



### What is a man

Transvestite students at Rajabhat Institute Suan Dusit take thhe state in dresses during the Miss Lady Lady International 2003 contest at the Nimibutr building of the National Stadium in Bangkok. The contest was held as part of the campus' Freshies Day Suan Dusit 2003 fair.

*Bangkok Post* , 10/8/03

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.

Send all material to *Pukaar*, **Naz Foundation International**, Palingswick House, 241 King Street, London W6 9LP, UK.

visit our website  
[www.nfi.net](http://www.nfi.net)

Pukaar is produced and published by:  
Naz Foundation International  
Palingswick House, 241 King Street  
London W6 9LP, UK

Printed and distributed by:  
Shivlok Enterprises  
A/15 2nd Floor, Krishna Park,  
Devli Road, New Delhi 110062, India

**Naz Foundation International is a Charitable Company Limited by Guarantee (England).  
Registration No. 3236205  
Registered Charity No. 1057778**

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# A wake-up call for people working on prevention of HIV/AIDS in Pakistan

Tahir Khilji, Vision, Lahore, Pakistan

## Introduction

HIV/AIDS prevention work requires missionary zeal, sincerity and dedication. There is no other way of stopping this demon of death. The HIV infection does not distinguish young from old, boy from girl, or man from woman. It has appetite that can consume nations and countries. This creates an instantaneous need for Pakistani non governmental organizations (NGOs) and government to put their respective houses in order and work together to fight this ever threatening disease with vigor and passion.

The information regarding inflow of donor funding for HIV/AIDS prevention in Pakistan is encouraging news but could also be a reason for concern and caution. Is it possible that outsiders are seeing something happening in Pakistan that is not visible to Pakistani eyes and this easy flow of money into Pakistan for AIDS prevention may actually be pointing towards a scary scenario. In reality the environment may be signaling towards a catastrophe of unknown dimensions. If so, it is wise to have oneself totally protected from a hurricane because the ferocity and severity of it could be devastating.

## Interacting with communities

Along with vigor and passion what also is needed are attributes like sensitivity, non condescending attitude towards communities and basic human respect. Human respect and cultural sensitivity should be the hallmark of all community work, especially when communities are invited to workshops for practice sessions or interaction purposes.

## “A Bad Practice:

Various at risk groups were invited on the final day of a workshop for the participants of the workshop to practice their counseling skills. The groups arrived when the participants were about to break for lunch. During the lunch time the groups were made to sit in a separate room without being offered any lunch while the participants and facilitators were having lunch. After lunch was finished the counseling sessions started. The sessions went on till 4 in the afternoon. The groups were patient enough to sit till 4 without any lunch. At the end of the mock counseling sessions the groups were offered tea and sandwiches, which by no stretch of imagination is a substitute for lunch.”

## Need to be heard

It is understandable that while training or process workshops may not be an appropriate forum to vent anger and frustration, still, one cannot deny this privilege to those who otherwise are not heard, especially those who are infected with HIV or those who are working with people living with AIDS because in both cases due to lack of support infrastructure in the country these people are finding it difficult to sustain any efforts big or small. The need of such people to be heard is imperative and especially in forums organized by the government since it may act as catalyst to identify the needs and concerns of these groups.

## Non governmental organizations working on HIV/AIDS in Pakistan

The Non Governmental Organizations (NGOs) may want to avoid feelings of hostility, mistrust, resentment and cynicism towards each other and the government. Better work ethics should be promoted. Interaction with at risk communities should reflect sensitivity and professionalism. Communities such as men who have sex with men (MSM) or female sex workers (FSWs) have gone through the socialization processes that have constantly reinforced labeling and stigma. Understanding of such socialization processes is essential for all the NGOs working with marginalized groups.

Realistically assessing their own capacity may help NGOs to emerge as skilled and forceful groups who would have the expertise to facilitate different processes for the communities at risk. This will also assist the NGOs in conceptualization and implementation of

effective and successful interventions.

## Role of National AIDS Control Program (NACP) in Pakistan

On the other hand the National AIDS Control Program of Pakistan (NACP) has to become an institution that is pragmatic, tolerant and able to deliver. It should become a role model for people who are working for prevention of HIV/AIDS in Pakistan. Having an open door policy for NGOs to access NACP may not be sufficient in forming partnerships with NGOs. The open door has to be linked with open heart and open minds for NACP to become a truly democratic and mature institution. As a NGO worker, one wishes to visualize NACP as a benevolent mother to the NGOs who are working on HIV/AIDS prevention because they are the ones fighting from the frontlines and facing challenges each day of their work.

## What should be done?

Some steps that should be taken in order to combat HIV/AIDS effectively are:

The entire structure of provincial AIDS consortiums should be reviewed. A serious stock taking of the work these consortiums have done in past is required. If the consortiums have been ineffective and have not been able to deliver then a different strategy to bring NGOs under a single umbrella may be opportune.

The National AIDS Control Program of Pakistan (NACP) should rise above personal biases and objectively assess NGOs and their work. Dissent, feedback and critique should be understood and taken in a democratic spirit and should not be seen as an attack on persons or their work.

The NGOs should not be exposed to the tensions between NACP and their provincial counterparts. For NGOs, the roles of both NACP and the provincial AIDS program should be facilitative and professional. Any differences between NACP and the provincial AIDS programs should be resolved without involving NGOs as pawns in such battles.

NGOs working on HIV/AIDS prevention should realize their responsibilities and should work with a focused approach. Constructive lobbying and forming pressure groups for useful purposes is desirable but such groups should not be disruptive. They should not hinder the efforts of each other or the government as it may be detrimental to the larger cause of HIV/AIDS prevention.

In most cases NGOs may be the sole voice representing the marginalized communities and to make this voice effective, it is essential that such NGOs should do their work with integrity and sincerity.

Government and NGOs should form constructive and productive partnerships. The NACP should constantly be on a look out for those organizations that are making the difference and are delivering. It may be beneficial for NACP to be pro active and build bridges with such organizations.

Donors should show serious commitment to thwart the spread of HIV/AIDS.

Donors should avoid pre ordained agendas. A sensitive assessment of the local needs should be the base of donor's agenda.

*Vision is a non-government organization working with MSM and sexual health in Lahore, Pakistan*

I wonder?

In the range of education materials regarding promoting safer sex, I wonder if we are not reinforcing gender stereotypes and penetrative sexuality?

