Researching MSM[1] in South Africa: Some Preliminary Notes from the Frontlines of a Hidden Epidemic

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Introduction

This article outlines some views on researching MSM (men who have sex with men) in South Africa based, in part, on insights gleaned from a recent working conference on gender, same-sex sexuality and HIV/AIDS in South Africa. The core concern is understanding what research processes should consider in future MSM research in relation to community knowledge, community participation and the design of programmes targeted at intervention in the transmission of HIV.

To argue that questions of sexuality occupy critical zones of concern in African contexts is beyond dispute. Researchers asking questions about identities, bodies, health, disease, gender, power and difference are compelled to take sexualities seriously and indeed, virtually all aspects of our lives could be interpreted through the lens of sexuality, regardless of personal routes to sexual identity. Sexuality, as we have come to interpret it, could be broadly defined as "a set of social processes which produce and organise the structure and expression of desire" (Cranny-Francis, 2003: 9). As Rubin argued, more than two decades ago, it is when sexuality, as an abstract concept, moves towards tangible expression – sexual acts, sexual behaviours and sexual choices – that constructions of the social find themselves embedded in both overt and subtle articulations of sexualities, politicizing values, identities, and activities in ways that constitute embattled zones of citizenship (Rubin, 1984: 263). "Sex acts", Rubin (1984: 2) notes "are burdened with an excess of significance".

When applied to the context of disease (especially HIV/AIDS), and in relation to homosexuality, it is the bodies of homosexuals that often circulate within medical and social discourses as "pathological". Since HIV/AIDS was first diagnosed and since its first identification with homosexual transmission,

homosexuals have virtually been ignored in treatment and prevention programmes, except where – as in the United States of America between 1985 and the mid-1990's, gay and lesbian activism forced a focus on homosexual health rights. In South Africa, almost all medical and civil society-based research on HIV and AIDS has been focused on heterosexual transmission (or on mother-to-child transmission) (Abdool Karim & Abdool Karim, 2005). The near-erasure of homosexuals from the HIV/AIDS epidemiological picture in South Africa could be attributed to political exclusion (Fourie, 2006). It may also be due to a historical reluctance by policymakers to address HIV/AIDS in same-sex practicing populations because such an engagement would require engaging with sexual practices and identities that are already steeped in prejudice and pathologization (Johnson, 2007).

We would argue that the prevailing culture of denial *vis á vis* homosexuality in the South African context is in and of itself a hostile response towards homosexuality, and is something which warrants analysis in terms which include South Africa in other continental cultures of denial around homosexuality. These cultures tend to categorize homosexuality as a Euro-American perversion that has contaminated African "tradition"; despite increasing evidence of the existence of homosexuality in pre-colonial Africa[2]. The assumption that homosexuality is a sign of European and Western decadence is underpinned by homogenising discourses that view "tradition" as static, unchanging and fixed. Central to this discourse is the common and totalising argument that homosexuality is "unAfrican" with the argument often focused on homosexuality's absence in pre-colonial Africa (Antonio, 1997). Antonio (1997: 295) is reluctant to use the preposition "in" to locate homosexuality within "*African* culture", but chooses rather to explore the range of sexual practices possible within diverse African societies and claims that the "absence" of homosexuality in pre-colonial Africa is a construction deployed simply in the architecture of a homogenising and political homophobia.

When debating homosexual practices in African contexts, it is important to note that open articulation of homoerotic desire and activities is unusual; such desire is shrouded in codes of silence, secrecy and taboos that prevent public discussion and exposure[3]. However, public responses to ideas about homosexuality in many African contexts usually dramatise a contestation over the legitimacy of homosexuality, constructed through the representation of same-sex practices (Dunton & Palmberg, 1996; Reddy, 2002). Given that

language is one fundamental part of representation, and that representation of experience entails the rejection of any centralised or universal meaning, reference to homosexuality becomes a crisis of representation in relation to culture and politics. Engagement with simply 'naming' homosexuality becomes a political act of exclusion, where those who practice same-sex activities, express same-sex desire, and/or identify themselves in any way within codes identified as "homosexual" are excluded in the same breath as they are named. Such exclusion takes place for a number of cultural reasons: (1) notions of purity concerning sexual orientation (Hutchins and Kaahamanu, 1991: 221) where same-sex acts are scripted as "impure"; (2) various types of stereotyping such as promiscuity (Dunphy, 2000), where same-sex practices are already coded as part of a degraded promiscuity; and (3) stigmatisation via the labelling of homosexuals as HIV carriers (Aggleton, 1999a, 1999b, 1996; Herdt, 1997; Treichler, 1999; Sontag, 1991; Waldy, 1996).

Thus, research which seeks to uncover the realities through which men in African contexts desire one another sexually, seek one another out for sexual and other encounters of intimacy and friendship, and/or engage socially or politically with one another in the comraderies of acknowledged homosexual experience and desire, faces two overwhelming challenges. Firstly the challenge of researching the "unAfrican" within Africa raises complex questions of legitimacy. Secondly, even to name the "man-having-sex-with-a-man" – as a focus for research – is to place him within the vector of the pre-pathologized. This is particularly true where homosexuals are considered transmitters of disease and the bodies of overtly gay men in particular become sexed in relation to AIDS (Watney, 1997, 2000; cf. also Ruel & Campbell, 2006 for a more contemporary argument about the link between homophobia and HIV/AIDS). This article explores the complexities of researching MSM in African contexts, seeking to raise questions about research processes whose political location seem to make them doomed from the outset but which, we aver, are critical to a deeper understanding of the epidemiology and impact of the illness.

