



The core NFI team: (left to right); Sudeesh Singh - Administrator, Arif Jafar - Director, Kaushik Das - Information and Resource Officer, Amish Amin - Trustee, Kim Mulji - Director, Shivananda Khan - Executive Director, Aditya Bondyopadhyay - NFI Technical Advisor, Lok Prakash - NFI Technical Advisor.

Below: Some of our partners at the 3rd NFI Regional Consultation Meet held in Delhi, India (5th -7th April 2003)



Naz Foundation International is a development agency specialising in providing technical, institutional and financial support for the promotion of sexual and reproductive health of males who have sex with males in South Asia

Vision

We believe in a world where all people can live with dignity, social justice and well-being.

Mission

With a primary focus on marginalised males who have sex with males, our mission is to empower socially excluded and disadvantaged males to secure for themselves social justice, equity, health and well-being by providing technical, financial and institutional support

We believe in the innate capacity of local peoples to develop their own appropriate sexual health services, where the beneficiaries of a service are also the providers of that service. We will always support such initiatives.

Naz Foundation International's Ethical Policy

Naz Foundation International is a development agency focusing on male to male sexualities and sexual health concerns in South Asia. In its work Naz Foundation will fully consider the implications of males who have sex with males, for themselves, for any male or female sexual partners such males may have, and for any clients of those males who do sex work.

In this work Naz Foundation will be guided by the following principles:

1. promoting the reproductive and sexual health of males who have sex with males by encouraging sexual responsibility and safer sexual practices
2. encouraging males who have sex with males to access STD treatment whenever necessary
3. respecting confidentiality in the relationship between males and their sexual partners and/or clients
4. promoting the protection of children and non-consenting adults from abusive sexual relationships
5. promoting the reproductive and sexual health of any female partners of males who have sex with males by encouraging greater sexual responsibility of their male partners
6. encouraging communication of sexual health information between sexual partners and promoting partner notification of STD/HIV infection, irrespective of the gender of the partner
7. working with female reproductive and sexual health services in order to facilitate appropriate access to infected female partners of males who have sex with males.

Pukaar

Pukaar is the quarterly newsletter published by **Naz Foundation International**. It provides a forum for discussion, information, and advice, as well as general interest, regarding HIV/AIDS and sexual health, focusing on South Asian masculinities and sexualities.

The opinions expressed in *Pukaar* reflect the writer's views only and do not necessarily reflect the views of **Naz Foundation International** unless specifically mentioned.

We will always try to ensure that what we report is relevant to our readers, and we ask you, the reader, to keep us informed as to what is happening in your corner of the world. Send us your questions, letters, articles, stories (fact or fiction), poetry, drawings, photographs. Tell us about what you think and feel, whether it concerns HIV/AIDS, your sexuality, or whatever. Names will be changed and addresses will be withheld if required.

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Questions and thoughts

Shivananda Khan

HIV intervention discourse and strategies still tend to focus on exclusive categories of people, a policy that actually may well increase invisibilisation of risk behaviours and increase those risks for HIV infection. All sorts of people and behaviours fall through the w/holes which such discourse, by their nature, create. As a consequence our ability to develop effective and sustainable prevention programmes stutter and mutter along the way. Thus we talk of men who have sex with men, intravenous drug users, female/male sex workers, youth, and so on. One could also add PLHA. Cross-overs are ignored as the boundaries between risk behaviours are perceived as solid walls, rather than porous and amorphous.

By the very nature of these discourses, these imagined collectivities have generated new forms of identity, politicisation and activism. The risk is that they become closed, self-contained and self-identified groups.

So what happens to those whose range of behaviours do not fit into these neat categories? What about the person who sells sex infrequently when a financial need arises? Or the needle user who also is anally penetrated and has multiple male partners, but will also have vaginal sex with females, and maybe is married?

Risk behaviours are not neatly divided into separated and uncontested categories, individuated and isolated from each other. They tend to be perverse and polymorphous, situated in a socialised context that has a history, a position, and reflect personal/social needs, desires, and fantasies.

We ignore this at our peril.

Despite the use of the term men who have sex with men (or NFI's preference - males who have sex with males) male-to-male sexual behaviours is often a more accurate term to use in terms of the diversity of identities, genders, and frameworks in which such male to male sex takes place.

Despite the best intentions of HIV activists, service providers, donors and others, that the term MSM enables us to access those who are not gay/homosexual/kothi identified, this is not always a valid assumption. Too often the term MSM becomes a signifier for a homosexual within a heteronormative paradigm, i.e. these men/males are really homosexuals who do not have a specific sexual identity, and that this also means that they are a small minority of people in a large sea of normative heterosexual males. In other words, we still do not address the behaviour, but this supposed 'target group'.

Beyond this, as long as we equate anal sex behaviours as a homosexual practice/behaviour, a specialised phenomena limited to a small group of men/males, whether gay-identified or not, we will never adequately or appropriately address the sexual health needs of males and females.

Heterosexuality as the central biologic necessity is the Great Lie. Even so-called reproductive necessity as 'natural' and 'normative' is not valid as any reading of Biological Exuberance (Bruce Bagemihl, 1999, Profile Books) and similar studies on sexual behaviours and practices within animal societies clearly indicate. All these studies clearly show that not all adult males and females in a given animal society are only involved in reproductive sex as the sole purpose of sexual activity. Pleasure is also a key component of such encounters. Further many sexual encounters involve same-sex partners and that such same-sex encounters also involve those who participate in reproductive sex. In other words there is not some natural, inherent biological necessity for reproductive sex as the only normative behaviour. Pleasure and desire need also to be taken into account.

We have not taken into account pleasure, desire and fantasy, as well as object choice, in our AIDS discourses and prevention strategies. Why not? Surely we should also be asking the question WHY? as much as what, and how much, and how frequently. Otherwise how do we expect to enable, empower, and request individuals and groups to change high-risk practices to low risk encounters?

As long as we insist on seeing heterosexuality as essentialist, normative, biological, universal, and ahistoric, we can never develop, implement and sustain effective strategies for HIV prevention. As long as we confuse heterosexuality with reproductive necessity, we deny the central frameworks of pleasure, desire and fantasy in our sexual practices, which leads to a denial of those practices and behaviours that do not 'fit' the binary model of sexuality, that of heteronormativity versus so-called sexual minorities.

Another thought: the use of the term 'behaviourally homosexual' by some agencies also has the implication of the term 'behaviourally heterosexual'.

This perhaps is better understood with an illustrative example drawn from field studies on male sexual behaviours that NFI has done in South Asia.

In asking many married men why they have sex with males when they have a wife, a frequently common answer was that they found anal sex pleasurable. One rationale of this pleasurable feeling was that the anus was tighter than the vagina, but they couldn't ask their wife to do this act. But there are males who were available who offered them this pleasurable activity. Here we see that the choice for pleasurable sex was not the fact that the sexual object was a male, but rather the fact that he had a willing anus.

Naming questions??

* If a male who has sex with males as his primary sexual practice, and also has sex with females on a less regular basis, would you call him homosexual, bisexual, or just sexually active?

* If a male only has oral sex with other males, but also anally penetrates women, what would you call him, and where does his risk of infection arise?

* If a male has regular sex with his wife, but once a month will have penetrative sex with another male, then what would you call him?

* If a male's primary sexual practice is to have oral sex as the penetrator with another males, and also has regular vaginal sex with his wife/females, what would you call him?

Hidden within the above questions are deeper questions on pleasure, desire, and fantasy, and not necessarily a specific gender as object choices. What do such questions mean for sustained HIV prevention strategies?

What this leads me to question in terms of working with "males who have sex with male" or even males generally, and HIV prevention, is, how can we incorporate pleasure, fantasy and desire into our prevention strategies. How do we ensure that safer sex is pleasurable and desirable? Why are we not looking at what for many will be the pleasure of anal sex for both the penetrator and the penetrated, and therefore the desire for this act, along with the active seeking out of this act?

To paraphrase, the proper study of homosexuality is heterosexuality.

Recommended reading

The following list of books are, I believe, a good beginning for deconstructing the categories of heterosexuality and homosexuality, and develop a broader view of sexual behaviours and practices that reflect the reality of everyday life for most males. All these books are a part of the NFI Library and Information Centre. Of course this list is not definitive. They form a part of our own studies.

Bisexualities and AIDS - international perspectives, edited by Peter Aggleton, 1996, Taylor and Francis

A History of Bisexuality, Steven Angelides, 2001, University of Chicago

The End of Gay (and the death of heterosexuality), Bert Archer, 2002, Fusion Press

Biological Exuberance - animal homosexuality and natural diversity

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Kothi and other MSM sex work, poverty and exclusion

drawn from a workshop conducted at the 3rd NFI Partners Regional Consultation and Capacity-Building Meeting, held between 5th - 7th April 2003, in New Delhi. The workshop was facilitated by Paramita Bannerji and Maya Ganesh.

Within South Asia, male sex workers operating at public sites are primarily kothi-identified, but not exclusively so. Most are from low-income groups where poverty and support for their families drive much of their sex work. This is not ignore other types of male sex workers, such as malaishias of Pakistan and the boys who operate through massage parlours and hotels, many of whom offer their services to both male and female clients. In other words, there several frameworks of male sex work.

This workshop explored these frameworks, the reasons for male sex work, the various risks and issues involved, focusing on poverty alleviation. It will develop strategies for working with male sex workers and reduce risks for HIV/STI infection that are based on a framework of wellbeing.

Methodologies used were group work, discussions, storytelling and free-listing.

Participants first mapped out the range of MSM/kothi sex work, its location, the client groups, as well as understand the nature of the transactions

WHO is involved in MSM/kothi sex work?

Women, men/ "real men", panthis, police, kothis, drug users, kothis' partners, female and male commercial sex workers, friends, relatives, the military, doctors, drivers, labourers, teachers, students, salesmen, beggars, children, gigolos, migrant labour, carpenters, servants, jeweller, hotel boys, managers/the boss, domestic help, truckers, porters, gym trainers, DJs at discotheques, actors, models

WHERE does MSM/kothi sex work take place?

Brothels (interestingly, brothels of female CSWs is a pick-up location for MSM/kothi sex workers), public toilets, cinema theatres, lodges, parks, beaches, private homes, train/bus stations, hostels, 'dark areas', demolished areas/construction sites, police stations, jails, swimming pools, flyovers, in the bushes, hospitals, vehicles, national highways, schools, gay bars, karaoke bars, massage parlours, bars, health clubs and gyms, hotels, saunas

WHAT are the sexual activities?

Oral sex and mutual masturbation are most commonly practised in locations where privacy cannot be guaranteed, and where there may not be much time. Anal penetrative sex is practised where there is a private space and enough time

WHAT is the nature of the transaction?

Money is the most obvious transaction; gifts; mental and physical satisfaction (note that the participants did not use the word 'pleasure'); love and intimacy - an opportunity to be close to another person.

Some discussions followed the mapping:

- * MSM/kothi sex work can and does occur anywhere, at any time, with any one. It is not confined to any one physical location
- * Everyone in the 'WHO' list is both a client and a provider of sex/work. Not all might be in full time commercial sex work, but an individual shifts between the roles of client and provider depending on the situation.

Mapping interventions on a large scale will be confounded by the sheer spread and often times, invisibility, of male sex work. So rather than attempt the impossible it would make sense to focus on small, intensive interventions with specific groups/organizations towards creating sustainable effective models to be replicated elsewhere.

- * Beggars and children are the only two groups who are only sexual service providers; beggars because they are the poorest and - "they are dirty" - do not have the power to command what they will do and for how much. Children are powerless, in the control of adults and are sexual service providers. Though the group did say that children solicit sex even when it is not paid. They do not have the power to negotiate the terms though.

It was recognized nonetheless that children solicit sex for a number of different reasons, and it is not always true that they cannot



negotiate the terms, but the general idea was the different layers and expressions of power was not something that beggars and children possessed. The discussions on power were very important and the point was made that the greatest transaction of all is that of power.

- * Risk of HIV and STDs is relatively greater in hurried not-so-private sex work as there may not be time to use a condom or take precautions. (Of course, any kind of sex can be risky).

- * Sex work is engaged in primarily to survive. Poverty is the most important motivating factor. Some participants talked about how their semi-urban township offers no opportunities for youth, there are few jobs, no access to education etc. An army base nearby provides a regular source of income through sex work. Participants from an urban area and a slightly higher socioeconomic bracket talked of sex work as an easy way to make some extra money for themselves. These participants could not ask their parents or families for money to spend on themselves and occasional (or full time) sex work is a lucrative option.

Following this, participants then identified the main problems faced by the majority male/kothi sex workers. They identified:

- * An unending cycle of poverty - poverty is often the primary reason for commercial sex work, yet it doesn't really solve the problem because there are so many levels and layers of control, and even a lot of sex work does not necessarily raise the emotional, personal, financial standard of living
- * Harassment, abuse and violence - the actors are many, from the most intimate spaces with lovers/panthis to family, police, and society who inflict physical, sexual, emotional and psychological violence on MSM/kothi sex workers
- * Lack of information - about safety and sexuality
- * Emotional problems - emotional insecurity, loneliness, stigmatization, betrayal

Interestingly, the group did not see HIV as a 'problem' but more as a fallout of these issues. Despite the cultural diversity of the group it was found that the problems faced by sex workers were the same.

Two significant points were identified:

1. Sex work has two elements to it - the financial, and the psychological. The motivating factors, needs, and fallouts of sex work are both financial and psychological. The conundrum herein is that to 'work on' the economic issues of poverty is relatively easier to conceptualize, i.e. to create micro-credit or income generation interventions. But to address the psychological, psychosocial factors in sex work is more difficult to conceive of. What would you offer 'in return'?

How do you talk about 'comfort', '(emotional) safety', 'happiness', 'peace', 'love', 'fellowship' or 'pleasure' in terms of interventions and programs? How do you quantify these things as real and

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Workshop on kothi and other MSM sex work, poverty and exclusion

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tangible, both to sex workers and to donors? Sexual and bodily safety does not occur in a vacuum but stems from a sense of respect for the self and one's body. This therefore has to be the real aim of any intervention - a sense of self. Economic security is a necessary but not sufficient condition towards this. A program for sex workers therefore has to include both the financial and psychosocial/personal aspects to sex work. Existing interventions with female sex workers from across the globe can be useful models to learn lessons from and build upon.

2. Existing interventions on safety, or anything else for males (in general) approaches them from the perspective of the body. Sex work is viewed in terms of the acts of sex, the opportunities for it, the positions and proclivities. But behind sex/work is a whole personality that is rarely addressed. Sex work is (or rather, should be) less about sex and more about personhood, about the individual behind the organs, the heart and mind that experiences the acts of sex. The group was able to relate to this. The discussions leading up to this point began by looking at how sex workers are seen only terms of their bodies and not their hearts or minds.

Based on these points, programs and interventions for sex workers would need to incorporate the following issues:

- * The insecurity of not being able to earn, or even have a supportive group as one ages. Clients want younger and prettier MSM/kothis.
- * Therefore an enduring network of friendship and support is important and should be central
- * Panthis would also need to be sensitized

The Impact of Sex Work

As the focus was the self, the personhood of the sex worker we decided that the impact on the body and mind was the important thing to focus on:

On the Body

- * Health Risks - of HIV/skin diseases/STDs/Hepatitis/of cancer from injecting female hormones or using female contraceptive pills to develop breasts
- * Excessive beauty consciousness and concerns about physical attractiveness - to attract clients and panthis - and competition with other sex workers because of this
- * Unsafe and sometimes fatal castrations
- * Physical, sexual, domestic, and emotional violence from partners, clients, family, police
- * Cheating/Theft by owners and clients - clients may not pay the entire amount agreed upon
- * Substance abuse - alcohol, marijuana, and other drugs are used to numb the mind and body, or to create a feeling of false courage or bravado. The long term use of such substances takes its toll on the body and the mind
- * No Choices - there are very few choices sex workers have to decide anything in their lives. Being involved in sex work is a testament to that

On the Mind

- * Loneliness - a fear that as one ages one will not have the security of family or a community - a deep sense of pain and betrayal for rejection from families, from panthis who have dumped them for trophy kothis
- * Anger - at the injustices they have had to face since childhood - for being rejected, violated, for feeling worthless, for having to be engaged in commercial sex work.
- * Worthlessness - that one is 'good for nothing' but sex work, that one cannot get any other job or livelihood and has to sell sex to survive. Aging sex workers also feel intensely worthless and there is fear about approaching middle/old age - loss of attractiveness and therefore reduced earning capacity

- * Stigma and discrimination - for being involved in commercial sex work - HIV + status can lead to isolation and discrimination within the MSM/kothi sex work community
- * Shame/Guilt - for being involved in sex work - for not being what others expect of him/her
- * Forced marriages - some kothis and MSM are forced to marry leading to incredible tension, pressure, unhappiness. And concern for the wife who may not want to marry either, who could feel 'unfulfilled', or be stigmatized for being married to a kothi
- * Pressure to be attractive - fear that if one loses one's attractiveness there will be a significant drop in earnings.

Note from the facilitators

Listing the impact of sex work on MSM and kothis was a powerful and disturbing session. There was so much angst, pain, and anger one could sense; and how similar their lives were to female commercial sex workers! It is ironic that feminism created an alternative paradigm for women, freed them (at least in theory) from being judged on the basis of their physical attractiveness, put a sense of self and choice back in their control, and created spaces to address physical, sexual and domestic violence. How ironic that in a landmass where the Feminine is revered as the all-powerful origin of the universe, as Shakti, as Maya and Mahamaya, is reduced to a parody of itself. The lives of kothis are a chilling reminder of a world where the Female/Feminine is defined by, and adjusts itself, to suit the whims of the Masculine.