# Ravaging the vulnerable: abuses against persons at high risk of HIV infection in Bangladesh

Extract from a Human Rights Watch Report, August, 2003

## Summary

Bangladesh is at a critical moment in its emerging epidemic of acquired immune deficiency syndrome (AIDS). The prevalence of human immunodeficiency virus (HIV) in the population remains relatively low by official estimates, yet several factors suggest the risk of a devastating epidemic. Bangladesh is neighbor to major epidemics in India and Southeast Asia, and there is a good deal of migration across national borders. Bangladesh has a high rate of poverty, systemic gender inequality, and an inadequate health care system. Behavioral surveys have shown that sex workers and men who have sex with men often have unprotected sex, and injection drug users often share needles, in some cases because alternatives to these behaviors are limited. There is growing recognition within the Bangladesh government and among international agencies that the country must take immediate, concerted action to avoid a severe AIDS epidemic.

The Bangladesh national AIDS policy acknowledges that persons most at risk of HIV transmission—such as sex workers, men who have sex with men, and injection drug users—are essential partners in any successful fight against AIDS. These are the people in greatest need of HIV/AIDS information and services, and they are also often the people in the best position to deliver information and services to their peers. And yet Human Rights Watch found in investigations conducted in December 2002 that the Bangladesh government both commits and condones the commission of severe violations of the human rights of persons in all three of these high-risk groups, including peer educators who provide vital HIV prevention services.

Both sex workers and men who have sex with men are regularly abducted, raped, gang-raped, beaten, and subject to extortion by the police and by powerful thugs termed *mastans*. *Mastan* is the name given to criminals who sometimes act as musclemen for Bangladesh's political parties in exchange for the parties' tolerance of the *mastans'* racketeering and other criminal activity. Today the term is used to refer not only to thugs with direct political affiliations but also more broadly to powerful criminals.

One sex worker from Dhaka, Jahan H., told Human Rights Watch that in September 2002 a police officer locked her in a hotel room for two days during which he beat her with a belt and raped her seven times. The officer also brought three of his friends into the room each of whom raped her. She reported being raped by police officers several other times in 2002, and being raped as often as once a week by *mastans*. In mid-2002, she was forcibly taken to a warehouse and raped by seven *mastans* throughout the night. Jahan H.'s experiences are not anomalous. Another sex worker, Lani N., twenty, reported she was raped by police officers three times in 2002. She also said that one night in late 2002 she was forced onto a bus and taken to a place where she was raped and beaten by about twenty *mastans*.

Twenty-year-old Rakesh K., who identified himself to Human Rights Watch as a man who has sex with men, said that in December 2002 a police officer brought him to a police barracks where he was raped by four officers. Rakesh K. also said that *mastans* raped him approximately four to five times per month in the months prior to meeting Human Rights Watch. He said that *mastans* usually would rape him in groups of two or three and also would take his money.

Sex workers and men who have sex with men encountered by Human Rights Watch were often arrested seemingly for the purpose of the same kinds of abuse—rape, beatings, and extortion—rather than for law enforcement. When three police officers arrested twenty-year-old Shipna B. in late 2001, they did not charge her with a crime or even take her to the police station. Instead they demanded a bribe; when she was unable to pay it, one of the officers raped her.

The police deal a direct blow to Bangladesh's anti-AIDS efforts

by beating and arresting sex workers and men who have sex with men who work on HIV/AIDS outreach and education among their peers. Peer education is among the most effective and sometimes the only way to bring HIV information, condoms, and other services to these hard-to-reach persons. One outreach worker from Dhaka, Ali L., was beaten by police while distributing condoms and conducting HIV/AIDS education among men who have sex with men. "[The police] hit me with a cane, with their gun, they kicked me and slapped me and pulled my hair and pulled on my collar and the waistline of my pants."

Perpetrators of sexual violence and other forms of abuse are not held accountable by either the police or the government. Both sex workers and men who have sex with men reported that their attempts to make official complaints about the abuses they experienced were largely ignored and sometimes ridiculed. Durga R. said she had been raped by police officers more times than she could count, and that she had tried to complain about these rapes once, in late 2001. She spoke to a high-ranking police officer who told her that if police wanted to have sex with her she should "make them happy." He asked her how else she expected to do business in the street. She said that was the only time she complained.

Partly this impunity reflects broader social attitudes which stigmatize both sex workers and men who have sex with men. They are ostracized by their families and communities and denied access to education, employment, housing, and health care. Both groups are portrayed as inherently "bad" and face constant attacks on their dignity. They are particularly vulnerable to sexual violence, which is justified both by the perpetrators of the violence and by the unresponsive authorities as the deserved consequence of, in the case of sex workers, their work or, in the case of men who have sex with men, their sexual identity.

Injection drug users also face great stigma and ostracization. Because they use drugs, they too are portrayed as inherently "bad," though the abuse they face seems not to be specifically sexual. Injection drug users are beaten and subject to extortion by police and *mastans*, and needle exchange workers are sometimes arrested though rarely charged, all of which can have debilitating consequences for life-saving services. Farukh R., for example, told human rights Watch that prior to entering a rehabilitation program in December 2002, he regularly obtained clean needles from the CARE needle exchange program in Chapai Nawabganj. He said that after the arrest of a needle exchange worker in July 2002, he and other users were fearful and had a hard time locating needle exchange workers. Farukh R. said that as a result he shared needles with three to five other users for a period of about two weeks before he was able to reestablish regular contact with needle exchange workers.

These abuses—abductions, rapes, beatings, and extortion by police and *mastans*, arbitrary arrests and detentions, wider social discrimination—reflect the second-class status of sex workers, men who have sex with men, and injection drug users. The perpetuation of the abuses leads to even greater subordination. The abuses violate both Bangladeshi law and international human rights law, which are based on the inherent dignity and equality of all people.

Because sex workers, men who have sex with men, and injection drug users are so crucial to Bangladesh's fight against AIDS, the abuses have the additional consequence of reducing Bangladesh's capacity to curtail an emerging AIDS epidemic. HIV can be transmitted through rape. And even when rape is not part of the abuse, harassment of HIV/AIDS outreach workers directly interferes with efforts to

*continued on page 5, col. 1*

## Ravaging the vulnerable

*continued from page 4, col.1*

disseminate information and build awareness of HIV and to distribute condoms and clean needles. More generally, the abuses faced by sex workers, men who have sex with men, and injection drug users further alienate these already marginalized persons from society and decrease the degree of control they have over their own lives. They become more difficult to reach with prevention and care information and services and they are in less of a position to protect their own health and the health of others.