Lesbian and Gay Vulnerability to HIV and AIDS: Preliminary Research in African Contexts

While we know that the epidemic in South Africa is pronounced among heterosexual populations, we also know that lesbian and gay communities are not immune to HIV/AIDS. In his seminal study, *Off the Map: How*

HIV/AIDS Programming is failing Same-Sex Practicing People in Africa, Johnson (2007) suggested that HIV/AIDS stakeholders have jeopardized efforts to combat the AIDS epidemic in Africa, fuelled in large measure by the denial, criminalisation and erasure of same-sex desire and behaviour, resulting in increased vulnerability by same-sex practicing populations. Over and above people who self-identify as lesbian, gay or bisexual, HIV/AIDS also impacts on other men who have sex with men and women who have sex with women (categories of sexual practice that are often erased from studies and interventions). Where prejudice runs deep about homosexuality in many societies, this is fuelled in part by perceived (received) ideas about gender, belief systems, stigmatisation and socialisation, and the absence of human rights and the presence of human rights violations. While several studies about same-sex sexuality and HIV/AIDS in Africa have now been published[4], South Africa still lags behind; although data have been presented in posters and lectures at conferences, peer-reviewed papers are still rare (e.g. Lane *et al.*, 2008; Parry *et al.*, 2008; Sandfort *et al.*, 2008).

The medical literature shows that the first cases of HIV-infection and AIDS in South Africa, reported in 1983 and 1985, revealed that at that moment in time infections were largely confined to white men who had sex with men[5]. The concern among some medical professionals, as illustrated by a brief discussion paper in the *South African Medical Journal*, included recommendations for precautions in sexual activity, the importance of the existence of a gay community, and the need for rapid revision and change in South Africa's health care support system (Isaacs & Miller, 1985). In 1988, Schoub and colleagues (Schoub *et al.*, 1988) reported with careful optimism that the rate of expansion of the (white) homosexual epidemic in South Africa "shows preliminary signs of being checked". Beyond this period, concern around the illness appears to have been overtaken by fears of a heterosexual epidemic with no thought spared for what was happening to homosexual transmission.

Since the generalised HIV epidemic began to unfold in South Africa in the late 80s, attention has thus shifted away from MSM where this concerned openly gay men and has become focused on the prevention of heterosexual and mother-to-child transmission of HIV. Much more significantly, until very recently, there has been no recognition whatsoever that people who have sex with those of the same sex may simultaneously be involved in heterosexual relationships, including marriage. There is currently no information on the

prevalence of HIV among MSM in South Africa, regardless of whether these men identify as gay or bisexual, or do not identify. There is a paucity of information addressing the social situations and broader contexts in which HIV transmission among MSM is taking place, the strategies among MSM to prevent HIV infection (and on whether these strategies are working or not). There is also little information on how to ensure that their HIV prevention and care needs are being addressed by current programmes and services.

A recent overview by AMFAR (The American Foundation for AIDS Research) provides a global picture with regard to HIV prevalence among MSM in various low and middle income countries. The table below shows the ten countries with the highest prevalence.

	HIV prevalence among MSM (%)	National HIV Prevalence (%)	Criminalize MSM?
Kenya	43	6.1	Yes
Jamaica	25-30	1.5	Yes
Benin	25.5	1.8	Yes
Thailand	24.6	1.4	No
Ghana	25	2.3	Yes
Bolivia	21.5	0.1	No
Senegal	21.5	0.9	Yes
Guyana	21.3	2.4	Yes
Trinidad & Tobago	20	2.6	Yes
Ecuador	19.2	0.3	No

Source: AMFAR Special Report (2008: 5)

The data in the special report by Amfar Aids Research (2008) contains recent epidemiological data (128 countries) of HIV among MSM, showing an increased rate of infection in countries where the epidemic appears to be fueled by denial, indifference, inaction. The report also highlights necessary steps that are recommended for corrective action and intervention. In addition, some important community driven initiatives are also currently underway as a collaboration between LGBT (Lesbian/Gay/Bisexual/Transgender) partners in Southern Africa, Latin America and the Schorer Foundation (Netherlands) focused on same-sex populations. The aim is to upscale HIV/AIDS prevention programmes targeting LGBT people between 2007 and 2010. The Southern

African partnering organizations are OUT-LGBT Well-being (Pretoria), the Durban Lesbian and Gay Community and Health Centre, the Triangle Project (Cape Town), the Rainbow Project (Namibia), Lesbians and Gays in Botswana (LEGABIBO) and the Gay and Lesbian Association of Zimbabwe (GALZ). The Southern African Project is called PRISM (Prevention Initiative for Sexual Minorities). The needs assessment phase of the major partners in the Southern African project is complete. Preliminary conclusions from a needs assessment conducted by OUT-LGBT (Pretoria LGBT organisation) focused on men, indicate that "HIV and STIs are seen as serious health problems confronting gay men", and "casual sex seems to be occurring in a context where anal sex is a preference", indicating that "these men (are) at a high risk of contracting and transmitting an STI or HIV" (OUT, 2008a: 29).

