

# Assessment of sexual health needs of males who have sex with males in Laos and Thailand

## Part Two: A Rapid Needs Assessment



Conducted for Pact by  
Naz Foundation International  
May 2005

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This publication was made possible through support provided by the Office of HIV/AIDS, Bureau for Health, U.S. Agency for International Development, under the terms of Pact's Leader Award No. GPH-A-00-01-00007-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of Pact or the U.S. Agency for International Development."



## Acknowledgements

We would like to thank Family Health International, Asia Regional Office, especially Philippe Girault, for all their support and assistance, as well as John Deidrick and his team at PSI/Lao PDR for their logistical support while visiting Laos, along with access to their studies and all-round general assistance.

Special thanks should go to Andrew Hunter, independent consultant and researcher for his assistance for the study in Thailand, to Xay Boulommavong of PSI Lao PDR, and to many others who shared their experiences and knowledge in both countries.

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## Acronyms

CBO	Community-based organisation
FHI	Family Health International
HIV	Human immunodeficiency virus
IDU	Injecting/intravenous drug users
INGO	International non-government organisation
Lao PDR	Lao Peoples Democratic Republic
LGBT	Lesbian, Gay, Bisexual, Transgender
LYAP	Lao Youth AIDS Project
MOU	Memorandum of Understanding
MSM	Men who have sex with men/males who have sex with males
NFI	Naz Foundation International
NGO	Non-government organisation
PSI	Population Services International
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Children's Fund
USAID	United States Agency for International Development

# Executive Summary

## Introduction

This report makes recommendations for the development of programmatic HIV/AIDS prevention work with males who have sex with males (MSM) in Lao PDR and Thailand. The recommendations made derive from a consultation process commissioned by *Pact*, and undertaken by an external consultant, Paul Boyce, working for the Naz Foundation International (NFI), conducting the assessment in Thailand, along with Shivananda Khan of NFI, conducting the Lao PDR review.

The objective of the study was to provide evidence-based knowledge towards developing a comprehensive client-friendly outreach and peer-education focused interventions for MSM in both Lao PDR and Thailand. This involved identifying key services in target areas and the gaps that existed, along with key individuals and organisations working with MSM, as well as potential organisations that can be sub-grantees, while recommending a programmatic strategy for increasing coverage of key services. Further key capacity building needs of nascent organisations were also to be identified.

A three-week field visit to Thailand was carried out in February and March 2005, focusing on three regional sites identified by *Pact* and USAID as *hotspots*,<sup>1</sup> and most appropriate for the initial phase of programmatic development – Bangkok, Chiang Mai and Pattaya. In Lao PDR, a one-week study visit between 16<sup>th</sup> – 26<sup>th</sup> March, 2005 focused on Luang Prabang, Savannakhet, and Vientiane, identified in a USAID conducted workshop on 17<sup>th</sup> March 2005 as current *hotspots* in this country. (See the annexure for a caveat to the *hotspot* approach.)

In Thailand, field research explored existing HIV/AIDS interventions among males who have sex with males, assessing the best strategies to augment current community-based interventions and expand coverage of their HIV/AIDS prevention work. In Lao PDR, where HIV/AIDS interventions are implemented by international non-government agencies (INGOs), and in one specific case by the government sponsored Lao Buddhist Association, and where no community-based organising exists,<sup>2</sup> field research focused on those who were developing responses to the needs of males who have sex with males, and/or who wished to.

Due to a lack of knowledge by those accessed by the review, and time constraints, actual costings have not been done on the recommended interventions. Further work will need to be done to assist potential implementers to develop appropriate budgets.

## Key findings

### Lao PDR

- There are currently only two small-scale MSM interventions in Vientiane, which focus on *kathoey*-identified males. PSI Lao PDR is implementing one through a peer education model and social marketing of condoms. This intervention is approximately nine months old. The other is that of the Lao Youth AIDS Prevention Project, which comes under the government sponsored Lao Buddhist organisation. This is also relatively new. The former primarily accesses students who self-identify as *kathoeyes* and their partners, while the latter appears to access low-income self-identified *kathoeyes*.

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<sup>1</sup> USAID approach to HIV/AIDS prevention, treatment, support and care in the Mekong Region (Lao PDR and Thailand are both included in this region) is to focus on the most at risk populations (MARPs), in what can be defined as *hotspots* in the region. In the context of male-to-male sex, and HIV/AIDS risk and vulnerability, a *hotspot* can be defined as a locality that has significant levels of male-to-male high risk sexual activity, and where evidence exists of a local HIV epidemic. By supporting a “packaged comprehensive approach” intervention in such a *hotspot*, an epidemic can either be prevented, or its impact can be greatly reduced.

<sup>2</sup> In Lao PDR, forming a community-based response to social and health concerns is not legally possible.

- There is only one treatment and care programme in the country, based in Savannakhet, which is supported by MSF and is located at a government hospital. This does not appear to be accessed by self-identified MSM, particularly *kathoeyes*, who may be HIV-infected or living with AIDS.<sup>3</sup>
- There are no STI treatment services focusing on MSM and anal sex concerns along with other rectal problems that could have an HIV impact, i.e. haemorrhoids, rectal tissue damage, and rectal fissures. Self-treatment is common.
- While the Burnet Institute and FHI Lao expressed interest in working with MSM, with Burnet desiring to set up a *kathoey* peer education programme in Vientiane, neither had initiated any interventions amongst MSM at the time of the visit. FHI may have difficulties in expanding its remit, since its MOU with the government appears to preclude such an additional activity. A new MOU would be required which could take some time to negotiate. Burnet appears to be primarily a research agency and would probably also need to develop a new MOU with the government to develop such an intervention.
- There is significant government resistance to acknowledge the existence of male-to-male sex in the country, equating this with “foreigner influence”,<sup>4</sup> but this may change soon, since the PSI Lao and Burnett studies were conducted, where both indicated a significant level of male-to-male sex. The Lao PDR National AIDS Centre has accepted this data and plans to include MSM as “risk group” which needs to be addressed, but at the time of the investigator’s visit to Lao, had not gained the government’s acceptance.<sup>5</sup>
- While there is an apparent social tolerance in regard to *kathoeyes*,<sup>6</sup> anecdotal evidence exists that this tolerance does not lead to acceptance. Feminised males are still stigmatised (because of their femininity and crossing gender boundaries and/or because of their involvement in male-to-male sex?), but this stigmatisation is much more subtle and less visible, than the violence against such males in other parts of Asia.<sup>7</sup>
- Government policies and mechanisms preclude community-based, and even locally based non-government, interventions. Thus any possible intervention would need to be conducted through an INGO or a Government sanctioned body. However, even the former could be restricted if the INGO does not have some mechanism in its MOU with the government that would cover additional or new activities. It seems that PSI may be the only INGO in Lao currently, with a broad enough government sanctioned mandate to implement such an intervention.

## Thailand

- Very few focused interventions on HIV/AIDS for males who have sex with males exist, and what does, have only come into being in the last four years. This lack of such interventions maybe correlated with the high prevalence rate found in Bangkok. Significant levels of HIV prevalence among MSM also exist in Chiang Mai.<sup>8</sup>

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<sup>3</sup> One study respondent in Lao stated that he personally knew of three *kathoeyes* living with AIDS in Savannakhet who would not access this service because of the high possibility of double stigmatisation. Personal communication, 21/3/05.

<sup>4</sup> Male-to-male sex is illegal in Lao as “being against traditional values.”

<sup>5</sup> This was stated by Dr. Chansy Phimphachanh, the Director of the Lao National AIDS Centre at a meeting on 21/3/05, with the investigator at PSI staff. She hoped to organise presentations for the Ministry of Health officials.

<sup>6</sup> It was observed by the investigator that at a range of entertainment and beer venues, *kathoeyes* used the female toilets without any resistance from either females or other males, while *kathoeyes* in these venues, and in other social spaces were not harassed.

<sup>7</sup> See NFI report Against the Odds: the impact of the sociocultural, legislative and socio-economic impediments to effective HIV/AIDS interventions with males who have sex with males in Bangladesh, 2002, 2004, accessible on NFI website [www.nfi.net](http://www.nfi.net).

<sup>8</sup> See Assessment of sexual health needs of males who have sex with males in Laos and Thailand Part One: Rapid literature review of current knowledge of MSM and HIV/AIDS in Laos and Thailand, conducted for Pact, 2005 for information on studies conducted in Thailand on MSM behaviours and epidemiology up to 2004.

- Surprisingly, with such a vibrant male-to-male sexual culture, there are very few MSM community-based organisations implementing HIV/AIDS prevention, support and care with males who have sex with males. These few organisations are all small-scale and limited in coverage, have nascent capacity, and would require investment in training and skills building to increase their capacity to deliver appropriate services, along with increasing in coverage.
- In Bangkok there were two community-based agencies delivering HIV/AIDS services focusing on different populations of MSM, Rainbow Sky and SWING. In Chiang Mai, there also two community agencies – M-Plus and Purple House/New Friends Club, along with a web-based intervention HealthyGay.Com. In Pattaya no services existed.
- Whilst some key individuals in these organizations demonstrated high levels of conceptual aptitude and practical ability in their work, it was observed that skills and organisational strength in the relevant community projects tend to be clustered around two or three persons. Moreover outreach workers interviewed identified that they needed further training in order to develop professional skills that will enable them to reach many more men in the areas in which they are already working
- Government attitudes towards HIV/AIDS and men who have sex with men in Thailand are ambivalent. The Ministry of Public Health is relatively progressive and is supporting initiatives aimed at males who have sex with males. The Ministry of Interior appears to be more intransigent. This said, there is currently public government initiative to address ‘hard to reach populations’ including males who have sex with males – perhaps arising from the 2004 Bangkok International HIV/AIDS conference.
- There is no identifiable linking organization suitable for funding with men who have sex with men (which is why FHI, for example, funds community-based organizations directly).