In our work with female commercial sex workers (consistently coming back to this parallel to indicate that the experiences of sex work, social exclusion, affect marginalised men/women in the same way because the forces of social control and morality are the same everywhere although the specific impacts might be different) we have found that these experiences are normalized as 'the way things are', and there is a sense of resignation about them. But as soon as there is awareness of one's rights, and just a little bit of introspection and honesty about what one experiences, there has to be a rethink of many personal, relational, and social issues. The process of a workshop has to be sustained in some way in order to keep the internal dialogue going!

Participants listed all the negative feelings and emotions that MSM/kothi sex workers face: pain, fear, shame, anger, guilt, mistrust (in the self and in the world around), exclusion and isolation. All of this was seen as a violation of the self, leading to a rejection of the self.

The self, the 'I' lies at the core of a system where external actors are more evident and obvious than it. These external factors also define the I, and the aim is to understand the I, and the impact of these external actors on it. The shame, guilt, and exclusion come from the outside towards the self, and it is the I that feels fear and anger in response. The self is shaped and controlled by the perceptions of the Other, the external. Consistently being exposed to negative feelings and perceptions whittles away at an individual's sense of self. This is expressed and experienced as no confidence in oneself, and no belief in oneself and in one's worth.

Following this, participants then explored the range of messages given in traditional interventions for sex workers, including those from within the HIV/AIDS and MSM/kothi projects. The common constant messages were:

Change your behaviour! Know about HIV! Use Condoms!

Participants believed that this knowledge was well known, but there did not seem to be a corresponding sustained change in behaviour. In asking the question why this was so, participants felt that sexual behaviours do not occur in a vacuum but were an expression of who they were within. A series of questions were generated:

- * Who will implement these programs and interventions?
- * How do you use a condom if your panthi doesn't want to?
- * Does the self stand up for itself and its integrity, or follow the desires of the panthi although it could be life threatening?

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“Spread of AIDS in Asia’s militaries a threat to security”

HIV is increasing among Asian military personnel, and could threaten regional security if infections rise to levels seen in Africa, a Honolulu-based US consultant said Friday. Asian soldiers spreading the disease while serving abroad as international peacekeepers also put wider security at risk, said Gerard Bradford, director of the Centre of Excellence in Disaster Management and Humanitarian Assistance, headquartered at Tripler Army Medical Centre.

“Aside from the pandemic and the health problems and all the tragedy and loss of life that HIV/AIDS has created ... it presents a real threat to the stability of the region,” Bradford said. The 13th Asia-Pacific Military Medicine Conference in Bangkok May 11-16 brought together hundreds of delegates from about two dozen countries to discuss medical issues facing armed forces in countries across the region.

The Thai Royal Army has been particularly successful in combating the spread of HIV/AIDS in its ranks through prevention efforts, he said, but “it’s clear there are other parts of Asia that are significantly affected.” “Other countries are seeing it rise dramatically. It’s intravenous drug use as well as sexual activity,” he said. Bradford declined to say which countries or peacekeeping forces were most affected by the fatal illness. But he said Cambodia, India and Vietnam are “working the problem.” Bradford said his organization, which works with several international aid agencies, attended the conference to start a regional discussion to determine the extent of the problem and urge aggressive action to stop it. “I think all the trends are for increased incidence, and the idea is to try to mitigate that increase as quickly and aggressively as we can,” Bradford added.

Associated Press 16/5/03

Vietnamese police bust gay sex ring

Two Vietnamese men have been jailed for running a gay prostitution service in what communist state media on Saturday said was the first case of its kind.

A court in the southern commercial hub of Ho Chi Minh City on Friday jailed 30-year-old Nguyen Van Tuan for 10 years and an associate for five years and six months, the Tuoi Tre newspaper said.

State media said police last year broke into Tuan’s house and found a male couple having sex and several other men allegedly waiting for customers.

Tuan and his associate were also charged with pornography offences.

Newspapers said it was the first time someone had been charged with organising gay prostitution in a country which traditionally frowns on homosexuality. *Posted on JVNet, 12/4/03*

FDA approves Canadian biotech firm’s rapid HIV test

Halifax, Canada-based biotechnology company MedMira announced last week that the FDA has approved the company’s three-minute HIV antibody testing kit, the Hamilton Spectator reports. The company plans to begin distributing the test, which costs the company about \$2.25 to manufacture, in the U.S. market. According to a company spokesperson, MedMira will have an order from the United States for 500,000 rapid-detection test kits (Tutton, Hamilton Spectator, 4/21). The company is already rushing to manufacture 250,000 of the HIV tests to distribute to health clinics in China, where the test was approved earlier this month. Health Canada approved the test in 1998 (Kaiser Daily HIV/AIDS Report, 4/14). Jim Smith, vice president of corporate affairs for MedMira, said that U.S. approval has taken six years, adding, “About 80% of companies don’t make it through this process and end up failing” (Hamilton Spectator, 4/21). MedMira President and CEO Stephen Sham said, “We are very pleased to enter the United States market with the best rapid HIV test to date. Many

Circumcised men are less likely to contract HIV during unprotected sex than uncircumcised men

Circumcised men are at least 50 percent less likely to contract HIV during unprotected sex than uncircumcised men, according to a soon-to-be released report by US Agency for International Development.

Based on a systematic review of 28 scientific studies published by the London School of Hygiene and Tropical Medicine, the USAID report “found that to be infected by HIV as uncircumcised men.” “A sub analysis of 10 African studies found a 71 percent reduction among higher risk men,” said the report obtained by the Washington Times. The report, which will be published on the USAID Web site, shows a “strong association” between circumcision and HIV protection, Dr. Anne Peterson, USAID assistant administrator for global health said.

The skin on the inside of a male’s foreskin is “mucosal” - much like the skin inside the mouth - and contains many Langerhans’ cells, which are target cells for HIV, according to the Times. “HIV looks for target cells, like Langerhans’; it’s a lock and key,” Edward Green, a Harvard University senior researcher who has studied circumcision and HIV in Africa for 10 years, said. Although the foreskin is vulnerable to HIV infection, Green said that “(t)he rest of the skin on the penis is armourlike.” Green said that if all African men were circumcised, some regions’ HIV prevalence rates could fall from 20% to below 5%, according to the Times. Circumcision also reduces the risk of contracting other sexually transmitted diseases, is more hygienic and make condom use easier, Green added, according to the Times. “This is something tribal healers, the herbalists, faith healers and witch doctors have known for years,” he said. Peterson said that the information in the USAID report “looks profound and wonderful” but more information about HIV and circumcision will be needed from clinical trials in Kenya and Uganda, which are ongoing and being sponsored by NIH, Johns Hopkins University and the Bill & Melinda Gates Foundation, according to the Times. Peterson added that female circumcision has no protective benefit against HIV and may even increase risk. “We are adamantly apposed to female circumcision,” she said. Although male circumcision can have some protective effect, the practice does not make one invulnerable from HIV. “People who are circumcised still get HIV,” Peterson said, adding “It is still better to abstain, be faithful to marriage” or use condoms. *Washington Times, 25/04/2003*

Dear colleagues

“I always marvel at peoples’ surprise when HIV is found in the so-called “general population”. HIV does not spontaneously arise in sex workers and not all their clients are injecting drug users. Sex workers and drug users are part of a much larger community. They are not living separate lives from others in the community. They are sons, daughters, husbands, wives, fathers, mothers. Why is it so surprising that HIV goes beyond the artificial barriers of authority-given identity (sex worker/drug user)? I bet if you asked a sex worker how she would identify herself, she is as likely to say a mother or daughter or wife as she would say a “sex worker”. I think we have to remember that we who work in this field put identities on people that they may not recognize themselves. Unfortunately we often think the HIV virus originates in and transmitted by these identities rather than within the contexts of dynamic relationships and overall structural factors that determine the spread of HIV. Where did the HIV+ sex worker get HIV? Was it an immaculate infection? The idea that sex workers and drug users live in a closed loop of infection is ridiculous and unrealistic. When are we going to get beyond this???”

Lisa - from the net, 12/05/03

countries view the approval to market a diagnostic test by the FDA to be the gold standard of endorsement.”

Posted by Saathi, 25/4/03

Amsterdam's young gay men getting HIV from steady partners

Michael Carter

The overwhelming majority of new HIV infections amongst gay men in Amsterdam are happening within the context of steady relationships, according to a mathematical model which was constructed with reference to on-going surveys of young gay men's sexual practices and published in the May 2nd 2003 edition of AIDS. The model also predicts that any reduction in the infectiousness of HIV due to HAART could be cancelled out by increased rates of unprotected sex, particularly in relationships.

Every six months since 1995 members of the Amsterdam Cohort Study were asked to complete a questionnaire about their sexual behaviour. The cohort is made up of gay men aged under 30 who live in the Amsterdam area. Investigators constructed a mathematical model to predict the prevalence of unprotected anal sex within steady partnerships and in casual encounters. The model also indicated how HIV incidence would be affected by increased rates of unprotected anal sex with regular and casual partners; different levels of HIV testing; and the use of HAART.

Investigators calculated that at the 1995 pre-HAART baseline there were 0.67 new HIV infections per 100 person years of follow-up and that there was an overall HIV prevalence rate of 8.84% in the cohort. Between 1995 and 2000 HIV incidence fluctuated between 0.34 and 1.93 per 100 person years.

Far more unprotected anal sex took place between regular partners (30 instances per year) than casual partners (1.5 instances per year), and the investigators estimated that 86% of new HIV infections were occurring within the context of relationships. As less than 50% of gay men in Amsterdam had tested for HIV, gay men were often having unprotected sex without a reliable knowledge of their own or steady partner's HIV status. Further, an estimated 10% of gay men in steady relationships who were having unprotected sex with their main partner did not have a "negotiated safety" agreement to help prevent HIV being introduced into the relationship from unprotected sex with casual partners. In addition, an estimated 12.5% of gay men who did have such agreements broke them by having unprotected sex with casual partners.

Increased amounts of unprotected sex between regular partners had the potential to cancel out the reduced infectiousness of HIV from HAART. The investigators calculated that a HAART-related reduction of between 75% and 99% in HIV's infectiousness would be cancelled out if the amount of unprotected anal sex between regular partners increased by 50%. Because so little HIV transmission was calculated to occur during casual sexual encounters, the investigators predicted that HAART would still reduce HIV incidence even if the amount of unprotected anal intercourse between casual partners were to double. At the start of the study, approximately 42% of gay men in Amsterdam had tested for HIV. According to the investigator's model, if HIV testing increased from the baseline level to 80% and use of HAART by HIV-infected men increased from 80% to 85%, the incidence of new HIV infections could be further reduced.

An increase in HIV testing to 70% would require a 30% increase in risk behaviour between regular partners and over a 100% increase in unprotected anal sex between casual partners to cancel out the beneficial effects of more gay men knowing their HIV status. HAART would only fail to limit new infections when unprotected anal intercourse between regular partners had increased by 70%, and HAART would continue to reduce the incidence of new infections even if the level of unprotected anal intercourse between casual partners doubled.

The investigators note that the mathematical model used in their study "suggests that the majority of new infections among young homosexual men in Amsterdam can be attributed to steady partners. Changes in risky behaviour with steady partners thus have a greater impact on HIV incidence than the equivalent changes among casual partners." They add that the potential for HAART to reduce the

infectiousness of HIV could be cancelled out by increases in the amount of risky sex men have with steady partners, noting "the model also shows that increases in risky behaviour may counterbalance the positive effects of HAART, although such increases could be outweighed by increased HIV testing and HAART administration." *AidsMap, UK, 22/4/03, posted on JVNet*

Dear JVnet,

I rarely make comments on messages posted in this forum. This time, however, I am inclined to do so because I feel strongly the need to point out the superficiality of most studies on vulnerability to HIV infection, especially when it comes to issues concerning sex and sexuality. The posted news brief about the study among Amsterdam's young gay men is a case in point. As I understand it, the news brief tells us that young gay men in Amsterdam, which has one of the most vibrant gay communities in the world, are at risk of HIV transmission because they lack necessary knowledge and skills. They lack knowledge about their partners' HIV status; they lack necessary skills to make 'negotiated safety' agreement with their steady partners (and even when they have such agreements they often broke them); and last but not least, they are unwilling (because they lack appropriate knowledge and attitudes?) to take voluntary HIV testing and therefore put their partners and themselves at risk for not knowing their own HIV status. The solution for all these 'lack', though not offered explicitly in this article, is education, more education, and more BCC.

What the news brief does not tell us, I would argue, is equally, if not more, important than what it does. It does not tell us what factors put gay men in steady relationships more vulnerable than their fellows who engage only in casual sex. (In some ways, the news brief tells us something counterintuitive and, especially, against one of the most common slogans about how to avoid HIV transmission i.e., one should not engage in sex with multiple partners concurrently.) I would venture to offer some of the factors that are at work here. They are love, trust, and associated desire to prove one's love and trust; the need for bonding, especially in a world where homophobia and discrimination is a growing plague; and pleasure, a factor one should not forget when talking about sex. I believe that sex are not merely calculated (aka. rational) acts, as quoted scientific numbers and mathematical modelling seem to tell us, but also involve some of the most 'irrational' rationality that are not easy to measure. I also believe that these factors and rationality are as important in difference-sex relationships as they are in same-sex relationships. And, finally, I doubt that education or BCC alone would work here.

I loved it when someone put it to me that 'Safe sex is sex with someone you don't know, don't love and don't trust'. I am sure that there are other subscribers in this forum who are more knowledgeable than I am on this issue, and I would like to hear more from them.

Le Minh Giang

AIDS cuts life expectancy in Zambia to 33 years

AIDS has cut life expectancy at birth in Zambia to 33 years from 44 a decade ago, the country's Central Statistical Office (CSO) said on Monday.

"The adult mortality rate has increased in the last decade...an adult has lost about 11 years of survival due to the AIDS problem," CSO Director Buleti Nsemukila said in a statement.

AIDS and the HIV virus that causes it have emerged as a huge development problem in this poor southern African country.

Treasury data shows one in every five adult Zambians has HIV or is living with AIDS. The government says AIDS kills 200 Zambians daily while 500 people are infected with HIV per day.

Zambia's population stands at 9.8 million people, according to CSO data released on Monday.

Reuters, 05 May 2003

High percentage of Surat's sex workers have

Around 43.2 per cent of sex workers were found to have seroprevalence of HIV or were HIV positive, according to a recent study. The findings were on the basis of a cross sectional study among sex workers in a health camp over a period in the year 2000.

The study was conducted by the department of community medicine, Government Medical College in Surat, under a project sponsored by Department for International Development (DFID) of the UK.

Though the HIV tests were done secretly through administration of behavioural questionnaire followed by clinical examination of sexually transmitted infections (STIs), laboratory tests were conducted over a period of time from February 2000 to September 2000 after obtaining the consent of the participants, report said.

Out of 600 sex workers in the red-light area, 124 in the age group of 16 to 50 - with about two-thirds being below 30 - opted for clinical tests, the report revealed. Notably, among the sex workers in the red-light area here, three were locals, over 33 per cent were reported to be from Nepal and the rest had migrated from other states, the report said.

In all, over 80 per cent were illiterate, and about 95 per cent reported to use condoms during sex. The range in the number of different partners per day varied from two to 25, the mean being five clients per day in each case, according to the report.

Since sex workers being one of the core groups for transmission of STDs (sexually transmitted diseases) and HIV as a 'bridge group' to the general population, a comprehensive intervention is being focused on, said Dr Vikas Desai of department of community medicine in the Government Medical College here. "We had some data base on a survey done in 1992 which has been effective as a baseline for the

prevention of STDs and HIV among sex workers," she forwarded.

"HIV cases have been on increase here, but source of transmission by the sex workers or by the clients need to be examined thoroughly for a comprehensive intervention," she said.

For the purpose of creating awareness, 17 peer educators and about 34 link workers have been working among the sex workers. Even through social marketing for distribution of condoms have been intensified, but due to lack of adequate trained manpower along with proper financial resources, the intervention for the targeted group is yet not up to the mark, she said. Though the report was based on the targeted group of sex workers in the redlight area here, but no such surveys have been conducted in the case of over an estimated 5,000 sex workers operating from different parts of the city, Desai said. Many of them, in fact, come from Mumbai on regular basis, she said.

The World Health Organisation (WHO) has emphasised on a syndromic approach for case measurement and management, particularly in high prevalence areas with inadequate resources for surveys, according to Dr H Thakore who works for WHO and had been associated with this report.

For continuation of prevention among the HIV positive cases, a similar one-year project has been sponsored by the United Nations Development Programme (UNDP), Thakore informed. Interestingly, one well-equipped voluntary counselling and testing centre (VCTC) at the New Civil Hospital here is functional since January, 2000, but even services being free-of-cost, hardly anyone other than those referral cases, come here, Desai said. Even toll free number 1097 for free tele-counselling at the hospital has been without much of use, she informed.

Posted by Saathi - Times News Network, 22/5/03

Safety and acceptability of the Reality condom for anal sex among men who have sex with men

Unprotected anal intercourse is the major mode of sexual transmission of HIV and other STDs between men and has been associated with increased heterosexual transmission risk. Latex male condoms are the main barrier method promoted for HIV and STD prevention but are associated with usage problems including breakage, slippage, latex allergies, and lack of control by receptive partners.

The Reality "female condom" was approved in the United States in 1992 for vaginal contraceptive use and has since been reported to reduce re-infection with trichomonas. The Reality condom has two flexible polyurethane rings and a thin, loose-fitting polyurethane sheath, demonstrated in laboratory studies to be impermeable to viruses and less likely to rupture than latex condoms. The removable inner ring is used for insertion and to anchor the condom to the cervix; the non-removable ring at the open end of the sheath is designed to cover the external genitalia.