The *2008 Report on the Global AIDS Epidemic* (UNAIDS: 30) indicates that in the three decades of AIDS, we have seen that worldwide incidence has peaked, with the generalised epidemic nearing saturation and that mortality is rising globally. In 2007, 67% of all people living with HIV were in sub-Saharan Africa, while Southern Africa shared the disproportionate share of the global burden: 35% of HIV infections and 38% of AIDS deaths. In most regions outside sub-Saharan Africa, HIV is disproportionately affecting injecting drug users, sex workers, and men who have sex with men. Apart from evidence in modes of transmission with heterosexual intercourse related to serodiscordant couples, sex workers, and injecting drug users, recent studies demonstrate that unprotected anal sex between men is another factor in the Sub-Saharan African epidemic. Evidence showing HIV transmission between men who have sex with men revealed some important data: (1) in Zambia one in three (33%) surveyed men who had sex with men tested HIV-positive; (2) in the city of Mombasa (Kenya) 43% of men who said they had sex with other men were found to be living with HIV; (3) in Dakar, Senegal an HIV prevalence of 22% was found among 463 men who have sex with men. The above data suggests that men who have sex with men is a mode of transmission that should be investigated and examined in terms of sexual orientation and cultural interdictions against homosexuality.

Global responses to HIV/AIDS are increasing. At the first UN General Assembly Special Session (UNGASS) on HIV/AIDS, UN member states adopted a Declaration of Commitment on HIV/AIDS, which was followed by an agreement in 2006 to achieve universal access to HIV/AIDS programmes by 2010. In South Africa, there have been some developments, with the National

Strategic Plan [hereafter NSP] for 2007-2011 dedicated to identify key interventions to reduce new infections. The contextual factors that underpin such interventions are poverty, gender and gender-based violence, cultural attitudes and practices, stigma, denial and discrimination, mobility and labour migration and informal settlement.

Taking three examples, the NSP (2007: 30) recognises the link between sexual violence and HIV infection and argues that the "culture of violence involves negative attitudes (e.g. deliberate intention to spread HIV) and reduced capacity to make positive decisions, or to respond appropriately, to HIV prevention campaigns". In respect of cultural attitudes and beliefs, the NSP (2007: 31) draws attention to the element of patriarchy in that patriarchy prescribes women's lower status and therefore "impacts significantly on the choices that women can make in their lives, especially with regards to when, with whom and how sexual intercourse takes place". With regard to stigma, denial, exclusion and discrimination, the NSP (2007: 31-32) recognises that stigma is a factor that "interferes with HIV prevention, diagnosis and treatment as (stigma) is widely perceived as an outcome of sexual excess and low moral character leading to a strong culture of silence [...] because of fear of rejection and isolation by close relatives and the community at large".

In the NSP discussion of populations that are considered vulnerable to HIV infection, several groups at higher risk are included: women, adolescents and young children (15 to 24 years), children (0 to 14 years), people with disabilities, people in prisons, sex workers, people engaging in mobile, casual and atypical forms of work, refugees, and men who have sex with men (MSM), the first time that MSM has been included in the NSP. The NSP timeously calls for research to prioritise vulnerable populations with MSM being one example. The NSP states that there is "very little currently known about the HIV epidemic amongst MSM in the country" (69) and that "MSM have also not been considered to any great extent in national HIV and AIDS interventions" (p.38). The strategic plan further argues that behaviours of MSM are wide-ranging and include bisexuality, implying that "the HIV epidemic amongst MSM and the heterosexual HIV epidemic are thus interconnected" (p.38). The extent to which this actually is the case is currently unclear. The proposed study addresses this gap by combining an exploration of the sexual practices and sexual networks of MSM with HIV testing of this understudied population.

Researching "MSM"

In all of this, pertinent questions abound for the researcher embarking on research to find potential solutions to better understand "marginalized and hidden populations" and to formulate interventions that change behaviour and so help to minimize the epidemic. If research is to be seen as setting up "objects of inquiry", it is also about ontology and epistemology. Research implies finding answers to questions, implying engagement with *process* rather than merely the output of a *product* (with value accruing to the steps in the research process). It also serves an applied function, and in our case, we see research as essential as a basis for evidenced-informed strategies to resolve problems, and for finding potential solutions to unanswered questions. Therefore research serves multiple purposes that should enable us to engage between theory and praxis, the context within which we work, the communities which we engage in our quest to research that which is "hidden", "private" and oftentimes "taboo". The context against and within which such work is undertaken, is of immense importance to how we interpret the meaning of "surveillance", "prevalence" and "intervention" in same-sex practicing populations. We shall return to the question of categories and their meanings later but first a brief context for our own research.

Despite South Africa's progressive legal protections on grounds of sexual orientation, prejudice, hate and discrimination against homosexuality and against anyone practising same-sex sexual behaviour abound. With a full understanding of some of these material realities, as well as including the context of the diversity of sexual expression, and in the absence of data on homosexual transmission, we embarked on what we describe as first steps in exploring a research-based project on same-sex sexuality and HIV/AIDS in South Africa. We reflect in the following section on method and implementation by drawing into our argument ideas about the research process.