## Recommendations

### Lao PDR

#### 1. *Pact* with PSI Lao

*Pact* develop agreements with PSI Lao to implement a scaled up prevention programme in Vientiane with two drop-in centres and outreach teams, each team affiliated to a specific centre. Further similar prevention services should be developed in Luang Prabang and Savannakhet, each with one drop-in centre and outreach team. Along with this will be a range of advocacy activities with local bureaucrats and police to support this programme. The cost for this would be approximately \$60,000 plus management costs per annum.

#### 2. *Pact* with FHI Lao or PSI Lao

*Pact* develop agreements with either INGO, whichever is the most appropriate, in terms of their current MOU with the Lao government, to develop and implement a male sexual health clinic in each of the three cities, to which the prevention services can refer too. It has not been possible to cost this element at this time.

#### 3. *Pact* with Burnet Institute in Lao

*Pact* develops an agreement with Burnet Institute to conduct a range of behavioural, epidemiological and sociological studies among different sub-populations of MSM, so that more knowledge and understanding is gained.

#### 4. *Pact* with an appropriate training agency/consultant

*Pact* contract in an agency/consultant with appropriate training skills in the areas of project implementation, development, and management, along with increased capacity building on staff and outreach skills. Further appropriate training for clinical services will be necessary. Costings will need to be developed for this component.

## Thailand

- Given the limited experience and existence of organisations working with men who have sex with men, which have only been formed over the last few years, it is suggested that support be concentrated on existing programmes to strengthen their capacity, rather than suggesting that new or alternative organisations be established. It will be more strategically practical, cost effective, and epidemiologically significant (in terms of reaching as many males as possible as soon as possible) to consolidate the work of existing projects in Thailand and to use this as a basis for the expansion of HIV/AIDS prevention activities.
- With no identified linking organisation appropriate to funding MSM community-based organisations, *Pact* may need to either develop an in-country office in Thailand, which can then fund such organisations directly, or develop collaborative work with FHI and PSI in the country where each of these agencies would fund appropriate interventions directly.
- Increase coverage in Bangkok among MSM. along with *kathoey* and male sex workers through:
  1. Support provided to SWING to increase its current coverage in Patpong area of Bangkok<sup>9</sup> by implementing prevention work in male-to-male massage parlours in Silom/Surawong, Sukhumvit and Din Daeng areas of the city, along with outreach activities in the Pak Kalong Market (Bangkok 24 hour flower market) and surrounding canal and river areas.
  2. Support to enhance Rainbow Sky's current outreach work in seven focal "cruising areas" in Bangkok through capacity building in outreach skills and volunteer recruitment, enabling Rainbow Sky to extend their capacity to cover other "cruising sites" in the city, along with conducting a preliminary needs assessment in these additional areas. Further it is also recommended that Rainbow Sky should be supported to expand its sexual health awareness training in local colleges incorporating male-to-male sexual health messages into this generic HIV/AIDS prevention programme. This will be especially vital as a complementary strategy to focused intervention, enabling outreach to address men who may have sex with men but who would not necessarily be included within the parameters of specifically 'MSM focused' interventions.
- Increase coverage in Chiang Mai and provide support and care services.
  1. Support provided to M-Plus through training and capacity building in outreach skills to maximize coverage in areas already being worked in. Such training should also extend to conducting outreach work among male sex workers who use intravenous drugs. Further M-plus should be supported to develop an MSM HIV/AIDS intervention in Lampoon, a town a few miles away from Chiang Mai where the agency already has existing networks. This would include establishing a drop-in centre, recruitment and training of staff and volunteers, and operating a clinic one or two evenings a week.
  2. Support provided to New Life Friends Club to implement community based work, offering advice on treatment, voluntary counselling and testing, well being, and other related concerns through a drop-in and referral service, particularly focus on MSM who are HIV positive. New Life Friends Club also has links with men from hill tribes in the outlying districts near Chiang Mai, many of whom come to the city (and other parts of the country) to work as sex workers, where the majority do not identify as gay, *kathoey* or even necessarily think of themselves as men having sex with other men, providing a good opportunity to implement an 'upstream intervention', educating them about HIV/AIDS and sexual risk before they are exposed, as well as developing alternative income possibilities other than sex work.
- Developing new interventions in Pattaya.

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<sup>9</sup> Currently SWING is working in the Patpong area of Bangkok, providing outreach services, sexual health products distribution, and a drop-in service along with referrals to an appropriate clinical service.

1. Support provided to SWING of Bangkok to implement an HIV/AIDS prevention programme among foreign and Thai gay tourists as clients of male sex workers, and long term gay residents in Pattaya. This will include IEC materials in a number of foreign languages as well as Thai, along with prevention focused performances through outreach teams in venues and street areas where gay establishments are clustered, as well as provide referral services to STI doctors.
2. Further, while PSI Thailand will be developing an intervention focusing on kathoey sex workers in the city, including a drop-in centre, outreach activities and clinical support, it is recommended that SWING also be supported to implement a parallel intervention with male sex workers in conjunction with the PSI Project, also including a drop-in centre and outreach activities. In regard to access to STI treatment, negotiations should be held with PSI Thailand to access the clinical service that they will be developing.

No costings could be developed for these potential developments in Bangkok, Chinag Mai, and Pattaya within the time frame of developing report. The authors are still waiting appropriate information.

# Assessment in Lao PDR

Total Population (end 2001): 5,403,160

US Census Bureau

## Country HIV and AIDS estimates, end 2003

Adult (15-49) HIV prevalence rate	0.1% (range: <0.2%)
Adults (15-49) living with HIV	1700 (range: 550-3300)
Adults and children (0-49) living with HIV	1700 (range: 600-3600)
Women (15-49) living with HIV	<1000
AIDS deaths (adults and children) in 2003	<200 (range: <400)
No information on MSM living with HIV/AIDS	



Male-to-male sex is illegal in Lao PDR as “being against traditional values.” However, the National AIDS Centre has recently recognised the category of “men who have sex with men” as a “high-risk group.”

## Background

Lao PDR is a sparsely populated and mountainous country of some 5.4 million people, where the vast majority of people live in rural areas. Surrounded by countries with significant levels of HIV/AIDS (Cambodia, Myanmar, Thailand, and Vietnam), Lao as yet still shows a low prevalence (see above).

There is no information available in regard to STI/HIV prevalence among ‘MSM’. A PSI Lao PDR qualitative report (2004)<sup>10</sup> of the sexual behaviour and HIV/AIDS risk among “transgender men and their partners” in Vientiane, Luang Prabang, and Savannakhet, stated that “no reported cases through homosexual transmission” had been documented among the “over 1,100 people reported to have HIV/AIDS.” This report goes on to say that “the incidence of HIV among this *group* (emphasis mine – do partners of “transgender men” form a group?) is thought to be increasing in the region,”<sup>11</sup> adding “many MSM have [unprotected] penetrative anal sex. Here transgender means *kathoey*-identified males.

What the current state of knowledge indicate, is that the sexual frameworks of male-to-male sex in Luang Prabang, Savannakhet, and Vientiane, are complex and diverse, with differing sexualities, masculinities and gender frameworks, where desire, poverty and alcohol appear to be significant drivers of sexual encounters, and where increasing tourism, external communications, and media, are also bringing in an emergent gay framework. Further, anal sex is common, regular condom use varies considerably, and multiple partners, both male and female is not uncommon.

<sup>10</sup> PSI Lao PDR, October 2004: *Sexual behaviour and HIV/AIDS risk among transgender men and their partners in the Lao PDR - a qualitative report.*

<sup>11</sup> A 17.3% HIV prevalence rate found among MSM in metropolitan Bangkok - TUC/TRCS/RSOT 2003 – *The prevalence of HIV and associated risks among men who have sex with men (MSM) residing in the Bangkok metropolitan area*, Thailand MOPH – US CDC Collaboration/Thai Red Cross Society/Rainbow Sky Organisation of Thailand, 2004 (power-point presentation).

In the literature review conducted as a part of this Assessment<sup>12</sup> it was pointed out that the categorisation of a behaviour as ‘men who have sex with other men’ and as a “target group,” is problematic, where such diversity and complexity exists. Further, while *kathoey*-identified males, along with gay-identified men, may well be visible in a range of settings, sexual partners of *kathoeyes* and male sex workers may well merge into the general male population.

As the development of the above study evidenced, along with a quantitative baseline survey<sup>13</sup> conducted among a similar population group, also by PSI Lao PDR, a small study conducted among *kathoey*-identified males in Vientiane and Savannakhet on sexual health issues<sup>14</sup> by an independent researcher, and a study conducted by the Burnet Institute looking at young men’s sexual behaviour in Vientiane<sup>15</sup> that included issues around male-to-male sex,<sup>16</sup> this growing interest in MSM and sexual health concerns is very recent.

While the National AIDS Centre of Lao PDR has only recently included “MSM as a target group”<sup>17</sup> in the latest National AIDS Control Plan, the government continues to find itself in a quandary where the National AIDS Centre and the Ministry of Interior find themselves at odds (while the Health Ministry itself has still accept the concept of “MSM as a target group”), where the Director of the Lao National AIDS Centre stated that while she accepts the existence of male-to-male sex in the country, she was not sure whether “the government would be as accepting.”<sup>18</sup> Despite Dr. Phimpachanh’s level of acceptance, an issue was a size estimation of males who have sex with males in the country.<sup>19</sup> Neither Burnet’s or PSI Lao’s studies had been presented to the government.