Sex workers, men who have sex with men, and injection drug users experience an especially brutal manifestation of what are in fact nationwide problems in Bangladesh: violence and exploitation by police and mastans. Both civil society and, at certain points, the Bangladesh government have recognized that the police are widely corrupt and ineffective and that mastans wield a great deal of unchecked power over the general population. The predominance of mastan criminal activity and the police's inability or unwillingness to control it led the government to mobilize the army to fight domestic crime in late 2002. That mobilization, which the government called Operation Clean Heart, resulted in many serious human rights abuses, including the deaths in custody of at least forty people. The government has since immunized soldiers, police officers, and government officials from prosecution in the public courts for abuses that occurred during the campaign. Ultimately, Bangladesh must reform its law enforcement system to curtail the system's own abuses and to make it effective in protecting citizens' rights against mastans.

The plight of sex workers, men who have sex with men, and injection drug users lies, then, at the intersection of two great challenges for Bangladesh: its crisis of law and order and its struggle against the threat of a massive AIDS epidemic. In regard to both challenges, the situation of sex workers, men who have sex with men, and injection drug also represents an opportunity. If Bangladesh can end police abuse of these groups and protect them from abuse by mastans, the nation will have made critical progress, both toward strengthening its fight against AIDS and toward creating an effective, rights-respecting law enforcement system. The nation also will have extended a measure of basic human dignity to people to whom dignity has been long and brutally denied.

### RECOMMENDATIONS

To the Government of Bangladesh

*Re form the law enforcement system*

Human Rights Watch's research demonstrates that the police are both violators of human rights themselves and ineffective at protecting against abuse by mastans. The government should consider the following proposals for police reform.

*Police Conduct*

- Send a strong and clear message to police officers, through words and actions, that human rights violations will not be tolerated and that violators will be dismissed from their positions and prosecuted as criminals.
- Establish an active, independent, civilian body for monitoring and investigating police misconduct. This body should solicit and receive complaints from civilians, and should be vested with the power to dismiss individual officers. Its findings should also automatically be forwarded to government prosecutors for possible criminal prosecution against officers.
- Supervising officers who fail to discipline, retrain, or otherwise address the behavior of officers who repeatedly violate human rights should also be investigated, disciplined and/or dismissed.
- Eliminate informal arrest quotas.
- Institute regular, rigorous training for police officers, including training on human rights-in particular the human rights of vulnerable groups-and on HIV/AIDS.

- Reform recruitment and retention practices for the police, including eliminating corruption in police hiring, raising police salaries, raising education requirements for police work, and creating a rigorous, merit-based hiring process.

- Develop a uniform code of conduct for police officers. The code should be consistent with the U.N. Code of Conduct for Law Enforcement Officials.

*Investigation and Prosecution*

- Give high priority to prosecuting persons in positions of power who commit human rights abuses, including police officers throughout the chain of command and mastans. Consider establishing special prosecutors for the prosecution of rights-abusing police officers and mastans.

- Develop and publicize an accessible process for filing and recording complaints (First Information Reports or FIRs). Citizens should have recourse to a second avenue for registering a complaint if an initial attempt is ignored.

- Develop a system for monitoring each police station's investigative and prosecutorial follow-up to complaints filed.

- Prosecute abductions, rapes, beatings, and extortion against women, men, and children regardless of the identity of the victim and/or perpetrator. The special courts established by the 2000 Repression of Violence Against Women and Children Act for the speedy prosecution of violent crimes against women and children may provide a useful forum for these cases. Rape and other crimes committed against men should not be overlooked.

- The law should be amended to recognize sexual violence against men and boys.

- Create a National Human Rights Commission for the independent investigation of human rights abuses.

*Criminal Procedure*

- Repeal section 54 of the Code of Criminal Procedure-which grants broad latitude for arrest and detention without a warrant or an order from a magistrate-and replace it with clear, strict limitations on situations where an arrest without warrant is permissible, such as when a crime is occurring (*flagrante delicto*) or about to occur. An officer's decision to arrest should be subject to review in court.

- Ensure that all arrestees are charged promptly and presented without delay before a magistrate, as is required by section 62 of the Code of Criminal Procedure and the International Covenant on Civil and Political Rights.

- Ratify the Convention against Torture and Other Cruel Inhuman and Degrading Treatment or Punishment.

*Vulnerable Persons and Victims of Crime*

- Establish regular contact between supervising officers and representatives or organizations of groups that typically face police abuse, so that persons from these groups have a forum for communicating their concerns.

- Provide medical and legal services for victims of violent crime. Fulfill Prime Minister Zia's promise of instituting crisis centers in all divisional city hospitals to provide treatment and legal aid for women survivors of violence.

- End the illegal practice of confining sex workers in vagrancy homes.

- Revise rape laws-section 375 of the Bangladesh Penal Code and the Repression of Violence Against Women and Children Act-so that they protect victims regardless of gender.

- Repeal section 377 of the Bangladesh Penal Code, which has been interpreted to criminalize male-to-male sex.

*continued on page 6, col. 1*

## Ravaging the vulnerable

*continued from page 5 col.2*

### *The Army*

- The army should only be deployed for domestic law enforcement in extreme circumstances.
  - If the army is to continue to have a role, ensure that the army respects the law and the rights of suspects and all civilians. Institute procedural requirements for soldiers' conduct and revoke immunity for abuses committed by soldiers during Operation Clean Head.
- Enhance and expand the national effort against HIV/AIDS*  
The government must take immediate, concerted action to avoid a major epidemic.
- Raise public awareness about the modes of HIV transmission, methods of prevention, and elements of AIDS treatment and care.
  - Respect and raise awareness of the rights of people vulnerable to HIV/AIDS and the rights of people living with HIV/AIDS. This may include the use of mass media and human rights trainings for community and religious leaders.
  - Recognize and support Bangladesh's needle exchange programs and ensure that needle exchange outreach workers are not harassed or arrested by the police.
  - Support HIV/AIDS outreach work with sex workers, men who have sex with men, and other vulnerable groups, including peer-driven approaches. Ensure that outreach workers are not arrested and are not harassed by the police or mastans.
  - Ensure access to high-quality, affordable condoms.
  - Raise awareness of the connection between sexual violence and HIV/AIDS, and undertake education efforts to eliminate the social stigma connected to being a victim of rape or other acts of sexual violence.
  - Expand the availability of humane, effective treatment for drug addiction.
  - Provide sex workers with access to training and counseling for the pursuit of alternative careers.

- Improve institutional capacity to make use of resources available for addressing HIV/AIDS, such as the 550 million loan/aid package from the World Bank and the U.K. Department for International Development that was approved in 2000. (Implementation problems have largely stalled the project.)

