bangladesh (Nahar & Ahmed, 1999) 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, a technique that can generate large samples but tends to build on the proclivity of such organisations to work to their strengths and through their existing networks. In other words, there are sampling biases inherent to these studies right from their inception. The only studies that attempt broader (and somewhat more rigorous) approaches are those that list a larger variety of MSM (for example, BSS #2, which lists ‘MSW’, ‘MSM’, ‘rickshaw pullers’ and ‘hijras’).

The often-used division between MSW and MSM is not a sturdy one, as there are no studies to document the ‘career’ of MSW or suggest with any confidence that such careers conform to similar sex work 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 (those aged around 40 and greater). 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 hijras, and men who do not sell sex, their relatives, or those who seek only casual sex with men (e.g. fisherman, truck drivers, 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 – an expensive and difficult thing to carry out. 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 with the partners of the existing socially or self-labelled groups of MSM are needed.

5. Sexual Practice

BSS #1 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 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 (1999) 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 hijras (92% receptive AI and 1% insertive AI). Only one study reports on other high-risk groups: Gibney et al. (2002) 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 (Naz Foundation, 2000c) 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 an investigative project of Dhaka MSM (Khan, 1997a), 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 (Khan & Bhuiya, 2001) 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 (Kamrul et al., 2000; Bayzid, 2001) reaching largely kothis (and a few reports on hijras) 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 (Khan, 1996b) and among other MSM (Naved, 1996).

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 hijras). 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 STIs reported. This would place the kothis and hijras 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 hijras.

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 hijras) subsection of the MSM populations. In BSS #1, 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, the average number of clients in the previous week was reported as 6.19 (with a range from 1 to 45). In BSS #3 (National AIDS Program, 2001), MSW and hijras reported between 8 and 11 clients 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 sub-samples and/or sites. Note also: one study of 150 hijras (Nahar & Ahmed, 1999) 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).

The Chittagong situational assessment (Khan & Bhuiya, 2001) of MSW reported an average of 4.4 partners in the last week, with a range of 0–14, whereas Jenkins' Chittagong study (Jenkins, 1998a) of MSW reported 10 clients per week. A small study in two parts of Dhaka (Kamrul et al., 2000; Bayzid, 2001) also reported 10 clients per week.

The Naz Foundation (2000c) 4-site study of kothis provides a range for numbers of partners in Sylhet in the previous month:

Table B1: Number of Partners for Kothis in Sylhet in Previous Month

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 1/4 having 10 or fewer partners per month.

The frequency of sex events is not so different in the Naz Foundation's investigative Dhaka study (Khan, 1997a), 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, (as seen in Hossain, 2002) 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 (Aziz & Maloney, 1985; Khan, 1997d; Pasha, 2002; Khan & Rauyajin, 1997; Khan, 1999b; Ahmed et al., 1998; Ahsan et al., 2002; Khan et al., 2002; Khan, 2000b; Khan & Sharmine, 1999; and Khan, 1999a).³ 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

³ Some of these overlap as they were conference papers extracted from reports or studies elsewhere reviewed.

HIV risk for women and even a single category 'women' in considering HIV infection trajectories in Bangladesh. One could also decide where to place hijras within this category, further complicating the picture.

BSS #3 noted 40% of MSW reported buying sex from both men and women in the previous month, while in BSS #2 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 (Khan & Bhuiya, 2001) 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 (range 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. (2002) report that 50% of MSM (i.e. MSW and clients) engaged in unprotected AI with their female partners.

A small Dhaka two-site study (Kamrul et al., 2000; Bayzid, 2001) notes 22% of kothis were engaged in sex with their wives. In contrast, in a Sylhet study of 200 MSM, only 8 men reported vaginal intercourse with women. Yet, the Naz Foundation (2000c) reported 22% of kothis in Sylhet were married. But then in Khan (1997a), 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 (Khan, 2000a), all men reported sex with women, including anal intercourse (mentioned also in Khan, 1996b).

In one of the few studies outside socially or self-recognised MSM categories (Gibney et al., 2002), 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 the whole sample. Yet, Jenkins' study of Dhaka truck drivers (Jenkins 1999), drawing on BSS #1 data, 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 (Khokan et al., 1997) 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 (Khan, 1996b; Masud et al., 1997; Khan, 1997d; Jenkins, 1998a; Aziz & Maloney, 1985; Khan, 2000a; Khan & Raayajin, 1997; Khan et al., 2001; Jenkins, 1998b; Khan, 2000b; Khan & Sharmin, 1999).

In BSS #1, 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, 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'.⁴ 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, 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 (e.g. Rahman et al., 1999) reported 26% condom use for the previous week, but this sample included female and male sex workers.

The Naz Foundation four-site study (Naz Foundation, 2000c) 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%

⁴ This may not be a trustworthy figure and may have a considerable social desirability factor in it when compared with results from other questions.

KY Jelly. Khan's investigative Dhaka study (Khan, 1997a) 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 (Khan & Bhuiya, 2001), 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 (Kamrul et al., 2000; Bayzid, 2001) 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 (Nahar & Ahmed, 1999) 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 (Hossain, 2002) 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. Neogi (2002) 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 (Haque & Ahmed, 2001) 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 (Haque & Ahmed, 2000) 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 (Gibney et al., 2002), 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 hijras, the figures on condom use in BSS #3 are 89% 'never' use and 7.4% 'sometimes' use condoms – worryingly low. Condom use with women was rarely reported (it was rarely asked), but one study (Alam et al., 2002) reported 13% condom use with spouse and 13% condom use in the last 'commercial' sex with FSW.

6. Sexual networks

In Dowsett (1999), 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 hijras). 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 that maps collected by NGOs had revealed 81 sites in Dhaka alone at which MSM activity could be assessed.

This framework, when tested in BSS #2, 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 Khan (1997a) 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 in the last year (Gibney et al., 2002). BSS #3 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 (Naz Foundation, 2000c) 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 houses (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 (Khan, 1997a): 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 where 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 (Khan, 1997a) also suggests that higher educational levels delay entry to male-to-male sex. Jenkins’ early qualitative work (Jenkins, 1998c) with 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 Naved, 1996, 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. Hossain (2002) 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 (Choudhury, 2002) 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 Jenkins, 1998c), 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 (2000a) 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 number of arenas outside their male ‘commercial’ transactions.

Jenkins (1998a) 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 of male-to-male ‘sexual outlet’ in Bangladesh is impossible to estimate (Kinsey et al., 1948).

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 Kamrul, et al. (2000) and Bayzid (2001), 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 Rahman et al., 1999), MSW were reported to engage in less ‘commercial’ sex activity than FSW, and 30% of men reached in outreach programs were married (see Ahsan et al., 2002).

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 Gibney et al. (2002), 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 STI clinic (Khan, 1997d), 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 (Khan & Rauyajin, 1997; Kamrul et al., 2000; Bayzid

2001), but also in various categories of girlfriends, relatives, FSW, extra-marital partners (Khan & Bhuiya, 2001; Khan, 1996b; Khan, 2000a; Khan & Raayajin, 1997; Khan, 1999b; Ahmed et al., 1998; Ahsan et al., 2002; Khan et al., 2002; Khan, 2000b; Khan & Sharmine, 1999; Khan, 1999a) and female clients (Masud et al., 1997). In their study of Chittagong MSW and clients, Khan et al. (2002) 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 #1, 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 reported MSW twice as likely to inject drugs as FSW – again with no corroborative data elsewhere available and verification needed.

The data on hijras in Nahar & Ahmed (1999) 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 hijras). Rape by police was reported by 41% of hijras and 46% reported rape by 'mastans'. Combined with the evidence above, clearly hijras 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 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 lot 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, intra-familial 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). 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 men 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.

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 in India was reported 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 to Map 1).

Map 1: States Grouped by High, Moderate and Low HIV Prevalence

ADULT HIV PREVALENCE: 2000



[Source: WHO, 2001]

- **Group I** – High HIV prevalence States include 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 include the five States of Gujarat, Goa, Kerala, West Bengal and Nagaland, where HIV prevalence rates were 5% or more among high-risk behaviour groups but below 1% in antenatal women.