Given the need to identify safe and acceptable alternatives to the male condom and the limited safety data available for Reality condoms for anal sex, the present study compares Reality and male latex condom for anal sex with respect to safety (breakage, slippage, rectal disruption, inflammation and bleeding) and acceptability in future partnerships.

The study enrolled 56 monogamous HIV-seroconcordant MSM couples who had not regularly used condoms in the past 3 months for a crossover study of male and Reality condoms. Participants were recruited from HIV clinics, advertisements, and outreach in Seattle, Wash., during 2001. Eligibility criteria was 18 years or older, relationship duration of 3 months or longer, and willingness to use each condom during anal sex up to 10 times (minimum of 3 uses each type). Each couple designated one partner as receptive and the other as insertive for anal sex.

Baseline information was obtained at screening with HIV counselling and testing. At enrolment, couples were randomly assigned to an initial condom type, 10 reality or lubricated male latex condoms without Nonoxynol-9, to use with anal sex during the subsequent 6 weeks. In the second six weeks, couples crossed over to other condom

type. Couples were instructed to remove the inner ring of the Reality condom to reduce potential rectal trauma and bleeding, based on previous reports of discomfort and rectal bleeding from the inner ring.

Safety outcomes included self-reported condom breakage, condom slippage, semen spillage, rectal bleeding, and pain or discomfort during condom use. Participants were instructed to examine used condoms for breakage and bleeding. Condom slippage was defined as the condom slipping off the penis either into or out of the rectum during use or withdrawal. Rectal epithelial disruption was assessed among receptive partners who consented to rectal biopsies at baseline and after each condom use phase. After each condom use, participants separately completed a structured diary sheet on safety outcomes. At the end of each period of 6 weeks, acceptability was assessed by willingness to use Reality or male condoms for anal sex in future partnerships of varying degrees of HIV risk. The primary acceptability outcomes measure was strongly or somewhat preferring the Reality or male condom for anal sex with a new partner of unknown HIV status.

The objectives of this study was to determine whether the Reality condom was a safe and acceptable form of barrier prevention among MSM who were not regular condom users. Slippage with removal was reported more frequently with Reality than male latex condom. Receptive partners were more frequently reported pain or discomfort and rectal bleeding with Reality condoms than with male condoms. For the 20 percent in this study who reported a preference for Reality condoms, the potential utility and equivalent breakage and inflammation rates are balanced by a need for further evaluation of rectal bleeding and the significance and sources of discomfort. Training is needed related to slippage and methods for avoiding semen spillage that might expose anal mucosa. Given recent increasing rates of HIV and STDs among MSM, effective and acceptable barrier protection methods for anal sex for MSM and heterosexuals who engage in anal sex must be identified. *AIDS (28/03/2003), Vol.17, No.5, p. 727-731*

Report details anti-gay abuse in Africa

Government-sanctioned harassment and violence against GLBT people in Southern Africa is pervasive, according to a joint report released on Wednesday by two human rights groups.

The 298-page report, "More Than a Name: State-Sponsored Homophobia and Its Consequences in Southern Africa," documents widespread anti-gay violence in Botswana, Namibia, South Africa, Zambia and Zimbabwe. It was compiled by Human Rights Watch and the International Gay and Lesbian Human Rights Commission (IGLHRC).

"Lesbian, gay, bisexual and transgender people have been vilified by presidents and political leaders, which has led to a culture of intolerance," said Paula Ettelbrick, executive director of IGLHRC. "These attacks are just the first step in creating a climate in which all rights are at risk."

The report is based on interviews with numerous people in each country and includes first-person accounts of police brutality and mob beatings, among other anti-gay violence.

"When Southern African leaders like President Robert Mugabe of Zimbabwe make speeches saying that gays and lesbians are 'worse than dogs and pigs,' it should be no surprise that violent attacks follow," said Scott Long of Human Rights Watch, co-author of the report.

The two human rights groups called on the African countries to stop anti-gay abuse by repealing sodomy laws, enacting protections against discrimination and creating mechanisms for dealing with incidents of anti-gay violence.

Gay.com / PlanetOut.com Network, 14/5/03

Uzbekistan journalists face gay 'offence'

Three human rights journalists in Uzbekistan may be charged with the "criminal offence" of homosexuality for what a leading international rights watchdog claims are politically motivated reasons.

The three men were detained on Monday, reports the Associated Press. Ruslan Sharipov, a journalist who leads an independent civil rights group focusing on protecting media freedom, has already been charged with sex abuse and homosexuality. His colleagues Oleg Sarapulov and Azamat Mamankulov have been threatened with similar charges, but have not been formally cited.

US organization Human Rights Watch (HRW) said in a statement that Sharipov's history of writing critically about the Uzbek government's policies and past harassment against him and his colleagues raised "strong suspicions" that the charges were politically motivated.

Elizabeth Andersen, the group's Europe and Central Asian division director, said: "That the authorities would charge him with committing homosexual acts, violating his fundamental rights to nondiscrimination and privacy, makes it doubly egregious."

Sharipov had told an HRW representative, who had been allowed to visit him in custody, that police had threatened to rape him with a bottle and put a gas mask on him.

Paris-based media watchdog, Reporters Without Borders, has written to Uzbek President Islam Karimov expressing their deep concerns about the arrests. The group's secretary-general, Robert Menard, called the arrests "a new, sordid way to harass or get rid of critical journalists who have upset the authorities."

Homosexuality is not uncommon in Uzbekistan but is still regarded as a social taboo. While it is a criminal offence, cases of criminal prosecution are rare. *Gay.com UK, 29/5/03*

all humans make mistakes, and all leaders are humans

Delegates walk out of Islamic conference on AIDS after speaker criticizes religion's response to epidemic

About 20 delegates from Africa, Malaysia, Britain and other countries on Tuesday walked out of the Second International Muslim Leaders' Consultation on HIV/AIDS in Malaysia after an American speaker said that traditional Islamic practices have worsened the epidemic's spread, the Associated Press reports. Amina Wadud, an associate professor of Islamic studies at Virginia Commonwealth University, said that "Islam and Muslims exacerbate the spread of AIDS" because Muslim women are required to comply with their husbands' desires for sex even if the man is HIV-positive, according to the Associated Press. The delegates who walked out issued a statement condemning Wadud's comments as "blasphemy," adding, "[Wadud's] vicious and venomous attack to Islam is unfounded and unsubstantiated" and her comments were meant to "demonise Islam." Wadud stood by her statements, saying, "My paper just states opinions that are different from others and perhaps they take exception to that" (Singh, Associated Press, 5/21). The protesting delegates called for the conference to expel Wadud, but Malaysian AIDS Council President Marina Mahathir, chair of the International Advisory Committee of the conference, said that a panel had decided to allow Wadud to stay at the meeting, according to the Bernama News Agency reports. "The walkout by the delegates is something we regret happening," Mahathir said, adding, "It is the objective of the conference to give space to different opinions. Surely we cannot expect a consensus on an issue like AIDS and as we quarrel over differences of opinion, Muslims everywhere are dying of AIDS".

Bernama News Agency, 21/5/03

Indonesia's low rates could mask Growing Trend, UNAIDS warns

With a relatively low HIV/AIDS prevalence of 0.1 percent, Indonesia has the opportunity to deal a decisive blow against the disease, Joint UN Program on HIV/AIDS Director Peter Piot said today in Jakarta, warning that the low rates of the disease could also mask the growing risk of HIV spreading in the country. Speaking at the launch of Indonesia's National HIV/AIDS Strategy through 2007, Piot said urgent action is needed to slow the spread of the disease. "The current low levels of condom use and widespread sharing of unsterilized needles among injecting drug users can be a lethal mix for HIV spread in the country," Piot said during a three-day visit to the country, which ends tomorrow. According to UNAIDS, the majority of the estimated 90,000 to 130,000 HIV/AIDS cases in the country are concentrated in high-risk groups, including drug users and sex workers. "Indonesia must urgently scale up prevention interventions targeting sex workers and their clients, and injecting drug users, if it is going to succeed in slowing the spread of the epidemic," Piot said. "Young people must also be given the life skills to protect themselves from HIV infection." Indonesia's National AIDS Commission decided to revise the National HIV/AIDS Strategy because of an increase in HIV infections in recent years and to respond to commitments made at the 2001 U.N. General Assembly Special Session on HIV/AIDS. The new national strategy outlines six priority areas - surveillance of the epidemic; prevention; treatment, care and support of people living with HIV/AIDS; human rights of people living with HIV/AIDS; research; and government coordination at all levels. "AIDS cannot be fought by one sector alone - every part of the government and every force in society must be harnessed in a common fight," Piot said. "The challenge now is to implement the national strategy and to ensure that resources and capacity are in place so that it can be translated into action".

UNAIDS release, 9/5/03. Source: UN Wire 9/5/03

Certain words can trip up AIDS grants, scientists say

Scientists who study AIDS and other sexually transmitted diseases say they have been warned by federal health officials that their research may come under unusual scrutiny by the Department of Health and Human Services or by the members of the Congress, because the topics are politically controversial.

The scientists, who spoke on condition they not be identified, say they have been advised they can avoid unfavourable attention by keeping certain "key words" out of their application for grants from the National Institute of Health or the Centers for Disease Control and Prevention. Those words include "sex workers", "men who sleep with men", "anal sex" and "needle exchange," the scientists said.

Bill Pierce, a spokesman for the health and human services department, said the department does not screen grant application for politically delicate content. He said that when the department singles out grants it is usually to send out a news release about them. But an official at the National Institute of Health, who spoke on condition of anonymity, said project officers at the agency, the people who deal with grant applicants and recipients, were telling researchers at meetings and in telephone conversations to avoid so-called sensitive language. But the official added, "You won't find any paper or anything that advises people to do this."

The official said researchers had long been advised to avoid phrases that might mark their work as controversial. But the degree of scrutiny under Bush administration was "much worse and more intense," the official said.

Dr. Alfred Sommer, the dean of the Bloomberg School of Public Health at John Hopkins University, said a researcher at his institution had been advised by a project officer at N.I.H. to change the term "sex worker" to something more euphemistic in a grant proposal for a study of H.I.V. prevention among prostitutes. He said the idea that grant might be subject to political surveillance was creating a "pernicious sense of scrutiny" among researchers.

Senate approves Bush's AIDS plan

Early Friday morning, the U.S. Senate passed a \$15 billion funding plan aimed at fighting the AIDS pandemic in some of the world's poorest countries.

President Bush, who introduced the five-year global AIDS initiative in his State of the Union address in January, said he will sign the bill as soon as possible. The measure was approved by the House on May 1.

Senate Majority Leader Bill Frist, R-Tenn., called the plan "the first major step in reversing this greatest of humanitarian challenges of the 21st century."

"Congress has given the hope of life to millions of people in countries most affected by AIDS," President Bush said on Friday. "This historic legislation will enable us to provide critical treatment and care for millions who suffer and greatly expand successful prevention programs to help those at risk."

The measure authorizes \$3 billion per year for the next five years to be spent on HIV/AIDS programs in Africa and the Caribbean, with up to \$1 billion provided during fiscal year 2004 to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

According to the Associated Press, the package recommends a breakdown of spending: 55 percent for treatment programs, 20 percent for HIV prevention, 15 percent for palliative care and 10 percent for children made orphans by the disease.

Sen. Dianne Feinstein, D-Calif., sought to amend the bill's requirement that one-third of all prevention funding go to abstinence programs, but the effort was defeated.

The Bush administration's emphasis on abstinence for preventing HIV infection has been criticized by many public health officials, international AIDS specialists and gay rights advocates.

Gay.com / PlanetOut.com Network, 16/5/03

At the National Institute of Health, for example, grant applications are evaluated and rated by a panel of independent reviewers. The grant application is then given a score.

In another example of the scrutiny the scientists described, a researcher at the University of California said he had been advised by an N.I.H. project officer that the abstract of a grant application he was submitting "should be 'cleansed' and should not contain any contentious wording like 'gay' or 'homosexual' or 'transgender'."

The researcher said the project officer told him that grants that included those words were "being screened out and targeted for more intense scrutiny."

He said he was now struggling with how to write the grant proposal, which dealt with a study of gay men and H.I.V. testing. When the subjects were gay men, "It's hard not to mention them in your abstract."

The titles and abstracts of federally financed grants are available to the public on a computer database maintained by the national institutes. This database, called CRISP, is also frequently read by Congressional staff members on the lookout for research on topics that are concern to the politicians they work for. Over the years, studies on cloning, abortion, animal rights, needle-exchange programs and various types of AIDS research have been criticized by members of Congress.

But researchers said they feared that the concerns of individual members of Congress were being taken more seriously by the health and human services department.

John Burklow, a spokesman for the N.I.H., said project directors at the agency were responsible for "providing advice and guidance on myriad issues related to grant applications, "but he did not confirm or deny that the project officers were cautioning researchers about the language they used.

He said that health and human services department "from a management perspective has a right to oversee N.I.H. affairs" but that department officials "have not interfered with the awarding or renewing of any N.I.H. grant." *New York Times, 18/04/2003*

Australia censors AIDS info site

AIDS activists in Australia are pressing for the return of a website that promotes safe sex. The site, maintained by the Australian Federation of AIDS Organizations (<http://www.afao.org.au>) was closed after the Department of Health and Ageing said it contained obscene material.

Funding for the AFAO comes from the government agency. AFAO Education Team Manager Dermot Ryan said the site was taken off-line during a departmental review of its funding, according to gay newspaper The Melbourne Star.

The site, which contained sexually explicit material was aimed at promoting safe sex between men who have sex with men.

Part of the government funding review was a determination if the site could be put back up.

Ryan said a government review process finished last week and the AFAO hoped to know soon whether or not the site could be returned. "At this stage we believe that access to the material may be outside the guidelines for the Office of Film and Literature Classifications, which is a part of approval procedures and are awaiting advise on this," Ryan told the paper.

Last week, AIDS scientists in the US said they are being warned their federal grants will be in jeopardy if they use words and phrases such as "gay", "men who have sex with men".

365Gay.com Newscenter, 21/4/03

compassionate love is to give freedom to another to be who they are, rather than who we want them to be

Seven in ten adult Americans support U.S. Supreme Court overturning same-sex sodomy laws

Research Shows Broad Public Support on Right to Privacy

Seventy-four percent of American adults surveyed last month favour the U.S. Supreme Court overturning state laws that criminalise private, consenting sexual relations between same-sex couples, yet allows that same private conduct to occur between opposite-sex couples. This was the latest finding of a national online poll released today by Witeck-Combs Communications and Harris InteractiveR.

The new survey also reveals that Americans almost equally oppose laws regulating consenting sexual relations that occur in the private homes of opposite-sex and same-sex couples. Nearly nine out of 10 Americans (87%) oppose state laws regulating private, sexual relations that are applied to opposite-sex married adult couples and almost as many (82%) oppose such laws that are applied to same-sex adult couples in a domestic partnership.

"Even when we exclude respondents who self-identify as lesbian, gay, bisexual or transgender, support for overturning state sodomy laws does not change significantly," said Darin Johnson, vice president at Witeck-Combs Communications. "It is clear that an overwhelming majority of Americans believe the Supreme Court should overturn all state laws that interfere with private sexual relations between consenting adults, whether same-sex or opposite-sex couples."

These are highlights of a nationwide survey more than 2,000 adults, of whom approximately seven percent self-identified as gay, lesbian, bisexual or transgender (GLBT). The survey was conducted online between April 17 and 23, 2003 by Harris Interactive, with analysis of GLBT data provided by Witeck-Combs Communications, Inc., a strategic public relations and marketing communications firm with special expertise in GLBT issues.

"These numbers tell the same story we've been telling courts in this country for years: the vast majority of Americans support the right to privacy of all people, including gays and lesbians, and oppose anti-gay discrimination," said Kevin Cathcart, executive director of Lambda Legal Defence and Education Fund, the national gay rights organization bringing the Supreme Court challenge to consensual sex laws.

Across the board, regardless of income, gender, age, region of the country, or political philosophy, Americans overwhelmingly oppose

state laws that regulate sexual relations that occur in the private home of an adult same-sex couple.

Key findings from this survey include:

- 75% of self-described Republicans oppose state laws that regulate sexual relations that occur in the private home of an adult same-sex couple in a domestic partnership (as do 88% of self-labelled Democrats). In addition, seven out of 10 Americans (70%) who characterize their personal ideology as "conservative" also oppose such laws.
- Americans from all regions in the U.S. express opposition to state sodomy laws, including 76% of Southerners; 80% of Midwesterners; 88% of Westerners; and 89% of Easterners who say they oppose state laws that regulate the private, sexual relations of adult same-sex couples in a domestic partnership.
- 66% of adults over the age of 50 agree the U.S. Supreme Court should overturn state sodomy laws that apply solely to same-sex couples.
- A majority of all American adults surveyed said same-sex couples who engage in private, consenting sexual relations should not be denied basic rights and opportunities: 82% opposed denial of health benefits to a couple; 87% opposed denial of rental housing; 74% opposed denial of certain jobs, such as teaching; and 59% opposed denial of the right to adopt children.

"These results are not surprising," commented David Krane, senior vice president at Harris Interactive. "They closely align with findings from previous studies we have conducted with Americans on privacy. The public feels very strongly that the government should not interfere with matters related to their personal privacy - and particularly, as this study shows, with their choices related to sexual practices."

On March 26, 2003, the U.S. Supreme Court heard oral arguments testing Texas same-sex sodomy statute. This case, *Lawrence v. Texas*, will examine the constitutionality of Texas law (and other similar state laws) that imposes criminal charges on same-sex couples who have consenting sexual relations in the privacy of their home. [see www.witeckcombs.com](http://www.witeckcombs.com) or www.harrisinteractive.com 6/5/03, online

Muslim alliance set to derail historic UN vote

An historic vote at the UN on gay human rights was derailed at the last minute by an alliance of Muslim countries.