HIV research collaborations between the United States and South Africa have been going on decades, but such collaborations are exclusively focused on heterosexual transmission. Collaborations between the North and South also reflect the uneven terrain of resources at our disposal, the varied contexts in which we work, access to knowledge, and donor driven priorities in the broad field of development. To concretize these differences between us as co-researchers, and authors of this piece, Theo works principally through the lens of the psycho-social, and Vasu's is informed by cultural studies. Together

we have been able to bring our disciplinary, cultural, and activist toolkits to engage a process that is directed toward the creation of material that brings together research and advocacy sites. It is also the case that Theo's location in the North, and Vasu's location in the South, highlight the question of authenticity and location. The location of researchers within disparate geographies often results in tension around who speaks, who engages with what issues, and how such an engagement will lead to mutual collaboration. From our initial discussions about the context for research which meaningfully engages community participation as active agents, we were able to name these tensions, and commit to a partnership which could transform the political hierarchies at play. Theo, for his part, has been an attentive listener, persuaded by the value of research that has a purpose, sensitive to context and location, and a methodology that is inclusive and accountable to the beneficiaries of research. Vasu has taken the lead in terms of designing an approach to a context he shares which can respect the potential dangers of creating a new category of homosexual men to be hated by the state: "MSM".

We began with the recognition that same-sex sexuality and any engagement with homosexual transmission had disappeared from the epidemiological picture in South Africa, and that the role of same-sex transmission within the overall epidemic was completely unclear. We also found that while lesbian and gay populations in South Africa are visible and actively engaged in identity-based politics, there are other "hidden" populations that do not self-identify as either lesbian or gay, but who are part of the subcultures within same-sex practicing populations (Isaacs & McKendrick, 1992). It was essential to work with the hypothesis that such 'hidden' populations might be considered vulnerable in the context of the HIV/AIDS epidemic, but equally essential to recognize that such populations might overlap with "heterosexual" people and that the categorization of people via their sexual behaviour alone (not by their politicized affiliation to a socially marginalized constituency) was a fraught business. "Vulnerability" in our interpretation refers to the lack of opportunity, skills and power to make informed decisions about sexual practice and sexual negotiation. Vulnerability could be compounded by societal prejudice and discrimination linked to sexual orientation, to the reality of living a double life within both heterosexual social circles and zones in which same-sex sexual activity could take place, and to the stigma attached to sexual activity between men regardless of the identities, or contexts, concerned.

To explore potential answers about the experiences of MSM in South Africa, we decided to put together a three-day working conference at which a diverse group of approximately thirty researchers, community leaders and activists would take stock of available knowledge, establish some research priorities, explore and resolve challenges related to undertaking such research, and create a basis for innovative, community supported research activities. For this purpose the Gender and Development Unit (Human Sciences Research Council), the HIV Center for Clinical and Behavioral Studies and the Department of Sociomedical Sciences (Columbia University, USA), the Durban Lesbian and Gay Community and Health Centre and OUT-LGBT Well-being (Pretoria), came together.

We had collectively a threefold purpose to be implemented in a workshop format to (1) review the history of research strategies on homosexuality and to evaluate available research pertaining to same-sex sexual practices in its relation to HIV/AIDS; (2) identify research needs and priorities related to same-sex sexual practices and HIV/AIDS; and (3) explore challenges and potential solutions to research on same-sex sexual practices and HIV/AIDS.

The gathering also brought together prominent activists from Namibia, Zimbabwe, Malawi, Mozambique and South Africa, including policymakers from the South African government, as well as researchers and programmers. The approach to our conference considered the value of diversity and collaboration in a participatory research process that acknowledged the active presence of the researcher in processes of knowledge production. In addition, the value of experiences, concerns and voices of stakeholders who are themselves subjects of research (in our case, same-sex populations) is crucial to address power relationships when seeking to combine the knowledge of researchers and the experiences of those who are researched. Significant also is the fact that knowledge is best generated *with* people (Reason, 1994), that research is not merely about generating new knowledge, but directed toward change in society. In broad terms, the notion that science, what Harding (1991) describes to be a "strong science" requires us viewing the world from a variety of perspectives, and especially those of people normally excluded from positions of power (Ramazanoglu & Holland, 2002). In all of this, we recognised that future work in research necessitates a process of relationship building between the researcher and researched. But more importantly, a relationship between researcher and the subject of research (and the *researched*) should proceed with responsibility, as expressed at the conference by Nonhlanhla Mkhize (Durban Lesbian & Gay Centre):

> "There's a greater need to assist our communities to understand the need for the research, to engage with the researchers and the questions are developed towards that research being undertaken. But also and even more important, there is a need to even hold those researchers responsible for the information that they send out after having engaged with the relevant communities. There's a whole lot of misinformation after researchers have engaged with us and it's about time that we mobilise against dealing with such issues."

The ideas generated within the conference confirmed for us community knowledge is central to any future work. There was an overwhelming solidarity by all participants at this conference. The majority of participants also argued that there is no information about HIV prevalence among those who have sex with same-sex partners, that there is no understanding of how homosexual transmission plays a role in the overall epidemic and that there is no understanding of the prevalence of unsafe sexual practices among men who have sex with men and little knowledge of the psychosocial determinants of HIV risk behaviours. Flowing from a lack of knowledge were other consequences, namely: (1) lack of political support and resources for prevention; (2) current limited prevention efforts are not evidence-based; (3) nothing is known about the effectiveness of current prevention efforts; (4) knowledge can be gained by future studies focused on same-sex populations, and by (5) including same-sex sexuality in large population-based studies.