### *To bilateral and multilateral donors*

- Support reform of the Bangladesh law enforcement system with the aim of eliminating abuse by police and mastans and protecting the human rights of all citizens, including persons vulnerable to HIV/AIDS.
- Support the development of an effective national program to address HIV/AIDS, including protection of the rights of people vulnerable to HIV/AIDS and the rights of people living with HIV/AIDS.
- Engage publicly and privately with the Bangladesh government to highlight the importance of respecting the rights of persons vulnerable to HIV/AIDS.
- In particular, the World Bank and the U.K. Department for International Development should insist that as Bangladesh implements the loan/aid package negotiated in December 2000 for addressing HIV/AIDS (which is currently being scaled down in the face of implementation difficulties), the government take serious steps toward curtailing abuses by police and mastans against persons vulnerable to HIV/AIDS.
- Support the development of membership organizations among sex workers, men who have sex with men, and injection drug users such that these persons can have collective institutional voices.

### *To the United Nations*

- Engage in public and private advocacy about the need to protect the rights of persons vulnerable to HIV/AIDS. In particular, U.N. agencies that work with persons vulnerable to HIV/AIDS and/or with the law enforcement system, such as UNAIDS, WHO and UNDP, should ensure that their programs support the pursuit of greater protection for the rights of persons vulnerable to HIV/AIDS.
- The names of witnesses have been changed for their protection.*  
*For a full copy of the report access the website of Human Rights Watch on [www.hrw.org](http://www.hrw.org)*

## Declaration on political leadership in combating HIV/AIDS first National Convention of the Parliamentary Forum on HIV/AIDS

*Adopted in New DELHI on 26 July 2003 at the India's first National Convention of the Parliamentary Forum on HIV/AIDS, on July 26-27, 2003*

We, the activists of the political parties

RECOGNIZE that as political workers we have a crucial role, both individually and collectively as the link between the people and the government, as advocates for the rights and needs of people, as legislators to make laws to protect these rights, and as policy-makers to mobilize resources, involve civil society and create the enabling environment necessary to fight HIV/AIDS.

ARE CONVINCED that together we can overcome the HIV/AIDS epidemic, prevent its further spread, work for an enabling environment and alleviate the impact of the epidemic.

Have gathered at this National Convention of Elected Representatives being held today at Vigyan Bhawan, New Delhi, to reaffirm our collective commitment to mobilize communities against the spread and impact of HIV/AIDS. We solemnly declare to:

ENSURE leadership by everyone in his/her area of responsibility in the fight against HIV/AIDS by intensifying advocacy, allocating and raising resources and guiding the response to the HIV/AIDS epidemic both in prevention and care within our constituencies in

particular and the country as a whole;

PROMOTE a positive environment by confronting stigma, silence and denial, eliminating discrimination and ensuring the full enjoyment of all human rights and fundamental freedom by people living with HIV/AIDS

ASSURE gender equality and the empowerment of women as a fundamental element in the reduction of the vulnerability of women and children to HIV/AIDS

TAKE STEPS to ensure that the response includes a focus on youth

INTENSIFY AND STRENGTHEN multisectoral collaboration and mobilizing for full and active part of a wide range of non-governmental organizations, the business sector, media, community based organizations, religious leaders, families, citizens as well as people infected and affected by HIV/AIDS in the planning, implementation and evaluation of the response to HIV/AIDS.

*SAATHI listserver, 02/08/03*

## Supreme Court strikes down Texas law banning sodomy

The Supreme Court struck down a ban on gay sex Thursday, ruling that the law was an unconstitutional violation of privacy.

The 6-3 ruling reverses course from a ruling 17 years ago that states could punish homosexuals for what such laws historically called deviant sex.

Laws forbidding homosexual sex, once universal, now are rare. Those on the books are rarely enforced but underpin other kinds of discrimination, lawyers for two Texas men had argued to the court.

The men "are entitled to respect for their private lives," Kennedy wrote.

"The state cannot demean their existence or control their destiny by making their private sexual conduct a crime," he said.

Justices John Paul Stevens, David Souter, Ruth Bader Ginsburg and Stephen Breyer agreed with Kennedy in full. Justice Sandra Day O'Connor agreed with the outcome of the case but not all of Kennedy's rationale.

Chief Justice William H. Rehnquist and Justices Antonin Scalia and Clarence Thomas dissented.

"The court has largely signed on to the so-called homosexual agenda," Scalia wrote for the three. He took the unusual step of reading his dissent from the bench.

"The court has taken sides in the culture war," Scalia said, adding that he has "nothing against homosexuals."

The two men at the heart of the case, John Geddes Lawrence and Tyron Garner, have retreated from public view. They were each fined \$200 and spent a night in jail for the misdemeanor sex charge in 1998.

The case began when a neighbor with a grudge faked a distress call to police, telling them that a man was "going crazy" in Lawrence's apartment. Police went to the apartment, pushed open the door and found the two men having anal sex.

As recently as 1960, every state had an anti-sodomy law. In 37 states, the statutes have been repealed by lawmakers or blocked by state courts.

Of the 13 states with sodomy laws, four - Texas, Kansas, Oklahoma and Missouri - prohibit oral and anal sex between same-sex couples. The other nine ban consensual sodomy for everyone: Alabama, Florida, Idaho, Louisiana, Mississippi, North Carolina, South Carolina, Utah and Virginia.

Thursday's ruling apparently invalidates those laws as well.

The Supreme Court was widely criticized 17 years ago when it upheld an antisodomy law similar to Texas'. The ruling became a rallying point for gay activists.

Of the nine justices who ruled on the 1986 case, only three remain on the court. Rehnquist was in the majority in that case - Bowers v. Hardwick - as was O'Connor. Stevens dissented.

A long list of legal and medical groups joined gay rights and human rights supporters in backing the Texas men. Many friend-of-the-court briefs argued that times have changed since 1986, and that the court should catch up.

At the time of the court's earlier ruling, 24 states criminalized such behavior. States that have since repealed the laws include Georgia, where the 1986 case arose.

Texas defended its sodomy law as in keeping with the state's interest in protecting marriage and child-rearing. Homosexual sodomy, the state argued in legal papers, "has nothing to do with marriage or conception or parenthood and it is not on a par with these sacred choices."

The state had urged the court to draw a constitutional line "at the threshold of the marital bedroom."

Although Texas itself did not make the argument, some of the state's supporters told the justices in friend-of-the-court filings that invalidating sodomy laws could take the court down the path of allowing same-sex marriage.

*The Associated Press, 26/06/03*

## Cycling may be damaging to sex lives, says study

Cycling can damage rider's sex lives and may do health more harm than good, according to a study.

A report by Belgian academics show that male cyclists are twice as likely to suffer virility problems as other men, while female bicycle riders are more likely to experience increased health risks. Fashionable bicycle saddles with holes are shown to be of particular danger to women because they create excessive pressure in the genitals.