This was the first time the UN, in its 60 year existence, was going to vote on gay human rights, but five Muslim countries introduced amendments to the bill with the intention of killing it off.

These amendments remove any references to discrimination on the basis of sexual orientation - thus rendering the resolution meaningless.

Sources in the UN said that Egypt, Pakistan, Saudi Arabia, Libya and Malaysia were pulling out all the stops to make sure a vote wouldn't take place.

The resolution was tabled by Brazil at the UN commission on human rights in Geneva with the support of 19 other countries include the UK. The resolution calls on all UN member states to promote and protect the human rights of 'all persons regardless of their sexual orientation.'

Of course many UN states simply cannot swallow such sentiment. Gay sex relations are outlawed in almost half of the member states and over 70 countries maintain a total ban on homosexuality. In some cases being gay carries the death penalty.

Peter Tatchell said: "The vote has been derailed and delayed by Islamic fundamentalist states were gay people are either flogged, jailed or beheaded."

He went on to say that the UN resolution was desperately needed because of those countries' horrific track record on gay human rights. *Gay.com UK, 25/04/2003*

Vadodara has 6,000 HIV positive cases

If India has approximately about 40 lakh HIV positive cases, Vadodara has a startling 6,000 cases, according to a recent survey conducted by a state government-funded project. "Gujarat, being an industrially-developed state, is highly vulnerable to AIDS owing to its floating population, mostly comprising of migrant labourers," said Dr Yogesh Marfatia, a skin specialist, during a training programme for doctors organised by the People's Training and Research Centre. "The alarming number of HIV cases is an indication that only a negligible portion of the population in the city practices safe sex," he said. "Unless we control sexually transmitted diseases, we can't contain the spread of HIV," Marfatia said, adding that a decade ago, the city did not have even a single case of HIV. PTRC, a voluntary organisation, is working towards prevention of HIV among industrial workers in the city. PTRC workers have so far mapped about 10,000 workers in the industrial belt of Makarpura. "Industrial workers are among the high risk groups for HIV like truck drivers, commercial sex workers, migrants, etc. We have identified about 15 slum pockets in the Makarpura area, where we conduct awareness and health camps," said Suresh Parmar, a project officer. "Training of medical professionals from all streams - be it ayurveda, homoeopathy or allopathy - we are providing a wider choice to industry workers for whom treatment is never affordable. The latest strategy is to have a single approach to tackle all endemic diseases, including the sexually-transmitted diseases (STDs)," said PTRC director Jagdish Patel.

Posted by Saathi, 18/5/03

Denial marks South Asians' HIV/AIDS experience

By Akhilesh Upadhyay

Ask any HIV/AIDS outreach workers in New York how the city's fast growing South Asian community is faring in its new home and they are most likely to say, "old habits die hard".

"South Asians believe that AIDS is something that doesn't happen to them," says Gurpreet Clair of the city's APICHA (Asian & Pacific Islander Coalition on HIV/AIDS). "They associate it with morality."

Traditional fixation with family privacy and prestige coupled with low rates of health insurance coverage means South Asians are less likely to seek professional assistance, say civil society groups. And while they are as promiscuous as others, South Asians are also less likely to discuss sex and dating topics with their friends, family members or anyone else.

One study of 165 Asian Indian adolescents in the New York area found that while the majority of them knew about HIV/AIDS, many had crucial gaps in their knowledge about how the disease is transmitted.

"I have never seen Nepali or for that matter any Asian parents discuss sex or AIDS with their children openly," says Kiran Thapa, a social worker with Help Nepal who has extensive experience working with high school students from immigrant families in New York.

"Even among the second-generation Asians, AIDS is still a taboo in the family circles and these children grow up less equipped when it comes to handling AIDS than others."

It is left to outreach organisations to better equip New York's South Asians, and publicise patterns that they have observed over the years.

Most of the South Asians seeking assistance with APICHA, for example, are married couples in their 30s and 40s: unsuspecting wives who were infected by their husbands, who first got the deadly virus through female prostitutes or gay sex.

Some groups work with the tens of thousands of South Asian taxi drivers. "The drivers are obviously exposed to a lot and they need to be prepared," says Chris Lobo of Cab Watch, adding it is important to make the drivers aware of the risks of unprotected sex.

A nongovernmental organisation (NGO) Cab Watch provides advice to more than 6,000 members in New York City. More than 45 percent of them are ethnic South Asians.

The U.S. government lumps South Asians in the "Asian and Pacific Islander" category, a group that has reported increasing rates of newly diagnosed AIDS cases in recent years, while rates have been declining for most racial groups.

Few U.S. states have compiled figures on HIV/AIDS prevalence among the South Asian subgroup, but a 1999 study by California's department of health found 26 Indians infected with HIV, the virus that causes AIDS.

Though the prevalence of 0.9 percent was smaller compared to other large Asian communities - Chinese (2.9 percent of the population), Filipinos (2.7 percent), Vietnamese (1.3 percent), research workers warn that the figure could only be the proverbial tip of the iceberg.

"This is just in California alone and is thought to be an underestimate due to under-reporting," says Ushma Upadhyay, a research writer at John Hopkins University School of Public Health. "While it may seem like a small number, it's too large a number in light of the lack of tailored health services for this ethnic group," says Upadhyay. "This number also disproves the belief that (HIV/AIDS) does not exist among the South Asian community and that there is no risk of the number increasing exponentially."

She assumes the numbers are similar in the states of New Jersey, Texas and New York.

According to the 2000 census, Indians, Pakistanis, Sri Lankans and Bangladeshis are among the fastest growing immigrant groups in New York City - all registering more than 100 percent growth over 1990 numbers. Numbering almost 200,000, Indians make up the largest Asian community in the city after Chinese, who have a much older history of immigration in the United States.

The 2000 census also revealed that most South Asians are new immigrants who spend a lot of time among themselves, and maintain their old habits. On a recent weekend, many stores in Jackson Heights, or "Little India", buzzed with shoppers from the subcontinent, busy buying home favourites like saris, salwaars and samosas.

An estimated 850,000 to 950,000 people in the United States currently live with HIV, and about 40,000 new infections occur every year. Some 6,300 Asian and Pacific Islanders are HIV infected, according to the U.S. Centers for Disease Control.

"It's urgent to work on promoting better dialogue about sexual and reproductive health in South Asian American communities," says Vandana Tripathi, of Planned Parenthood of New York.

"The idea that one goes to the doctor only when very sick has carried over here," she adds. "Our communities have very low rates of utilising preventive reproductive health services like pap smears. And, we have low insurance rates, so it's harder to access services."

Some 64 percent of South Asians in Queens, one of five of New York City's boroughs, have no health insurance, according to a study done last year by the New York Asian American Network for Cancer Awareness, Research and Training.

Twenty percent of the HIV/AIDS-positive people who seek counselling with Clair's APICHA in New York are South Asians, most of whom came for assistance only after they were very sick.

There are some ominous signs that the low usage of health services is having a negative impact, Tripathi warns. Chlamydia rates, for example, rose 32.9 percent among Asians in 1998, the highest growth rate of all racial groups. The number one sexually transmitted disease (STD) in the United States today, chlamydia is particularly common among teens and young adults.

Despite the high risk, many South Asians still associate AIDS with stereotypes - it infects white men who have sex with men, and taxi drivers. "There is a feeling in our community that it is only the taxi drivers who get AIDS," says Clair. "But it's as much the white-collar workers. In fact, it's across the board."

What is particularly disturbing is that the level of AIDS awareness remains low even among South Asian professionals, she adds. This could expose them to greater risks when they travel to their home countries. At any given time a quarter of U.S. adult Indians are believed to be in India, a country with more than four million HIV cases - second only to South Africa - and the U.S. government warns that the number could shoot up to 20-25 million by 2010.

"Blood is yet not adequately protected in India," says Linda Groetzinger, a public health Ph.D. candidate in Chicago who specialises on the sexual health of South Asian Americans. "This issue of international transmission is not discussed yet."

Outreach workers with APICHA also found out that social expectations and parental pressure have led many South Asian men to lead a double life - one of a heterosexual family man in public and of a homosexual in private.

"Arranged marriages and living in joint families create unnecessary pressures which often means leading a double life," says Help Nepal's Thapa, "one approved by your traditional family members and friends, and another away from your community".

New York, May 9 (IPS)



Update

After seven years of intensive work with vulnerable and marginalised male populations in South Asia, Naz Foundation International (NFI) has embarked on a strategic review of its organisational structure, its institutional processes and its core programmes. Supported by the UK Department for International Development (DfID), the purpose of this review is to ensure that NFI is fully prepared to meet the expanding needs of its key constituencies while simultaneously addressing the changing nature of the HIV/AIDS epidemic.

A central aspect of the strategic planning process is to review what constraints we have experienced, what lessons have been learnt and what actions need to be taken to enhance our services and their delivery.

Principal constraints

Our review has identified a range of constraints that we have experienced:

- * Lack of NFI staffing capacity to follow through with advocacy work and enhance relationships with donors, international, national and state level institutions.
- * Human rights abuse of NFI Lucknow staff, the temporary closure of the NFI Regional Liaison office in 2001, along with the harassment of MSM CBOs and their staff at local levels has made visible policy conflicts between National AIDS Programmes/Ministries of Health policies with regard to MSM peer led HIV/AIDS interventions and Home Ministries concerns about promoting homosexuality. This is within a hostile environment where stigmatisation and marginalisation of MSM is pervasive and extremely difficult to counteract in a political climate that often arises from religious beliefs and values.
- * Pervasive “genderphobia” that deeply affects MSM who are kothi-identified.
- * In India it has been difficult to obtain donor support for emergent MSM sexual health self-help organisations. International donors are limited to specific states, while State AIDS Control Societies appear to be unwilling to directly support new MSM CBOs and where they do funding is inadequate for a comprehensive service.
- * With the increasing sensitivity in regard to terms such as men who have sex with men, or male-to-male sex, of even MSM with both some donors and certain government institutions in the South Asia region, alternate language has to be identified. Terms such as “males at risk”, “stigmatised males” and such like are being explored, but this often makes it difficult to promote activities for reducing HIV/AIDS risks among these constituents.
- * A lack of knowledge and understanding at all levels regarding constructions of male sexual behaviours in the region.
- * A lack of adequate research from reputable institutions that would support our contentions of the level and risks of male-to-male sexual behaviours in South Asia.

Lessons learnt

Initially, NFI believed that its work programme should be developed with the minimum of publicity so as to reduce possible conflict with religious, cultural institutions and others, who believed that MSM was a “foreign issue” and does not exist in South Asian countries. Hence local projects were promoted as male sexual health and HIV/AIDS prevention programmes.

However, with the arrest (subsequently released) of NFI regional staff in July 2001, based on charges to “conspire to promote sodomy”, along with the resultant international and local advocacy work that NFI became involved with, it became rapidly clear that the agency must be more pro-active on the issues of MSM and human rights abuse in the future.

Not enough networking with other agencies and NGOs working

with women’s reproductive health issues, human rights concerns, and other arenas, had been done in the past (mainly due to staffing and funding constraints). Nor had there been enough promotion of NFI and its activities in the public arena.

The Regional Office events between July - September 2001 spurred NFI to extensively advocate locally, nationally and internationally in terms of MSM and their needs, network across the region with non AIDS agencies, and to develop coalitions of support for its work. Further, NFI now regularly posts a range of documents on its work, its Briefing Papers, and other records, on a number of internet egroups, as well as sending its reports to a range of donors and other institutions, internationally and locally.

This level of advocacy is having a significant impact in the areas of concerns, including increased sensitisation and possible additional funding support for NFI work. More interest is now being shown by USAID, SIDA, CIDA and FHI in regard to our work and the processes we have developed.

National government rules regarding foreign funding have also had an impact. In Bangladesh, the model for service implementation has required a single agency (Bandhu Social Welfare Society) to manage a number of MSM sexual health projects under its umbrella. In India, NACO has a three-year rule, in that organisations should have existed for three years. We have been in discussions with a number of bi-lateral donors, as well as State AIDS Control Societies to see whether this can be a discretionary rule. While an alternative is to hand an MSM sexual health project over to an existent NGO, we have found through previous experience that this is not an effective process towards building self-help organisations for sustainable risk reduction among MSM.

More work needs to be done through the bi-lateral donors and NACO to develop this funding rule into a discretionary principle, so new CBOs can receive funding quickly.

Such constraints in funding MSM CBOs in India leads to a conclusion that NFI itself should develop the capacity to fund its partner projects directly.

With regard to recruiting local staff with appropriate skills to manage the local sexual health projects, NFI believes that more networking, sensitising, and working with gay networks will be vital.

Since we primarily work with MSM who are gendered and are from low-income networks and collectivities where project development and management skills are usually low, NFI has had to provide a much higher level of on-going technical support than previously thought, since we believe in community ownership and community-based agencies.

This could reduce the level of technical support that is currently needed by individual projects, which was intensive, and unanticipated. At the same time, NFI has been working with a range of bi-lateral donors to recommend changes with NACO policies in regard to its funding guidelines so ensure more appropriate salaries are paid in regard to the projects it supports, thus increasing the range of access to appropriately skilled individuals.

The framework for the provision of technical support to NFI partner projects has been through either the Regional office, or through accessing NFI trainers/consultants that are locally based. This has been difficult because of the lack of funding to support such on-going interventions through external advisors. It is clear that NFI will need to build up an in-house team to provide such support as an on-going process as an integral part of the NFI regional based work team.

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With the increased networking amongst donors and other institutions working in the field of AIDS, we are anticipating an increased sensitivity to the sexual health needs and issues of concern that MSM express.

NFI urgently needs to obtain direct core support to reduce the pressures and increase its staffing capacity in order to manage the growth and intensity of its technical support programme. This means broadening its funding base, and we are currently in discussions with a number of donors on this issue.

A way forward

The cornerstone of NFI's work should continue to be the technical assistance and support provided to NFI partner projects, both current and new. By implementing the fundamental NFI service model - a safe and friendly drop-in centre, well-trained outreach workers, effective behaviour change interventions and accessible clinical services - these CBOs are playing a critical role in reducing the risk of HIV infection among the target populations.

However as the number of PLWHAs amongst MSM increases, the NFI model needs to evolve to provide care and support services for these people as well. The challenge for NFI will be to rapidly increase the number of MSM self-help CBOs to reach substantially more of the at-risk males in the region, particularly in India.

Consequently, NFI will need to develop a management approach that provides more extensive technical support to state-level CBOs in India and national-level CBOs in other South Asia countries that will, in turn, enable these organizations to build and support a network of local CBOs that provide services at the grassroots level. This new approach will ensure that every organization working at the grassroots level will continue to receive the necessary support without overtaxing the resources of NFI's core operations.

As an international NGO with offices in the UK and India, NFI will also need take a more active role in the much-needed "upstream" work that it is well positioned to take on. These upstream activities include essential work in advocacy, policy, research and fundraising. This will mean developing a long-term and well-coordinated advocacy and policy initiatives that are required to ensure that the importance of working with NFI's target populations is understood, accepted and

supported by decision makers in government and civil society in the region.

As a part of this NFI will also need to develop research partnerships with prestigious institutions in India, Europe, the US, Australia, and Asia for the primary purpose of expanding the knowledge base on high-risk behaviours among vulnerable and marginalised males in South Asia. Expanding the knowledge base is critical to advocacy and policy work as well as to ongoing improvements in field interventions. NFI will therefore need to expand its fundraising efforts, both to broaden the base of support for its work and to accelerate its plans to scale-up coverage of the target populations.

In addition, NFI will continue to add to the holdings of its library, which, as one of the most extensive collections on male sexualities and risk behaviours in South Asia, is already an important resource for donor organizations, international NGOs, Indian NGOs and CBOs et al that are interested in working with vulnerable and marginalised males.

Lastly, NFI will strive to remain a lean and cost-effective organisation as it evolves. Although expanding its activities to include significant "upstream" initiatives will require additional staff with professional skills, the organisation is committed to ensuring that its overhead costs remain below international norms and that it has the ability to demonstrate quantifiable cost-benefit analyses of its work. The challenges of working with vulnerable and marginalised men in South Asia are too great and the available resources are too limited to expect any less of NFI.

Years of experience in South Asia with these difficult-to-reach populations have given NFI a unique perspective on the situation. As vulnerable and marginalised people, they have long suffered from stigma, discrimination and social exclusion. HIV/AIDS has increased this stigma and discrimination at the same time it has increased their risk of dying prematurely. Ironically, despite the risk, the stigma and the discrimination, these men have responsibilities to family and community, which - left unfulfilled - can have a very negative and very broad impact.

The current strategic review of NFI's work and its future builds on the organisation's knowledge of how to reach these males with the dignity and respect they deserve and that they need if they are going to reduce their risk of contracting HIV/AIDS.

News from the frontline

NFI continues to support Naz Foundation (India) Trust's Milan Project

The Milan Project of Naz Foundation (India) Trust is an autonomous sexual health service for MSM in New Delhi. NFI has been supporting this initiative for the past few years through a grant from the Community-Fund of the UK.

NFI has applied to the Community Fund for funding an extension proposal for Milan, which has now been granted. This means that NFI through Community-Fund support can continue to fund the Milan Project for a further five years. The total amount of the grant for Milan is £195,000. The funds will go towards enhancing the Milan drop-in centre, outreach work to both kothis and other types of vulnerable males as well as hijras, ensure clinical access for treatment, care and support, and work in partnership with NFI on social justice and human rights of MSM.