Underpinning all of the above factors was the issue of labels and language. Why do we use concepts such as "same-sex sexuality" and what purpose does this serve in the context of destigmatising discourses of homosexuality? The term "same-sex sexuality" for its part could be conceived as a broad concept that is inclusive rather than exclusive. While there may be a pragmatic dimension to this usage, the term "same-sex sexuality" discloses its own limitations. Given the complexity of identity-based categories such as lesbian, gay, bisexual, transgender and intersexed, such terms place a premium on visible, politicised and established markers of identity. It should be noted that even identity politics is a recent development: where sexual identity became a fashionable term since the 1970s, the term has served the purpose of mobilising collectively LGBT populations against homophobia in a rights-based discourse. But even identity-based politics has not resolved the problem of discrimination. And where it comes to researching the prevalence of sexual activity between men (or between women), identity markers (especially those

believed to be borrowed from the West, such as "gay" or "lesbian") are more of a hindrance than a help.

Cheik Niang (a Senegalese researcher) expressed some of these concerns about the relevance of language in MSM research:

> "What I would like to insist on, is that we have to go back to the ontological and philosophical debate. There are a lot of things to be explored at the philosophical, symbolic level, spiritual level, even language. The language is full of expressions that show different constructions of male-to-male sexuality or women-to-women sexuality. There are multiple identities and if we don't know the identities, if we don't work with the identities, the multiple identities, we will be sending a message that will not be received. People only receive the message when they think that you are talking to them. You will only reach them when it is clear that you know them, you know each other. You are in a position of empathy and empathy most of the time is excluded from the scientific research. Empathy could help to understand the other and redesign all the programs, messages and politics. If you say African societies are homophobic, I say okay, one side only, one level. If you go deep, you will find a completely different story. How can you use what is deep in order to challenge what actually exists in order to arrive at comprehensive HIV/Aids strategies? We should use a holistic approach of MSM as a marginalised group and make our research part of the process of social and political transformation. Societies are not rigid, are not fixed. Societies move, they have to evolve. New agendas will push for transformation when they take into consideration everything I said before."

If we assume that homosexual transmission of the HIV virus is not merely applicable to self-identified individuals, it is plausible to make the case that there are some people whom we describe as men who have sex with men (MSM) and women who have sex with women (WSW) who may not self-identify on these grounds. Such descriptions also do not fit the conventional label of homosexual men and women. Growing out of the global response to HIV/AIDS, such terms may be seen to run counter to the political interests of an identity-based constituency in some quarters. The terms MSM and WSW describe behaviour rather than a specific group of people. The terms foreground and aggregate sexual practice around same-sex desire but also minimize identity and differences between the varieties of sexual expressions of sex between men. Included in this category could be self-identified LGBT

people, as well as heterosexuals. Many men in particular who have sex with other men do not consider themselves gay or bisexual. As a result of marriage, and where discrimination persists, including social stigma, particularly men who have engaged with sex with other men, choose to keep their private sexual lives hidden from public purview. Fear of exposure and public embarrassment compel such individuals to remain in the closet. This is particularly true of repressive social contexts where homosexuality is criminalised and where heteropatriarchal power persists.

We were aware that with the categorization "MSM" or "WSM", there is the possibility of further stigmatisation. Given the fact that HIV/AIDS is already fraught with blame, shame, denial and discrimination, often allocated to vulnerable groupings such as women and homosexuals, the tendency exists that with new labels such stigma could be perpetuated. As early as 1991, Carol Vance points out as an example, the fact that homosexuality is seen in a variety of ways with varying degrees of recognition, that in some societies is tolerated as well as encouraged, or in others seen simply as **acts** and not as an **identity**. Vance concludes her article by foreseeing a reversal back to a biomedical approach to sexuality (and therefore a loss in momentum to the cultural or social side) due to the AIDS outbreak. She maintains that with the advent of AIDS, the biomedical model of sexuality has come to the forefront. The danger here is that it reduces sexuality to being a "derivative from physiology and a supposedly universal functioning of the body". It denies that sexuality has a history and that changes bring about a difference in how we interpret it over time and in different cultural contexts. Even though Vance does not refer to MSM, the value of her argument lies in the fact that if we are to consider homosexuality in its relationship to HIV simply in terms of *acts* rather than *identity*, we run the risk of viewing sexuality purely in terms of its biological function.

It is true that with HIV/AIDS, the medicalization of sexuality is intensifying. The public turns to medical authorities for sexual information and advice. Donors and funders are insistent on quantifiable data that explains "prevalence" and "incidence". Thus, medical and public health interests in sexuality are expanding to new areas beyond the specialities to which it was traditionally confined: sexually transmitted diseases, obstetrics and gynaecology, and psychiatry. According to Vance (1991) there are also some limitations about biomedical responses to sexuality. These are (i) re-medicalization; (ii) re-pathologization of sexuality; (iii) emphasis on quantification i.e. "behavioural data" (iv) "safer sex" becomes an issue.