- **Group III** – Low HIV prevalence States include 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 report only 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-positive 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 aged 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 was from December 1999 to March 2004. Lack of resources hinders full-scale

implementation of the plan. Current available resources at the time of writing are US\$60 million per year, with additional resource requirements at 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:

- **Enhance policy and support** to build capacity at State, district, and municipal levels;
- **Scale up the behavioural change activities and targeted interventions** among high-risk and vulnerable groups, seeking to achieve high coverage;
- **Increase community-based approaches** to prevent new infections, in particular with high-risk groups and youth;
- **Promote low-cost community-based care** without stigmatisation for those living with HIV and AIDS; and
- **Increase mobilisation** 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 (Ministry of Health and Welfare, 2002).

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 (Narayan, 1998; Taylor Nelson Sofres Mode, 2001). 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, 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. At the time of writing, patent laws in India are set to change from 31 December 2004.

2. Epidemiology

A large number of studies of widely varying quality have been undertaken in India over the last five to eight years, many of which have not been published through processes of peer review. One hundred and ten reports or studies are included in this review, and 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 small amounts of 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 (AIDS Prevention and Control Project, 2001) 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 BSSs, but without explanation of their assumed pertinence in India). However, in AIDS Prevention and Control

Project (2001), 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 (Nandi et al., 1994) 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 HIV2 (in all, 20.6%). However, we have no other characteristics of the sample other than a mean age of 31.6 years. In addition, there were 22 cases of condylomata, 20 of herpes, 15 of gonorrhoea, and 3 each of candidiasis and syphilis. In a Delhi study of 19,840 male and female clinic attendees (Rathore & Ray, 1998), 96 (0.5%) were found to be HIV-positive and only two 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 (Kumta et al., 2002), Kumta et al. found that:

- 17% of MSM and 68% of TG were HIV-positive;
- 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; and
- HIV prevalence was 48% in MSM with syphilis and 88% in TG with syphilis, 62% in MSM with hepatitis C and 100% in TG with hepatitis C; and 38% in MSM with herpes simplex virus 2 and 80% in TG with herpes simplex virus 2.

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 findings for TG, it must be noted that percentages 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. (2001), presented in a poster exhibition at the 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 (Setia et al., 2000) 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 Annotated Bibliography for details). A study presented in Barcelona in 2002 noted similar levels of HIV infection – Mathur et al. (2002) 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 in using the terms 'homosexual', 'heterosexual' and 'bisexual'. For TG, 41% tested positive for HIV and 25% tested positive for syphilis. These are all Humsafar Trust studies and the relationship between the samples in Setia et al., 2000b; Kumta et al., 2002; Mathur et al., 2002; and Kumta et al., 2001 is not clear, and the small numbers must again be noted with a cautionary tone.

An unpublished study of STI clinic attendees at the Government General Hospital in Chennai (University of Indonesia Centre for Health Research, 1999) 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 (Venkatesan & Sekar, 2001) noted that 14% self-reported as HIV-positive and 26% were clinically diagnosed with an STI.

An earlier multi-country review of HIV and MSM (Chan et al., 1998) 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, 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 and in which 73 (3%) were homosexual. The study reported 62% of the subjects had an STI (mainly syphilis), and an ELISA test among the homosexual sub-group found only 4–5% positivity for HIV. But this figure is not surprising given the sampling.

Aher (2002), reporting on a KAPB study of more than 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 (Packianathan, 2002) noted that 12% reported being HIV-positive. A similar dissertation (Timothy, 2002), involving 50 hijras in Chennai, noted 6% reported being HIV-positive (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) (Singh et al., 1999; Singh et al., 1998).

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, might consistently overestimate HIV prevalence, while self-report, given the exigencies of HIV testing in India, might consistently underestimate. For example, in contrast to the Humsafar Trust figures for TGs, Timothy, in a socio-economic and sexual behaviour study of hijras (Timothy, 2002), 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 not attached to 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*. We 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 during the previous month, with 44% reporting having accessed treatment for the same condition (Ministry of Health and Welfare, 2002). In the Maharashtra BSS (ORG Centre for Social Research, 2001), 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 (Indian Market Research Bureau [Bangalore] & Family Health International, 2001), undertaken in six regions in India, reported on the incidence of genital discharge/ulcers in the previous twelve months for truck drivers (5%), helpers (5%), related 'stationary' workers (3%).

Kumar and Ross (1991) note in a study of four STI clinics in northwest India that, unsurprisingly, all MSM reported being infected with an STI. The Humsafar Trust, in an undated survey (item ID15 in References) 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 (Direm ANALYTIX, 2002), 35% of MSM reported STIs in the last six months, with redness and swelling in the groin reported by about 42%. Very few (3%) reported multiple symptoms. Of the 327 respondents, 68% had HIV tests, 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 (ORG Centre for Social Research, 1999) and found that only 5% reported genital discharge or ulcers in the previous year.

Also, the Chennai Corporation AIDS Prevention and Control Society (CAPACS) found in 70 men (Anbu Illam Charitable Trust, 2002) the following STI problems in the previous twelve months: 20% had pain in the genitalia while passing urine; 14% had genital ulcers; 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 (Naz Foundation, 2000b) 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:

- **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;
- **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;
- **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, 0% pus/discharge from penis, 0% pain when defecating, 0% pain during sex, and 0% 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) include 32% (Trikmami et al., 2002) in Mumbai and 24% (Thakur, 2002) among MSW and male masseurs in the last six months (also in Mumbai). Others reported STI infections, but without figures (Kumar & Ross, 1991; Kulkarni & Kulkarni, 2001).

Finally, a survey of long distance truck drivers (Singh & Malaviya, 1994) – 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. Three of the 302 (1%) truck drivers tested positive for HIV. Bamne (2000), at Durban in 2000, reported from a study reaching out to 800 truck drivers (including 350 cleaners) via a mobile clinic, that 21% had STI at the time of examination, with 67% reporting having had a STI in

the past (no specific information was available for MSM truck drivers). In contrast, in Indian Market Research Bureau (Bangalore) & Family Health International (2001), 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 of 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 in gaining certainty on STI infection levels arises in part because these are not, literally speaking, underlying levels or 'baseline' assessments. In many places, figures were gained *after* interventions were already in place. This is particularly the case with some CBO-based assessments.

3. Methodology

The studies reported here (and in more detail in the Annotated Bibliography on CD-ROM) 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 most often impossible to assess. There are some BSS surveys available and these are generally regional, never really national, offering little, if any, comparable data. Only one (non-BSS) study (Collumbien et al., 2000) attempts to situate MSM within a more general population framework for one city, in this instance Orissa. And one Madras (Chennai) study (Asthana & Oostvogels, 2001) attempts to estimate the volume of MSM activity overall.

At times, the clinic-based studies report on samples of men (in general) and then sub-section 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. For example, 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, socio-economic status (an exception is Narain et al., 1994), or by religion or ethnic minority grouping. Most of the reports are from the big cities, particularly Chennai and Mumbai, with Delhi, Kolkata, Pondicherry and Bangalore mentioned occasionally. 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 here as it is in Bangladesh.

Many of these cruising site 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 for 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.

ORG Centre for Social Research (1999) is one of the few projects 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 studies, not just in 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. Muraleedharan (1998) is a good example, where modernisation has valorised the nuclear family and challenged social places for same-sex intimacy, particularly that which is organised by various cults, such as Ayappa, which foster male sexual intimacy. Similarly, Vanita & Kidwai (2000) 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 categorised 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 – for example, 37% of men in a survey of educated business executives reported homosexual relations (Narain et al., 1994) and 15% of truck drivers reported previous homosexual experience (Nag, 1994). In contrast to this, 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 (Indian Market Research Bureau (Bangalore) & Family Health International, 2001) 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 (Bhoruka Public Welfare Trust (Calcutta) & Family Health International, 2001; India Rural Reconstruction and Disaster Response Service, Andhra Pradesh State AIDS Control Society & Family Health International, 2001) add little to this picture, except that 10.3% of truck drivers at 'dhabas' – or halt points – in northern India (Voluntary Organisation Indulged in Community Enlightenment, 2001) 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 (Goparaju, 1997) 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.