The findings, published in the Bicycle Saddle Report 2003, are based on a study of 1,000 cyclists of whom 94 per cent said that they had experienced physical problems while cycling. Of these, 60 per cent said that the discomfort was felt in the genital area.

The research team, led by Dr Luc Baeyens, the head of gynaecology of University Hospital in Brussels, found that men who cycled were twice as likely to suffer erectile problems that non-cyclists. For women riders, genital swelling was found to be much more common than previously realised. The report, however, said that it was impossible to calculate the scale of the problem because women did not generally raise the issue because of embarrassment. The research makes several recommendations including that women buy only women's saddles, cyclists sit upright as often as possible and rise out of the saddle every 10 minutes by standing on the peddles.

*Asian Age, 16/6/03*

*Has any similar study been done with cycle rickshaw drivers?*

## Bihar MPs set a trend, agree to AIDS test

Patna: Forget about crime, corruption and caste-class chasms, Bihar's legislators are giving the people a real reason to be proud of them.

They will probably become the world's first elected representatives of the people to be tested for AIDS in an awareness campaign.

"Bihar's ministers and legislators have agreed to be tested for AIDS to create awareness about the deadly disease. This will be the first time, not only in India but in the world, that people's representatives would participate in an AIDS test like this," said Tarun Kumar of Helping Hand Foundation, an NGO.

The New Delhi based organisation would conduct its awareness campaign in October. Bihar Health Minister Shakuni Chaudhary would inaugurate the event on October 1.

Kumar said the state's legislators and ministers had agreed to the unusual step to take the message of the campaign to the people.

He said the move would be very effective as legislators had a direct link with people at all levels, in the cities and in the remotest villages. It would send a strong message about the dangers of the deadly disease to the people.

The activist said legislators were a strong link between the government and the people. Their collective participation would help check the spread of AIDS in a country like India.

Bihar has another first to its credit.

It became the first Indian state last year to make it mandatory for all new HIV/AIDS cases to be reported to the government.

The state is showing an alarming increase in HIV/AIDS cases, with migrant labourers and truck drivers being the major vectors of the disease. By the end of May this year, the total number of HIV/AIDS cases crossed 2,500 as against only 1,200 till September last year.

According to official records, there are 143 full-blown AIDS cases in the state. Till date, eight AIDS patients are said to have died in the state.

Though Bihar is behind developed states like Maharashtra, Andhra Pradesh and Tamil Nadu in the number of HIV/AIDS cases, health officials said the increase in cases recorded during the last six months was an alarming trend.

*newindiaexpress.com, Posted AIDS India egroup 12/8/03*

## Uzbekistan: HIV/AIDS on the rise, experts say UN

HIV/AIDS is on the rise in Uzbekistan, say experts. Despite a currently low HIV/AIDS prevalence, health officials believe that the country occupies one of the leading positions in the world in terms of the rate of the disease's spread.

"The situation with HIV/AIDS in the country is getting more complex, with the number of HIV/AIDS cases increasing," Muntaz Khakimov, the director at the National HIV/AIDS Centre, told IRIN from the Uzbek capital, Tashkent.

According to Khakimov, there were some 2,000 officially registered HIV/AIDS incidences as of April 2003, compared to over 1,000 cases in 2002, thereby highlighting the growth dynamics of the disease. Since the first case was registered in 1991, there had been some 61 HIV/AIDS-related deaths, he noted.

Concurring with Khakimov, Aziz Khudoberdiev, the national programme officer for the joint UN Programme on HIV/AIDS (UNAIDS), told IRIN from Tashkent that, like in all the other Commonwealth of Independent States, Uzbekistan had seen a rapid growth of HIV/AIDS incidence.

"Two years ago, Uzbekistan was just in the beginning stage of HIV/AIDS," he said, noting that the officially registered number of cases was only the tip of the iceberg, the real number being more than 10 times the official figure. Khudoberdiev asserted that the real number of cases could be as many as 30,000.

"Eighty percent of the HIV-positive cases are men, while women constitute 17 percent, with the rest being children aged 0-14," he said, observing that almost 70 percent were injecting drug users, some 13 percent were sexually transmitted and 23 percent remained

unknown. "However, the official ratio of sexually transmitted cases has risen from 10 to 16 percent," he added.

"Since 1998, the number of HIV/AIDS cases has increased dramatically. During 2001-2002, the number of reported HIV cases rose by more than three times," Khudoberdiev said, noting a particularly steep rise in the first three months of 2003, during which the average number of monthly registered cases had been three times as high as during the same period the previous year.

The registered cases had predominantly been found in Tashkent, as well as southeastern Surkhandarya Province bordering on Afghanistan, Turkmenistan and Tajikistan.

Turning to the government's efforts to deal with the problem, he said it had approved a national strategic programme on HIV/AIDS prevention for 2003-2007. "This programme is a complex one, involving not only the Ministry of Health but other ministries and organisations as well, along with NGOs," he said, adding that the authorities had applied to the Global Fund to Fight AIDS, Tuberculosis and Malaria for assistance. Khudoberdiev said UNAIDS in Uzbekistan had been working with the authorities in applying for US \$24 million for HIV/AIDS prevention.

The government had also opened about 230 points for the supply to the public of replacement syringes and condoms, along with educational and informative programmes.

"The main goal of these activities is to prevent the spread of HIV/AIDS among the injecting drug users," Khakimov said, pointing out, however, that the country needed assistance comprising "at least one million to two million syringes and one million condoms a year", to enable it to deal more effectively with the spread of the disease.

*Posted by sea-aids, 2/7/03*

## Sanctions worsen Burmese poverty

By signing a bill last week containing sanctions against Myanmar, President George W. Bush sent a strong signal of condemnation over the government's attack in May on the National League for Democracy and the arrest of the opposition party's leader, Aung San Suu Kyi. But sanctions against Myanmar, also known as Burma, will only prolong and deepen the suffering of the Burmese people, who are facing a serious humanitarian crisis.

Policymakers in the United States assume that pressuring General Than Shwe, Myanmar's paramount leader, will ultimately force the military junta to release Suu Kyi and that this, in turn, will create the conditions for greater democracy and potential regime change. Unfortunately, this assumption is deeply flawed. Leaders do not make democracy. People do. And a population that is ailing is in no shape to support a move towards democracy.

The trade embargo imposed by the new U.S. sanctions bill - which it is estimated will cost Myanmar \$356 million a year - will have a debilitating effect. Garment workers who earn as little as 30 cents a day, will lose their jobs. Many of these girls and young women, away from home, will turn to prostitution or other marginal means to make a living. Higher unemployment in Yangon will lower wages, which are already well below a minimal living standard. The effects of sanctions will ripple to other parts of the country.