Despite the risks here, however, we believe that the lack of attention for same-sex sexuality in the HIV/AIDS epidemic is unacceptable. From a public health perspective, limited attention to same-sex sexual transmission might undermine the overall fight against HIV and AIDS in Africa. It is obvious that much work needs to be done and the conference on which some of these insights are based raise questions that address: (1) how are same-sex sexual expressions and practices organised and networked? and; (2) what is the prevalence of HIV among same-sex practicing populations, and what is the contribution of homosexual transmission to the South African epidemic? While wariness around medicalization of homosexuality was part of the conference deliberations, and while it was broadly agreed that the MSM category – in its overt connection to issues of public health – carried dangers, it was also agreed that the vulnerability of men having sex with men (and women having sex with men) to HIV transmission warranted activist-oriented research.

There was general consensus among conference participants that, in relation to HIV transmission, research is needed that not only acknowledges prevalence of same-sex sexualities, but which also fosters an understanding of the diversity in same-sex sexual practices. Furthermore, labels that are being used do not necessarily have identical meanings for the persons involved. The label "gay" as used by black men in townships intersects with gender-role identification and differs in this respect from the meanings in the industrialized world. For example, in South Africa, terms such as *isitabane* (hermaphrodite) are used. Then there are terms such as *skesasana* (a boy who likes to be fucked), *injonga* (one who proposes and does the fucking) and *imbube* (a man who sleeps with men and women)[6]. Understanding diversity of sexual expression implies acknowledgement of the fact that the organisation and expression of same-sex sexuality is tenuous: the use of identity labels is changing while men and women's self-understandings change. This is the result of increasing exposure to different ways of expressing same-sex sexuality, within South Africa as well as more globally. Research is also part of this process and is likely to contribute to it. Whatever future studies will be conducted about same-sex sexuality and HIV/AIDS, there is a great need for understanding of the meanings attached to identities and practices.

A second point, critical to developing our research strategies, is that HIV cannot be understood, and also not be effectively addressed, without interrogating the context and issues that affect men and women with same-sex sexual desires, a point highlighted by Pierre Brouard (active in HIV/AIDS as an activist and counsellor for over two decades):

> "In our research and prevention, we should not only focus on behaviour. Behaviours don't occur in a vacuum, they occur in a social context. Ideas circulate in the social and I think it is important to look at the labels people use. I am thinking about research Graeme Reid has done in townships outside Ermelo, where you define yourself as a lady or a gent and the ladies are the bottoms, the gents are the tops. And the tops often are involved with women and marriages as well. Those labels define your behaviour and your roles and your identity and what you do sexually, how you negotiate. So I think it is worth looking at labels and language too."

This is in line with current thinking about HIV/AIDS that emphasizes that in addition to the role of micro level factors, attention should be given to structural factors as well. This implies that the socio-economic and cultural circumstances in which same-sex sexuality is practiced, including the stigma attached to same-sex sexuality – while South Africa currently has the most liberal constitution as far as homosexuality is concerned, the country's social norms form a sharp contrast with its liberal constitution: the level of acceptance of homosexuality in South Africa is very low (Inglehart & Welzel, 2005). Discrimination and violence, resulting from the stigma attached to same-sex sexuality affect how MSM and WSW shape, structure and experience their sexual practices, including the risks they take. Instead of exclusively focusing on individual determinants of risk, research should furthermore account for *how* sex is expressed in social relationships, calling attention to power dynamics and structures. Understanding the potential spread of HIV also requires looking beyond individual behaviour, and exploring social and sexual networks.

The representation of various practical and scholarly disciplines at the conference also introduced a discussion of research ethics. In the discussion, participants expressed that there was a strong need for constant reflection upon what researchers are doing: Why are specific research questions asked? What could be the consequences of the outcomes of the studies we initiate? Is there acknowledgment of the context in which the work is being done? The ethics of "highlighting for science" the sexual practices of people who would be socially stigmatized by neighbours, friends, family members, for their sexual activities and desires needed to be constantly under interrogation. While there was acknowledgement that this was easier said than done, the recognition that researching same sex sexuality could bring "justification"

to state-based homophobia ("these men are spreading the virus") was reiterated frequently within conference discussions. This placed "researching MSM" within a dynamic very similar to that already inhabited by lesbian and gay people in South Africa: "coming out" as people publicly willing to acknowledge the meaning of same-sex sexuality is risky – as much as there is potential to engage (and perhaps disperse homophobia through discussion, new knowledge, and activism), so is there the risk that the mere visibility of homosexual people intensifies local homophobia.

It was agreed that research about same-sex sexuality and HIV/AIDS needs to follow specific ethical guidelines. To start with, directly affected communities (notably the LGBT communities) should be involved in as many parts of the research process as possible, a point articulated by Ian Swartz (Rainbow Project, Namibia):

> "People who participate in research should get their information back. Once we started signing agreements with researchers stating that the study findings would make their way back. One of the researchers for instance just sent an electronic version via internet, a 150-page document to people here who have hotmail addresses. These are all people that access the internet from internet cafes where they pay per ½ hour and then you end up paying anything between R1,00 and R2,50 per page. So again now people have received the information, but there is nothing they can do with it. In fact they can't even open the document properly, forget about reading it, because you pay per minute that you access the internet at an internet café. The other thing is that the information is written in a language, I mean it is written by an academic. The language is such that people can do very little with it. And so what we do nowadays is that we actually agree on <u>how</u> the information is going to make its way back. That you as a researcher promise to come back to Namibia and not just send us something. That you do a little presentation. And if there were too many people, then you would train some people who were part of the research project to go out and do that presentation to others. But to get the information out so that it has meaning and so that people can really benefit from it. That is important".