Interconnected patterns of risk were reflected in only one study (Singh et al., 1999), 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 Kulkarni et al., 2000), some of which refer to attributed or preferred sexual mode, some to gendered behaviours, some to age, and some reflecting both the impact of 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, Khan (1996a) 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 – 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 (2001) maps out the broader 'homosocial' universe in Hyderabad as spanning the realms of tradition and modernity. There are traditional identifying terms 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. Khan, 2000b). 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. Humsafar Trust, 1994), in contrast to its noticeable absence in Bangladesh. However, Purkayastha (1999) disagrees 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 (1998), drawn in relation to mainstream sexuality, that what is occurring in India is a proliferation of discourses on sexuality built on already extant and multiple frameworks (unlike the West with its reliance on the binary opposition 'heterosexual/homosexual'); this would include gender. HIV/AIDS mobilisation has entered 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 workers and otherwise) are high, and there is clear evidence that husbands' male sexual partners are not always MSW. Yet, there are large numbers of MSW in the studies. Perhaps this reflects the emphasis many NGOs/CBOs place on these populations and the origins of the development of interest in MSM activity in HIV/AIDS and activist mobilisation in India. There are certainly a) different forms of MSW activity (e.g. selling to truck drivers as reported in Singh & Malaviya, 1994) that involve cruising sites, b) somewhat ambiguous reports of sex work among college students, and c) evidence-based indications of MSM who will pay for sex. What is less clear is the extent of MSW activity in total, 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, although anecdotal evidence suggests they exist. This dispersal of MSW activity, noted also in Kinsuk (1999), suggests varying vulnerabilities to infection (and the experience of violence is noted in this regard [Peoples' Union for Civil Liberties – Karnataka, 2001]). At least one report, on boy prostitution (Chandran & Balachandran, 2001), 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 alone 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 Sharma et al, 1998; Singh et al., 1998; and Ramakrishna et al., 2001 for further details, including data on the boys' sexual activity with women).

Those studies that survey a range of sexual practices (e.g. Kumar & Ross, 1991) reveal a full repertoire, and this indicates considerable MSM activity that is not simply related to quick satisfaction (e.g. 'discharge' in Naz Foundation, 2000b), but that is possessed of relational meaning for large numbers of men. This stands in some contrast to discourses of 'discharge' in

some reports and in the literature on semen-loss. Such variety in sex acts also suggests that the concept of 'sexual cultures' may be a 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 suggest innovative modes of intervention.

This is especially important in regard to hijras. Nanda (1999) discusses the hijra role as an institutionalised third gender in India, as 'neither male nor female', containing cultural and embodied elements of both. Hijras 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 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 '**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, 1991). Note, for example, Kulkarni et al., 2000 (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 that AI or oral sex (OS) occurs, with no estimates or quantification (Nandi et al., 1994; Khan 1994; Chandran & Balachandran, 2001; Humsafar Trust, 2000; Chakrapani et al., 2000). 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* (Nandi et al., 1994), who report *inter alia* that 37% of educated business executives surveyed reported having homosexual relationships.

One study, Collumbien et al. (2000), comes close to offering a general population-based picture of male sexual practice. 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, where 8.6% of single men 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 in which local differences are noteworthy, suggesting, once again, situational or locational sexual cultures or economies.

In a magazine survey of readers (Debonair Magazine, 1991) of *Debonair* (an expensive and erotic English-language magazine with 85,000 readers, of whom 1,424 returned questionnaires), 29.4% reported engaging in 'homosexual intercourse', with 17% participating in 'group' homosexual activity. Among college students (Goparaju, 1997), of the 15% of men who had sex with men, 27% had had AI with male partners. Yet, a report from an intervention among young men in Lucknow (Awasthi et al., 2000), 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 20 men reported OS or AI with men. 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 (ORG Centre for Social Research, 2001), Orissa (Asian Information Marketing and Social Research Ltd. (AMIS Research), Orissa State AIDS Control Society & Family Health International, 2001) and Kerala (Taylor Nelson Sofres Mode, 2001) from multi-site surveys of classic 'high-risk groups'. Surveys were somewhat different in each site. In Gujarat (ORG Centre for Social Research, 2001), 2.4% of male clients of FSW and a small proportion of other male sub-groups reported AI 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 (Asian Information Marketing and Social Research Ltd. (AMIS Research), Orissa State AIDS Control Society & Family Health International, 2001), 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 AI with a male partner in the previous year. Finally, in Kerala (Taylor Nelson Sofres Mode, 2001), 7% of male clients of FSW and 2% of male university students reported AI with a male partner during the preceding year. These figures are low in contrast to studies reported below, but they 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.

Clinic-based samples offer a different picture. Kumar and Ross, in a comparative study of Indian and Australian MSM (Kumar & Ross, 1991), reported for the Indian men recruited in four STI clinics in the northwest that the most frequent sexual practice reported was 'dry', and then 'wet', kissing, followed by AI insertive and OS insertive.

Table ID 1: Frequency of Sex Practices by MSM in Northwest India

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
Oral with ejaculate	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 Kulkarni et al. (2000), these are interesting figures, revealing less anal sex than might be expected. The very low 'Oral with ejaculate' percentages are also interesting.

Data from another clinic-based study from Mumbai (Lindan et al., 2002) revealed that, of the 386 men enrolled in the study, 24% reported past receptive or insertive AI with men. And, in a clinic-based sample from Chennai (Unknown Author, 1999; item ID40 in References) 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 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 a community-based clinic in Chennai (Venkatesan & Sekar, 2001) 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 (Singh & Malaviya, 1994) noted that 5% acknowledged regular sex with men, mostly with MSW. More recent BSS data from Tamil Nadu (AIDS Prevention and Control Project, 1996) 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 AI 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. The subsequent 2001 BSS study in Tamil Nadu and Pondicherry (AIDS Prevention and Control Project, 2001) found that 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. (2001), 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. nearly 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 (Singh et al., 1999) 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 men.

When locally defined sub-populations of MSM are involved, the figures are different once again. A study of 300 MSM recruited in railway stations in Mumbai (Direm ANALYTIX, 2002) 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 (2002) 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 (ORG Centre for Social Research, 1999). Similarly, Row-Kavi et al. (2001), in a Mumbai survey of MSM, note that 64% reported insertive AI and 73% receptive AI. The Humsafar Trust surveyed readers of *Bombay Dost* (Humsafar Trust, no date; *Bombay Dost*, no date) and eighty replied (out of 1000 questionnaires sent out), with 45% reporting AI, 43.5%

reporting OS, 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 (Packianathan, 2002) where only 26% report practising AI and OS (an unpublished dissertation). The higher figures suggest that a focus on locally defined sub-populations 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 sub-populations, unwittingly or deliberately. While these findings do point to the existence of sexual networks operating according to particular sexual or situational dynamics, these populations may not be good or general indicators of MSM as a wider 'at-risk' population.

Where sex with MSW is concerned, the picture changes again. One study (ORG Centre for Social Research, 2001; Adhikary et al., 2001) that attempted to develop a 'baseline' of high-risk populations by interviewing, among others, 626 MSM in four sites (Mumbai, 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% reporting sex with MSW. A four-site Naz Foundation situational assessment in Hyderabad, Bangalore and Pondicherry (Naz Foundation, 2000b) noted:

- **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 during the last month was 2,355 (from 62 people involved);
- **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 the last month was 1,122 (from 60 people involved);
- **Pondacherry** – AI 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 the last month was 1,168 (from 72 people involved).

The vulnerability of those who sell sex is clear. A second report from Naz on the Bangalore data alone (Khan 2000a) 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 'double-deckers' 1,390 vs. 596), while among those who were labelled 'gay' the proportion was less marked (233 vs. 139) – an interesting difference.

In a study of 120 MSW and masseurs in Mumbai, Thakur (2002) reported 92% of the sample engaging in AI. Yet, a baseline study in Chennai (Anbu Illam Charitable Trust, 2002), mainly of MSW but 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 20 'room boys' in hotels in Pune and New Delhi (Khan, 1993b), 8 reported anal sex with male guests, with a further five reporting non-penetrative acts. Of those 8 engaged in anal sex, 6 were receptive and all were insertive. One qualitative study (Murthy & Karott, 2000), focusing on 121 street boys in Bangalore, found 14.9% had 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, Setia et al. (2002) reported that all 28 TG (in a study which included 122 men) indicated 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 (Timothy, 2002) reported only 26% practising receptive AI, while 64% reported practicing receptive OS. One small baseline study of transsexuals ('Aravanni') in Chennai (Tamil Nadu Aravanigal Association, 2002) 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 Narayan (1998) that three-quarters of hijras were not castrated (we have no sample size or methodological information to verify this judgement). So, the possibilities for insertive sex cannot be disregarded, despite that the cultural concept of 'hijra' might not allow for an insertive mode (much as kothis claim receptivity but many insert).