The government of Lao PDR can be defined as a single party socialist/communist state, with no independent judiciary, and where, as one key respondent during the country visit was to state, that “the rule of law was based on the whims of the government at any given time.” The country, following the communist take-over in the mid 1970s with the overthrow of the monarchy in a “people’s revolution,” is only just coming out of international isolation, with the economy is beginning to open-up, international donors are offering support, and international tourism becoming a key player in the country’s economic growth. The Party still makes all decisions.

In such environment, there is no history of independent non-government organisations in the country, where civil society is underdeveloped, and where any health interventions are either by the government or government sponsored/organised organisations (very few), along with a few INGOs, who all have experienced significant difficulties in operating in the country. Such INGOs are required to sign a Memorandum of Understanding (MOU) with the government, a difficult proposition that appears to take several years. These MOUs also tend to clearly demarcate what such an INGO can do in its service delivery, which then makes it difficult for the INGO to do any work outside these boundaries. Any additional or new activity would require a new MOU to be signed.

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<sup>12</sup> Shivananda Khan, NFI, February 2005. Assessment of sexual health needs of males who have sex with males in Laos and Thailand, Part One: rapid literature review of current knowledge of MSM and HIV/AIDS in Laos and Thailand.

<sup>13</sup> PSI Lao PDR, November 2004: *Knowledge, attitudes and practices related to HIV/AIDS and STIs among transgender and their partners in the Lao PDR*.

<sup>14</sup> Doussantouse, Serge, 2004, 2005. *Male Sexual Health: Kathoeyes in the Lao PDR, South-East Asia – exploring a gender minority*. An unpublished paper

<sup>15</sup> Burnet Institute, February 2005. *Study of young men’s sexual behaviour. Vientiane, Lao People’s Democratic Republic. August – November 2004*.

<sup>16</sup> See note 12 above.

<sup>17</sup> Personal conversation with Mika Niskanen, Advisor/Liaison Officer, UNAIDS Laos Office. He pointed out that the inclusion of “MSM as a target group” in the new National AIDS Plan currently being developed has come out against a great deal of resistance from the other sections of the government. UNAIDS Laos Office has been at the forefront to ensure such an exclusion.

<sup>18</sup> Personal statement during a discussion with her as a part of the study visit. During this meeting Dr. Phimpachanh, agreed to set up a presentation of findings with Ministry of Health colleagues, but she was concerned about the possible reaction of the government.

<sup>19</sup> Personal conversation with a researcher in an INGO in Lao that the National AIDS Centre only accepted the figure of 80 such ‘MSMs’ in the country “because this was the figure of the number of respondents in a particular study.”

## Methodology

With a focus on male-to-male sexual practices, risk behaviours, and any HIV/AIDS interventions, discussion were held with a range of representatives from international non-government organisations and where these agencies were also acting as implementing agencies. Along with these meetings, a meeting was also held with the Director of the Lao PDR National AIDS Centre. These discussions focused on what knowledge the organisation had in regard to male-to-male sex, risky practices, and HIV/AIDS vulnerability, along with how the organisation is responding to these issues.

Based on perceived needs and knowledge by in-country INGOs at the USAID workshop in Vientiane held on 17<sup>th</sup> March 2005, in terms of MSM, Savannakhet and Vientiane were identified as the two primary *hotspots*.<sup>20</sup> Luang Prabang was also selected, based on significant levels of international tourism, and current knowledge of risky sexual practices among MSM in this city.

With this *hotspot* selection, visits were made to specific sites within these three cities where males meet other males that could lead to possible male-to-male sexual encounters. Along with observational analysis of these sites, discussions were also held with specific self-identified MSM in each city. Sites included entertainment venues, such as beer and karaoke bars, and discos, along with college campuses, beauty parlours, and eating establishments. Other meetings were held with key stakeholders.

### Meetings

Agency	Individual
Independent researcher/consultant	Serge Doussantousse
Care International in Lao	Geraldine Zwack
Lao Youth AIDS Prevention Programme	Vieng Akhone Souriyt
FHI Lao	Donna Flangan
Friends International Lao PDR	Tamo Wagener
MacFarlane Burnett Institute	Dr. Niramonh Chanlivony
National AIDS Centre, Lao PDR	Dr. Chansy Phimpachanh
PSI Lao PDR	John Deidrick Xouchai Payaouvong
UNAIDS Lao	Mika Niskanen

Meetings were also held with PSI Lao's MSM peer education team in Vientiane, along with *kathoey*-identified males in all three cities, as well as with gay-identified men in Luang Prabang. Specific sites visited in the three cities included a range of entertainment venues, beer halls, college campuses, beauty parlours, and discos.

Discussion were also held with:

- Matt Friedman, USAID, Bangkok
- Catherine Esposito, CARE International, Bangkok office
- Kurt Macleod, Pact Cambodia

Thus, methods used in this study included:

- Review of current knowledge
- Discussions with organisations, agencies and government representative
- Observational analysis of meetings places of males involved in male-to-male sex in Luang Prabang, Savannakhet, and Vientiane
- Discussions with self-identified 'MSM', including *kathoey*-identified males and gay-identified men, both Lao and foreign.

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<sup>20</sup> From HIV surveillance data between 1990-2003, Savannakhet had the highest total of 535 out of a figure of 1212, with Vientiane, second with 325 infected persons. Luang Prabang with a total of 20 identified HIV infected persons was selected because of it being a key international tourist destination, as well as evidence of significant male-to-male sex occurring.

## Current HIV/AIDS and MSM interventions

There are only two specific MSM and HIV/AIDS interventions in the country, both based in the capital Vientiane, and both focusing on *kathoey*-identified males. Both these interventions are very recent, less than a year old.

PSI Lao manages a limited peer-education programme, and conducts a range of sexual health and condom promotion work in Vientiane. Its MSM peer-education team are primarily college students who are *kathoey*-identified, who conduct outreach education at a range of venues known to them as places where *kathoeyes* can meet other males for sex, primarily college campuses and entertainment and drinking establishments. However, it was observed that some members of the PSI team did show certain biases, against low-income populations and occupation groups. For example no work was going on with labourers, construction workers, or *tuk-tuk* drivers. Further PSI Lao, as a part of its social marketing of condoms and peer education, conducts a number of HIV/AIDS awareness and condom promotion workshops for *kathoeyes* in Vientiane, which are facilitated by the PSI trainers and members of its *kathoey* peer-education team.

The Lao Youth AIDS Prevention Project (LYAP), a part of the Lao Buddhist Association, implements a broad based youth programme on HIV/AIDS education. They also have a specific *kathoey* outreach programme through street theatre and working with at beer halls and nightclubs. They tend to reach more low-income populations with this programme.

As an outcome of Burnet Institute's study of young men's sexual behaviour, they were discussing establishing a *kathoey* outreach programme.

While UNAIDS Lao had been involved in advocacy work with the government in regard to MSM as a vulnerable population in Lao (and can claim credit for this being taken into account in the design of the latest National AIDS Control Programme).

Care International in Lao PDR does have a reproductive health programme using outreach techniques, which reaches young men and *kathoeyes*, where they do discuss anal sex issues. However, their programme is funded by UNFPA, which has strict separation between reproductive health and HIV/AIDS.

Friends International has a street children's project in Vientiane, which does at times access some adolescent *kathoey* and other male sex workers through their general street children's programme and drop-in centre.

There are no STI services focusing on the needs of MSM, where the majority appear to use self-treatment. In terms of access to anti-retroviral treatment programmes, no such service exists specifically focusing on MSM. There is only one hospital-based programme in the country, and that is located in Savannakhet and supported by Lao Red Cross and *Medicine Sans Frontieres*, which is for all positive people. There is some anecdotal evidence that *kathoey* HIV infected persons, and other males who have sex with males who are positive do not access this service for a range of reasons including double stigmatisation and visibilising their gendered/sexual choices.

## Developing services and increasing coverage

As can be seen from above, MSM interventions in Lao PDR are very recent and minimal, while lacking coherence, appropriate structures, and a strategic approach to MSM and HIV/AIDS prevention, support and care. For *Pact* to invest in Lao in this area, a more strategic approach will need to be taken, seeing anyh interventions in the three *hotspots* as a coherent whole.

Due to government policies, there are no non-government organisations in the country. HIV/AIDS are all being implemented by INGOs, with the exception of Lao Youth AIDS Project, which is under the government-sponsored Lao Buddhist Association. In order for *Pact* to achieve its objectives in Lao PDR, and to avoid the time consuming negotiations with the government of Lao PDR (which could take more than two years!), it would be necessary for *Pact* to enter into an agreement with an implementing INGO in the country that has an already existing broad-based MOU with the government. The most obvious choice would be PSI Lao, because

of its national spread and an existing broad-based MOU.<sup>21</sup> Further, PSI Lao is already implementing an MSM (*kathoey*-based) HIV/AIDS intervention in Vientiane, albeit on a small scale.<sup>22</sup>

Because PSI Lao and LYAP appear to be accessing different socio-economic groups of *kathoeyes*, these agencies should discuss ways and means of working together, while PSI Lao should address the economic class bias of its peer-education team. It is unclear whether it would be possible for PSI Lao, or *Pact* itself, to directly fund LYAP to expand its own programme and scale up this initiative, or whether PSI Lao's intervention should be scaled up and its outreach programme extended in partnership with LYAP. This needs to be clarified.