Bandhu Social Welfare Society, Bangladesh

BSWS has developed a concept of a "revolving fund" for the support of its STI clinical service. This acts as the start-up fund for the purchase of medical supplies for the treatment of STIs and a range of general health concerns. Marketing the clinic as a male sexual health clinic with a small fee for registration and subsidised costs for treatment packages, BSWS can achieve medical cost recovery for the purchase of further medicines. Experience has taught BSWS the level

and maintenance of such costs. BSWS has been able to secure the support of the Elton John AIDS Foundation in the UK for an initial investment for such a revolving fund for its 9 current male sexual health clinics in a number of cities in Bangladesh.

In 1997, BSWS consisted of 2 staff and one small room. Initial support from the Royal Norwegian Embassy in Dhaka enabled BSWS to launch a full service programme (utilizing the NFI service model of outreach, drop-in and clinic services) in Dhaka city. In 2000, BSWS gained the support of Family Health International Bangladesh and the Government of Bangladesh to scale up its activities across Dhaka, will adding Chittagong and Sylhet to its service areas. Further, BSWS initiated a hijra service project in Dhaka.

Today, BSWS, with the continued support of the Royal Norwegian Embassy and FHI Bangladesh, as a self-help CBO has scaled up to become a national MSM CBO currently providing local services in some 6 cities in the country as well as a scaled up hijra project operating in two. From the initial 2 staff, BSWS now has over 200.

Congratulations BSWS, and to its Executive Director, Shale Ahmed.

From West Bengal

Following a meeting at the 3rd NFI Partners Regional Consultation Meet held in New Delhi between 5th - 7th April this year, where delegates from West Bengal had an opportunity to talk and share information, a further meeting was held in Calcutta on the 4th May. With 9 organisations present, the Bengal network was established.

The network has been given the tentative name MANASH (MSM Action Network for Advocacy and Sexual Health). It was also suggested that this should be prefixed by BENGAL to locate it.

Here is an illustration as to how local groups and projects can work together to mutually support each other. Good news.

Social Justice and MSM - further news from NFI

NFI has received funding support from the British Foreign and Commonwealth Office to develop advocacy and policy work in terms of a rights-based approach to sexual health for MSM. Aditya Bondyopadhyay, NFI legal advisor has been contracted to implement the 2-year project in the region.

The project will work closely with a number of NFI partner projects to provide training in legal literacy and advocacy work, conduct research in legal, social and judicial abuse of MSM, and develop national MSM task forces.

Blue Diamond Society, Nepal

Gays allege detention, torture; cops spin another tale

The police forced a group of homosexual men into custody early this morning and detained them for about four hours at Durbar Marg police station and tortured them, says the group.

"We went to a disco last night and then to Oriental restaurant which is open 24 hours a day. As soon as we got out of the restaurant and were heading home, some police personnel took us to a corner and told us they were taking us to a police station," said Ramesh Rai.

"We refused to comply with their ridiculous order and asked them if we had broken any law. Then they started beating some of my friends severely with their truncheons and guns for no reason. I told them to stop beating my friends with the gun fearing it might accidentally go off. They did not listen to me. So I threw the policeman's gun away," he said.

A police van soon arrived on the spot and took the group to the station while two managed to escape and inform Sunil Pant, director of Blue Diamond Society (BDS), an association that supports gays.

The police ridiculed them for being gay and mentally and physically tortured them, according to the group. Pant phoned lawyer Sapna Malla Pradhan and the group were released at 6.45 am.

"Their right to self expression and right to live were violated right in front of the Royal Palace," he stated.

"We have reported such incidents to the headquarters but till date action against such guilty policemen has yet to be taken. Even human rights organizations ignore our plight," he stressed.

That is not all. Homosexuals have been facing huge problems for a long time. "They are beaten up, extorted, raped and blackmailed regularly by the police," said Pant.

Anil Pandey recalled an incident when a cop stopped him when he was travelling in a taxi, took him in the van, sexually abused him and threatened to kill him. "That cop said he would shoot me and tell his superiors he killed me in an encounter," he said.

Bishal Thapa who managed to escape from the spot said they had been "facing similar incidents for a long time and it has become a routine."

"We behave differently than straight people but we have the same feelings like others, therefore we should be allowed to live with dignity. Our basic rights should not be curtailed," Rai said.

Nepali law does not accommodate homosexuals and the word 'homosexual' is not mentioned in the constitution.

Pradhan said the law did nothing to support homosexuals but "it does not mean that they do not have the right to live and express themselves like any individual."

According to her, there have been allegations of routine torture and abuse by the police who are supposed to safeguard the public. "Why are they targeting a weaker and vulnerable section of society when their duty is to protect the public and bring criminals to book?" questioned Pradhan.

Umesh Ranjitkar, inspector at the Durbar Marg police station, said the police took the group into custody who were found to be under the influence of alcohol. "It was reported that a person from the

group threw away a policeman's gun and bit off his ears," he said.

"I politely told the group they should not have retaliated even if they felt the police were harassing them and they should have reported the incident to me in the morning instead," said Ranjitkar. He, however, denied that the police physically tortured and abused them in custody. (Names have been changed to protect their identity)

"Dikshya Thakuri". Kathmandu, April 22/4/03
lgbt-india@yahoogroups.com,

The indefatigable Sunil Pant, Executive Director and founder of Blue Diamond Society (BDS) has been initially supported by FHI Nepal for establishing an MSM service project in Kathmandu.

With support from PSI Nepal BDS is developing an information and resource centre dealing with a range of issues relating to HIV/AIDS, MSM, sexualities and human rights.

They are seeking support from our readers by requesting them to send any books, articles, videos and other information resources to build up this library. Send to BDS, GPO Box 8975, EPC No 5119, Kathmandu, Nepal.

Further PSI Nepal is also supporting BDS to enhance its human resource capacity, as well as develop a strategic plan for scaling up coverage across Nepal. NFI will be supported to provide technical assistance in these areas.

Along with this FIAR in the US is working with BDS to assist in establishing an HIV/STD clinical service.

Mithru, Andhra Pradesh

Several months ago a series of accusations had been made against Mithru regarding its financial probity. As a consequence of these accusations, Mithru was investigated by the Technical Resource Unit in AP. We are pleased to announce that Mithru was fully cleared of these accusations, and continues to work providing sexual health services for MSM in the city.

Along with this, Mithru has been working closely with the International HIV/AIDS Alliance project in the state assisting in the MSM mapping exercise.

Sahodaran, Tamil Nadu

NFI has been supporting Sahodaran with funding from the UK Department for International Development and technical support for these past five years, a total of £215,000.

This funding comes to an end in September 2003, and we have worked closely with the agency to gain the support for FHI India for continuing funding. This has been provisionally agreed (as of this edition) pending a review of the project, which is currently underway.



NFI Liaison Office in Lucknow believes strongly in working with its neighbours by providing support on a range of issues. We call this building good neighbourhood relations. As a part of this, and at the request of neighbourhood families, the Liaison Office has begun classes on English speaking for young adults who want to improve their chances for finding employment. We are grateful to Neil for volunteering his teaching skills.

Why are sex diseases rising?

The number of people being diagnosed with sexually transmitted infections (STIs) [in the UK] is now at record levels.

Key statistics:

HIV: 4,419 cases - up 17%

Syphilis: 715 cases - up 119%

Gonorrhoea: 22,697 cases - up 7%

Chlamydia: 71,125 - up 10%

Herpes: 17,850 - up 5%

Warts: 67,672 - up 2%

(Source: PHLS)

Doctors have warned ministers they risk having a major public health crisis on their hands unless they take urgent action to tackle the problem.

STIs have jumped sharply in recent years. Syphilis has risen by 486% since 1996. Chlamydia is up by 108% over the same period and rates of gonorrhoea are 87% higher than they were seven years ago.

More people are also being diagnosed with HIV. In 2001, a total of 4,419 people were told they had the virus, up 17% on the previous year. The number of new infections is predicted to double between 1997 and 2005.

An estimated 40,000 people living in Britain are now HIV-positive. As many as one in three of these do not realise they have the disease.

Complicated issue

There is no clear explanation for the sharp rise of recent years. For instance, there is little evidence to suggest it can be attributed to more people engaging in casual sex.

"Changes in sexual behaviour are not sufficient to explain the increase in sexually transmitted infections," says Dr Roger Ingham of the Centre for Sexual Health Research at the University of Southampton.

"It may be the case that more people are engaging in casual sex. However, the rise in STIs is so high that it cannot be explained by this."

The most obvious explanation is that people are simply failing to practice safe sex.

However, even this isn't clear cut. Teenage pregnancy rates are falling suggesting that more couples are using contraception.

Recent studies have also found that more people are using condoms when they first have sex.

Problems appear to be linked to the choice of contraception. While more teenage girls may be taking the Pill or emergency contraception, the statistics suggest they are not using condoms. Condoms are the most effective way of preventing the spread of STIs.

Complacent couples

In addition, there is evidence to suggest that couples put themselves at risk by deciding to stop using condoms when their relationship becomes more stable.

"Our research shows young and older people are finding it difficult to maintain condom use once they are in a trusting relationship," says Dr Ingham. "Obviously, if there is a STI it can then be transmitted."

The sharp increase in STIs suggests that couples are becoming more complacent and are not listening to calls to practice safe sex.

"In the late 1980s and early 1990s, we had campaigns warning people about HIV. They also helped to prevent STIs," says Derek Bodell, director of the National Aids Trust.

"While there have been some new campaigns, overall there hasn't been the same level of promotion. Increasingly, generations are coming forward who have not heard about HIV and who do not know much about using condoms. They are missing out on the key messages," he says.

This is compounded by the fact that many people have major misconceptions about STIs and HIV. A study published last year suggested one in three 18 to 24 year olds wrongly believed there is a cure for HIV.

Cultural issues also play a part. Many people are simply too embarrassed to talk about sex, let alone STIs, with their friends or family.

"We don't talk about sex," says Simon Blake, director of the Sex Education Forum.

"A lot of people have feelings of embarrassment, shame and guilt around sex. People also do not access sexual health services or get the support they need.

"We need to raise awareness and to tell people that STIs are still around and that HIV is still here."

Government strategy

The government published a 10-year-plan to improve sexual health in July 2001. The National Strategy for Sexual Health and HIV Services was backed with £47.5m.

However, that money represents a mere drop in the ocean. According to doctors, it won't even cover the cost of implementing a national screening programme for Chlamydia let alone improve services elsewhere.

"Sexual health is not an NHS or political priority," says Professor Michael Adler, chairman of the group which drew up the strategy. "It is no exaggeration we now face a public health crisis in relation to sexual health."

Experts believe that the situation will fail to improve unless sexual health becomes a government priority.

"A lack of prioritisation is making it very difficult for charities, local hospitals and primary care trusts to deliver the services which are so badly needed," says Colin Dixon of the Terrence Higgins Trust.

One of the major problems is that money for sexual health services is allocated at a local level. In many areas of the country, it comes a long way behind other health priorities such as fighting cancer and heart disease.

As a result, many sexual health clinics are struggling to cope with demand. While clinics have seen their workload increase by 155% over the past 10 years, their budgets and staff levels have largely remained the same.

Patients are often forced to wait days for an appointment and sometimes weeks for treatment even after they have been diagnosed with a STI.

"Clearly, if you have someone who has a STI then diagnosis and ease of access for patients is crucial in preventing it from spreading," says Derek Bodell.

"Some professional associations have suggested that as many as 150,000 people are waiting to be seen at sexual health clinics at any one time."

These delays increase the risks of people passing on infections, according to the Liberal Democrats.

"People are turned away from overloaded sexual health clinics, remaining at risk to themselves and to others," says Patsy Calton, its health spokeswoman.

The Department of Health insists that its 10-year strategy will deliver improvements.

"Teenage pregnancy rates have come down over the past three years," says Dr Roger Ingham.

"We would hope that given the same time, we will see similar improvements in STIs."

BBC News, 15/04/2003

The most deadliest of errors arise from our obsolete and obsessive assumptions parading as truths.

Masculinities, sexualities and vulnerabilities

A gender based rights approach to prevention

from a speech presented at the 3rd NFI Partners Regional Consultation and Capacity-Building Meeting, held between 5th - 7th April 2003, in New Delhi.

Aditya Bondyopadhyay

When we talk of sexualities masculinities and vulnerabilities, I feel that it is time we get to the root of the problem and stop doing the things that we have been doing thus far. For this we need to get to the basics of the way our culture works.

In the orient as opposed to the occident we have what may be described as a shame based culture, as opposed to the guilt based culture typical of the occident. I use the terms orient and occident consciously, since large parts of where we live and work follow and repose its conduct on this cultural frame. Here it does not matter as much what one does, if one's actions does not have a repercussion of shame. These repercussions of shame go outwards in concentric circles at the centre of which is the person himself. He is then surrounded by his immediate family, which is encircled by his larger clan, his neighbourhood, his caste, his community, his state. If he does not shame these expanding circles of people, he is free, or rather reasonably free to do what he feels like.

In the Occident by contrast we have what is a guilt based culture where you are responsible for your actions before your god or authority. Therefore the notion of sin is so much greater in the occident, and the emphasis is so much greater on the individual, as opposed to on the collective.

This culture of shame leads to a system of silence, where what is not acknowledged is non-existent. In the case of vulnerability we see this in the individual's denial of his risks and risky behaviours, thereby absconding from his responsibility and onus. Also on the other hand we see this in the denial of the state about behaviours that are presumed to be shaming of society, therefore an absolving of responsibility to target these behaviours with preventive interventions. All of these are not good news for containing an epidemic like HIV in this country.

This shame based culture lays a big emphasis on adherence to what is supposedly the norm. Any deviation is to be silenced. One such norm that society preaches is hetero-patriarchy. In this scheme of things there are two rules to be followed to be normative. The first is that heterosexuality is the only and acceptable type of sexuality and therefore heterosex is the only type of sex. The other is that of patriarchy, or "Man is good, woman is bad".

The manifestation of hetero-patriarchy in its copulation with shame means that the man can do what he wants, with impunity, and with disregard of consequences, while the woman is to keep the silence. It also manifests by targeting anyone who does not adhere to this normative-ness with abuse. Therefore, if you are born a male and do not conform, if you do things that a man is not supposed to do or you do things that a woman does, then you are not man enough, therefore you are less than a man, therefore you are like a woman, and therefore you can be abused. You have effectively fallen from grace in the scheme of "man good, woman bad".

Kotis and other gender variant males can therefore be targeted. Anyone whose sexual orientation is non-heterosexual can therefore be targeted. And the vehicle that carries this target is violence and abuse, that denies these males a free expression of their selves, restricts their lives to the fringes, and marginalises them from the mainstream of society and its activities. Full and free participation in society becomes an object of shame to be shut down with ridicule and abuse.

I understand that what I am saying sounds deceptively like what the feminists of this country has been saying for ages. And the feminist movement has made gains in their struggle against hetero-patriarchy and against the culture of shamed silence. We, any male who is gender variant, and does not adhere to norms set by this same

system is similarly targeted, and we are in a nascent stage in our struggle for equality and dignity, for ensuring social justice for our selves. What I would urge this movement to desist from is to re-invent the wheel - to learn its lessons from the strides that the feminist movement has made.

This becomes important not only because today we are increasingly understanding, at a great cost to ourselves counted in countless lives that have been lost or jeopardized, that the only way in which we can do something about the HIV pandemic is by ensuring for those who are most at risk the power to protect themselves, negotiate with equality and with dignity the terms by which they lead their lives, and to stop looking narrowly at just what is under the social microscope at the moment, but holistically at the entire social mechanism and environment in which the social organisms to be studied are based.

But sad as it makes me to say this, in this country, if not this part of the world in general, we have due to our shame induced silence and myopia miserably failed to do either. We started dealing with HIV more than a decade ago and the situation today is worse than it ever was. We have not succeeded because we have not broken the silence, we have not called a spade a spade, we have not given rights and dignity and social justice to those who need it the most, we have lacked the moral courage to stand up and be counted for the powers of those most in need of empowerment, we have taken shelter behind the bogey of culture or religion or national identity to deny the reality out there of abuse and hatred and violence out there, and in the process we have failed to get to our main objective, to get rid of HIV. We, collected in this room from all parts of this region and fighting the pandemic for years now, are also sadly a face of that collective failure.

Does that mean that nothing can be done? No, things can always be done. That the beauty of optimism that carries all of us through most of the hardships that our work brings us. We can choose not to be silent about our reality. We can choose not to be silent about the violence and abuse against us. We can choose not to acknowledge the superiority of men against women or anyone else womanlike. We can choose to call the bluff that the state puts up in the bogey of culture, of faith, or nationalism, and keep pointing out our existence and reality, we can choose not to be afraid, we can choose to fight back, and if we have chosen all this we would have chosen the path to self respect and dignity, of self empowerment in the face of hetero-patriarchy, and that by itself is a long way on in the arduous march against a very difficult sly little virus.



These are two rickshaw drivers from Pondicherry (one with his wife), along with many other men in the city, who dress up as women once a year for a local religious festival. Whither masculinity?

South Asia appears to have very fluid frameworks of masculinity - we should really talk about masculinities - within a culture that is both homosocial and homoaffectionalist.

Lessons in transformation

The annual festival of Aravan at Koovakam gives the hijras a way of asserting themselves. The others who throng the occasion - wrapped in many secrets - must learn from this openness, writes Tishani Doshi. Recently, I returned from Koovakam, a village 30 km from Villipuram, which plays host to the largest annual gathering of hijras in India. I spent a night on the roof of the Koothandavar temple and watched as an otherwise dormant village transformed itself in a brilliant display of colour, vitality and spirit. Koovakam has come to mean many things to many people. For hijras, it is the most important event of the calendar year, a time when they are reunited with friends, a place where they are given a platform from which they can be seen, heard and applauded, where they get to embody all the things they want to be: woman, bride, Goddess. In Villipuram, which is where they stay during the five-day lead up to the actual festival, they overtake the town, strolling up and down the main streets in bright clothes, with flowers in their hair and bangles on their wrists, frequenting the various roadside restaurants and bars; confusing, teasing, beguiling onlookers about what is true and what is false, what is man, what is woman, and what is the place in between that defies definition. It is precisely their sexual and gender ambiguity, their ability to move within an apparently boundary-less world, that have made them a fascinating community for me to study, and the reason for accompanying a group of them from their home in Perungalathur with a fellow-friend and camera man to document their journey to Koovakam.