Sexual partners

Nandi et al. (1994) report, from a clinic-based study of 63 MSM in Mumbai, that men in the study averaged 2–3 partners per week. In the study of MSM in Mumbai railway stations (Direm ANALYTIX, 2002), 76% reported casual male partners, with an average of 7 per month. In Mumbai, in the *Bombay Dost* reader survey (n=80), the mean number of partners in the previous six months was 6.12, while the median was 3 (Humsafar Trust, no date). Also, 174 MSM in Mumbai surveyed by Row-Kavi et al. (2001) reported an average number of 11 partners in the previous month. However, Asthana and Oostvogel (2001) 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 (Ministry of Health and Welfare, 2002) 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 & Ross' (1991) finding 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 (ORG Centre for Social Research, 1999), in its sub-sample of 400 MSM, found that in the previous month, 34% of men had no partners, 11% had one partner, 54% had 2–7 partners and 24% had >7 partners (these figures refer to male AI partners specifically). The Tamil Nadu and Pondicherry BSS, conducted by APAC (AIDS Prevention and Control Project, 2001), 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 sub-populations studied (e.g. truck drivers, IDU). However, the six-region study of truck drivers, their helpers and related 'stationary' workers (Indian Market Research Bureau (Bangalore) & Family Health International, 2001) reported quite low average partner numbers in the previous year (truck drivers 1.7, helpers 1.6, and 'stationary' workers 1.2). Other BSS-derived data from:

- **Gujarat** (ORG Centre for Social Research, 2001) reported the average number of male AI partners in the previous 12 months (for those small number of men who reported a male partner) was: for male clients of FSW 2, for male diamond industry workers 1, for male slum dwellers 4, and for male university students 1;
- **Orissa** (Asian Information Marketing and Social Research Ltd. (AMIS Research), Orissa State AIDS Control Society & Family Health International, 2001) found that the average number was 0;
- **Kerala** (Taylor Nelson Sofres Mode, 2001) noted the average number was 3 for male clients of sex workers and 5 for male university students.

Low figures indeed.

In contrast, Khan (1994) provided the following averages for the previous year from qualitative studies:

Table ID 2 – Number of Sex Events in Previous Year

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

And in Khan (1993a), based largely on the same data, Khan reported for various age groups:

Table ID 3 – Average Number of Different Sex Partners for the Current Year

Age group	Average number of different sex partners for the current year
14–16 years (n=50)	2
17–21 years (n=120)	5
22–35 years (n=355)	42
36–45 years (n=234)	35
46–60 years (n=105)	8
>60 (n=24)	5

The Naz Foundation (2000b) four-city situational assessment reported:

Table ID 4 – Number of Sex Partners for Three Cities

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 (Setia et al., 2000b) reported 6% having regular partners, while the rest had casual partners. From the same clinic, in a study (Pandya, 2002) of 17 men (of whom 14 were HIV-positive), 50% also

reported 11–30 partners per year. The much higher levels reported in these studies, compared with earlier BSS samples, seem to suggest the use of particular sampling strategies, 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 (Unknown Author, 1999; item ID40 in References) collected data on lifetime partners (male and female) among a clinic-based sample of homosexual and bisexual men, 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% stated 'only one', and 13% stated 'more than one'. Of the 49 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%) daily, 12 (39%) weekly, 12 (23%) monthly, and 9 (17%) occasionally; for 'bisexuals', 0 daily, 14 (21.5%) weekly, 34 (52%) monthly, and 17 (26%) occasionally, suggesting somewhat lower levels of activity for bisexual MSM. These data are particularly important, for they reveal the complex nature of male to-male sex beyond the easily reached and more readily recognised sub-populations captured in many of the community-based NGO reports.

Male sex workers (MSW) reveal quite varied numbers of partners. Thakur (2002) notes an average of 11 partners (but no time scale was given). One street boy study (Murthy & Karott, 2000) found 41.9 % had 'few' partners and 31.1% had 'several'. Finally, hijras, in one report (Rayapu et al., 1998) presented at the XII International AIDS Conference in Geneva in 1998, were noted to have 15 times more sexual partners than FSW (although it is not clear how this figure was reached).

Female partners

Setia et al. (2002), in a study of MSM and TG clients of the Humsafar Trust, found that 44% of 122 MSM studied had visited FSWs, 22% of MSM were married, and 20% lived with their wives. In the study of MSM in four clinics in north-west India, Kumar and Ross (1991) 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 (in which 30% reported MSM behaviour) revealed most men were married; Kumta et al. (2002) had a similar general finding. In contrast, in a Mumbai clinic offering services to men in general (Lindan et al., 2002), 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 (Awasthi et al., 2000), 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 are too small to make such a proportional comment trustworthy). The *Bombay Dost* survey of 80 of its readers (Humsafar Trust, no date; Bombay Dost, no date) reported only an average number of 0.25 female partners in the previous six months.

In an unpublished qualitative study based on focus groups with MSM with female partners (Khan, 2002), 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 do so, even though a few stated that they had tried. Related work (Kumaramangalam & Khan, 1999) noted that 78% of MSM were married, while 46% had sex with other women. Khan (1993b) also noted, in his account of hotel room boys, that 7 of the men only have sex with women (and of these, 3 have a regular girlfriend) and 14 men visit FSW on average once a month after payday, with 6 men having anal sex with women also. The Naz Foundation four-site MSM study (Naz Foundation, 2000b), with one site in Bangladesh, noted that 25% of Hyderabad, 26% of Pondicherry and 30% of Bangalore respondents reported being married. In addition, Khan (2000a) reports that 9% of MSM respondents in Bangalore have sex with females other than their wife.

The 2002 *National Baseline High Risk and Bridge Population Behavioural Surveillance Survey* (Ministry of Health and Welfare, 2002) reported that nearly 33% of the 1,387 MSM respondents reported sexual experience around the age of 20 years with a female partner, while 31% of 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 (Anbu Illam Charitable Trust, 2002), 31% of respondents reported having sex with female partners. Meanwhile, also in Chennai, in a STI clinic sample of men (Unknown Author, 1999; item ID40 in References), 65 of 117 respondents self-identified as 'bisexual' (with all the caveats that that term implies). Another Chennai study (Venkatesan & Sekar, 2001), 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 (Direm ANALYTIX, 2002) noted 52% of MSM participants 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 2. And 28% of MSM were married, but only 22% co-habitated with their spouse. Another Mumbai study of cruising sites (Trikmani et al., 2002) reported 89% of men as 'bisexual', while 56% of MSW and masseurs in yet another Mumbai study had had sex with female partners (Thakur, 2002). Meanwhile, the Mumbai-based (1991) *Debonair* magazine survey found that 32% of their readers who were married have had sex with another man. Another survey, of 174 MSM in Mumbai (Row-Kavi et al., 2001), noted that 50% of self-identified MSM reported having had sex with women during the previous month. Indeed, only 5% reported 'never' having had sex with a woman. Even among hijras in one study (Timothy, 2002), 24% reported having 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 (Ministry of Health and Welfare, 2002), 39% of 1,387 MSM reported using condoms in their last sexual encounter with MSW, but there was no data on condom use with other partners. The fifth wave of the Tamil Nadu BSS (AIDS Prevention and Control Project, 1996) found 63.3% of truck drivers and their helpers used condoms for AI, while 40% of the slum dwelling young men did so (but, as noted above, very small numbers of men in these categories were sexually active with other men). The sixth wave (AIDS Prevention and Control Project, 2001) also included Pondicherry and found that 44.7% of over 11,000 MSM having sex with men in the previous six months reported using condoms in their latest AI 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. However, much lower condom 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:

- **Gujarat** (ORG Centre for Social Research, 2001) – 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 AI experience, and only 20% of male clients of FSW reported consistent condom use with male partners during AI in the previous 12 months (n=2 out of 10);

- **Orissa** (Asian Information Marketing and Social Research Ltd. (AMIS Research), Orissa State AIDS Control Society & Family Health International, 2001) – None of the male respondents reported condom use during the last AI with a male partner; and
- **Kerala** (Taylor Nelson Sofres Mode, 2001) – Condom use at last AI with male partner was 14% for clients of FSW 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 partners during AI in the previous 12 months.