It is further recommended that a community-based approach to addressing the sexual health<sup>23</sup> needs of self-identified MSM (*kathoeyes* and gay men) be adopted as a core strategy, as this is likely to offer a more successful and sustainable risk reduction outcome. However, *kathoey*-identified males do not form a community currently, hence it will be essential to include a community building and development approach in this strategy.

To implement such a strategy will require two key components:

1. A drop-in centre for socialising and community-building and development activities, as well as counselling, economic development, access to information and sexual health products.
2. Outreach to access differing networks of *kathoeyes* across the city providing networking, friendship building, information and sexual health products to both *kathoeyes* and their partners.

In regard to STI treatment and referral, a separate project is being recommended (see below).

To be effective, the current peer education intervention will need to be perceived within a broader framework of *Social Change Agents* providing a broader service than they currently do. To support this, extensive capacity building will need to be provided, not only in outreach skills, but also in project management and implementation. These skills will include:

- Outreach methodologies
- Strategies for risk reduction, community-building, and mobilising, condom promotion and other techniques and skills
- Basic HIV/AIDS and sexual health knowledge
- Address masculinities, gendered identities, and the diversity of male to male sex dynamics in Lao PDR
- Sex work and HIV
- Psychosexual counselling
- HIV/AIDS counselling
- Transgender issues, including knowledge of appropriate medical regimes
- IEC development and training

Such an HIV/AIDS prevention, support and care programme, to be successful, will require a sense of ownership by beneficiaries. However, government policies within Lao PDR make it impossible to create a separate community-based agency to implement such a strategy. It is recommended here that PSI Lao/LYAP develop an autonomous sub-project either within PSI Lao's current structure or, if possible, within LYAP, with its own Project Manager and staff coming from beneficiary networks, where PSI Lao/LYAP has overall management

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<sup>21</sup> The investigator was told that it would not be necessary to renegotiate with the government in terms of additional activities, or to develop a new MOU for new activities.

<sup>22</sup> While FHI Lao does implement a sexual health programme for female sex workers in Luang Prabang, it would seem that the agency would be required to amend its MOU with the government if it was to extend this programmes to provide an MSM HIV/AIDS intervention. This could be a lengthy process. Perhaps, discussions could also be held with FHI Lao to explore whether its programme with female sex workers in Luang Prabang, which includes a drop-in centre and clinic, could be expanded to include a separate 'MSM' project that would also include a drop-in centre and clinic. During the assessment it was not clear whether Burnet Institute would also be required to negotiate with the government to change its MOU or develop a new one. Both options would be a lengthy process.

<sup>23</sup> Sexual health: Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. Source: WHO Draft working definition, October 2002

responsibility, and provides technical support and overall supervision. Further a Steering Committee should also be developed consisting of specific “community” members with relevant skills and knowledge along with representatives of PSI Lao on Board to act as an interface with the project and the host agency.

While such a project will be able to access differing networks of *kathoey*-identified males across Vientiane, and perhaps some of their partners, it will not be able to reach all males who have sex with males who are at risk.

This is because, often, the sexual partners of *kathoeyes* primarily come from the general male population who may feel uncomfortable attending a space primarily used by *kathoeyes*, while other non-identified MSM who access non-*kathoey* males may experience vulnerability and visibility in such a space, or where many male sex workers primarily do not identify with their sexual practices and appear to prefer being identified as “complete men,” separate from *kathoeyes*.

A different and additional approach is therefore required to maximise the benefits of an MSM HIV/AIDS intervention, in parallel with the *kathoey* HIV/AIDS prevention framework. It is recommended that an STI treatment project be also developed and implemented through a *Male Sexual Health Clinic*, open to all males, irrespective of gendered/sexual identities and/or sexual practice.

It is necessary to see the male sexual health clinic as a separate and distinct project in its own right. Discussions will need to be held with PSI Lao and FHI Lao as to who would be the most appropriate (or possible) host for this component.

It is recommended that there be two drop-in centres in Vientiane (primarily because of its geographical spread, and costs of travelling within it) in order to make them more easily accessible, and one male sexual health clinic. Further, taking into account the other two identified *hotspots* in the country where no services exist, it is suggested that PSI Lao be contracted to develop similar prevention interventions in Luang Prabang and Savannakhet, each with one drop-in centre, and where the appropriate agency implements one male sexual health clinic in each too. PSI Lao does have some funds available and will be able to establish one drop-in centre in Vientiane.

Appropriate management structures will need to be developed, along monitoring and evaluation procedures, as a part of the package.

Costings for each drop-in centre, along with its activities, outreach programme, and operational costs is approximately \$15,000 per drop-in centre. Along with this would be management costs, including monitoring and evaluation, travel, and training programmes. Costs have not been developed for this.

In regard to the three male sexual health clinics linked to the project, these will involve start-up costs (appropriate space, equipment and access to a laboratory), along with recurring costs (recruitment of doctor and ancillary staff, operating costs, and promotional materials). Specific costings have not been developed for this. Further, it needs more exploration as to whether these clinics provide syndromic management, diagnostic approach, and/or presumptive treatment. These will have different cost implications.

Access to appropriate technical and institutional skills, along with the required training and capacity-building programmes is vital and key to success. These include project implementation, development and management, monitoring and evaluation, outreach methodologies, IEC materials development, STI treatment, counselling, and so on appropriate to MSM HIV/AIDS interventions. Such training does not appear to be available in-country, and these will have to be contracted in from appropriately skilled resources.

It is essential that more knowledge is required regarding male-to-male sexual behaviours and practices in Lao, along with the contexts and dynamics of such behaviours. Further specific epidemiological data is also needed. Burnett Institute, along with perhaps the independent researcher, Serge Doussantousse, (who has access to a range of *kathoeyes* in all the target cities), should be supported to conduct appropriate epidemiological, behavioural and sociological studies amongst MSM to gain more effective knowledge and evidence, and to develop an understanding of the dynamics of male-to-male across with all its complexity and diversity in Lao PDR.

Further advocacy work will need to be undertaken with district and provincial government officials, particularly in regard to local police, in order that the above activities can take place. Part of this strategy will include the project title, and it is suggested here that this should be either include male sexual health, or male HIV/AIDS prevention programme.

In regard to HIV/AIDS treatment, care and support specifically focusing on MSM, assistance could be provided to Lao Red Cross/MSF to scale up their programme to cover Vientiane and Luang Prabang also, expanding the anti-retroviral treatment programme to include support and care, along with appropriate sensitisation training in regard to the specific needs of feminised MSM, such as *kathoeyes*, along with other MSM. However, better epidemiological data will be required to justify this cost.

To summarise the Lao MSM intervention programme will consist of:

- Four drop-centres, two in Vientiane and one each in Luang Prabang;
- Three male sexual health clinics, one in each target city;
- A range of training programmes addressing lack of knowledge, skills and capacity;
- Advocacy work with local bureaucrats and police;
- Research into epidemiological, behavioural and sociological; and
- Possible expansion of the anti-retroviral treatment programme to include support and care and cover Luang Prabang and Vientiane in addition to Savannakhet

# Assessment in Thailand

Total Population (end 2001): 63,584,000  
 US Census Bureau

Country HIV and AIDS estimates, end 2003

Adult (15-49) HIV prevalence rate	<1.5% (range: 0.8%-2.8%)
Adults (15-49) living with HIV	560 000 (range: 310 000-1 000 000)
Adults and children (0-49) living with HIV	570 000 (range: 310 000-1 000 000)
Women (15-49) living with HIV	200 000 (range: 110 000-370 000)
AIDS deaths (adults and children) in 2003	58 000 (range: 34 000-97 000)
'MSM' and HIV	17.3% among 'MSM' in central Bangkok (2003)*



Source: UNAIDS report on the global AIDS epidemic, 2004 and \* TUC/TRCS/RSOT 2043 – The prevalence of HIV and associated risks among men who have sex with men (MSM) residing in the Bangkok metropolitan area, Thailand MOPH – US CDC Collaboration/Thai Red Cross Society/Rainbow Sky Organisation of Thailand, 2004 (power-point presentation)

There are no laws in Thailand against male-to-male sex.

## Background

HIV was first detected in Thailand in 1984 in a person who was MSM (as defined by the report mentioning this), but in these early years, IDUs and female sex workers and their clients appeared to be the primary groups affected by the virus. “By 1989, the virus has spread, primarily through heterosexual contact, from groups that practice high risk behaviours to the general population, where Thailand’s HIV infections and AIDS cases are concentrated more in the northern part of the country but have been found in all 76 provinces.”<sup>24</sup>

Strong government commitment and its adoption of a “100 percent condom use policy” at national level, and increased investment in AIDS programming, has led to dramatic fall on the number of new annual infections from 143,000 in 1991 to 29,000 in 2001 continuing to fall to 19,000 in 2003.<sup>25</sup>

AIDS is Thailand’s leading cause of death, with 53,000 dying in 2003 from AIDS-related causes, where 90% of these deaths occurring in the 20-24 age group, while the estimated adult HIV prevalence rate is 1.5%.<sup>26</sup>

FHI/Dowsett reports that two independent epidemics, one among injecting drug users and the other among female sex workers, were indicated by sero-prevalence data since 1985, and that there has been a change in the

<sup>24</sup> Policy Project, 2003. *HIV/AIDS in the Mekong Region: Cambodia, Lao PDR, Thailand and Vietnam.*

<sup>25</sup> UNDP, 2004. *Thailand’s Response to HIV/AIDS: Progress and Challenges*

<sup>26</sup> Family Health International, 2002. *A review of knowledge about the sexual networks and behaviours of men who have sex with men in Asia*, p 64 by Gary Dowsett, Jeffrey Grierson and Stephen McNally, Australian Research Centre in Sex, Health and Society, LaTrobe University, Melbourne, Australia. Unpublished. This study covered the countries of Bangladesh, India, Indonesia and Thailand.

composition of new infections in recent years. The incidence of HIV among female sex workers has fallen, illustrated by an HIV prevalence rate of 24 to 30% rate in the Central and Northern regions in 1993-1994 to 13% in 1999. Further the incidence among military conscripts has also fallen from its peak of 4% in 1993 to 1% in 1999.