The ability of the Burmese people to cope even in the worst of times is inspiring. But present conditions have undermined traditional survival strategies. The gradual liberalisation of the Burmese economy has, ironically, increased vulnerability, bringing higher inflation, a weak local currency, a banking crisis - which has shrunk the middle class - and greater income inequality.

Poverty is on the increase and in some regions has already reached dangerous levels. Just south of the Chinese border, where the government has introduced a crop substitution programme for heroin production, villagers are starving. In the Delta region, where rice production has declined, landless peasants are resorting to scavenging to find a meal. In the Rakhine district, anemia is increasing. In the arid

central zone near Pagan, chronic malnutrition levels match those of Somalia and Sudan.

In this climate of poverty, AIDS is wreaking havoc. Government figures put the number of AIDS cases at nearly 180,000. Last year the UN AIDS agency estimated the real number is more than double that.

From 1997 until this year, international nongovernment organisations made important inroads in tackling everyday problems in Myanmar. As sanctions tighten these humanitarian measures must expand, focusing on the hardest-hit areas as well as the small middle class, which will comprise a much-needed civil society foundation for democracy in the future.

Policymakers must not let the Burmese people suffer because of the decisions of their leaders.

*International Herald Tribune, 8/8/03*

The term men who have sex with men should not be seen as a "target group" that is exclusive and bounded.

A consequence of this approach is that a great deal of prevention work misses the point along with significant male populations.

It is supposed to reflect a particular behaviour between males rather than an identity label, or defining a sexual orientation.

This does not mean that they are no MSM who have specific gendered/sexual identities, and focused work should be done with such males where the identity can act as a rallying call. But it does mean that MSM behaviours are not exclusive to such individuals, groups, or networks.

## CDC warns AIDS group over programs

The US Centers for Disease Control and Prevention (CDC) is once again threatening to withhold funding from the San Francisco-based Stop AIDS Project, accusing the non-profit of promoting sexual activity through its safe sex workshops.

In a June 13 letter sent by Sandra Manning, the director of the CDC's Procurement and Funding Office, the federal agency told the group it was violating the Public Health Services Act due to three of its workshops: "In Our Prime: Men for Hire," which discussed seven guidelines for safe and friendly relations with escorts; "Bootylicious," which discussed ways to better enjoy anal sex; and "Oral Sex = Safe Sex?" which talked about how safe oral sex was in terms of HIV transmission.

"It's pretty confounding to us," Stop AIDS Communications Director Shana Naomi Krochmal told the Gay.com/PlanetOut.com Network. "We are doing the same work we were doing four months ago when the CDC said we were using current effective models of HIV prevention. We're doing the same work we were doing six months ago when a Department of Health and Human Services audit proved we weren't doing anything wrong."

Stop AIDS' struggles with the CDC began more than two years ago, when then-inspector general of the Department of Health and Human Services (HHS) Janet Rehnquist audited the group. Stop AIDS was found to be in compliance, and Rehnquist (daughter of Supreme Court Justice William H. Rehnquist) ended up resigning from her HHS position under a cloud of controversy that led to a congressional investigation.

In August 2002 the CDC sent a team of investigators to San Francisco to see if the Stop AIDS prevention workshops were scientifically sound and consistent with U.S. government guidelines for AIDS-related materials.

In February, CDC director Julie Gerberding wrote a letter to Rep. Mark Souder, R-Ind., who has been a critic of Stop AIDS Project and similar programs in the past, and said the investigators found "the design and delivery of Stop AIDS prevention activities was based on current accepted behavioral science in the area of health promotion."

"We do workshops that target gay and bi men in San Francisco," Krochmal said. "They are conversational. It's not like any of these were live demonstrations."

The CDC provides about \$600,000 of Stop AIDS' almost \$2 million annual budget. Krochmal explained that Stop AIDS is focused on helping men build communication skills and self-esteem so they can better negotiate safer sex. "That makes it pretty clear this isn't about public health or about effective prevention," Krochmal said. "This is about politics." *Posted June 16, 2003*

## HIV/AIDS in Bangladesh

This year, the fourth round of sero- and behavioural surveillance has detected four per cent HIV prevalence among the injecting drug users in central Bangladesh, health ministry officials disclosed at a press conference yesterday at the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). The report titled "HIV in Bangladesh: Is the time running out?" revealed that the prevalence of the virus that causes AIDS is less than one per cent among other vulnerable groups like floating sex workers and hermaphrodites, their male clients, homosexuals, sex workers in brothels etc. But, unfortunately, the low HIV infection rate in these groups is not due to decrease in high-risk behaviours. The survey revealed a higher percentage of men buying sex in Bangladesh than elsewhere in Asia.

In his opening speech, Director of the ICDDR,B Dr David A Sack said, "We should care for the HIV positive patients and voluntary counselling and blood testing. For those who have tested positive, there should be a programme of care, treatment and, if necessary, rehabilitation instead of leaving them on their own."

The report also showed that the majority of men still do not use condoms in commercial sex and female sex workers report the lowest

## Drug-resistant HIV strain grows

About 10 percent of Europeans infected with HIV contract a strain of the virus that is resistant to at least one AIDS drug, according to the first large-scale study of the problem.

Scientists have known that HIV can become resistant to drugs and that resistant strains can be spread, but the extent of the transmission has not been clear.

Resistance is mainly caused by patients not taking medicines on schedule, allowing mutant viruses to evolve that are resistant.

An earlier study in the United States showed that at least half of all Americans under care for HIV infection carry drug-resistant viruses.

Dr. Peter Piot, executive director of UNAIDS, said the findings presented Wednesday at a conference of the International AIDS Society are the most reliable to date.

Piot, who was not involved with the research, said the extent of resistance was not surprising, but it serves as a warning that the delivery of drugs in poor countries requires care.

"It reminds us that when we introduce anti-retroviral therapy we've got to do it well," he said, adding that a universally followed standard prescription for initial treatment should be part of the strategy.

Kevin Frost, director of Treat Asia, a program of the American Foundation for AIDS Research, said the results show the world is at a crucial point with AIDS treatment.

"We are in a somewhat volatile period right now and the therapeutic anarchy that is going on — we have to get a handle on it," Frost said.

"Doctors have the freedom, especially in the West, to prescribe whatever they want. There are 19 drugs approved in the United States now with 21 or 22 formulations. ... It means there are hundreds, if not thousands, of potential combinations."

In the developing countries, doctors prescribe what they can get. But what they can get is often not what they should be prescribing, Frost said.