General comments are available in some studies. Kulkarni et al. (2000) and Purkayastha et al. (1997) report low condom usage but offer no figures; Collumbien et al. (2000) reports no condom use for AI among its respondents; Asthana & Oostvogels (2001) is similar; 1% reported 'sometimes' in Setia et al. (2000a); no consistent use with male or female partners was reported in Chakrapani et al. (2000); and condom use is rare among Mumbai MSM in Row-Kavi et al. (2001). See below for other findings.

In the Chennai-Tamil Nadu clinic-based study of male attendees (Unknown Author, 1999; item ID40 in References), condom use among 'homosexual' men was 4% for 'always', 42% for 'occasionally', 54% for 'never' and, among the 'bisexuals', 54% for 'occasionally' and 46% for 'never'. Kumar and Ross' four-clinic study in north-west India (Kumar & Ross, 1991) found very low levels of condom use during oral sex (4.5% 'sometimes' for receptive OS and 4.3% 'sometimes' for insertive OS) and anal sex (2.4% 'always' for insertive AI and 11.4% 'sometimes' for insertive AI; 0% 'always' for receptive AI and 5.6% 'sometimes' for receptive AI). In other clinic-based reports from Mumbai (e.g. Jerajani et al., 2002), 80% of MSM had 'never' used condoms. A Humsafar Mumbai clinic-based report (n=100) presented at Durban in 2000 (Setia et al., 2000b) noted only 5% of men used condoms 'regularly', 20% 'sometimes', and the rest 'never'. Meanwhile, a similar Humsafar clinic-based report, presented at 6ICAAP (Kumta et al., 2001), noted 'consistent' condom use among 28% of MSM and 10% of bisexually active men. Finally, in Venkatesan & Sekar (2001) 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% condom use with other MSM in their 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 (Awasthi et al., 2000), in which only 20 of 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 (Hausner et al., 2001) found that condom use varied with partners (male or female) and sex acts (vaginal sex, or anal sex with either male or female partner). Only 12% of the men whose sexual initiation involved anal sex with another man used condoms.

Meanwhile, in a Delhi taxi driver intervention study (Sahay, 1998), 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 (Bamne, 2000), some of whom were sexually active with men, reported 4% of homosexually active men used condoms regularly, compared with 12% of heterosexually active participants. Reasons for not using condoms included: 46% 'no pleasure', 32% 'non-availability', 20% 'doubts about condoms as preventive measure', and 2% 'fear of developing impotency'. The six region study of highways (Indian Market Research Bureau (Bangalore) & Family Health International, 2001) 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 (reported in Durban in 2000), among 6,885 MSM in 72 cruising sites in Chennai, found that, at baseline, 27% reported condom use, rising to 40% after the first year of intervention. This offers some hope for rising levels of condom use (Jayaram et al., 2000).

In Chennai, of 50 MSM interviewed for an unpublished dissertation (Packianathan, 2002), 35% reported using condoms. In another Chennai study (Anbu Illam Charitable Trust, 2002), intended as a baseline study of 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, 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* (n=80), offered similar findings, with 18% reporting condom use as 'always', 39% 'sometimes', 34% 'never', and 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 (Direm ANALYTIX, 2002) for MSM (n=300) reported 87% have easy access to condoms. Of the 52% who engaged in insertive AI in the previous month, 89% used condoms and 82% did so on a consistent basis. 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, an 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 twenty sites noted 60% condom use in last AI with regular partners, 72% with non-regular partners, and 79% with MSW. 'Consistent use' figures were respectively 30%, 54% and 66%, indicating important levels of condom use uptake among these MSM. Other reports from Mumbai, presented in Barcelona in 2002 from NGOs/CBOs, note 65% usage (Trikmami et al., 2002), non-availability for masseurs and MSW (60%), and client resistance (68%) (Thakur, 2002). Also, 58% usage with only 34% consistent usage (Aher, 2002). 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 (Naz Foundation, 2000b) 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% soap; and among MSW, condom use with previous 5 clients was 12% 'every time', 48% 'sometimes', and 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% soap; and among MSW, condom use with previous 5 clients was 27% 'every time', 39% 'sometimes', and 34% 'never' (see also Khan, 2000a); and
- **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% 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' among MSW are worrying, particularly in Pondicherry. And the findings on breakage and lubrication indicate that interventions on condom use alone are not sufficient and that 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 Khan (1993b), only 1 used condoms 'regularly', 3 'irregularly'. A hijra study (Timothy, 2002) noted

that, of 50 respondents, 86% insisted on condom use with their clients, but 58% did not reject 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 between men and their female sex partners, 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. Cultural analyses (see below, and in Section 3 above) suggesting any singular notion of an 'Indian MSM' culture (or even a 'South Asian MSM' culture for that matter) seriously underestimate the variability and 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.

6. Networks

Khan (1993a) reported on information from successive investigations of MSM cultures in South Asia and rated several practices in terms of sexual enjoyment, offering significant possibilities for focusing on safe practices in prevention education, as well as signalling once again the diversity of the sexual repertoire (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 answered: 'masturbation' (60%), 'inter-femoral 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 *choreography* of sex (Dowsett 1996) that requires more than a tree or shrub to hide behind, perhaps requiring a room, bed or more private place for a longer encounter. They also suggest an affectional and intimate quality to such encounters that amounts to more than mere 'discharge'. These findings also de-centre AI from the heart of male-to-male sex in India.

The Naz Foundation (1999) notes that there are no 'communities' as such among MSM, but networks connected to – and developed through – these sites. This can offer the possibility of building stronger links between MSM. These sites are varied. For example, in Humsafar Trust (no date; item ID15 in References), places where sex occurs were reported as toilets

(11%), hotels (75%), brothels (this could be female brothels; it is difficult to assess) (4%), and public places (11%). Moreover, as reported above, partners were strangers (33%), MSW (2.5%), FSW (2.5%), friends (64%), blood relatives (6%), and spouses (16%). 18.8% had paid for sex and 7.5% had been paid. Other studies (Kulkarni et al., 2000; Naz Foundation, 2000b; Khan, 1993a; Unknown Author, 1999 [item ID40 in References]; Khan, 2000a; Direm ANALYTIX, 2002; Bombay Dost, no date [item ID58 in References]) report similar varieties of cruising sites 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, for 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 or boys to other men. The phrase has come under increasing pressure because of what it masks, namely various transactions and forms of exchange that bear little resemblance to the commercial sex work industry that dominates (as far as we know) the way in which Western sex workers are positioned in HIV/STI epidemiological, social and behavioural research. This too-easy adoption of the term 'commercial' 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, sex in sporadic moments of economic need (e.g. among street boys), sex in exchange for money on an irregular basis as supplementary income (possibly among students) or as the main or only income, sex work in brothel-based or other sex industries as a primary occupation (e.g. the bar boys in Thailand), etc. We cannot tell from 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 (Kinsuk, 1999 concurs). The distinction made in one paper (Anbu Illam Charitable Trust, 2002) between a 'pleasure' circuit and a 'commercial' circuit cannot be seriously sustained.

We also cannot tell from the cruising sites studies, or from the few studies where MSM report paying for sex, exactly what these terms mean with respect to 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 (i.e. a boyfriend), sometimes 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. Asthana & Oostvogels (2001) also notes the transient nature of panthi participation in cruising sites and suggests a social class differential in play, but provides no detail. What we do know, however, is that 'panthi' is a term those men do not use themselves, 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. AIDS Prevention and Control Project, 1996; AIDS Prevention and Control Project, 2001), 'street boys' (Murthy & Karott, 2000; Chandran & Balachandran, 2001; Ramakrishna et al., 2001), 'business executives' (Narain et al., 1994) – but no real analyses of sexual networking that might be associated with ethnicity, religion, race, age, generation, or class are available. In relation to young men, we must note that the report (Collumbien et al., 2000) of onset of sexual activity is 18.2 years for single men, 22 years if first sex was within marriage. However, Sharma et al. (1998) report that, among street children, older boys force AI on younger ones. Packianathan (2002) reports 52% of 50 largely effeminate MSM interviewed had been practising homosexual sex since 10-15 years of age. Similarly, in Anbu Illam Charitable Trust (2002), 83% of respondents had had their first sexual experience between at the ages of 10 and 19 (see also Chandran & Balachandran, 2001).