However, this has not been the case with IDUs, which perhaps illustrates the failure of government campaigns. In Bangkok a 1% HIV-positive rate in 1987 increased to 30% in 1998, and since then has remained between 20% - 50%, both inside and outside Bangkok.

This political commitment has not been the case in regard to males who have sex with males and as a result there has been relatively little HIV/AIDS prevention work targeting this population (compared to work with other populations). Whilst Thailand has been well regarded as having implemented effective HIV prevention strategies, government focus on the promotion of 100% condom use with sex workers has precluded policy and programming addressing the needs of other 'vulnerable social groups'. As a consequence "concern exists that HIV is spreading in other at-risk populations in Thailand, such as men who have sex with men."<sup>27</sup>

A recent questionnaire survey of a cohort of males who have sex with males living in Bangkok found a high level of HIV prevalence, 17.3%. This finding is supplemented by data demonstrating an eclectic variety of risk factors as enhancing vulnerability to HIV infection, such as "lower education, being recruited at a park, self identifying as homosexual, practising both insertive and receptive anal intercourse and having a higher number of lifetime male anal sex partners."<sup>28</sup> As the authors of this study argue, these findings indicate the need for the continued development and expansion of specifically focused HIV/AIDS prevention addressing the needs of MSM in Thailand.

However, as the FHI/Dowsett report states, the lack of reliable HIV incidence data in MSM populations, continues to be a barrier in understanding the Thai epidemic. The report goes on to say that, "without such data, the situation of Thai MSM vis-à-vis HIV remains at best speculative, at worst invisible." (p67)

One of the consequences of this is that there are few community-based organizations implementing HIV/AIDS prevention and sexual health promotion with and for males who have sex with males in Thailand, and as observed those currently operating are nascent. A study conducted in 2000, for example, found that "no sustained prevention strategies have so far targeted homosexually active men in Thailand."<sup>29</sup> This view was reiterated at the recent regional meeting 'Strategising Interventions among MSM in the Greater Mekong Region'<sup>30</sup> at which various delegates observed the recent development work in this field in Thailand. These observations give an indication of the limited experience of community-based organizations working with males who have sex with males, which have only been formed over the last few years. Given this, the recommendations made in this report concentrate on supporting existing programmes to strengthen their capacity, rather than suggesting that new or alternative organizations be established. It will be more strategically practical, cost effective and epidemiologically significant (in terms of reaching as many men as possible as soon as possible) to consolidate the work of existing projects in Thailand and to use this as a basis for the expansion of HIV/AIDS prevention activities.

## Methodology

With a focus on male-to-male sexual practices, risk behaviours, and any HIV/AIDS interventions, discussions were held with a range of representatives from international non-government organisations and community-based organisations. Along with these, discussions were also held with Dr. Pachara Sirivonggrangson of the Ministry of Health. These discussions focused on what knowledge the organisation had in regard to male-to-male sex, risky practices, and HIV/AIDS vulnerability, along with how the organisation is responding to these issues. Further a range of

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<sup>27</sup> van Griensven, F. et al. 2005 *Evidence of a previously undocumented epidemic of HIV infection among men who have sex with men in Bangkok, Thailand*. AIDS, Vol 19 No 5.

<sup>28</sup> See note 42.

<sup>29</sup> McCamish, M., Storer, G., and Carl, G. 2000. *Refocusing HIV/AIDS interventions in Thailand: the case for male sex workers and other homosexually active men*. Culture, Health & Sexuality, Vol. 2, No. 2. 167-182.

<sup>30</sup> CDC-GAP/USAID-RDM/FHI-APD Workshop, Bangkok, 28<sup>th</sup> February – 2<sup>nd</sup> March, 2005

USAID Bangkok office had identified both Bangkok and Chiang Mai as *hotspots* in the current, based on currently knowledge. Pattaya was identified as a possible *hotspot* because of the known male-to-male behaviours, a vibrant male commercial sex environment, and as a significant international and national tourist destination well reputed as a “popular site for gay men.”

With this *hotspot* selection, visits were made to specific sites within these three cities where males meet other males that could lead to possible male-to-male sexual encounters. Along with observational analysis of these sites, discussions were held with specific self-identified MSM in each city, and where existent, MSM community-based responding to sexual health needs. Sites included a range of “cruising” areas, popular venues, massage parlours, as well as the offices and drop-in centres of the MSM CBOs.

### Meetings

Agency	Individual
Independent researchers/consultants	Andrew Hunter Carol Jenkins
CARE International, Bangkok	Catherine Esposito via email and telephone
CDC	Frits van Griensven
FHI Asia Regional Office	Philippe Girault
Ministry of Health Bureau of AIDS/TB/STIs	Dr Pachara Sirivonggrangson
PACT	Polly Mott Kurt MacLeod
PSI Asia	John Hetherington Olivier LeTouze
UNESCO	Jan W De Lin van Wijngaarden
USAID Asia Regional Office	Matt Friedman Wanne Kunchornratana Patchara Rumakom
WHO	Som Pong

Meetings were also held with a range of MSM community-based organisations in Bangkok and Chiang Mai, who are providing HIV/AIDS services. In Bangkok these were SWING and Rainbow Sky and in Chiang Mai, M-Plus, Purple House/New Friends Club, and Healthy Gay.com (a web-based service).

## Current HIV/AIDS and MSM interventions

There is a remarkable lack of work addressing the HIV/AIDS related needs of males who have sex with males in Thailand, and the lack of prevention work with men who have sex with men can be correlated with high HIV prevalence. A recent study has found 17% prevalence of HIV infection amongst a sample of men who have sex with men in Bangkok.

### Community-based organisations and current HIV/AIDS interventions in Thailand

Agency	City	
SWING	Bangkok	An organisation working with male and transgendered/ <i>kathoey</i> sex workers in Bangkok. Outreach interventions focus on men working in bars in Silom/Surawong, Sukhumvit, Din-Daeng and Sapan Quay. The organisation has a drop-in centre in Sukhumvit and provides basic education and English literacy classes. Clinical referrals to Pradipat clinic, where patients receive 40% discount on production of SWING identity card. Provides and pre and post HIV test counselling. Work is funded by FHI

Rainbow Sky	Bangkok	An LGBT community support organization working with men who have sex with men in Bangkok. The organization has a considerable but not exclusive focus on gay men. Conducts outreach work in ‘cruising areas’ in Bangkok and has a drop-in centre in Sukhumvit. Rainbow Sky is initiating some general health promotion work in colleges, including information on male-to-male sex. Has links with clinical services. FHI, Thai Red Cross
M-plus	Chiang Mai	A community support organization working with men who have sex with men, gay men, <i>kathoey</i> and men who sell sex. Has a drop-in centre and outreach work in local cruising areas. Drop-in clinic with referral services and pre and post HIV test counselling. Runs a ‘friendly pharmacy’ scheme for TGs. Services funded by FHI.
Purple House/New Friends Club	Chiang Mai	A community-based organization working with men who have sex with men. Is not conducting outreach work but has well established linked with networks of men who have sex with men in Chiang Mai. The organization has particular skills and knowledge in working with HIV + men. Have plans to work with male sex workers from tribal areas of Northern Thailand.
Healthy Gay.com	Chiang Mai	A web-based intervention working with men who have sex with men who ‘cruise’ via in the Internet in Chiang Mai. The intervention consists of participating in web-based chat for men who have sex with in Chiang Mai. Funded by UNESCO.

## Gaps in service provision

As can be seen from above, there is very little service provision specifically focusing on males who have sex with males. What does exist (two interventions in Bangkok, two in Chiang, and an internet service also in Chiang Mai, along with a planned intervention in Pattaya) are of limited scale and low coverage. Further, these community-based organisations implementing this work with have nascent capacity and would require significant investment in training and skills building towards enhancing their programmes. Currently there are no MSM HIV/AIDS interventions in Pattaya, despite this being a significant tourist destination, with a large number of commercial gay bars and male sex work establishments. Currently PSI Thailand is planning a *kathoey*-based HIV/AIDS intervention in this city.

There are, apparently, appropriate STI clinics and HIV/AIDS counselling services to which these agencies refer clients, but if there is to be a scaling up of service delivery, a quality review of current services, along with mapping and review of appropriate STI treatment service delivery will be required, so that more clinics can be brought into the purview of such a scaling up.

Few studies have been done into the complexities and diversities of male-to-male sex, risk and vulnerability, in Thailand. This lack of knowledge can lead to misunderstandings, sometimes denial, and often a reductionist approach to the issues.

Advocacy work seems to be very limited, particularly in creating more effective dialogue between the Ministry of Public Health and the Ministry of the Interior, as well as media, research institutions, and other bodies.

