Inaugural Statement by Dr. Nafis Sadik

Special Adviser to the United Nations Secretary-General and
Special Envoy for HIV and AIDS in Asia and the Pacific

Male Sexual Health in Asia and the Pacific International Consultation: "Risks and Responsibilities"

Strategies, Removing Obstacles and Addressing Challenges
– Specific Programming and Scaling Up

CHECK AGAINST DELIVERY

23 September 2006
New Delhi, India

Experience

The current situation

Thank you for inviting me to inaugurate this important Consultation. I bring you the greetings of Kofi Annan, Secretary-General of the United Nations.

Your presence here this evening shows that a new era is starting in the path towards overcoming the burden from HIV in Asia and the Pacific. It is the first time that the issue of male sexuality is addressed on such a scale in our region and this certainly marks a turning point in the fight against HIV.

UNAIDS estimated in 2005 that in the worst case scenario 12 million adults and children in Asia and the Pacific could be infected by 2010; the cumulative death toll could reach three million; and the economic cost could be $18.7 billion.

UNAIDS estimated in 2005 that in the worst case scenario 12 million adults and children in Asia and the Pacific might be infected by 2010; the cumulative death toll from AIDS might reach three million and the economic cost of the epidemic might be as high as $18.7 billion.

Although we are not facing an epidemic situation comparable to that of many African countries, we must never forget that the issues we are addressing at this Consultation are essential if we are to succeed in our goal of turning back the epidemic.

I also wish to underline that we have very little specific information on the magnitude of the problem, as available data is being distorted by stigma, discrimination, denial and concealment.

HIV will remain a major threat in our region if countries fail to address the specific aspect of male sexuality through enlightened policies, courageous leadership and determined action. We know that while prevalence may be low overall in Asia, there are explosive outbreaks among sub-populations, such as men who have sex with men. In Asia, these sub-populations number in the millions – more than the total population of many small countries in Africa.

Cultures and societies in Asia and the Pacific have deep roots – but they have no special quality that protects people from infection. HIV is transmitted from person to person here in the same way as in other regions. The disease is spreading now mainly by sexual contact between men and women. Actually, deep pockets of prejudice, discrimination and misinformation prevail that hamper effective prevention because they are targeted at these populations that often are at higher risk of HIV transmission.

The so called high-risk categories overlap to a considerable degree, and each in turn overlaps with society at large. I think it is important to stress this point, because the designation of high-risk categories tends to separate them from the mainstream.

I want to emphasise that many members of all the high-risk groups, including men having sex with men, are very much part of the mainstream. In Karachi, Pakistan, for example, a government survey in 2003 found only one case of HIV among injecting drug users. Seven months later, 23 per cent tested positive. Possibly even more ominous, a fifth of the Karachi users had also injected in other cities, and about half used non-sterile injecting equipment.

There is a high degree of interaction between drug use and transactional sex, both male and female. According to the survey, over 20 per cent of female sex workers in Karachi and Lahore had sold sex to injecting drug users.

Protection was almost nil: one in five sex workers could not even recognize a condom, and three-quarters did not know that condoms prevent HIV. In fact, one-third had never heard of AIDS. These persons have jobs, families, social and professional lives. When we speak of the epidemic breaking out of the high-risk groups, we mean that a man who has had sex with men has infected his wife; or a business associate; or the wife or son or daughter of a relative or friend. For example, a survey in India showed that more than a quarter of male clients of male sex workers were married or living with a female partner.

One of the biggest risks in our regions is denial and refusal to respond to realities, whether it is drug use, sex work, extra-marital sex, or sex among men. The countries of Asia and the Pacific can roll back the threat of a widespread HIV epidemic in the next ten years; but only if governments and societies are willing to face facts and respond to them.

Men who have sex with men

Sex among men is one of the most sensitive and deeply-hidden of the facts with which Asia-Pacific countries have to deal. Many leaders and policymakers in Asia and the Pacific choose not to recognise its existence at all; or if they recognise it, they prefer not to address it. Many people react with derision and contempt to the idea of male-to-male sex. In many countries, sex between men is a criminal offence – 16 out of 20 countries responding to a recent UNAIDS survey. But ignoring, stigmatising or criminalising an unwanted fact will not make it go away.

The experience of western societies in dealing with the threat of HIV among men having sex with men is of only limited use in Asia and the Pacific. Relatively few men identify themselves as "gay" in the way that the West understands it. Instead, there is a wide range of gender identities and sexual practices, which vary from country to country, and which the practitioners themselves see in different ways. Acceptance varies by socio/economic class, as well as by country and type of practice.

For example, in South Asia, many middle-class men who have sex with other men lead conventional married lives. Truck drivers in Lahore or rickshaw-pullers in Dhaka may frequent male sex workers, or have relations with male colleagues, but do not define themselves as homosexual or "gay".

Many men have sex with people they do not recognise as men. Some transgendered people belong to categories whose existence has been known for centuries, but who have always lived on the fringes of mainstream society and whose sexual health needs have never been addressed.

There is certainly a vital need for countries to address male-to-male sexuality. Not only is this sexual behaviour, in its different forms, present in all countries in Asia and the Pacific, but HIV has taken hold in communities of men who have sex with men and transgendered persons, and is spreading among them largely unchecked by prevention programmes. For example, prevalence has reached 28 per cent among men who have sex with men in Bangkok, according to one study, and may have reached as high as 16 per cent in the Indian state of Maharashtra.