Secrecy (Bondyopadhyay & Khan, no date) and violence (Peoples' Union for Civil Liberties – Karnataka, 2001; Das Asit, 2002) are noted 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. Khan, 2001; Khan 1996a) 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 (Balachandran, 2001) attempts to head in this direction, but, in its attempt to re-categorise MSM on secrecy/cluster axes, it offers no findings of use to this review.

Collumbien et al. (2000) notes that it excluded labour migrants and students who live 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 – truck drivers and their helpers, whatever ‘helpers’ means (are they truck boys who are sex partners of the drivers or work peers who, as friends, seek sex with third parties?), taxi drivers, factory workers, hotel room boys (Khan, 1993b), and prisoners (scant, but noted in Srivastva, no date).

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 (2000a) notes, 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 Purkayastha, 1999).

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 intra-familial 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 provide 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. Others claim traditional (and often deeper) sources of meaning, more akin to designated social ‘roles’ or derivatives 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 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 (i.e. those attending clinics), in which one might assume higher levels of STI/HIV infection. 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. Still, 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, voluntary testing and counselling. Notably, there are no HIV prevalence data on MSW, possibly revealing, once 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 this population within the globalising HIV/AIDS category of MSM; the imperative to ‘prove’ vulnerability in order to obtain funds; the confusing of sexual practice with ‘risk-taking’ behaviours; the use of particular strategies of recruitment: these all play with dangers of overemphasis and misconstrued convergence of thought about the MSM category 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 spaces 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, particularly in the CBO-based studies, evidence of denser networks of MSM. The importance of cruising sites to the structure of these networks, and the sexual practices they produce, are not clear from these studies, as they tend to mask potentially different sexual economies situated in the same settings. What is also more difficult to assess in India is the inter-relatedness of sex between men, masculine sexuality itself, and the place of male erotics in 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 socio-demographic descriptors (age, ethnicity, religion, sect, location, situation, occupation, etc.) all confound the possibility and utility of the MSM category.

Appendix to the India Report

Table 1: HIV Prevalence Levels by State – Round 2000 – NACO 2003

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

S.No	Name of State/UT	Number of sites	HIV Prevalence (%)
16	Meghalaya	IVDU 1	1.41
		STD 2	0.00
		ANC 2	0.00
17	Mizoram	STD 1	2.00
		ANC 2	0.37
		IDU 1	9.61
18	Nagaland	IVDU 1	7.03
		STD 1	6.90
		ANC 4	1.35
19	Orissa	STD 4	2.60
		ANC 2	0.27
20	Punjab	STD 2	0.80
		ANC 2	0.00
21	Rajasthan	STD 4	2.84
		ANC 4	0.25
22	Sikkim	STD 1	0.00
		ANC 2	0.00
23	Tamil Nadu	STD 3	16.80
		ANC 6	1.00
		IVDU-1	26.70
		MSM-1	4.00
24	Tripura	STD 1	1.34
		ANC -	-
25	Uttar Pradesh	STD 7	1.80
		ANC 6	0.12
26	West Bengal	STD 5	1.96
		ANC 4	0.50
		IDU 1	-
27	A & N Islands	STD 1	1.20
		ANC 3	0.25
28	Chandigarh	STD 2	3.35
		ANC 1	0.80
29	D & N Haveli	STD -	-
		ANC 1	0.00
30	Daman & Diu	STD -	-
		ANC 2	0.00
31	Lakshdweep	STD-1	0.00
		ANC 2	0.00
32	Pondicherry	STD 3	4.1
		ANC 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.

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 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 dramatically reduced from 143,000 in 1991 to 29,000 in 2001, the number of people infected with the virus is 1 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, according to projections at the time of writing, remain around 1.5% until the end of 2006 (UNAIDS, 2002).

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

- **Incidence of HIV among sex workers** has fallen. For example, surveillance data indicate that HIV prevalence peaked among FSW and their clients in 1995 and 1996 and has since begun to decline. Also, HIV prevalence among sex workers in the central and northern regions fell from 24%–30% in 1993–1994 to 13% in 1999.
- **Rates of HIV among military conscripts** have also come down, falling from a 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 IDU tested has remained between 20%–50% both inside and outside Bangkok. Half of Thailand's IDU are infected with HIV. Although the number of IDU is generally declining for several reasons, this 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% condom use in all commercial sex establishments. This 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 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, the National Advisory Committee on AIDS was established within the Ministry of Health. In 1987, Thailand launched its National AIDS Program, 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:

1. **Sustaining and expanding condom use beyond commercial sex.** Targeting condom and behaviour change programs towards other high-risk groups (e.g. indirect sex workers);
2. **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; and
3. **Ensuring access for people living 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 from brothels (direct), massage parlours, and other places (indirect) (WHO, 2001).

Military recruits have also been used as a source of epidemiological information, through annual anonymous testing of 60,000 21-year-old military men. 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

It was estimated that by the end of 2002 the Ministry of Health would supply anti-retroviral (ARV) treatment to up to 23,000 people. The Global Fund to Fight AIDS, TB & Malaria has promised funding to Thailand, which is supposed to increase the provision of highly active anti-retroviral therapy (HAART) from 3,000 people to 70,000 over five years. The Thai government, through the Ministry of Public Health, is also providing free ARV to all HIV-positive 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 anti-retroviral treatment into the health insurance scheme was being considered at the time of writing.

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. (1995), the sample is of 2,047 men with 134 MSM identified (any lifetime same-sex partners); in Nopkesorn et al. (1993), there were 1,115 men with 126 MSM identified.

In the Beyrer et al. (1995) study, conducted in northern Thailand, an HIV incidence among 20–22 year-old men ($n=2,047$) 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 behaviours 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 (1996) study of five cohorts of military conscripts from six provinces of northern Thailand, HIV incidence among these men ranges from 10.4% to 12.5%. In May 1991, the HIV incidence was 10.4%. In November 1991 it stood at 12%, in May 1993 at 12.3%, in November 1993 at 11.5%, in May 1995 at 6.7%, and in November of 1995 it was at 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 report, 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 report 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 report fails to indicate whether this was over the lifetime or in the previous year; data on both were collected).

In Nopkersorn et al.'s (1993) paper, 10% (8 out of 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.

HIV incidence among MSW is rarely reported. Kunawararak et al. (1995) and Beyrer et al. (1997), in studies of MSW in Chiang Mai, found an HIV incidence of 16.6% (27 of 219) and 16.5% (17 of 103) respectively.

Information on other STI incidence among MSM is very scarce. Kunawararak et al. (1995) reported the incidence of syphilis among MSM at 7.6% for Chiang Mai, while Beyrer et al. (1995) noted that MSM were significantly more likely to report STI than other men. Sitattrai et al. (1992) noted 7.7% of MSM had reported an STI in the 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 (UNAIDS, 1999:12) 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'. 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 either 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 problematise 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 seeks to a) identify the causative factors for homosexuality and gender non-normativity and b) propose cultural interventions to limit its development; and
5. Research by Thai academics, generally published in Thai, that seeks to manage the social well-being of 'kathoe' – 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: kathoe; 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 kathoe

[Borthwick, 1999; Ten-Brummelhuis, 1999]

'Kathoe' is a gender category, historically consisting of both men and women, but in recent times applying almost exclusively to men. The current use of 'kathoe' 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 1997:53). Importantly, the status of kathoe as a separate gender category allows so-called '100% men' (i.e. heterosexual men) to engage in sex with them without 'endangering' their

masculinity. Kathoe are understood to be the receptive partners in anal intercourse (AI) within both popular and academic discourse, *but this might not reflect the reality of their sexual practice*. Much of the research on kathoe pre-dates the HIV epidemic and operates within a project of social control and the amelioration of social disadvantage.

Research on military conscripts

[Celentano & Bond, 2000; Beyrer et al., 1998; London et al., 1997; Celentano et al., 1996; Nelson et al., 1996; Beyrer et al., 1995; Nelson et al., 1993; Nopkesorn et al., 1993a; Nopkesorn et al., 1993b; VanLandingham et al., 1993]

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. At the same time, 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. (1995:174) note that '[d]eferments are given for men in higher education, limiting the conscript base to a less educated sample of the general population'. 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-kathoe men may lead to under-reporting of both of 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

[Kanggerruer, 2001; McCamish et al., 2000; Biehle, 1999; de Lind van Wijngaarden, 1999; McCamish, 1999; Storer, 1999a; Storer, 1999c; Beyrer et al., 1998; McCamish et al., 1998; Beyrer et al., 1997; McCamish & Sittitai, 1997a; McCamish et al., 1997b; Natpratan et al., 1997; Beyrer et al., 1996; Kunawarak et al., 1995; Sittitai & Brown, 1994; Sittitai et al., 1994; Sittitai et al., 1993]

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 (Sittitai & Brown, 1994; Sittitai et al., 1994;

Sittitrai et al., 1993), sexual networks and sexual geographies (McCamish et al., 2000), HIV incidence (Beyrer et al., 1997; Beyrer et al., 1996; Kunawararak et al., 1995), discourses of identity (Storer, 1999a; Storer, 1999c), social support (de Lind van Wijngaarden, 1999; McCamish, 1999), and workplace safety (McCamish & Sittitrai, 1997a). There were no studies with a primary focus on clients of MSW.