Such participation should not be limited to the recruitment of study participants, but also include the development of research questions, the methodology as well as decisions about dissemination of the outcomes. Inclusion of the community will facilitate that research resonates with the

realities of the target group and promote the use of findings in ways that are planned and thought through as part of local strategies against homophobia. Furthermore, it was agreed that researchers should be aware of the needs that might be elicited by their studies and make services available to address the needs identified. It was also suggested that researchers should take the responsibility for providing proper and adequate feedback to the target group once a study was finished.

In all of this, researchers need to reflect upon their social position as researchers and the role of research. This implies an understanding of the political dimensions of the work they are doing and the power dimensions involved. This also includes an awareness of the fact that in research, issues can be framed in various ways and that the way an issue is being framed is also embedded in a politics. Researchers should ask the question: does my study and the terminology used do justice to the reality of the persons involved?

While intellectually we know that research is supposed to further our knowledge of a problem, issue and a field, in relation to HIV/AIDS (as may be the case for other fields), there is similarly an applied aim to research as well: research should help us to prevent further transmission of HIV, to make sure that affected people receive the support they need, and to counteract stigma attached to HIV/AIDS. Consequently, the aim of most HIV/AIDS research is to develop interventions, respond to policies and develop new ones where existing policies fail.

It also became clear in discussions at this conference that research about same-sex sexuality and HIV/AIDS could have several additional functions. One of these functions may seem basic, yet the political implications are vast in the context of silence and denial: research can deliver proof that homosexualities of many diverse shapes exist; dispelling through an evidence-based framework that homosexuality is simultaneously African. Any discussion of same-sex sexuality must include the relevance of identity politics that confronts homophobia and bigotry. Several activists expressed the view that the institution of science (through a research endeavour) could be used to challenge homophobia, as well as to advocate and increase visibility of same-sex sexuality. In parallel, and perhaps idealistically, research can have a legitimizing function for people who engage in same-sex practices. “Science” can be harnessed, despite its history some argued, to urge political attention to problems and to promote the release of resources for prevention. The

inclusion of same-sex sexuality in mainstream population studies, such as the upcoming South African National HIV prevalence survey, is likely to promote some acknowledgement of same-sex sexuality and increase its visibility.

There was a strong consensus that what should be prioritized in South Africa is research that brings about *change* that has an impact on a variety of levels, and can be used by various stakeholders. These stakeholders include policy makers, LGBT communities, health care workers, and persons with same-sex sexual desires and practices. Different stakeholders will of course have different research needs. In this sense the *value* of collaboration received overwhelming support by the stakeholders present. But while there was consensus, a number of concerns remain for us. The key concerns flow from the dearth of previous research in the area. The sheer number of questions we need to answer is overwhelming.

Key Questions: The Politics of Choosing "Research Foci"

While all participants acknowledged a strong need for research on same-sex sexuality and HIV/AIDS, there was also an awareness of the various barriers to the kind of research proposed. One major barrier was the difficulty of gaining access to relevant populations, partly resulting from reluctance which formed a barrier to participation in research due to a homophobic climate. Another factor, making research interesting but also complicated, is the diversity of expressions of same-sex sexuality. While research should acknowledge this diversity, and even make it an object of study, this diversity also will limit the possibility to develop generalizing conclusions. More structural barriers signalled by the participants were the scarcity of financial and material resources and the lack of a social scientific research infrastructure in South Africa focused on same sex sexuality.

The list of questions related to same-sex sexuality and HIV/AIDS that require research attention is extensive and it is hard to set priorities. The research questions requiring attention can be organised into various categories.

Firstly there are several epidemiological questions. Research is needed to assess HIV prevalence among MSM and WSW and to understand the role of homosexual transmission in the South African HIV/AIDS epidemic. The political need for epidemiological data is to be able to legitimize attention for HIV prevention aimed at MSM and WSW and to claim needed resources to do so. Understanding homosexual transmission of HIV also requires determining who is having sex with whom, and what people are actually doing together

in their social and sexual networks. Are people having sex with persons from within their social network or do sexual networks exist relatively independent of social networks? Understanding sexual networks will help to find out what the best places to intervene to prevent the further spread of HIV are[7]. Epidemiological research also requires sophisticated sampling approaches that allow for generalization of study findings. Integrating homosexuality in general population surveys would give the opportunity to make comparisons, and to utilize the findings regarding same-sex sexuality into proper perspective.

A second group of research questions should help to successfully address the prevention and care needs of persons who engage in same-sex sexuality. This involves the exploration of the various factors associated with unsafe sex as well as with the adoption of preventive strategies. Also relevant in this context is to understand how sexual interactions come about: what kind of sexual communication takes place and how are desires negotiated? Beyond the individual level, research focused on communities might be helpful: how are communities being built and how do such communities support safer sex practices? Other questions deal with access to health care, including voluntary counselling and testing, and treatment for HIV: what kind of barriers exist and how could these barriers be removed?