## Developing services and increasing coverage

Given the limited experience and existence of organisations working with men who have sex with men, which have only been formed over the last few years it is suggested that support be concentrated on existing programmes to strengthen their capacity, rather than suggesting that new or alternative organisations be

established. It will be more strategically practical, cost effective, and epidemiologically significant (in terms of reaching as many males as possible as soon as possible) to consolidate the work of existing projects in Thailand and to use this as a basis for the expansion of HIV/AIDS prevention activities.

With no identified linking organisation appropriate to funding MSM community-based organisations, *Pact* may need to either develop an in-country office in Thailand, which can then fund such organisations directly, or develop collaborative work with FHI and PSI in the country, where each of these agencies would fund appropriate interventions directly.

One of the most effective ways to increase coverage of HIV/AIDS prevention services for males who have sex with males will be to invest in capacity building and training for existing MSM community-based organisations. This will enhance coverage in the sites covered by this study and provide a skills base from which to develop core community-based work in other areas in the future. The most immediate and sustainable strategy to extend coverage of sexual health promotion and HIV/AIDS prevention in this field will be to arrange a training package for the relevant community-based organizations. This would cover:

- Outreach work skills
- Strategies for safer sex promotion
- Basic HIV/AIDS knowledge
- Sex work and HIV
- Connections between intravenous drug use, sex work and sexual risk
- Transgender issues, including knowledge of appropriate medical regimens
- Counselling skills
- IEC development and training

*While NFI does has a comprehensive training workshop that could perhaps be appropriate to address many of these needs, other local and regional consultants and NGO's may also be able to provide relevant training, e.g. Asia Pacific Network of Sex Workers Projects, FHI, Asia Pacific Rainbow.*

Further research on the epidemiological, behavioural and ethnographic aspects of male-to-male sexualities in Thailand, where appropriately skilled and knowledgeable researchers and research institutes should be supported to conduct such studies. A range of rapid assessments and operational studies will also be necessary.

As pointed out above, it is believed that the most effective approach to scaling up coverage of HIV/AIDS services in the three target hotspots is not to create new organisations, but to focus on the knowledge, skills, and capacity of existing organisation wherever possible (apart from Pattaya, where there are no current interventions), and enable them to improve the quality of their current work, as well as extend their service delivery. The following recommended activities have arisen from this assessment study, along with discussions with the relevant agency along with a review of their capacity and technical skills (if the above recommendation on capacity building is adopted and implemented as a part of the initial phase of scaling up).

*Note: No costings could be developed for these potential developments in Bangkok, Chinag Mai, and Pattaya within the time frame of developing report. The authors are still waiting appropriate information.*

## 1. Increasing coverage of MSM HIV/AIDS interventions in Bangkok among *kathoey* and male sex workers

### *Recommendations pertaining to SWING, Bangkok*

Currently SWING is working in the Patpong area of Bangkok, providing outreach services, sexual health products distribution, and a drop-in service along with referrals to an appropriate clinical service.

**A. Increasing coverage of HIV/AIDS MSM intervention in Bangkok among *kathoey* and male sex workers, through development of prevention and referral activities in male-to-male massage parlours in three areas of Bangkok:**

- Silom/Surawong
- Sukhumvit
- Din-Daeng

These parlours, which advertise ‘massage for men by men’, are increasingly popular, and have a large Thai clientele. Most of the massages use oil and/or cream, which make the sexual services offered especially unsafe, even if condoms are used.

HIV/AIDS prevention activities in these parlours would focus on two peer-based strategies:

1. Working with staff and management to provide water based massage products, so that latex condom use was not compromised.
2. Promotion of non-latex condoms, including female condoms (complementing a PSI strategy to generally promoted the potential of female condoms for anal sex).

These two strategies could work in with the present management promoted massage training for new staff, where new staff members are trained in the massage services provided by each establishment.

Outreach workers would need to be peers who knew of the services provided in these centres and could provide staff with condom training (and other risk reduction activities) that fits into the style of massage and sexual services on offer. This would probably need to include provision or sale of male and female condoms, and information about (or direct sale of) alternatives to oil based massage lotions to ensure that correct products were being used and are readily available.

Referral services to male sex worker friendly doctors and clinics would need to be included, as well as general HIV and STI education. This would also require appropriate skills-building of such doctors in regard to anal sex issues and STIs.

In addition post-exposure prophylaxis for condom breakage during anal sex should be explored as a service option, and referral to HIV counselling and treatment at friendly service providers would also need to be established.

#### **B. Outreach in Pak Kalong Market (Bangkok 24 hour flower market) – and surrounding canal and river areas.**

The flower market area has large numbers of *kathoey* and other MSM working at various stalls and shops, as well as coming into the area to buy flowers for religious, personal or professional needs. The area provides ample opportunities for cruising for sex and also as an area for male sex workers for local customers.

The few interventions that work with *kathoey* tend to focus on their status as sex workers, but the role of *kathoey* as customers of (often younger) ‘masculine’ male sex workers is an area that needs attention. Targeting of (usually older) *kathoey* and non-*kathoey* identified MSM as clients of sex workers is a strategy that needs to be adopted in such an area where large numbers of commercial and non-commercial liaisons are more “opportunistic”.

Strategies including peer outreach condom and lube provision would be suitable here, but it needs to be taken into consideration that the outreach workers need to be peers on a more specific basis than just as Thai MSM or *kathoey*. To be accepted into this locality they would need to have some knowledge of the area and it’s people as well as some status within those who work in and use the flower market area.

Sex worker peer educators could be used amongst the more obviously commercial sex workers who work along the canal area.

#### ***Recommendations pertaining to Rainbow Sky, Bangkok***

##### **Expansion of Rainbow Sky’s current outreach services in Bangkok**

The scope of Rainbow Sky’s outreach work could be significantly enhanced by further investment. This should include investment in outreach skills training since staff have had only had limited training in this regard. Training would significantly enhance Rainbow Sky’s capacity to expand coverage in areas where it is already working.

Rainbow Sky currently works in 7 focal cruising areas in Bangkok. Whilst this represents good coverage, many places where men who have sex with men meet in the city are unaddressed. Investment in outreach training and outreach staff and volunteer recruitment would considerably enhance the scope of work in this field. This should include funding for a preliminary needs assessment, which will focus on male-to-male sexual health promotion/HIV prevention beyond the most obvious cruising milieu.

Rainbow Sky has also carried out some health promotion sexual health awareness training in local colleges. Investment in the expansion of this work would enable expansion of work with young people, incorporating male-to-male sexual health messages into generic HIV/AIDS prevention. This will be especially vital as a complementary strategy to focused intervention, enabling outreach to address men who may have sex with men but who would not necessarily be included within the parameters of specifically 'MSM focused' interventions.

## **2. Increase coverage and scaling up in Chiang Mai**

### ***Recommendations pertaining to M-Plus, Chiang Mai***

#### **A. Training in outreach skills to maximize coverage in areas already being worked in.**

Outreach workers in M-plus identified that they are unable to reach many men in the areas of Chiang Mai where they are already conducting work because they lack the skills to be able to approach all men. Training, building the confidence and professional capacity of workers is required. Such training could be provided by specialist trainers, and/or by NFI.

#### **B. Developing work relating to IDU, MSM and sex work**

Outreach workers in *M-plus* identified that the river and park area near Chiang Mai university is especially popular amongst men who have sex with men, sell sex and use intravenous drugs. However they were unable to say much about the risks and behaviours of men in this area as they feel that they lack the skills to work there. Whilst one NGO is working with NGOs in this locality it is felt that they lack specific skills in linking IDU issues to male-to-male sex and sex work.

The intervention in this area would focus on;

1. Training *M-plus* staff and volunteers to be able to understand the relevant issues and incorporate them into outreach work.
2. Liaison with the existing NGO to develop a complementary working strategy that will explicitly address the needs of MSM IDUs.

#### **C. Developing work in Lamphoon**

Lamphoon is a town several miles from Chiang Mai. *M-plus* has nascent links with networks of men who have sex with men in this locality, but as yet has not developed any regular or sustained intervention. Implementing work in Lamphoon would provide an opportunity to begin work in rural/suburban areas, which is especially needed in Thailand.

*M-plus'* existing skills should be utilised in carrying out this intervention, since the organization already has experience in initiating work of this kind. Further training for *M-plus* will enable them to expand the scope of work in Lamphoon.

Work in Lamphoon should consist of;

- Establishing a local drop-in centre
- Regular outreach work in local cruising areas and meeting points – initially a few evenings a week, expanding as new staff and volunteers are recruited
- Training for local volunteers.
- Eventual recruitment of volunteers as staff once capacity has been built over approximately 6 months.
- *M-plus'* drop-in clinic to operate from Lamphoon 1 or 2 evenings per week

Prevention work in Lamphoon could be used to initiate more in-depth research into the needs of men who have sex with men who have not been addressed in areas covered by existing interventions in Thailand.

### ***Recommendations to New Life Friends Club, Chiang Mai***

This organisation predates *M-plus* and has links with networks of men who have sex with men with who *M-plus* has little contact. The director of the organisation acts as an advisor to *M-plus*.

#### **A. Working with HIV + MSM**

Given this organisations skills and expertise in this area they will be able to develop community based work with HIV+ MSM, offering advice on treatment, VCT, well being etc. Access to VCT is complicated in Thailand because government clinics can only be accessed by people who are registered (from birth) within the clinic's regional catchment area. Also, whilst the government is increasing availability of free ARVs, CD4 tests are not free of charge and prohibitively expensive for many people. People work in *New Life Friends Club* have a good appreciation of these issues and would be well placed to offer specific advice and support in this regard.

Developing a drop-in in the organisations existing facility will be especially valuable and has the potential to complement the kinds of services offered by *M-plus*.