Theoretical work

(Jackson, 2000; Borthwick, 1999; Jackson, 1999a; Jackson, 1999b; Jackson & Sullivan, 1999; Murray, 1999; Storer, 1999b; Jackson, 1997a; Jackson, 1997b; Jackson, 1995; Morris, 1994; Sittitrai et al., 1991)

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 categorisation 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 (Borthwick, 1999; Storer, 1999c; de Lind van Wijngaarden, 1995; Sittitrai et al., 1992). There are two general population studies (non-military) that make some reference to MSM (Nelson et al., 1993; VanLandingham et al., 1993), and one study using medical students (Pongthai, 1990) that includes a sub-sample of MSM.

4. MSM Population

Estimates of either the size of the population of MSM or incidence of MSM sexual practice 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. (1995), 6.5% of conscripts reported one or more lifetime male sexual partner. In Nelson et al. (1996), recruits across three years (1991, 1993 and 1995) reported 2.8%, 3.8%, and 4.8% respectively on sex with male partners. In London et al. (1997), 16.3% reported AI/OS with a male partner. In Nopkesorn et al. (1993a), 11.3% reported AI with a male partner (10% insertive, 4.1% receptive).

Borthwick (1999), in her paper on models of community development and service delivery among MSM in northern Thailand, argues that 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 man. 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 categorisations, suggests that the incursion of Western discourses is far reaching.

The study of medical students (Pongthai, 1990) 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 'homosexual'. 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 homosexual males engaged in homosexual contact than heterosexual males.'

Similarly, studies of MSW sometimes classify participants by 'identity' or sexual 'practice' outside of sex work. In Sittitrai et al. (1993), 82% of MSW reported only male partners in the previous year. In the clinical study of MSW (Kunawararak et al., 1995), 57% of MSW described themselves as 'heterosexual'. In McCamish (1999), 20% of MSW self-identified as 'gay'. In Beyrer et al. (1997), 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 – MSM samples in some studies are defined *ipso facto* by the presence of same sex partners, in others the samples are derived from identity characteristics, while a number of studies make no categorical distinction at all. Therefore, studies may report the incidence of sexual acts among all men, among men with a same-sex partner(s), or among men defined by some other criteria as 'homosexual'. There are, however, consistent findings that rates of insertive AI with other men are greater than rates of receptive AI with other men. This may reflect a reporting bias that would be consistent with the system of values proposed by Jackson (1999a).

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 categorisation (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. Beyrer et al. (1995), 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. Nopkesorn et al. (1993a) reports that 11.3% of *all* male conscripts have had AI with a male (10.0% insertive AI and 4.1% receptive AI). London et al. (1997), with 512 conscripts, reports 16.3% of all male conscripts have had anal or oral sex with another male. And Nopkesorn et al. (1993b) is particularly informative in understanding these findings as it includes partner type: 13.6% of the 157 men reported insertive AI with a kathoey, 3.2% had had insertive AI with a non-kathoey, and 3.3% had had receptive AI.

The study using self-defined MSM populations in north-eastern Thailand (Sittitrai et al., 1993; Sittitrai et al., 1992), 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, median 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 Sittitrai et al. (1994), 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 Kunawarak et al. (1995), 42% reported inconsistent condom use with clients and 58% always used a condom with clients. In Beyrer et al. (1997), with 103 MSW, 72.1% reported inconsistent condom use.

The UNAIDS synthesis document (UNAIDS, 1999:25) notes that '[b]ehavioural 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'. The 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 (e.g. wives, girlfriends, 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 categorisations offered by Jackson (1999b, 1999a, 1997b, 1997a), Storer (1999c, 1999b, 1999a) and Murray (1999). 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 make a distinction based on the *transactional* quality of the sexual practice of limited value.

McCamish et al. (2000), 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 (1999) notes the difference between MSM networks in Bangkok and Pattaya – in Bangkok, there is considerable mobility between bars (with low social bonding between workers) and in Pattaya the workers remain in the same bars for long periods (with high social bonding between workers).

In an examination of the male sex work industry in Chiang Mai, de Lind van Wijngaarden (1995) 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 ways 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. 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, a 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 (1999b, 1999a, 1997a) 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 stigma 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 not considered 'same-sex' (or even 'sex').

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 assessment of the veracity of HIV incidence estimates difficult.

8. Conclusions

Overall, there is a paucity of reliable and generalisable data on the current incidence of HIV among 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 this 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 problematises 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 stigmatisation 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 hazard that must be highlighted is the temptation to make trans-Asian generalisations about the characterisation of transgendered communities. What should be clear when these reports are read is that the 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 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 both by research efforts and the funding of interventions. While Thailand has, as a whole, been the subject of an intense academic and health organisational gaze, and the site of intensive interventional effort throughout the history of the HIV/AIDS epidemic, MSM as a 'group' and MSM sexual practices have been exceedingly marginalised. The recency of much of the research that includes, even peripherally, MSM, speaks strongly of this phenomenon and offers some hope for the future.

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 HIV 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 (IDU) and sex workers. The economic, political and social upheaval of recent years has provided an opportunity for HIV to spread rapidly. The 2001 MAP Report states that Indonesia is experiencing an explosive epidemic.

The most notable increases in HIV infection levels are in Jakarta at 18% in 2000 for female sex workers (FSW) and 47% for IDU in 2002. There has also been an exponential rise in infection among blood donors, with a ten-fold rise in HIV prevalence from 1998 to 2000 (MAP, 2001). 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).

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

Indonesia has tested sex workers anonymously for HIV infection since 1988, expanding from two cities to cover 15 provinces. Very few FSW 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 FSW in Merauke, Irian Jaya.

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

Estimates for end of 2001 by WHO/UNAIDS

- 120,000 adults 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)

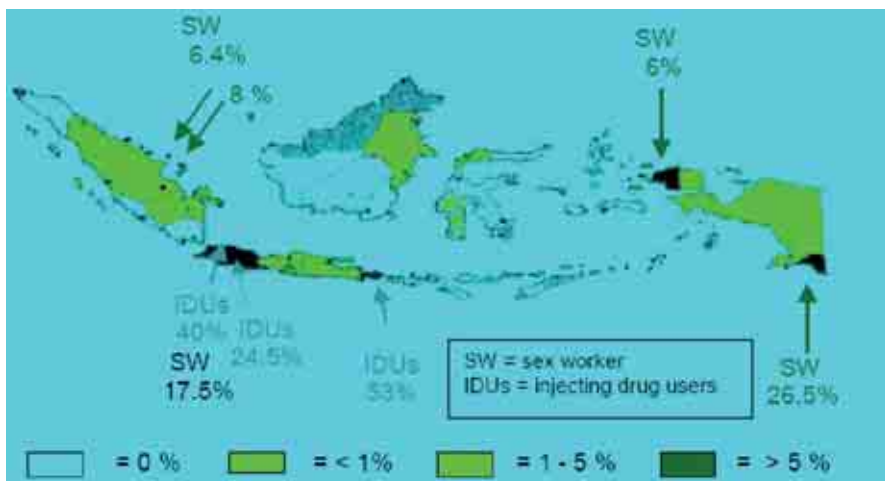
National strategic framework

In 1987, the Government of Indonesia established a National AIDS Control Commission (NACC) and began HIV surveillance activities. In 1994, 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 organisations 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;



[Source: MAP, 2001]

- Legal curbs to effective harm reduction interventions; and
- 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 BSSs 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 BSSs, due to each of the sites having cosmopolitan and urban characteristics, major entry ports and active sex industries.