But four days in Villipuram are enough to realise that Koovakam isn't merely about hijras; although they are the star attraction, how can they not be? Koovakam is about the basic right to express oneself - a startling revelation that has developed from a culture struggling with issues of identity and repression. The trend of moving towards an increasingly dichotomous way of viewing the world, of classifying, pigeon-holing, pinning down all manner of things; be it problem, opinion or concern, in a bi-polar fashion, has created a stultifying atmosphere which gets to be aired out only once in a long while in places like Koovakam. The result is a strange display of exhilarating liberation paired with unsettling sordidness.

What is most visible is the intensity of physical experience against the backdrop of spirituality with the ever-present ghost of sexuality hovering about. People come to Koovakam without any apology. They come because it is a time for them to be what they want to be. This includes not only hijras but a vast array of men; homosexual, bisexual, straight, cross-dressers, married, single, divorced, college boy, auto-driver, tea-shop owner, businessman - they are all here, walking up and down the streets along with the hijras, mingling and intermingling in various combinations of the aforementioned, physical, spiritual and sexual. For people not taking part in these interactions, the spectacle forces contemplation.

What is obvious is that there is a need to address issues of sexuality and gender conflict within the framework of our society, especially with the growing menace of AIDS crashing through the horizon. Koovakam is a microcosm of a country caught in contradiction, because it shows what is right and wrong about our society simultaneously. The fact that hijras are not only treated with respect, but welcomed by the ordinary town-people and village folk during their short stay here every year is heartening proof of how the basic Indian philosophy that envisions a universe boundlessly various, including all possibilities of being, proscribing the notion of plurality of selves and allowing opposites to confront each other without resolution, is still alive and kicking. By the same token, hijras as a community are still struggling to regain their place in the world, denied the most basic rights - the right to own a passport, ration card, property, equal opportunities in the areas of education and employment, simply because they refuse to be categorised as either male or female and wish to claim a third gender for themselves. Hijras have always occupied the fringe of the Indian subconscious, they are

accepted without question, even if it is with a mixture of fear, ridicule and contempt, because of their inherited centuries old court history combined with the eternal spring-well of mythology, which constantly affirms and validates their existence, quite unlike their western counterpart, the transsexual, who must resolve sexual anomalies one way or the other without the luxury of floating in man-woman limbo. But acceptance does not mean openness; it could simply mean that you don't care one way or the other because a thing has no bearing on your life. It is the same veil through which we view the problems of poverty, war and disease. Unless problems come steamrolling into our own immediate lives, we don't feel the need to address them.

So what does it say about the young, homosexual men who come to Koovakam every year to dress in women's clothes, their parents unaware of their son's double life lead and busy plotting weddings with girls who are equally uninformed? What does it say about the hundreds of straight young men who flock to Villipuram because sex is cheap and easily available? This is not an attack on men, but rather an attack on the ruthless nature of sexuality in our society.

It is a dangerous thing when sexuality is linked with confusion and dishonesty. The dilemma is not so much what one says to these young men who are questing - whether for their identity, their sexuality, the ambivalent feelings of their gender - but what does one do about the existence of repression in a society which perpetuates a rigid demeanour of prudery, while kicking all disparity and deviation under the rug, refusing to accept it as a part of our existence? Koovakam should be seen for what it is; a possibility in transformation and liberation, of crossing over boundaries and erasing lines. The festival at Koovakam celebrates the life of Aravan, who in the Mahabharata must be sacrificed for the Pandavas to emerge victorious. Aravan is willing, but wants to be married before he is to die. No woman will come forward to marry him because she knows that what lies waiting for her is the doom of widowhood. So Lord Krishna, taking the form of a beautiful woman, comes down to satisfy the desire of coital bliss. For the thousands of hijras who throng Koovakam dressed as brides for Aravan, theirs is a martyr's role; they experience these important stages of womanhood symbolically and sometimes physically. They are brides, wives and widows in a span of two days, and for many of them, this annual pilgrimage to Koovakam is their way of asserting themselves.

The life of a hijra is a dubious chimera of sexual ambiguity, but it is also a life that has embraced this ambiguity and called a spade a spade, so to speak. Hijras should be saluted for taking this stand, for disallowing for pretence, for wearing their hearts on their sleeves and parading around the streets with them. They stand in stark contrast to the unhealthy display of magnified need expressed by the other actors of Koovakam, who have also left their normal lives for a few days, but have come draped in veils and other secret layers in which to get lost. It is to them that Koovakam must teach its transformational lessons to, and to society, which is continually turning its face at the slightest rustle of confrontation.

The Hindu, 25/05/2003, URL: <http://www.thehindu.com/thehindu/mag/2003/05/25/stories/2003052500600500.htm>

There is no dichotomy between masculinity and femininity. Rather they are complimentary expressions of our androgynous beingness, common to all of us, men and women.

If we deny what we are, we become what we fear.

Living on a prayer

by Afdhere Jama

What's it like to be a Muslim and HIV positive? Afdhere Jama recounts three personal testaments from across the Muslim world. From Iran, Jordan, and Kenya, three Muslim men and women tell their stories of rejection and new-found hope after being diagnosed HIV positive.

Persian melodies

You are an Iranian. You are Muslim. You are infected with HIV. What do you do? "You hide it," says Saheeba Ahmed Parham, an Iranian woman who got infected five years ago. "You either hide it or you become the untouchable. No one would even talk to you any more." For her bravery, Saheeba took the less travelled path. She came out to her community. Saheeba, a 32-year-old woman, lives in Tehran with her three children. How did she contract HIV? "From my former husband," confides Saheeba, whose T-cell count is currently normal. "He had an extra-marital affair in Europe. He didn't even know from which country he got it from. We just know it was Europe."

Seven years ago, Saheeba's late husband went to Europe, as he did many times before that, on a business trip. The couple lived in Bombay, India, at the time. No one knew he was infected. "He just got sick one week," recalls Saheeba. "And then we found out he had HIV. It was shocking to us all." Saheeba, who did not know much about the disease, initially thought all of them were going to die, including the kids, because they had touched us. "Anything that he ever came in contact with I thought would have got the disease from him." When she tested negative, Saheeba and the rest of the family could not believe it. "I asked them to do it again," she says. "So they did it again. Three times and I was negative. I started to disbelieve in the doctors at that moment."

To her surprise, Saheeba's second opinion also told her the same thing. The doctor she went to for a second opinion was a family friend. She went all the way from Bombay to Tehran just to make sure. All of them tested negative. "I trusted our doctor," says Saheeba. "He was our family doctor. He examined me even when I was a little girl. I trusted him."

But, some time after the tests, Saheeba got sick. "I knew before I even went to the hospital that I would be positive this time," she says. "Within a 24-hour period, I was given the news that I did test HIV positive." Saheeba says it would have been a lot easier if she got tested positive the first time. "They made me believe I wasn't going to die from this disease," she said. "They cited to me cases where one partner never got it. And then when I finally believed it, it hit me." Her husband got sicker and sicker and finally died, after a few years of battling with the virus. "It was a hard time for the entire family" remembers Saheeba, who brought her husband to Iran just before he died. "We didn't know if he would survive or not. It was so sad."

After burying her husband, Saheeba left the country and went back to India for a year. "I was running away," she says. "I knew what the women said behind my back in the village. Hurtful rumours and gossip. I didn't know how to deal with that." Later she confronted her demons and decided to return to her homeland, Iran. Once there, she came out to the village and started educating. She volunteered in medical centres and begged to teach for free in some schools. She united the women of her village and taught them the basics of the HIV virus, something she wishes she had known more about when her husband was diagnosed with the disease. "I think I would have handled him a lot better," she says. "At least I would not have treated him like I did. I isolated him in bed and in life. I regret that now."

Now, Saheeba has a small class in her village. Every evening, she puts on some classical Persian music and then she lets her students 'venture into the disease'. She cuts articles out of the newspapers and translates them from Hindi and English into Farsi, Iran's most spoken language.

Everyday, in a world where a woman sometimes feels she has no purpose, Saheeba strives to make the world a better place, starting with her village.

Arabian nights

Not far from Iran, a man lights candles around an empty room in Amman, Jordan. It is 6.00pm, just after salat al maghreb (sunset prayer) and Nasir Rashedi is getting ready for his group. "Around ten people come together every Thursday night," says the 28-year-old Palestinian-born Shia Muslim. "We sit around and discuss the weekly news and gossip about HIV and Aids-related issues." Nasir, who got infected three years ago, puts ads in the newspapers asking for people with HIV who want to share their experiences to get in touch with him. "Many times, the hardest part is getting through the advertising departments," Nasir says. "Any day I have managed to get through one advertising department was a victory that called for a celebration!" he recounts.

Three and a half years ago, Nasir was on vacation to the United Arab Emirates when he met a man he calls 'Jabber'. Jabber, an HIV positive gay Arab man, did not disclose his HIV status to Nasir. "You are afraid to ask them," explains Nasir, who says he knew he himself was gay ever since he was five. "You don't want them to think you doubt their purity. No, an Arab may not even have sex with you then." Nasir talks about the problem with condoms. "If you want to use a condom, the other person assumes you have a disease," he adds. "No, you must trust your partner. Otherwise no sex." No sex! However, Nasir admits he wishes he didn't have sex that night. It is in that regret that he finds his 'mission in life.' The mission to educate others that it is okay to ask for condoms and to use condoms. "My main goal is to teach as many Arab young people as possible that using condoms is only preventative, not an accusation or an act of disclosing a disease you have," stresses Nasir. "If I get that to at least 100 kids, then I will feel like I have paid my dues." Nasir gives his prevention lessons in a rented room in case some kid hears about them, decides the place is teaching evil and burns it down in the middle of the night. "That has happened in some Arab countries," says Nasir, laughing. "I'm not taking any more chances. I have taken enough already."

Nasir displays a picture on the wall of his rented room that he received in the mail; it's a picture of a late victim of HIV. "Knowledge is good. It frees your mind from self-doubt." Nasir's new boyfriend comes to the meetings every week ever since the couple met. Since April last year, Nasir has received grants from the Jordanian government to support his education work. He hopes to open a centre soon. In the mean time, this one room, lighted with candles and lamps, will do for now.

African sunrises

In Mombasa, Kenya, A A Kasim makes a visit to the beach daily. He lives a five-minutes drive from the beach. He also works for a waterfront resort. Every morning when he goes to work, he gets there twenty minutes earlier. Sits by the sea. Thinks and breathes. "It is the most peaceful time of my day," says Kasim, a 23-year-old Indian-born Muslim. "It really soothes my head. My conflicted feelings with HIV and my life as a Muslim."

Kasim, who is engaged to be married to a positive woman he met through a support programme, says his life has changed ever since he was diagnosed with the disease six years ago. "I just notice the little things now. I forget nothing. Everything is more precious. I'm becoming more and more positive, no pun intended."

Six years ago, he met a woman in a party and the couple had sex. The woman, who was drunk when the two met, left him a note in the morning, informing him that she had HIV. "It wasn't a big deal," says Kasim, who got himself tested a week later. "I just thought 'if it

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Report from leading AIDS experts documents large gap between HIV prevention need and current efforts

current annual prevention spending falls nearly \$4 billion short of need - access to prevention interventions severely limited in every region

Fewer than one in five people at risk of HIV infection today have access to prevention programs, and annual global spending on prevention falls \$3.8 billion short of what will be needed by 2005, according to a new report released today by the Global HIV Prevention Working Group.

The report, *Access to HIV Prevention: Closing the Gap*, is the first-ever analysis of the gap between HIV prevention needs and current efforts, and provides recommendations for expanding access to information and services that could help save lives and reverse the global epidemic.

"Twenty years into the AIDS epidemic, most people in the world still don't have access to effective HIV prevention," said Helene D. Gayle, M.D., M.P.H., director of the Bill & Melinda Gates Foundation's global HIV/AIDS program and co-chair of the Working Group. "A dramatic scaling up of HIV prevention, combined with increased access to treatment for the millions already infected, can control and ultimately reverse AIDS."

"There is no magic bullet to prevent the spread of HIV. Only a combination of approaches that addresses the needs of different populations at risk can be effective," said David Serwadda, M.B.Ch.B., M.P.H., of the Institute of Public Health at Makerere University in Kampala, Uganda, and co-chair of the Working Group. "In Uganda, we have brought a severe HIV epidemic under control through the use of combination prevention, including abstinence education, condom promotion, voluntary HIV counselling and testing, and STD control. Other nations must be supported in their efforts to introduce a wide range of science-based prevention interventions, tailored to the needs of their people."

The Global HIV Prevention Working Group is composed of nearly 40 leaders in public health, clinical care, biomedical, behavioural, and social research, and people affected by HIV/AIDS from around the world. (See attached list). It was convened in 2002 by the Bill & Melinda Gates Foundation and the Henry J. Kaiser Family Foundation to inform global HIV prevention policy-making and program planning.

Access

According to the report, most people at greatest risk do not have access to proven prevention interventions, and access varies widely depending on the region and the intervention. Globally:

- * Only 5% of pregnant women at risk have access to drugs to prevent mother-to-child transmission
- * 12% of people have access to voluntary HIV counselling and testing
- * 19% of injecting drug users have access to harm reduction programs
- * 24% of people at high risk have access to AIDS education
- * 42% of people in need have access to condoms

Access to treatment is even more limited, and both prevention and treatment will need to be scaled up simultaneously. Careful integration of prevention and treatment services will help ensure those who test positive are quickly linked to treatment, and that those in treatment have the tools necessary to protect others from infection.

Spending

The report found that current HIV prevention spending in 2002 totalled \$1.9 billion, far short of the \$5.7 billion that UNAIDS estimates will be needed annually by 2005, and the \$6.6 billion that will be needed by 2007. (See attached fact sheet for spending data on each region). UNAIDS and WHO estimate that these resource levels could avert 29 million of the 45 million infections projected to occur by 2010.

"The resource needs are acute, but to date too many donor

governments have not contributed their share," said Drew Altman, Ph.D., President of the Kaiser Family Foundation and co-convenor of the Working Group. "We found that developing countries themselves are actually the greatest financial contributors to AIDS programs, which is important. But developed nations need to do much more. Many donor governments are contributing amounts that would be expected of private foundations, not wealthy countries."

The Working Group estimates that in 2002 developing countries contributed \$782 million to prevention, donor governments \$780 million, foundations and non-governmental organizations \$160 million, the United Nations system \$100 million, and the World Bank \$64 million.

Prevention Priorities

The report identifies key prevention priorities in each region:

- * Sub-Saharan Africa: Prevention programs for youth and for adults at greatest risk are urgently needed, and mother-to-child transmission programs should be dramatically expanded.
- * Asia and the Pacific: The diverse epidemics of Asia require expansion of a broad range of approaches, including behaviour-change programs targeted at high-risk groups such as sex workers and men who have sex with men, new efforts to curb rising STD rates, harm reduction programs for injection drug users, and interventions to address the gender inequities that often drive the epidemic.
- * Eastern Europe and Central Asia: Because the rapidly spreading epidemic in this region is driven by injecting drug use, harm reduction, including needle and syringe programs, is essential to prevent HIV from spreading to the broader population.
- * North Africa and the Middle East: Programs in this region should target high-risk populations, including injecting drug users, sex workers, and men who have sex with men.

Recommendations

Based on its analysis, the Working Group recommends:

- * **Funding:** Global spending on HIV prevention activities from all sources should increase three-fold by 2005 to \$5.7 billion, and to \$6.6 billion by 2007. Donor governments should increase spending on HIV prevention to 0.02 percent of national GDP. No donor nation is currently at this level. Annual spending on treatment, care and orphan support should increase from \$1.6 billion today to \$5.5 billion in 2005.
- * **Scale-Up:** Prevention scale-up must be a central priority in every region, focusing on especially cost-effective, high-impact interventions, such as behaviour change programs to delay the initiation of sexual activity, reduce the number of sexual partners, and promote the use of condoms, voluntary counselling and testing, STD control, and prevention of mother-to-child transmission, among other proven strategies.
- * **Prevention and Treatment:** As both prevention and treatment programs are brought to scale, these initiatives should be carefully integrated to ensure those who test positive are quickly linked to treatment, and to ensure those in treatment have the tools necessary to protect others from infection.
- * **Building Capacity:** In addition to funding for prevention interventions themselves, donors should provide extensive additional support to build long-term human capacity and infrastructure.
- * **Policy Reforms and Aid:** Policy reforms and international aid should address the social and economic conditions - such as gender inequality, stigma, and poverty - that increase vulnerability to, and facilitate the rapid spread of, HIV/AIDS.

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Kamasutra cross-tab sex survey 2003

KamaSutra, the leading brand of premium condoms, delved into the minds of the Indian urban population through an online survey once again this year and the findings were from interesting to intriguing. Here for you is the fascinating findings of the various topics covered on sexual attitudes, habits and behaviour of the urban Indians.

Frequency - On an average the population was having sex once every 4 days and about 69% are satisfied with their current frequency. The favourite time to indulge in sexual activity is at night during weekdays but it shifts to daytime on weekends!

Sexual Arousal - Breasts are the number 1 sexual arousal point for men followed by overall looks and buttocks whereas women prefer overall looks, eyes and muscular physique in men.

Foreplay - Kissing is the most common activity used in foreplay followed by stimulation using hands. Most of the sample is of the opinion that sexual foreplay prepares both the partners for satisfying sexual encounters and is a very essential part of lovemaking.