#### **B. Work with Hill Tribes**

This organisation has exiting links with Hill tribes from outlying districts near Chiang Mai. Many of these men come to Chiang Mai (and other parts of the country) and work as sex workers. The majority of these men do not self identify as gay, *kathoey* or even necessarily think of themselves as men having sex with other men. Working with these men would be a good example of an 'upstream intervention', educating them about HIV/AIDS and sexual risk before they are exposed.

The work would consists of

1. Education about HIV/AIDS and safer sex
2. Development of alternative income possibilities, other than sex work

This intervention would offer a fantastic intervention opportunity to learn more about the diverse cultural construction of male-to-male sexuality in Thailand and appropriate intervention strategies that may e taken forward in this context.

#### **3. Developing new interventions in Pattaya**

PSI Thailand is initiating an intervention programme with *kathoey* sex-workers in Pattaya, based on a drop-in centre, outreach activities and clinical support. The planned intervention has a very specific focus and given the broad range of male-to-male sex milieu and risks scenarios in the area, it is recommended that the following would complement PSI's work.

#### ***Work pertaining to SWING***

Financial and technical support should be given to SWING to extend their current reach in Bangkok, to include service delivery in Pattaya.

#### **A. Foreign tourists as clients of male sex workers, and long term MSM residents of Pattaya.**

Sex worker prevention projects in Thailand have tended to focus on the sex worker rather than focussing on the client - who is ultimately the person who asks for unsafe sex.

Pattaya in East-central Thailand has both a large gay tourist industry and a large resident foreign gay community. The focus of the tourist industry and of most of the long-term residents could be said to be the commercial gay sex venues. Pattaya, despite the size of its sex industry, has few HIV related services for sex workers and no concerted HIV education or prevention campaigns for clients.

Foreign gay men have a highly visible presence in Pattaya:

- They own many of the bars and commercial sex venues
- They organise the Pattaya gay festival
- They have their own long established gay magazine “Sticky Rice” (formerly Thai Guys Magazine) which also targets gay tourists
- They raise money for HIV treatment projects for Thai MSM

A project that addresses the needs of clients of male sex workers, could be run SWING in Pattaya, in liaison with some of the above organizations/businesses/networks.

Activities should include:

- HIV prevention information specifically for gay tourists as clients of sex workers in a number of relevant languages including English, French, German, Dutch, Russian, Arabic, Chinese and Malay/Indonesian.
- A brochure targeting Thai men who come to Pattaya as tourists could also be developed.
- Prevention focussed performances could be developed by male sex worker outreach teams which played to customers and sex workers in venues and in street areas where gay venues are clustered including Boyztown, Soi VC area and Jomtien Beach and Plaza.
- Referral services for HIV and STI doctors who speak appropriate languages.

## **B. Male sex workers in Pattaya**

Male sex workers who identify as “complete men” have no access to HIV prevention services in Pattaya, despite the large number of sex workers working there. PSI Thailand is currently planning to open a drop in centre, including a clinic, for *kathoey* sex workers. A male sex worker project could work in conjunction with this project.

Male sex worker services could include:

- HIV prevention outreach and male and female condom provision
- Peer support groups and services
- Referral to MSM/MSW friendly HIV/STI clinical services
- Referral to HIV treatment services
- Access to post-exposure prophylaxis
- Development of performance based HIV/STI education project for bars and street areas along the lines of Empower’s “honey-bee” shows
- Advocacy with management for improvement of workplace health and safety

## Annex 1: A caveat to the concept of *hotspots*

This study, by its nature, is partial. As a rapid assessment the intent is to provide information that is adequate for the development of community-based work derived from an exploration of current capacity and needs. The previous literature review on this subject conducted by NFI for PACT identified enormous gaps in knowledge and understanding of the socio-cultural context in which male-to-male sexual desires and practices take shape in Lao PDR and Thailand, and specifically how such knowledge may be related to HIV/AIDS interventions. The focus of the few studies on this subject in these two countries has arguably focused on the most apparent and accessible males who have sex with males. This curtails knowledge of the sexual risk behaviours of the broader population of males who may (sometimes) have sex with other males but who would not explicitly conceive their sexuality in such terms, nor necessarily be included within the cohort of conventional MSM studies. Understanding of the epidemiological relevance of the larger and more amorphous population of MSM is, as elsewhere, extremely limited.

Given the issues outlined, the concept of *hotspots* is limited as a guide to determining localities where HIV/AIDS prevention ought to be implemented. Focusing on hotspots tends to compound an erroneous interpretation that males who have sex with males are a demographically distinct component of the population who occupy discrete geographical areas. It is important to remember when designing an HIV/AIDS prevention strategy that such men are a part of the general population. WHO guidelines, for example recommend that;

...it is misleading to think of men who have sex with men as an easily identifiable separate 'group' in society. While in some settings men who have sex with men have formed community groups, and some of these men may share similar lifestyles, such outwardly visible and 'organised' groups of men only make up a small easily identifiable proportion of a far larger population of men who have sex with men, who may be far less visible within the general population [...]. At the planning stage, remember that in thinking about men who have sex with men, it is important to bear in mind that many of the men eventually worked with may not be an obviously identifiable group. Perhaps the majority of men who have sex with men, are not easily distinguished by the way they dress or behave. Indeed [...] due to prejudice and stigma they may not want to draw attention to their existence and sexual orientation. (Boyce and Aggleton 2004: 10)

This has an implication for the geographical scope and focus of work, as the same WHO guidelines recommend.

Do not to make assumptions about the places where men who have sex with men socialise. Remember too that men who have sex with men are part of the general population. Because of this try not to restrict yourself to work in well known "cruising areas" and meeting places, because this may limit your understanding of the diversity of male-to-male sexual life. (Boyce and Aggleton 2004:15)

Given this, it is important not to conflate a programmatic focus on specific *hotspots* with a reductive perception of the social scope and boundaries of male-to-male sexuality. The concept of *hotspots* does offer a practical conceptual starting point for interventions, enabling a conceptual and geographical point of access to the most apparent population of males who have sex with males. This is relevant to HIV/AIDS prevention, not only because such males are at risk, but because by working with such populations in such places the reach of an intervention may expand beyond the boundaries of the immediate group being worked with. Addressing these men offers scope to reach their less apparent and less accessible sexual partners (who may be both men and women). However this model is only a partial solution and runs the risk of precluding direct intervention with a large (probably the largest) population of men who have sex with men who may never be sexual participants in such milieu. This needs to be kept in mind in conceiving the horizons of a prevention strategy, which ultimately needs to extend beyond reductive understandings of who these males who have sex with males are. For example:

Male Thai Army recruits who engage in same-sex activities are more likely to be infected with HIV and have a greater number of several types of female sex partners, than do other men. The extent of bridging transmission is likely to be further increased in prisons where large numbers of IDUs are also exposed to a greater likelihood of male-to-male sex (Jenkins 2002: 9).

## Annex 2: A word about *kathoey* in Thailand

It is worth saying a little more about *kathoey* (and what is discussed below can also be seen to a significant extent in the Lao PDR context), because this is one of the categories routinely subject to simplistic representations as expressed in the previous paragraph. The aetiology of the *kathoey* category is complex, arising from a combination of indigenous (and historically poorly understood Thai categorisations) coupled with discourses concerning non-heteronormative gender and sexuality, articulated in the *Pali* canon (the scriptural source of *Theravadin* Buddhism, the form of Buddhism practiced in Thai society). As with other forms of sexuality, *kathoey* can be understood in different ways.

Different Thai authors use the term *kathoey* to refer to at least four distinct conditions covering a diverse range of physical, psychological and emotional phenomena that are now usually separated out into biological sex (hermaphroditism), psychological gender (transvestism and transsexualism) and sexuality (homosexuality). Originally *kathoey* appears to have referred to true hermaphrodites. However, it has come to be used more broadly to refer to people who are believed to possess or take on physical, behavioural or attitudinal characteristics generally ascribed to the opposite sex. The complex of phenomena referred to by the term *kathoey* reflects Thai cultural norms of masculinity and femininity and notions of appropriate sex roles, gender behaviour and sexuality. *Kathoey* denotes a type of person not simply a type of behaviour and in different contexts can include one or more of the following groups:

1. Hermaphrodites (Pali: *ubhatobyanjanaka*; Thai: *kathoey thae* or "true *kathoey*s"): that is, people who to a greater or lesser degree are either born with or at some time after birth naturally develop physical characteristics of both sexes. Hermaphrodites also include people born without any clearly determinable sex (Pali: *napumsakapandaka* ).
2. Transvestites and Transsexuals (Pali: *pandaka, itthi- & purisa-ubhato byanjanaka*; Thai: *kathoey thiam* or "pseudo-*kathoey*s"): that is, people who are physically male or female but prefer either to dress and behave as a member of the opposite sex or, in the case of transsexuals, to undergo hormone treatment and/or surgery in order to change their body to more closely approximate the physical features of a person of the opposite sex. In the Pali canon transsexualism is described as a spontaneous change of sex caused purely by psychological factors and not requiring medical intervention.
3. Homosexuals (Pali: *pandaka*; Thai: variously, *kathoey, gay, tut*, etc. for men; *kathoey*s, tom, dee, etc., for women): that is, people who are physically male or female and are sexually attracted to people of their own sex.