Treatment for HIV

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

2. Epidemiology

Overall, there is a paucity of information on men who have sex with men (MSM) in Indonesia, especially in comparison with the other countries included in this report. 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 organisation Lentara Sahabat Remaja (1995a, 1995b, 2000) is based in Yogyakarta with gay-identified men and 'waria' (transvestites). The material from Ford, et al. (1995, 1994, 1993) is based in Kuta, Bali, and is concerned with commercial sex workers (CSW) and their clients. The behavioural surveillance surveys (BSS) from Utomo & Dharmaputra (2001, 2000, 1999) and Utomo et al. (2000, 1999) 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 localised, 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 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 (2000) suggests that the discursive power of the HIV/AIDS epidemic has increased the use of the term 'gay' and of variants of 'homosexual' – including 'homoseks', 'homoseksual', 'homoseksualitas' and the increasingly common 'homo' (not pejorative). Both Oetomo (2000, 1991) and Boellstroff (2003, 2001a) argue that 'gay' is a term that is primarily used in privileged Westernised contexts and within academico-political discourses.¹ We will, for preference, use the term 'MSM', 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 2001 report from the Indonesian National AIDS Commission (2001) gives HIV prevalence rates among waria as 3.1% in 1996 and 6.0% in 1997, and refers to a 1999 study of 300 waria in which approximately half tested positive for syphilis and 27% had some other sexually transmissible infection (STI). And that is all we know of HIV at this time.

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

¹ Oetomo has also written about 'warok/gemblak' relationships in Ponorogo, Java, in publications not included in this review (mainly in electronic format or in community publications; visit www.sshe.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 (approximately 8 to 15 years of age). They don't call themselves 'homosexuals' and don't identify themselves as homosexual, such as one finds in the West or in modern Indonesia. Instead, they would call themselves 'warok-gemblakan'. It is a tradition of prowess, and of performing arts. The older performers in the Reyog Ponorogo dance are usually waroks, and, traditionally, the younger boys (nowadays some of them are women) are the gemblakan. (Source: www.sshe.murdoch.edu.au/intersections/issue2/Oetomo.html). Yuwana (1994) reports on the sexual practices in these relationships, which consist exclusively of thigh sex and masturbation.

conducted by this organisation were part of an AIDS awareness program. In Lentera Sahabat Remaja (1995a), 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 Lentera Sahabat Remaja (1995b), with a sample of 43 transvestites, 30% had visited a doctor, and 21% were diagnosed with an STI (2% gonorrhoea, and the remainder uncertain). Notably, in-country reviewers gave a low quality rating to this material.

The publications from Ford, et al. (e.g. 1993) detail the HIV/STI knowledge, behaviours and condom use of male sex workers (MSW) and their clients in the Kuta area of Bali. In Ford et al. (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 Ford et al. (1995), with 80 MSW and 100 clients, the only STI information reported was that some of the MSW reported STI symptoms or experience with STI since they had started sex work.

The BSSs (Utomo, Dharmaputra et al.) provide information from a number of sites on STI treatment seeking and self-treatment. The table below summarises the findings from Utomo et al. (2000) [item IS41] and Utomo & Dharmaputra (1999) [item IS43].

In addition, the 2000 BSS (Utomo & Dharmaputra, 2000) 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 operationalisation 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 timeframes for sexual practices, and meaningful denomination of findings, adds considerably to the difficulties of interpreting these data.

Table IS1: STI Treatment Seeking and Self-Treatment

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

4. Sexual Practice

As noted, the studies from Lentara Sahabat Remaja (1995b, 1995a; see also Lentara Sahabat Remaja, 2000) 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 and transvestites also differ from data 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 (AI) with both paying and non-paying partners. The table below summarises the two studies from Lentara Sahabat Remaja (1995a, 1995b).

Table IS2: Percentage of Participants Reporting Specific Sexual Practices

Sexual practice	1995a (n=64 MSM)	1995b (n=43 Transvestites)
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%
Receptive chest sex ²	-	14%
Kissing	85%	100%

The studies of MSW and their clients conducted by Ford et al. (1995, 1994, 1993) 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 Ford et al. (1993), 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 Ford et al. (1995), where the greatest amount of detail is reported. The other publications (Ford et al. 1994; Ford et al. 1993) offer similar findings.

Table IS3: Percentage of MSW and Tourist Clients with Paying, Paid and Non-Paid Partners Engaging in Various Sexual Practices in Previous Week

(n= 80 MSW and 100 male tourist clients)

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 Ford et al. (1995), condom use for AI 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 rationalisations, on condom use. Interestingly, in Ford et al. (1993), 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 BSSs (Hidayat, 2001; Utomo & Dharmaputra, 2000; Utomo et al., 2000; Bali Team, 2000; Utomo & Dharmaputra, 1999) give limited data on sexual practice among MSM, concentrating on condom use. The BSSs use the terms '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 57% of the respondents reported their last sex as having been with their current boyfriend. About 32% reported their last sex with a heterosexual 'boyfriend'. A few reported their last sex was with their 'wife', 'girlfriend' or a CSW (Utomo & Dharmaputra, 2001:25). The 2000 BSS on transvestites in Jakarta (Utomo & Dharmaputra, 2000) includes information on the number of clients provided with anal sex on the day before the 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.

² Rubbing of the penis against the partner's chest/breasts.

The summary document of the 1998 and 2000 BSSs (Utomo & Dharmaputra, 2001) 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, Adhi (2001) reports that, of the 37 'gay-identified' men interviewed, 20% had anal sex, 20% oral sex, 16% inter-femoral or thigh sex, 8% rimming, and 36% a combination of these. In an unpublished thesis, Yuwana (1994) reports on the sexual practices of seven 'gemblak' participants, noting that they only engage in inter-femoral/thigh sex or masturbation.

5. Sexual Networks

The critical issues for sexual networks 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 waria. The extent to which MSM also have sex with women is evident in a number of documents. As mentioned above, the BSSs include information on last sexual partner. The Lentara Sahabat Remaja material (1995a, 1995b) 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 Ford et al. (1995), 4% had had sex with women in the last week, while in Ford et al. (1993), 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 (Oetomo 2000, 1991). When one considers the available data on the sexual practices of waria with clients (i.e. waria will often be the penetrative partner in AI), and of '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 or gender configurations.

There is very limited information on the geography of sexual networks; a few papers cite cruising sites with no further elaboration. Oetomo (1991) lists 'publicly known gay hangouts' as parks, street beats, shopping malls, hotel lobbies, amusement parks, swimming pools and gyms. The draft report for the Male Sexual Health Project (Girault, 2000), interestingly, describes sites in Jakarta as dual purpose, i.e. where MSM can find partners for 'commercial' and 'non-commercial' sex. These sites 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 (Blowfield, 1992a). 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 organised brothels to salons, 'fashion houses', streets, and word-of-mouth. Beazley (2001) presents an ethnography of 'street children' in Yogyakarta, with particular reference to sexual networks (both paid and unpaid). This paper, again, points to the complexities of sexual mixing, and the importance of local gender categories. The boys in the study have sex with peers, acquaintances, 'banci' (sex workers), 'renden' (street girls), girlfriends, adult men, tourists and sex workers (both male and female). The boys are both paying for and being paid for sex, and will often visit a banci with friends in order 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 evidence available at this time. 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. To extrapolate on the available data would be foolhardy. The few studies conducted thus far offer up some ideas on the MSM sexual cultures operating within several culturally and locally specific, fluid, and, importantly, permeable contexts. What is clear from the material reviewed here 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 characterisation of a singular Indonesian MSM population unfeasible. Indeed, the ways in which MSM activity is characterised 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 from West Papua) prohibits any premature foreclosure of a singular MSM category or related MSM categories.

Condom use levels 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.** Yet, 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.
3. **Various clusters of men who seek male sexual partners** (sometimes loosely called 'gay men'), sometimes as clients, local and foreign, of MSW 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 categorisation is that the categories are by no means mutually exclusive, nor are they stable over time. 'Transvestites' are sometimes sex workers, while 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.

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A code is provided in brackets at the end of each reference. This code [e.g. [IS3]] corresponds to the associated entry in the Annotated Bibliography, allowing for easy cross-referencing between the country reports, References section and Annotated Bibliography. Codes for Bangladesh begin with 'B' [e.g. [B12]], for India with 'ID' [e.g. [ID104]], for Thailand with 'T' [e.g. [T17]], and for Indonesia with 'IS' [e.g. [IS3]].

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