Understanding risk behaviour only makes sense if a broader context is taken into account. "Risk" as a concept is potentially dangerous and could have ambiguous meanings, depending on how it is being deployed. Risk often has moral implications, and when used in relation to sexuality and sexual practices, these meanings have to be carefully unpacked. Given the reality that same-sex sexual practices already operate in a stigmatized and specifically homophobic environment, the meanings of "risk" in relation to such sexual practices must be first understood by people who self-identify with same-sex sexual practices. More importantly, to address populations effectively, it is of crucial importance to understand what same-sex roles, identities and practices mean to individuals and communities. What kind of understanding do people have of same-sex sexuality? How are these understandings changing and as a consequence of what kind of factors?

In order to promote adequate political attention to same-sex sexuality and HIV/AIDS, we also need to understand the history of policy making. What happened for it to take so long to include same-sex sexuality in South Africa's National Strategic Plan? Such questions should be studied in the context of South Africa's general HIV/AIDS policy, taking into account the social

meaning attached to homosexuality, and the role that should be played by lesbian and gay organizations in mobilizing around HIV/AIDS. Other questions that would fall under the rubric of policy research deal with current decision making processes: What attention is being paid to same-sex sexuality in policy? How can a research-based advocacy influence the latter?

A final set of questions addresses programmatic needs and program evaluation. Even though solid evidence is lacking for the development of interventions aimed at people with same-sex practices, such interventions are being implemented, predominantly by LGBT organizations and community centres (notably in South Africa) but in other African contexts (for example, Malawi, Mozambique and Zimbabwe), but this is difficult where homosexuality is criminalised. If and where interventions do take place, ongoing monitoring of the quality of program implementation and the target populations' responses to the programme is also important.

It is clear that one research project cannot take on all the above questions, and yet, the vulnerability of MSM and WSW demand that all be addressed. The choice to pull together activist and expert LGBT constituencies in order to debate the way forward proved powerful in building partnerships for undertaking the research but at the same time generated expectations for the impact of the research – and a wealth of research foci – in ways that position us as researchers in a difficult place. Not all the questions can be answered; not all the expectations can be met.

Conclusions

Researching MSM and WSW within South Africa has a complex background. On the one hand, it is imperative that the vulnerability of men who have sex with men, and women with women, (in diverse contexts, ways, and identities) be much more deeply understood and comprehensively addressed. On the other hand, homophobic contexts, the vast diversities of practice, identities, and desires involved, and the need to ensure that what becomes "knowledge" about MSM and WSW contributes to social justice as opposed to stigmatization and increased homophobia presents researchers with daunting challenges. As researchers, we are emboldened by the solidarity of our conference allies, yet concerned about the tensions within the terrains. Would it be possible to create knowledges which "proved" to state-located homophobes that MSM are "responsible" for the epidemic? Will research on MSM pull donor funds and research interests away from the needs of (for example) poor, married,

women? How do we ensure that the man having sex with men, whom we meet as part of our research discussions, receives the ARVs he may need (or simply the care and respect he deserves from his community)? These are some of the worries that stalk our midnight hours.

However, the worry that gets us out of bed – towards the methodological design of research we are about to undertake – gnaws with even greater strength. In the vast South African literature on HIV and AIDS, where are "we", the MSM and WSM? Should we remain invisible for another decade, will it even be possible to say "we"?

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Endnotes

1. The label MSM (men who have sex with men) is used here as a descriptor for a myriad expressions of same-sex desire by men, including men who self-identify as gay, those who may self-identify as transgendered men (who have not fully transitioned to the opposite sex), those who may self-identify as bisexual, those who may not self-identify as either gay, bisexual or transgendered but engage in sex with their own gender, and those who use the acronym as an identity label. MSM are considered a vulnerable group as they are prone to stigmatisation, lack inappropriate targeted health facilities, have little or no attention within national AIDS programmes, and where inadequate or unreliable epidemiological information about their sexual practices exist. While South Africa has decriminalised homosexuality, the reality in most African countries is that homosexuality remains criminalised. Because criminalisation rights do not accrue for lesbians and gays, in the absence of rights, homophobia and discrimination persists. And despite decriminalisation in South Africa, homophobia and discrimination are also realities for many South African homosexuals because of the cultural stigma. Even though this article does not engage in detail with these issues, we recognise that when we talk about MSM, such men will also be located within lesbian and gay groupings even though they may not self-identify with the label "gay". We draw on LGBT groupings to research "MSM" because such groupings interrogate and challenge homophobia, make the case for a rights-based approach to sexual diversity, and because MSM interact and intersect within LGBT groupings.

2. See Amory (1997), Baum (1995), Bleys (1995), Epprecht (2004), Johnson (2001).
3. See for example, Constantine-Simms (2001), Epprecht (2004), Gevisser & Cameron (1994), Murray & Roscoe (1998).
4. Allman *et al.* (2007), Cloete *et al.* (2008), Geibel *et al.* (2007), Jewkes *et al.* (2006), Kajubi *et al.* (2007), Lane *et al.* (2008), Lorway (2006), Niang *et al.* (2003), Onyango-Ouma *et al.* (2005), Sanders *et al.* (2007), Sharma *et al.* (2008), Teunis (2008), Van Griensven *et al.* (2008), Wade *et al.* (2005).
5. Anderson *et al.* (1983), Puren (2002), Ras, Simson, Anderson, Prozesky, & Hamersma (1983), Sher & dos Santos (1985), Spracklen *et al.* (1985).
6. See Gevisser & Cameron (1994: 165-168).
7. See Friedman *et al.* (2006).