The term *kathoey* includes homosexuals because in Thailand homosexuality, on the model of hermaphroditism, is popularly regarded as resulting from a psychological mixing of genders. That is, within the Thai cultural context a male homosexual is commonly regarded as having a woman's mind and a woman's sexual desires and a lesbian is regarded as having a man's mind and a man's sexual desires. The blending of genders denoted in the term *kathoey* may thus be solely physical, solely an imputed psychological mixing, or a combination of both (Jackson 1997).<sup>31</sup>

Given this, it is important to avoid reductive characterisations of *kathoey*, as, say, a Thai version of transgenderism. Thus for example, whilst *kathoey* may share similar characteristics to *kothi* (a category of feminised same-sex sexuality in South Asia), not least a shared cultural origin in Buddhist and Brahminical literature, and ostensibly similar contemporary risks regarding HIV infection, such as a lack of work options, common employment in sex work and a nominal – if not necessarily actual - association with a receptive position in anal sex, and risks associated with inappropriate use of hormones and other medications associated with the cultivation of feminine bodily characteristics.

However it is crucial to take differences into account. Whilst *kathoey* occupy a generally recognised place in Thai society and are in many ways highly visible in public (for example on television, and performing in 'kathoey shows'), the category *kothi* in South Asia is generally hardly, if at all, known beyond narrow social

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<sup>31</sup> Jackson, P., 1997, *Kathoey<>Gay<>Man: The Historical Emergence of Gay Male Identity in Thailand*. In Sites of desire/economies of pleasure, sexualities in Asia and the Pacific, Manderson, L. and Jolly, M. (eds), Chicago: University of Chicago Press.

milieu of some males who have sex with males. The kinds of social stigma, and structural vulnerability to HIV/AIDS are likely to have as many differences as commonalities. This will be especially important in planning cross-regional planning and intervention in this regard. It will not be meaningful or effective to simply conceive *kathoey* as a regional transgender category and to envision such a conclusion as a basis for culturally appropriate HIV/AIDS intervention. NFI is already planning appropriate training strategies sensitive to these issues, drawing on understandings of cross-regional commonalities and differences in Asian same-sex sexual cultures. This has the potential to significantly enhance community-based HIV prevention with *kathoey*.

## Annex 3: Stigma, discrimination and attitudes towards male-to-male sexualities in Thailand

Assessing reasons for the lack of sentinel HIV surveillance data looking at men who have sex with men in Thailand, van Grievsan et al argue that stigmatization of homosexuality in Thailand may compound under-reporting of AIDS cases (van Grievsven et al 2005: 522). Whilst stigma may indeed compound lack of information, it is important to note that the correlation between this and *homophobia* is more complex, given the ambiguous social presence and status of male-to-male sexuality in Thai culture and society. This is not the place for an extended exposition on this subject and the NFI literature review conducted for *Pact* sheds some light. However it is worth noting that censure of male-to-male sexuality in Thailand is far from straightforward. Peter Jackson, for example, has argued that whilst on the one hand same-sex sexuality (and transgenderism) may be stigmatised in Thailand, it is too simplistic to say that common attitudes are explicitly homophobic. It is important to appreciate the nuanced social responses and values that such attitudes engender, so as to comprehend the cultural status and personal experiences of men who have sex with men in Thailand, particularly as these are distinct from the typical Western contexts;

Because of the historical intensity of antipathies towards homoeroticism in Western societies, which in the past have been both intolerant and unaccepting, observers from these societies commonly conflate these two concepts. In everyday life as well as in formal and legal contexts the Thai typically tolerate men who engage in non-normative sex/gender behaviours without intervening to punish or otherwise penalize them. However, very few people accept such non-normative behaviours as being unremarkable or immune from moral or other criticism. (Jackson 2004: 229)

In this ambiguous scenario, stigma impinges on the lives of males who have sex with males in Thailand, but prejudice is not commonly explicit or structurally integrated into Thai public:

Homosexuality is neither illegal under Thai law nor immoral according to Buddhist teachings, and homophobic violence against masculine-identified homosexual men appears to be almost non-existent. (Jackson 2004: 227)

This said, and as Jackson has argued elsewhere, during the early days of the HIV/AIDS in Thailand, when moral censure and blame was initially more explicitly directed at males who have sex with males, some Thai Buddhists were inclined towards interpretations of Buddhist scripture that stigmatised males who have sex with males. Intransigence about responding to the HIV/AIDS related needs of men who have sex with men can be seen to arise from this climate (Jackson 1993: ). This is not to say that such a 'centralised' understanding of (male-to-male) sexuality was shared universally throughout Thailand. As Graham Fordham has argued, Thai attitudes towards sexuality are culturally heterodox and regionally variable (Fordham 2001: ). Nevertheless at the policy and programme level, fairly uniform values have precluded attention to the HIV/AIDS related needs of males who have sex with males, which is only recently being addressed, in large part instigated by the efforts of local activists working with international development agencies. The recent international HIV/AIDS conference held in Bangkok in 2004 provided a forum that consolidated some efforts in this area.

Addressing stigma as a barrier to HIV/AIDS prevention with men who have sex with men in Thailand is especially complicated. Peter Jackson has observed that prejudice towards men who have sex with men in Thailand is in many ways discursive rather than obviously acted out. As a consequence manifestations of prejudice may not always be obvious;

If we focus solely on the often intensely negative attitudes to homosexuality expressed within discourse, whether academic or popular, then we will develop an inaccurate and overly negative picture of the situation of gay men and *kathoey* within Thai society. At the same time, however, if we focus solely on the practical, everyday tolerance shown towards males who breach sex and gender norms then we will develop an overly positive picture. Thai gay men and *kathoey* conduct their lives within highly charged discursive domains in which their homoeroticism and feminine gender identity, respectively, are often seen as pathological and, to varying degrees, are almost always labelled as

sources of shame. Accounts of the respective places of homoeroticism in Thailand must therefore be sensitive to this pattern of discursive unacceptability yet practical toleration". (Jackson 2004: 240)

This report not only applies to accounts of Thai same-sex sexuality in academic discourse, but to conceptualisation of the issues relevant to men who have sex with men in HIV/AIDS policy and programming. As Richard Jenkins and Kim Bryan have pointed out, there has been little synthesis between sociological, anthropological and historiographic writing on male-to-male sexuality in Thailand and the emerging behaviourally and epidemiologically oriented studies which tend to inform HIV/AIDS programming (Jenkins and Bryan 2004). In consequence, understanding of male-to-male sexual experience, especially the role of stigma, tends not to be very nuanced in this context – a point reiterated at the recent meeting on men who have sex with men in the Greater Mekong. There is a need for more subtle understandings because the ambiguous status of male-to-male sexuality in Thailand has tangible consequences for HIV/AIDS. Epidemiologically the image of Thailand as kind of ‘gay paradise’ persists, and international (sex) tourism is of course significant within the countries HIV/AIDS epidemic. Thai tolerance of homosexuality supports and encourages this, whilst a parallel lack of cultural acceptance arguably divorces perception of this arena as a relevant social context for HIV/AIDS intervention. The lack of intervention in (male-to-male) ‘sex tourism’ environments outside of Bangkok is remarkable (and one of the key concerns reiterated in the programmatic recommendations made in this report).

The ambiguous nature of *homophobia*<sup>32</sup> in Thailand also has practical implications for community-based HIV/AIDS prevention. Outreach workers in community-based projects for males who have sex with males can be hampered in their work by police officers and public officials. This is not commonly characterised by the overt oppression and extreme violence that some outreach workers in male-to-male sexual health projects have suffered in South Asia, for example. Rather official obstructions, for instance concerning an NGO’s registration, are more common, whilst of course there is no ‘official’ sanction against homosexuality in Thai law. This raises questions about how to address such actions, and indeed the HIV/AIDS related rights of males who have sex with males in Thailand, when there is a lack of policy explicit impinging on men’s rights.

It should be noted that discursive moral censure of male-to-male sexuality in Thailand, can have different emphases. Explicit stigma has arguably been most directed towards *kathoey*, since *kathoey* have a culturally integrated presence in Thai culture, which by its nature is associated with moral ambiguity, and – to some extent - negative representation (Jackson 2004). Other cultural constructions of male-to-male sexuality have been less present in Thai public discourse, and hence less subject to moral censure. This situation is changing, however, as gay identities achieve an increased profile in Thai media. As was observed above in regard to the growth of Thailand’s economy, international tourism, globalisation and electronic communication, and where FHI/Foreman stated that “*kathoey* appear less subject to criticism, appearing to the public as either figures of glamour or fun and to academics as individuals deserving sympathy and respect.” Part of the criticism is the belief that, while *kathoey*s are ‘born’, gays are ‘made’.

This quote is especially interesting because it contains traces of attitudes that mark contesting attitudes towards gay men and *kathoey*s. Thus, although public officials may criticise normalising media portrayals of homosexuality (in the context implied, gay men), the existence of these indicates corresponding positive portrayals of males who have sex with males. Likewise, the idea that *kathoey* are seen as figures of fun or as deserving sympathy indicates a rather reductive, and perhaps maligned view of *kathoey*’s place in society, which runs counter to straightforward respect<sup>33</sup>. Thai sexual culture, like any sexual culture, is characterised by contesting attitudes and values. This needs to be taken account of in any programme planning process if it to adequately address the variant, complex circumstances of the males being addressed.

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<sup>32</sup> Could this homophobia be a part of a larger framework of *genderphobia* as well?

<sup>33</sup> Peter Jackson, for example, has observed that amongst Thai academics the study of *kathoey* and other forms of same-sex sexuality is commonly stigmatised, even if rarely condemned. This is associated with common Thai attitudes, whereby men who have sex with men and ‘transgendered’ people may be tolerated, but unaccepted.