"We have to take our best shot first," he said. "If we use the right regimens and we use them correctly, we can minimize the opportunities for the development of resistance. If we don't get it right, we could be in for serious problems long term in developing countries."

The study, led by scientists at the University of Utrecht in the Netherlands, involved 1,633 HIV patients from 17 European countries diagnosed between 1996 and 2000.

It found that 9.6 percent of newly diagnosed HIV patients in Europe are infected with a virus that is resistant to at least one drug. About 2 percent had an infection that does not respond to two or more types of AIDS drugs. *Associated Press, Thursday, 17/7/03*

condom use in the region. About two-thirds of rickshaw-pullers and truck drivers reported during the survey that they never touched condom and they had no idea of HIV exposure.

The survey pointed out that contrary to the common belief, injecting drug users are not isolated. They are linked with the rest of society. They buy sex from commercial sex workers, sell blood and move between cities. Describing the findings as 'a matter of great concern', Director General of Health Services Dr Mizanur Rahman at the launch of the surveillance report on Wednesday, said, "This upsurge of HIV infection among a particular vulnerable group is quite a serious matter. It is also the most-cost effective option for a country like ours to halt the virus before the economic burden becomes too large to bear."

Dr Tasnim Azim, one of the researchers who helped prepare the report, presented the document at the press conference. Motiur Rahman, chairman of the National AIDS Committee's technical body, and Dr Ishtiaq A Zaman, head of the ICDDR,B's external relations and deputy programme manager of STD and AIDS programme, were also present.

*The Daily Star, 30/7/03*

## Forum delegates flunk HIV test

It is a disease that spreads through people who mingle with ladies; its growing because our films show 80 per cent nudity; you can get it by sharing food, but don't worry vaccines can cure it. We're talking about HIV and/or AIDS, or so would delegates at the Parliamentary Forum on HIV/AIDS have us believe.

These delegates, mostly MPs, MLAs, and zila parishad presidents will also be spreading 'awareness' about the disease countrywide.

Inaugurating the Parliamentary Forum, Prime Minister A.B. Vajpayee and Co. made impassioned speeches but most delegates weren't paying attention, it seems.

At the end of day one, the *Hindustan Times* did a pop quiz. Here's some of what we heard.

"I'm not a doctor, so don't ask me. All I know is, it's a dangerous disease that is a big problem among lorry drivers and people in slums. Normally it spreads through them and through people who mingle with ladies," said Rajana, a zila panchayat president from Bangalore.

Jairprakash Gupta, an MLA from Harayana, said, "AIDS is a death sentence as there is no medicine, no vaccine. It's growing because our culture has been forgotten as the media and films show 80 per cent nudity."

M.G. Muley, MLA from Karnataka, does not know the difference between HIV and AIDS but knows that "HIV is not popular, AIDS is popular" among people in his state. Also you can get it from sharing food.

Several of those asked said, "I don't know, Madam. You should." But they continued enthusiastically making plans for awareness campaigns. *Hindustan Times*, 27/7/03

## Kama Sutra guide to safe sex

*The government in India's West Bengal State is supporting a programme that offers prostitutes an ancient solution to modern concerns about safe sex.*

"Kama Sutra has many postures that can give men the highest pleasure without consummation and that is what the prostitutes are being taught. "They are learning something very useful," says Rajyashree Choudhuri, chief of the Institute of International Social Development (IISD), who designed the project.

Until now, thousands of Calcutta's sex-workers have tried to force customers to use condoms. Their powerful organisation, Durbar Mahila Samanoy Samity, has decreed that all their members perform safe sex and customers trying to force sex workers to have intercourse without condoms are thrown out of brothels.

### Three hour session

But what happens if a customer refuses to use condoms? The prostitutes lose business, which they can ill afford. That is a situation the IISD is teaching them to avoid.

In a conference hall in the posh southern locality of Gariahat, the IISD is running its "safe sex" workshop, with backing from the West Bengal Aids Control Society. Sex-workers from the city's major red light districts are joining up in droves.

"We will back any programme on safe sex. The number of HIV patients in West Bengal is increasing and we want to control it at any cost," says Sachinanda Sarkar, assistant director of the Aids Control Society.

Last year, 1,137 HIV cases were reported in the state. More than 600 cases have been reported this year.

Dozens of prostitutes turn up for the workshop and are taken through the voluminous Kama Sutra, India's most famous ancient treatise on sex.

The training lasts for two to three hours. "They are specifically taught foreplay and other poses that will give men a high degree of pleasure," said Rajyashree Choudhuri. "We teach the girls the art of ensuring a premature but very satisfying discharge by tactfully avoiding intercourse. The Kama Sutra is a treasure house for all that."

*BBC NEWS*, 08/08/03

## WHO-Asia: billions more condoms needed

by Ben Rowse

Billions more condoms are needed to prevent the escalation of the HIV/AIDS epidemic in Asia, the World Health Organization (WHO) said Monday, calling on the region to put safety before pleasure.

Asia-Pacific, which has seven million people living with HIV, is set to become the epicentre of the global pandemic in the next decade unless massive prevention efforts are undertaken immediately, the organization said.

It warned that at least 30 million people could be infected with HIV in India and China alone by 2010.

"Condoms save lives. We need to vigorously step up promotion of this life-saving device to prevent millions of people getting infected," said Dr Giovanni Deodato, the WHO representative to Laos.

His comments came ahead of Monday's opening of a regional meeting in Vientiane on the "100 percent condom use programme", a strategy to promote condom use in the sex industry, one of the most high-risk areas for HIV infection.

The four-day conference in the Lao capital brings together central and local government health officials from across the region.

"Condom use is still low in most countries in the region, including in many sex establishments, fuelling the spread of HIV," the WHO said.

Globally, an estimated six to nine billion condoms are distributed annually, but some 24 billion are needed, it said in a statement.

Of this total, over one billion condoms are needed for China's estimated six million sex workers, the WHO added, citing studies last year showing that fewer than 20 percent of Chinese sex workers use prophylactics regularly.

"A substantial proportion of HIV infections in Asia are attributable to commercial sex. Epidemics can explode with only a small pool of sex workers infected with HIV, as seen in Thailand", the UN agency said.

The adoption of the "100 percent" programme, however, has led to sharp declines in HIV infections, the global health body said.

"The programme has prevented a few million HIV infections in Thailand. This year, the Thai Ministry of Public Health will distribute 26 million condoms free to vulnerable groups."

The WHO also cited the example of Cambodia, where a record 20 million condoms were sold last year — or 50,000 a day, representing a massive 200 percent growth in sales over the last 10 years.

The programme is also currently being piloted in sex establishments in China, Myanmar, Mongolia and Vietnam. Similar projects were also initiated recently in the Philippines and Laos.