For a variety of reasons connected with stigma about both HIV and male-to-male sexual activity itself, many men not only do not use condoms but see them as unnecessary. Many know little about how HIV is transmitted or how to protect themselves. They often do not perceive that they are at risk for infection, despite manifestly high-risk conditions and practices.

Meanwhile, the social stigma that imposes secrecy and concealment contributes to furtive encounters and multiple partners. Stigma also prevents such men and transgendered people from resorting to available services. Police harassment is often a reality for them; the mere presence of condom is sometimes used as evidence of illegal behaviour; even where male to male sexuality is legal, prejudice among service providers may deter men from using the services. According to UNAIDS, access to outreach programmes for information and condom supply is less than 10 per cent of men who have sex with men in 16 countries in Asia and the Pacific.

Strategies

The variety of sexual experience and gender identity among men who have sex with men and transgendered people presents a considerable challenge to HIV and AIDS prevention and treatment programmes; especially because it is only now coming to light, and there is a very limited knowledge base to work with. Workers in the field are indebted to courageous governments such as Thailand, which has promised universal availability of anti-retrovirals to men having sex with men; Indonesia, which has promoted condom use among male sex workers, and India, which has announced a massive increase in funding for such programmes, even if its legislation remains far behind, but that might change.

We should also recognise the contribution of international non-governmental organizations such as Family Health International, which have funded research and action, and national ones such as Naz Foundation International and the Humsafar Trust in India that have spurred governments to recognise and approach this difficult and sensitive area.

I believe that non-governmental organisations have a very important part to play in finding a way through the labyrinth of male-to-male and transgender sexuality to promote safer sex, HIV counselling and treatment, care and support diagnosis and treatment of sexually transmitted diseases and the psychological and social support these individuals require. Civil society organisations have unique knowledge and experience of the communities they represent and work with, and can help avoid mistakes that cost both money and lives.

It will be very important to carry out good research as a basis for action and I hope this consultation will help to establish a strong research agenda. Given the wide variety of male-to-male and transgender experiences and identities, deep-rooted stigma, and prejudices imported from other cultures, it will be even more important than usual to ensure that research is correctly conceived and carefully executed, to obtain strategic information and evidence for programming and allocation of resources.

Preconceptions drawn from western experience may be of little value: countries must have the confidence to trust their unique knowledge of local culture and practices. At the same time, researchers must use the most rigorous science to develop and analyse information. The resulting action programmes will need equally careful execution. A blanket approach to all male-to-male and transgender sexuality will probably miss some key communities and may deter or alienate others. At the same time, there are several actions that countries should take now, without further delay.

The ***first*** is:

a. To decriminalise male-to-male sexuality in all its forms. Much of the current law is left over from colonial times, and should be simply removed from the books.
b. Countries should also reconsider their approach to commercial sex and sex work.
c. On the other hand countries may consider legal sanctions against those who knowingly spread the infection.
d. Police, judges, court officers and social workers will need retraining and reorienting on both the issues of HIV and sexuality; including male-to-male sexuality and that of transgendered people

The ***second*** necessary action is to increase awareness among the public at large and remove stigma about, and discrimination against, men having sex with men. The public must understand that sexual orientations are biologically determined and not driven by vice, crime or mental disease.

At the same time, we must not forget that women, including married women, will need the information, the means and the power to protect themselves from possible infection. Special attention should be given to protecting young married women, who know little or nothing about HIV/AIDS.

The ***third*** action is to develop awareness and tolerance among HIV and AIDS prevention and treatment service providers. This is an additional challenge for countries where discrimination and stigma persists against people living with HIV; but it is a necessary step. Services must make available different kinds of condoms—again, a challenge where condoms of any kind are in short supply.

Fourth, programmes should reach mainstream male communities, including prison populations; the armed services and police; migrant workers and professional travellers such as truck drivers. Whether they acknowledge it or not, all these groups are exposed to male-to-male sex, as well as to commercial sex with both men and women, and need prevention and treatment.

Finally, efforts to inform, educate and change behaviour among all vulnerable groups about HIV prevention and treatment should be redoubled, with particular attention to men having sex with men. Open discussion about the implications of unprotected anal sex will help the different groups of men having sex with men and transgender people to understand and respond to the need to protect themselves and others. At the same time, the public at large, and especially young people, need better information on HIV and AIDS, with the aim not only of increasing knowledge and reducing rumour and misinformation, but of removing stigma and prejudice about the disease.

Men who have sex with men are severely affected by HIV, and need close attention on that account alone. Because of the epidemiology of HIV and AIDS and the overlaps with other groups and society at large, concentrated epidemics among men having sex with men pose a grave risk in Asia and the Pacific.

Countries must find a way to go beyond the stigma and denial which has helped create this crisis. Experience shows the effectiveness of a non-judgemental, knowledge-based approach, using good science and well-tried public health techniques.

The other essential elements are courage, commitment and leadership in approaching a difficult and sensitive area. You are here today and in the coming three days to discuss just how to do this.

You can be assured of the support of the United Nations family in your common endeavour to win the battle against HIV among the MSM and transgender communities. If nobody else is there for you – we are here!
With that, I officially declare this International Consultation on Male Sexual Health and HIV in Asia and the Pacific: "Risks and Responsibilities" officially open. I wish you every success.

23 September 2006