Preferred Sexual Positions - Man on woman is the most popular position followed by woman on man. About 39% prefer rear entry! 3/4th of the sample has tried oral sex before. About 44% of the males need to persuade their partners for oral sex. The sample seems to be very open in their attitude towards oral sex. More than 70% of the respondents believe that oral sex is normal, whereas more than 10% feel that it is dirty and a very few feel that it is harmful for health. 72% of the sample claims to always attain orgasm while indulging in sex. **Contraception** - The usage of condoms while indulging in sex is fairly high. 34% of the respondents claim to use condoms whenever they have sex, especially, the unmarried respondents indulging in sex. 79% of the sample using condoms finds it to be very convenient. The overall awareness for the need for safe sex is very high. More than 90% feel that sex has to be safe. A high percentage of those using condoms feels that they are quite convenient and easy to dispose off. **Fantasies** - Having sex in different places emerges as the topmost fantasy. Sex with friends/ relatives and watching others having sex are the other significant fantasies. A quarter fantasizes having sex with film stars or other famous people! About 15% would like to tie the partner and tease him/her.

Homosexuality - 17% of the respondents have felt sexually attracted to person of the same sex and about half of them have indulged in homosexual activities! 78% of the population agrees that

Homosexuality is considered a taboo on the society. 20% of those who have responded on Homosexuality feel that it is normal to be attracted to a person of same sex.

Fidelity - 84% of the currently sexually active respondents claim to be loyal to their current partners. Nearly, 80% of the respondents believe that sexual integrity is important for one's marriage. 24% feels that both partners should be free to have extramarital sex with spouse's consent.

Pre-Marital Sex - About 53% of the sample claims to have had pre-marital sex and about half of them claim to have had it before they were 21 years old! About 60% of these have indulged in pre-marital sex with more than one individual.

Boyfriend/ girlfriend - This emerges as the number 1 partner for premarital sex while almost 39% of the married respondents claim to have premarital sex with their spouses before marriage. 84% of the population agrees that pre-marital sex percentage has lately increased. A quarter of the respondents feels that pre-marital sex is the result of lack of sex education. Although people seem to be much more liberal about premarital sex, only 35% find it cool to indulge in it.

Masturbation - Almost 87% of the respondents claim to have indulged in masturbation. Only about 7% feel that masturbation is harmful.

Sex education - Just about 3% of the respondents have obtained sexual education through professional help, while a whopping 84% have obtained information through self-reading or through friends (75%). The concern for HIV/ AIDS was extremely high with 91% being either very concerned or concerned. More than 85% feel that sex education is mainly directed to teach "responsible" behaviour. Almost 80% of the population feels that sex education should be imparted in school and 70% odd say that the education should begin by the age of 12 years. More than 10% however feel that sex is natural and there is no need of formal sex education.

Survey Base : 5213

Age : 18+

Cities : Mumbai, Delhi, Chennai, Kolkatta, Ahmedabad, Hyderabad, Bangalore, Pune, Lucknow and Chandigarh.

Male : 88%

Female : 12%

Posted on internet: AIDSIndia 21/5/03

Beyond abstinence

By David Serwadda

U.S. legislators have been debating how \$ 15 billion will be used to fight AIDS around the world. My country, Uganda, has often been cited as an AIDS success story, and rightly so. But the factors behind our success are more complex than they have been portrayed in Washington.

As a physician who has been involved in Uganda's response to AIDS for 20 years, I fear that one small part of what led to Uganda's success - promoting sexual abstinence - is being overemphasized in policy debates. While abstinence has played an important role in Uganda, it has not been a magic bullet.

Uganda has reduced HIV prevalence from as high as 30 percent among sexually active adults to 5 percent. This dramatic turnaround is the result of a combination of many HIV prevention approaches. Just as no physician today would offer a patient only one drug to treat HIV infection, we can't offer just one prevention intervention and expect it to succeed.

In Uganda, we have adopted the ABC approach to behaviour change - delayed initiation of sex (abstain), reduction in the number of sexual partners (be faithful) and condom promotion (condomise). All three elements have played an important role in reducing HIV transmission.

But Uganda's strategy goes beyond reducing risky sexual behaviour. It includes a broad range of essential interventions, such as HIV counselling and testing, treatment of sexually transmitted diseases and screening of the blood supply.

If policymakers want to learn from Uganda's experience, they will act quickly to step up access to a combination of all these proven HIV-prevention interventions. Today access to these interventions is strikingly low, even in the hardest-hit countries.

The Global HIV Prevention Working Group, an international panel of AIDS experts that I co-chair, recently studied prevention efforts worldwide. The results were sobering: Only 5 percent of women have access to drugs to prevent mother-to-child HIV transmission. Just 12 percent of people have access to voluntary HIV counselling and testing. Of those at high risk, 24 percent have access to AIDS education. Only 42 percent of people in need have access to condoms.

To close these gaps, the Working Group estimates that annual spending must increase by \$ 4 billion by 2005. The results of this new spending would be dramatic: UNAIDS (the joint AIDS program run

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Masculinities, sexualities and MSM

drawn from a workshop conducted at the 3rd NFI Partners Regional Consultation and Capacity-Building Meeting, held between 5th - 7th April 2003, in New Delhi. The workshop was facilitated by Dalip Daswani and Azizul Haque

The primary target population which NFI partner agencies focus on are self-identified kothis, and through them, their panthi partners.

A central issue of concern is how kothis identify with the feminine as a performative role, and the conflicting situations, both emotional and social, that such roles place them in. By linking the kothi identify with the feminine, and then linking the feminine with the female, kothis see themselves as NOT-MEN, while panthis are perceived (and perceive themselves) as MEN.

This gender construct generates enormous psychological self-damage, while at the same time increases risky behaviours with personal and societal impacts. It further disavows other frameworks of sexualities and behaviours, such as 'bisexual behaviour', a 'dubli/do-paratha' identity, and so on.

This workshop explored the context of kothi identities within a construct of multiple masculinities towards developing an empowering sense of self, awareness and behaviour change.

Methodologies used were group work, discussions, free-listing and role-play.

Participants were first asked how they discovered themselves and identified as kothi or gay. This was expressed through personal stories.

This discussion and team work also explored life experiences in terms of the treatment by others, and how they adopted the labels such as kothi, gay or homosexual.

All the participants described their personal feelings regarding their own identity labels. This was followed by descriptions of behaviours of masculine and feminised males, and participants were encouraged to identify their own desired behaviours within this spectrum. In this context these male behaviours were seen as a range of differing masculinities.

How and when participants developed their desires for these preferred behaviours were then discussed. The consensus was that usually participants would recognize their difference at early age (usually pre-adolescence) and then they would meet an older person who also had inner feelings like themselves. They had felt isolated and alone and found discrimination as a lived experience, until they met another person like themselves. These persons who create a sense that they were no longer alone, and enabled a sense of affiliation and community to be developed.

Though this exercise participants found people like themselves usually adopted the identity or label from that particular person. This person became a form of role-model and participants would thus adopt the perceived "normative" behaviours of that person. In other words identities and performative behaviours were socially constructed.

Group work followed on identifying the behaviours of kothis, gay men, men, and "real men". Again, it was accepted that these differences were all socially constructed and really all behaved as individuals. Social expectations generate certain accepted norms, which are often in conflict with what participants feel. Thus the kothi-identified male feels he is "not a man" because he does not fulfil social expectations of "manliness".

This was followed as to why kothis perform as kothis. Participants identified:

- * To attract the manly partners / clients
- * Following the original role model
- * Protective mechanism
- * Habit
- * Peer pressure
- * Don't want to rock the boat

Through story telling, participants explored personal sexual practices in terms of his sense of self and personal identity. This led to a general discussion on what sex is and how different sexual

practices and positions have been labelled masculine or feminine, i.e. being penetrated is socially constructed as a feminised act. In other words masculinity and femininity are socially formed and reinforced by our peers and ourselves. Sexual practices in themselves were neither masculine or feminine.

Following this exploration, participants in small groups expressed what they wanted from society:

- * Love, care support
- * Honest respect
- * Understanding
- * Acceptance
- * Live without fear

They also discussed what they can give to society

- * Love, respect
- * My existence through my good activities
- * Support
- * Comfort
- * Co-operation

From this participants then went on to identify what they were doing to enable society to accept and understand their different-ness, where it was discovered that they really were not doing anything. The demands were one-way, reinforcing their isolation.

The next session explored how masculinity was socially, culturally and religiously defined. It appeared that normative masculinity was essentially a performance with a set of socially sanctioned behaviours that often contradicted each other, and what we should be discussing was a range of differing masculinities which are performed in specific contexts, i.e. mother-son, father-son, husband-wife, between close friends, etc. From these discussions it was clear that kothi performative behaviour was not so much feminine, but rather glorified a particular form of exaggerated femininity - that of the cinema heroine, the vamp, the sexually aggressive.

In asking why kothis do not see themselves as men, it was clear that they have accepted what they have been told and acted out a particular version of exaggerated femininity. Yet even within this their behaviours still reflect different forms of masculinities. Masculinities and femininities are contextualised performances that are not specific to a particular biological sex. This masculinity can be seen as an attribute of femininity, and femininity an attribute of masculinity.

The final session focused on personal responsibility and ownership, working through personal sense of low self-esteem and disempowerment in the era of HIV/AIDS, where kothi performative identities can generate high risk behaviours, violence, and discrimination, while producing high anxiety, low self-esteem and disempowerment. This required intense work to pass through the sense of despondency and failure as a man, which often led to a sense of victimisation and relying solely on external factors only to bring about change. Change also has to come from within oneself.

In conclusion, all participants believed that they should seek out those positive attributes that each of us has, focus on those and build upon those in a personal sense of growth and achievement. At the same time all should take personal responsibility and ownership of our own lives and relationships. Participants ended the workshop exploring what was within their capacity to immediately begin to implement change at three different levels:

Myself

Work on attitudinal change, self-respect and self-worth

My community

work towards becoming a role model within MSM networks

The larger community

Awareness building and sensitisation.

Media guide to terminology

over 20 years into the epidemic and we still need to state this

Background information

The media has played a valuable role in informing the public about HIV. But at times, they have also used terms which can be misleading about the virus, or harmful to those people who are living with HIV/AIDS. The following excerpt on terminology is from the Australian HIV/AIDS Media Guide. It is intended to encourage accurate terminology and reporting that contributes to rather than takes away from the dignity of people living with HIV/AIDS, and vulnerable and marginalised communities.

HIV/AIDS Media Guide, Second edition 2000. Edited by Ruth Pollard. (c) Australian Federation of AIDS Organisations (AFAO) and the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD). From <http://www.afao.au>

Terminology

Here are some examples of derogatory or inaccurate terms, together with suggestions of alternative terms and phrases:

USE: HIV INFECTION, HIV POSITIVE, HIV/AIDS

DON'T USE: AIDS IF THE INTENTION IS TO REFER TO HIV.

AIDS is a range of conditions, which occur when a person's immune system is seriously damaged by HIV infection. Someone who has HIV infection has antibodies to the virus but may not have developed any of the illnesses, which constitute AIDS.

DON'T USE: AIDS VIRUS, HIV VIRUS

There is no such thing as the AIDS virus. There is only HIV (Human Immunodeficiency Virus) - the virus that can cause AIDS. The term "HIV virus" actually means Human Immunodeficiency Virus virus, which is not correct.

USE: PERSON WITH HIV OR PERSON LIVING WITH HIV/AIDS OR PEOPLE LIVING WITH HIV/AIDS (PLWHA).

DON'T USE: AIDS VICTIM OR SUFFERER

Many PLWHA feel these terms imply they are powerless, with no control over their lives.

DON'T USE: AIDS CARRIER

This term is highly offensive and stigmatising to many people with HIV and AIDS. It is also incorrect: the infective agent is HIV. You can't just catch AIDS. This term may also give the impression that people can protect themselves choosing a partner based on their appearance or by avoiding someone who they know has AIDS.

USE: PERSON WITH AIDS, OR PERSON WITH HIV INFECTION

DON'T USE: FULL BLOWN AIDS

This term implies there is such a thing as "half-blown AIDS". A person only has AIDS when they present with an AIDS defining illness such as an opportunistic infection.

USE: AFFECTED COMMUNITIES, HIGH RISK BEHAVIOUR (UNSAFE SEX, SHARING NEEDLES)

DON'T USE: HIGH RISK GROUP

This implies that membership of a particular group, rather than behaviour, is the significant factor in HIV commission. This term may lull people who don't identify with a high risk group into a false sense of security. It is high-risk behaviours such as unsafe sex or unsafe injecting practices that can spread HIV, not high-risk groups.

USE: PEOPLE WITH MEDICALLY ACQUIRED HIV OR AIDS, CHILDREN WITH HIV OR HIV POSITIVE PEOPLE

DON'T USE: INNOCENT VICTIMS

Usually used to describe HIV positive children or people with medically acquired HIV infection (through blood transfusions etc). It wrongly implies that people infected in other ways are guilty of some wrong-doing and somehow deserving of punishment. This feeds discrimination, particularly homophobia, and should be avoided.

USE: For your country, i.e. Sri Lanka or Jamaica, use: SRI LANKAN POPULATION/JAMAICAN POPULATION, HIV NEGATIVE PEOPLE, ALL SRI LANKANS/ALL JAMAICANS

DON'T USE: GENERAL POPULATION

This implies that people in the populations targeted for HIV prevention, education and care are not part of the general population. It artificially divides the world into those who are infected, or at risk of HIV infection and those who are not, and falsely implies that identity, rather than behaviour, is the critical factor in HIV transmission.

USE: BLOOD, SEMEN, PRE-EJACULATE, VAGINAL FLUIDS, BREASTMILK

DON'T USE: BODY FLUIDS

Confusion about the body fluids that can transmit HIV is a common cause of fear and misunderstanding about HIV and continues to cause discrimination against PLWHA. Always explain which body fluids contain HIV in sufficient concentration to be implicated in HIV transmission (i.e. blood, semen, pre-ejaculate, vaginal fluids and breast milk). HIV cannot be transmitted through body fluids such as saliva, sweat, tears or urine.

USE: PERSON LIVING WITH HIV OR AIDS, HIV POSITIVE PERSON

DON'T USE: AIDS PATIENT

Use "AIDS patient" only to describe someone who has AIDS and who is, in the context of the story, in a medical setting. Most of the time, a person with AIDS is not in the role of a patient.

USE: SEX WORKER

DON'T USE: PROSTITUTE

Prostitute is considered a disparaging term and does not reflect the fact that sex work is a form of employment for a sex worker, not a way of life.

USE: STREET WORKER

DON'T USE: STREET WALKER

Again, the term street walker does not represent the employment aspect of sex work, and is therefore derogatory and misleading.

USE: PERSON WHO INJECTS DRUGS, PEOPLE WHO INJECT DRUGS ILLICITLY, INJECTING DRUG USER

DON'T USE: JUNKIE, DRUG ADDICT

Illicit drug use is only one part of an injecting drug user's life. Terms such as junkie rely on a stereotyped image, which is not accurate.

China - SARS and AIDS: what the people don't know

By Christopher Horton

<http://www.atimes.com/atimes/China/ED24Ad03.html>

BANGKOK - Last October in the eastern Chinese city of Hangzhou, United Nations Secretary General Kofi Annan visited Zhejiang University to receive an honorary doctorate from the school. When he spoke at the presentation of his degree, he had a dire warning for the students, faculty and all of China. China was on the verge of a massive epidemic, Annan said, and immediate action must be taken in order to stem the spread of this deadly virus. He was not talking about severe acute respiratory syndrome (SARS), which would be first identified in Guangdong province the following month. He was talking about the human immunodeficiency virus (HIV), which causes AIDS.

"There is no time to lose if China is to prevent a massive further spread of HIV/AIDS," Annan said, "China is facing a decisive moment." Annan may have been spoiling the celebratory atmosphere for the gathering of 500 students who came to honour him, but he did not relent in his message. "For the truth is that today, China stands on brink of an explosive AIDS epidemic," he said.

Henan province: China's HIV hub

Central China's Henan province is a spectre that haunts the new leadership in Beijing. Henan became the focus of global attention in 2001, when overseas media reported an HIV epidemic in the rural province of more than 95 million. Henan's HIV epidemic, unlike SARS, was in essence spread by local officials of the Chinese Communist Party (CCP), who were making heaps of cash from illegal blood banks in the late 1980s and early '90s. They were making so much money from these unregulated and unsanitary "clinics" that they dubbed blood banks Henan's "third industry". In poor rural areas in Henan, locals were encouraged to sell their plasma to the numerous operations throughout the province. Unfortunately, employees at the blood banks either didn't know or didn't care about spreading HIV, as evidenced by the repeated use of individual needles on donor after donor. The inevitable result of such actions was an HIV explosion among people who could not afford health care even if they were lucky enough to have access to it.

The head of China's AIDS foundation, Zeng Yi, said last year that local authorities became aware of the Henan problem back in 1995. Blood banks were closed, but locals were not told they might carry the virus. Now Henan has more than 100 "AIDS villages", as they are called in China. The HIV infection rates for these bleak towns range from 60-84 percent. Economics were the impetus for silence from local officials regarding the rapid spread of HIV. "They are afraid the economy will suffer if the situation is revealed. Maybe investors would no longer be interested in the region. And they wish to assume no responsibility - their way of thinking is false," Zeng said.

Such intense, but initially localized, spread of HIV might not have been a problem for Beijing if it had occurred in a more remote area, such as sparsely populated western China, and if the Chinese government had been honest and open in dealing with AIDS. Unfortunately, provincial capital Zhengzhou, a city of 6 million people, is the main hub for China's extensive railway system. China's major north-south highway also passes through Henan. Throughout all of China - and particularly in poorer places such as Henan - poor, uneducated women choose prostitution as a last resort for earning a living. Because of years of silence regarding the transmission of HIV, most of China's prostitutes almost never use condoms, which are predominantly viewed by Chinese as only being useful in preventing pregnancy. The Chinese word for condom, *biyuntao*, literally "avoid-pregnancy glove", can be seen as contributing to this large-scale ignorance, but the blame should rest squarely on the CCP.

The few HIV information campaigns in China have usually painted the picture that as long as one is not homosexual, an intravenous drug user or a prostitute, one is not at risk for HIV. Today

many Chinese believe that if someone feels and looks fine, they could not have HIV because the only pictures they see of HIV/AIDS patients are images of people in very advanced stages of AIDS that are designed to shock the viewer. Last year in a Chinese poll of university students, far fewer than half of those polled knew how HIV was transmitted. Most of the people in Henan's AIDS villages had not heard the word "AIDS" until the past couple of years. It is this countrywide lack of information that makes a nationwide spread of HIV all too likely.

The histories of both HIV and SARS in China have one striking shared characteristic - Beijing's knee-jerk suppression of all relevant information out of fear of damaging China's economic growth. In the face of AIDS and now SARS, the Chinese government has spared no effort to suppress information regarding either illness. In both cases, the Chinese population is paying the price. The Chinese government said that by 2003 there would be a million cases of HIV on the mainland, roughly the same number of infections as in the United States. While a million infections in a population of 1.3 billion is only 0.08 percent of the population, it is still a disturbingly large number of people in a country whose government, even after Annan's visit, has made next to no efforts to inform its people about the virus. Last summer a UN report warned that if the Chinese government did not radically change its HIV policy, the number would reach 10 million by 2010.

HIV/AIDS, luckily for Beijing, has still been relatively easy to cover up, at least domestically. It appears that SARS is about to change things very quickly. As of Wednesday, Henan province - again, a poor province of more than 95 million - was referred to by Chinese state media as one of the provinces hit hardest by SARS, this despite having only officially reported two confirmed cases as of Wednesday. Henan is next to Shanxi province, which as Asia Times Online reported on location (SARS wreaks havoc in Shanxi province, April 18) has been suffering from its own SARS outbreak for weeks already. Just as China's links to the world have fuelled the international spread of SARS, China's massive web of domestic air, rail, bus and boat links combined with the world's largest population indicate that SARS will soon be in every province, city, and town soon, if it isn't already.

Beijing: Mass exodus, mass infection

Making things worse is the recent cancellation of school for Beijing's 1.7 million students, which has prompted a massive train and bus exodus out of the SARS-ravaged capital by students and migrant workers. These students and workers literally come from every part of China. They will be riding packed trains and buses out of the capital and to every corner of the country.

A typical Chinese train can hold more than 600 passengers. Restrooms are less than sanitary: the floors are usually covered with urine, and toilets are non-flushing holes that usually hold some residual faecal matter. Faecal matter is a suspected culprit in the spread of SARS. As the rapid spread of SARS among more than 300 residents of the Amoy Gardens residential complex in Hong Kong suggests, it could also be spread through the air or environment. Chinese trains typically have three passenger classes: "hard seat", "hard sleeper" and "soft sleeper". Hard-seat cars are in essence train cars filled with as many seats as possible, and in which seatless ticket holders sometimes sleep in aisles or even under seats. Hard-sleeper cars are divided into several small doorless compartments that hold six beds per compartment. Soft-sleeper cars are divided into compartments, each of which has a door, that contain four bunks.

If just one person infected with SARS is on any of the countless

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New biomedical interventions: opportunity knocks, nobody's home

extract from *The Second Wave Will Drown Us* by Michael Gross, PhD in *American Journal of Public Health*, June 2003, Vol.93, No.6

One National Institute of Health (NIH)-funded pilot study has evaluated the safety and acceptability of female condoms for anal sex in HIV-seroconcordant mutually monogamous male couples, among whom such pilot studies would pose the least risk of harm from an unproven application of this technology. Anecdotal reports of bleeding and discomfort noted in previous surveys (Gross M, Buchbinder SP, Holte S, et al. Use of Reality "female condoms" for anal sex by US gay/bisexual men at increased risk for HIV infection. *Am J Public Health*, 1999;89:1739-1741) were confirmed, suggesting that the extent, causes, and significance of such findings would require more intensive clinical assessment (Renzi C, Tabet SR, Stucky J, et al. Safety and acceptability of the Reality condom for anal sex among men who have sex with men. *AIDS*. 2003;17:727-731). Until safety concerns are more thoroughly addressed, female condoms cannot in good conscience be offered - even in the context of research - to men at higher risk than the couples in that pilot study. Yet unless female condoms are tested among higher-risk men, their potential contribution to prevention will remain unknown.

Pilot study participants responded without enthusiasm to the device; reinforcing complaints cited in previous user surveys, they found it awkward to insert, uncomfortable for both partners, noisy, and messy to remove. Riskier men - those with multiple partners of serodiscordant or unknown HIV status, who use latex male condoms inconsistently or not at all - can be expected to cite similar complaints. The question is whether the potential protective utility will offset the negatives. Given such uncertainty, efforts to design physical barriers that are safe, appealing, and effective for rectal use are fully warranted and arguably overdue. No such efforts are under way.

The potential of a vaginal microbicide has attracted researchers and advocates alike for over a decade as a technology that would protect women who are reluctant or afraid to raise the issue of condom use or whose partner obdurantly refuses. No remotely equivalent effort targets rectal microbicide design and development. Two years ago, an NIH-sponsored workshop convened the few scientists who had thought about rectal microbicides and many more colleagues who had not, but who brought needed expertise to discussions aimed at formulating a strategic research agenda (*Creating a Research and Development Agenda for Rectal Microbicides That Protect Against*

HIV Infection: Report From The Workshop. Baltimore, Maryland, June 7-8, 2001. New York, NY: Amercian Foundation for AIDS Research. Available at: http://www.amfar.org/binary-data/AMFAR_PUBLICATION/download_file/28.pdf. Accessed February 22, 2003). The workshop made evident that concepts considered plausible for preventing vaginal transmission are irrelevant in light of what already is known about the mechanisms of rectal transmission (Renzi C, Tabet SR, Stucky J, et al. Safety and acceptability of the Reality condom for anal sex among men who have sex with men. *AIDS*. 2003;17:727-731). The most thoughtful commentators on microbicide development continued to discuss rectal microbicides as an afterthought, focusing only on avoiding safety risks if future vaginal products are misapplied rectally (Coggins C, Rosenberg R, Van-Damme L, for the International Working Group on Microbicides. Recommendations for the clinical development of topical microbicides: an update. *AIDS*. 2001;15:857-868). Waiting for proof of the effectiveness of vaginal products - inconceivable before the end of this decade (*The Science of Microbicides: Accelerating Development*. Report of the Science Working Group of the Microbicide Initiative, New York, NY: The Rockefeller Foundation: 2002. Available at http://www.rockfound.org/Documents/488/rep4_science.pdf. Accessed February 22, 2003) - unnecessarily delays progress on rectal microbicide development. These efforts can and should proceed concurrently.

More than 2 decades into an epidemic that was first identified in MSM, basic scientists have yet to elucidate the fundamental biological mechanisms of rectal HIV transmission and dissemination, including factors associated with increased susceptibility or innate immune protective mechanisms. As with vaginal microbicides, characterization of these mechanisms would guide the development of investigational products. Knowledge we currently lack would characterize normal variations and abnormal perturbations of immune function in the lower gut, thereby establishing an indispensable baseline against which to evaluate the safety of candidate agents. Indeed, it is not even known whether chronic rectal exposure to latex in condoms is itself a source of irritation that may enhance transmission on those occasions when condoms are not used.

Good News

NFI has always urged the use of water-based lubricant as a sexual health promotion product for MSM who practiced anal sex. It is also good for vaginal sex as well.

However, for most people the only readily available product in the marketplace was Johnson and Johnson KY Jelly, which at almost 100 Rps for a 50gm tube, was beyond the means of most of those we work with.

We have been advocating at a range of levels for a cheaper product. And now one is available.

DKT India (Zaroor Condoms) has come up with convenient sachets of lube with brand name : Luve - Pleasure Lubricant at Retail Price of Rs. 3:55 per sachet. However for bulk orders for NGOs and organizations it is priced at Rs. 2:49 per sachet. The lube contains Dimethyl polysiloxane as basic ingredient The lube is manufactured by P & P Enterprises, W /68 , MIDC, Badlapur, District Thane and Marketed by DKT India. Contact them for further details and how to purchase in bulk for your agency.

In the meantime, NFI is also exploring developing its own lubricant product at a lower price in the near future. Watch this space.



SARS and AIDS

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trains now leaving Beijing, these trains could significantly increase the speed of the spread of SARS throughout China's interior. The tragic irony of this exodus is that everyone leaving Beijing hopes to avoid getting SARS there, but they will in all likelihood contract and spread it throughout the country, to strangers, friends and family. Which brings us back to HIV/AIDS.

Beijing has admitted to covering up SARS statistics in order to preserve the image of normalcy. This seriously hurts the CCP's credibility. When one considers the HIV cover-up in Henan, combined with Henan's location at the centre of the Chinese transportation nexus, it is also quite plausible that Beijing was fudging its numbers when it said last summer that there would be a million HIV cases in China by the start of this year. This was the number given long before Beijing came clean about its SARS cover-up. It is obvious that the highest levels of government in China are not averse to lying to its constituency or the world in order to maintain an image as a safe, stable environment for foreign direct investment.

Assuming that SARS makes its way to every populated area of China, it is quite plausible that China's SARS deaths could experience a ferocious increase. SARS is an atypical pneumonia caused by a coronavirus. AIDS sufferers are particularly susceptible to pneumonias. Indeed, the most common serious infection among AIDS patients in the United States is a type of pneumonia called *Pneumocystis carinii* pneumonia (PCP), which is typically fatal if not identified and treated quickly. Identification requires a laboratory test of fluid or tissue from a patient's lungs. Unfortunately, most of the people with AIDS, in Henan in particular, do not have access to laboratories, nor the money to pay for tests and treatment.

A bleak future gets bleaker

Unfortunately, because of Beijing's foolish handling of HIV, and now SARS, many Chinese are going to die. The question is how many.

It seems apparent from the government's reaction to either epidemic that the economy is its top priority. Therefore it is reasonable to conclude that Beijing will do little to protect China's impoverished hinterland. This makes it quite plausible that SARS could kill tens or hundreds of thousands of people in China alone. The majority of these deaths would likely be either elderly people who succumb to SARS more readily than young, previously healthy SARS patients - and China's AIDS sufferers. The world may find out just how serious China's AIDS situation really is as a result of the SARS epidemic.

When the Chinese people ask Beijing to explain why there were so many people with AIDS, the new leadership under President Hu Jintao and Premier Wen Jiabao will have two options. One option is to continue the state-sanctioned disinformation campaign regarding AIDS and its origins in China. This is unlikely, as not only has Beijing pledged to be more open with SARS, but nobody inside or outside of China is likely to believe Beijing's deceptive dismissals and denials. The other option is to throw the closet door wide and bring out the skeletons for all to see: the Chinese would have to be told that just as they had been duped regarding SARS, they had previously been deliberately kept in the dark regarding members of the CCP collecting profits as they spread the seeds of HIV in Henan.

How will the Chinese people react to either of these strategies?

Those who believe that they look upon life and nature with objectivity are those whose subjective beliefs blind them, for they cannot see through their own misinterpretations,

Large gap between prevention needs and current efforts - report

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* Prevention Research: Research into new prevention strategies and technologies should be significantly accelerated.

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- * David Serwadda, Makerere University, Uganda
- * Meenakshi Datta Ghosh, National AIDS Control Organization, India

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Organizational affiliations are provided for identification purposes only, and do not indicate organizational endorsement of the report's recommendations.

** Members of the Working Group who have officially endorsed the report at the time of publication.*

not social work, but social transformation

Workshop on kothi and other MSM sex work, poverty and exclusion

continued from page 5, col. 2

* How much more and higher do we rate the panthi and his being with us than our own selves?

* Does this perhaps come from not valuing ourselves enough?

* Who has given us an opportunity to love and respect ourselves?

All we have gotten from 'the world' is pain, shame, denigration, and rejection. It is very difficult to develop a healthy and respectful sense of self from such emotional, sexual, and psychological deprivation

The final session explored specific intervention tools and strategies for MSM/kothi sex workers. The participants were grouped on the basis of their linguistic affiliations and were asked to develop interventions as if they were the heads of their organizations and had the funds required.

Group 1

* HIV/AIDS awareness

* Handicrafts based income generation

Group 2

* Identifying donors

* Self-empowerment through creating a sex workers group that meets regularly. Encouraging them to share experiences in the group and form a cohesive bond; discussions about lifestyles, values, beliefs, towards self-awareness and self-empowerment

* Income generation

* Peer education

Group 3

* Every kothi has a special talent - hairstyling, make-up, dance, music, horticulture/flower arrangement, embroidery and tailoring etc., and this should be the basis of the income generation so that people enjoy what they do.

* Information about rights the implementation tools to use these rights actively

Group 4 (Cambodia)

* Drop In Centre and Clinic

* Peer Education

* Counselling

* Social work - sex workers should be engaged in some form of social work for other disadvantaged communities such as marginalised children etc., which would give them a sense of purpose, and to feel that they are not worthless and are making a tangible difference in another person's life.

Group 5

* Donor identification

* Needs assessment research and documentation. The research should use sex workers as research volunteers and assistants and through this a group could be formed as well

* Drop In Centre

* A community based program that is founded on a deep personal connection with individual group members, trust and rapport being essential, and an involvement in the day-to-day problems of sex workers. HIV information dissemination can come only after this basic link has been established. The aim of the group is to help sex workers to know how to use this information.

* Confidential counselling

* BCC/IEC - more audiovisual stuff

* Involving clients through male sex workers

* Links and referrals to general health systems and hospitals

* Basic literacy

* Rehabilitation out of sex work only if asked for

* Income generation programmes

Group 6

* Outreach in all major cruising areas

* Self-esteem building

* Trauma counselling

* Sensitisation of the police and bureaucracy

* Counselling for family of MSM/kothi sex workers

* Community mobilisers to be drawn from the sex worker community

The facilitators believed that some of these suggestions, and the ideas they stem from, are very important. Sex workers need their basic needs looked after and perhaps links can be made with larger systems of health, education, and income generation rather than limiting interventions to HIV. Microcredit is a powerful launch pad. It has worked tremendously for rural and disadvantaged women across South Asia, notably in Bangladesh and in India. Further it was also clear that more intense work will need to be done with kothi/male sex workers to address the psychological and emotional issues of sexual violence, male-on-male rape, violence from lovers. Further training on counselling needs to be given in this context and not just on HIV. Experiences of violence from childhood onwards damage self-esteem, personal boundaries, and prevent the individual from establishing a safe space for himself or herself.

Questions and thoughts

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The word health is based on the anglo-saxon word hale, which means whole,

So does the word holy

Living on a prayer

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happens, it happens.” Well, it happened alright. Six months later when he re-tested, he was positive. He didn’t even know the woman’s last name. She was drunk. He was horny. She came onto him. Well, you get the picture. “I could say I regret it,” says Kasim, laughing. “But I don’t. I used to say I did regret it. Now I accept the fact that it was in my destiny to get it. What I do with it is the question.”

So what does he do with it? “I’m kinder, intentionally, to the world,” he says. “I’m just being the ‘me’ I always should have been. That is what diseases do to you, they confront you with the real you.” Kasim goes to school part-time because he’s training to become a psychologist. “When I become a psychologist, I hope to heal those who can’t afford mental health. I expect to throw myself into the communities that need me without reservation.” Kasim says he doesn’t party any more. And he goes to the clubs but only to drop off condoms. “It is important to have condoms available,” he says, remembering he wanted to use one that fateful night. “It is just that sometimes it is not available when you really need it. And then what? Your genitals corrupt you to make hasty decisions!”

Inspired by a recent Aids conference in South Africa he attended, Kasim now also volunteers part-time for an HIV organisation in Mombasa. “I give my time. That is all I can afford now.” For the moment, his T-cells remain at a healthy count and he finds peace in the sun and sea.

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awareness does not grow from doing the "right" thing

Beyond abstinence

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by the United Nations and the World Bank) and the World Health Organization estimate that it could avert 29 million new infections by 2010.

We all agree that it is important to educate people at risk, especially youth, about the benefits of abstaining from sex. But we must not forget that abstinence is not always possible for people at risk, especially women. In much of the developing world, women have very limited social, economic and political power, and they are often highly vulnerable to HIV infection. Many women simply do not have the option to delay initiation of sex or limit their number of sexual partners.

For example, many girls are married by their mid- to late teens and as married women do not have the choice to abstain, even if their partner is HIV-infected. In fact, up to half of all new infections in Uganda occur among steady couples in which one partner is HIV-positive and one is negative. In addition, many women are the victims of sexual violence, while others enter into sex work as the only means to provide for themselves and their families.

The AIDS epidemic will not go away by itself. It will take foresight, leadership and a commitment to using proven prevention interventions to stop new infections. And while we must continue to focus on fighting AIDS in Africa, the world must also learn from Africa’s experience and act to contain widespread epidemics in Asia and Eastern Europe while there is still time.

Uganda’s lessons are important: While there is no easy answer to the question of how to stop the spread of HIV, we now know that a combination of approaches can work. It’s time to stop looking for a magic bullet and use every weapon we’ve got.

The writer directs the Institute of Public Health at Makerere University in Kampala, Uganda, where he conducts research on the transmission and epidemiology of HIV and AIDS.

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