"In all these countries, condom use needs to be considerably expanded, particularly in the sex industry," the WHO said, pointing to the high prevalence of sexually transmitted infections in China, Laos, Mongolia, the Philippines and among Pacific islanders.

A study of men attending clinics treating sexual diseases in southern Vietnam found 75 percent had visited a sex worker in the last three years but only seven percent used condoms regularly, the WHO said. Seventy percent of them had never used condoms.

In China, 26 percent of Chinese sex workers have never used a condom even once, according to government surveys. In 1995, this figure stood at seventy percent.

"Nearly everywhere in Asia, more efforts are needed to promote condoms. In many countries, they are unavailable or costly and there may be little public knowledge about their benefits," it said.

The WHO's condom programme, however, has been criticised by some non-governmental groups, which argue that the UN agency is effectively condoning prostitution by encouraging condom use among sex workers.

*Agence France-Presse*, 18/08/03

## Alarming increase in HIV/AIDS cases in Bihar

Bihar is showing an alarming increase in HIV/AIDS cases with migrant labourers and truck drivers being the major vectors of the disease, say health officials in Patna.

Health department sources said eight HIV positive cases were detected in Patna this week during a test camp jointly organised by a state government agency and an NGO. Most of those detected were truck drivers.

A senior health official said there were 1,200 recorded HIV/AIDS cases in Bihar till September last year, but the number jumped to 1,700 by early November and increased to 2,214 by December.

"By the end of May this year the total number of HIV/AIDS cases crossed 2,500," he said.

"In the last six months, a large number of new cases of HIV/AIDS have come to light, which is alarming due to its fast rise," he said.

"Most of those who have tested for HIV/AIDS are migrant labourers who have returned from places like Delhi, Mumbai and Surat and towns in Andhra Pradesh," said another health official.

Some half a million people are estimated to migrate from the state every year in search of jobs. Most of them are labourers in search of seasonal jobs who return to the state for a brief while before venturing out again.

Officials say the number of full blown AIDS cases in the state is only 143. Till date only eight AIDS patients are said to have died in the state.

Bihar lags behind states like Maharashtra, Andhra Pradesh and Tamil Nadu in the number of HIV/AIDS cases. Health officials say the large number of cases detected in the last six months is a result of

facilities provided to test such cases.

Now a dozen test centres and clinic to detect sexually transmitted diseases are operating where one can go voluntarily for HIV/AIDS tests free of cost. Besides, the government is also collecting information from three private laboratories.

But some NGOs and medical practitioners feel the number of cases in government records is unrealistic. A Muzaffarpur-based NGO said at least 40 cases of HIV positive were detected by his organisation every month. Similarly Patna-based Sen Diagnostic's chief Dilip Sen said October last year to March this year, his centre tested 474 samples, of which 97 were found positive.

Last year Bihar became the first Indian State to order that all new cases of HIV/AIDS be reported to the state government. Now all doctors, private clinics and pathological laboratories have to inform the government of any fresh cases.

While the number of HIV positive cases is increasing at a fast pace in Bihar, the AIDS awareness drive launched by the state government with the help of NGOs is yet to reach rural areas.

The National Human Rights Commission last year voiced concern over reports that an AIDS-affected family had been ostracised. It also asked government officials to reveal the true picture of AIDS.

The situation on the ground is quite alarming. An AIDS patient in Narkatiaganj in east Champaran district killed himself, his wife and his three children a few months ago due to the social stigma attached to the disease.

In another case, the residents of Sahilampur village in Muzaffarpur district ostracised a family after three of its members died of AIDS in 18 months.

*Indo-Asian News Service Patna, 12/6/03.*

## Warning over drug-resistant HIV

by Richard Black

The unregulated supply of AIDS drugs in the non-industrialised world threatens to accelerate the development of drug-resistant HIV strains. That is the conclusion of a study from the London School of Hygiene and Tropical Medicine, just published in the British Medical Journal. The study urges governments and international agencies to deal with the problem now.

Drawing on evidence from Africa and Asia, the study shows that uncontrolled prescribing of anti-retroviral drugs is widespread and rising. Where the state sector cannot or will not provide drugs, patients who can afford them naturally purchase where they can - from doctors, pharmacies, market sellers, or relatives abroad.

### Wrong dosages

The study's author, Dr Ruairi Brugha, says that often patients do not take their drugs as they should. "These drugs are not being used according to the correct regimens. For instance, monotherapy - just giving one anti-retroviral drug - is definitely bad practice. And we see evidence of that both from Zimbabwe and Uganda, and I'm sure it's happening in other countries too." Dr Brugha also found that in some places patients are changing medication frequently, taking the wrong dose, or stopping treatment in periods when they cannot afford it. This is exactly the set of conditions in which a virus quickly becomes drug-resistant. Even in the rigid treatment patterns of the affluent west, HIV is becoming resistant to established anti-retrovirals - and this study says that governments and health authorities cannot afford to wait for more dangerous resistance to emerge in the developing world. Doctors and clinics need treatment guidelines, they say, Supplies of drugs need to be stable, and the public sector needs to compete more effectively in providing the services that people want. A spokeswoman for UNAIDS confirmed that the problem is serious, and needs to be addressed urgently by scaling up structured treatment programmes.

*Posted by JVNET, 3/07/03*

## "Indonesia's insulation from HIV/AIDS wears thin"

The cultural and religious norms that have spared Indonesia from an HIV/AIDS epidemic may be the same factors that hinder prevention efforts in the country, experts warn. Indonesia shares the same ingredients that sparked an HIV/AIDS epidemic in neighboring Thailand - a serious IV drug abuse problem, a booming sex industry, high STD rates, a large mobile labor pool, and a local reluctance to using condoms.

Despite this, Indonesia's highest estimate for HIV infections is 130,000 with only 3,614 actual reported cases as of March 31 of this year, compared to Thailand's 670,000 cases. But part of the discrepancy may be due to underreporting. "It's a totally passive reporting system," said Stephen Wignall, Indonesia director for Family Health International, which has been working with the Indonesian government to curb the spread of HIV/AIDS.

Last May, the government announced a comprehensive HIV/AIDS strategy, including setting the goal of 100 percent condom use among high-risk groups, according to UNAIDS. But getting the message across poses problems. A safe sex advertisement depicting men visiting a brothel was pulled from Indonesian television stations last September because Muslim groups felt it was promoting promiscuity and adultery.

The incident has raised serious questions about whether Islam, which may have helped Indonesia avoid an HIV/AIDS epidemic so far, will hinder the more crucial need for a safe sex campaign.

For his part, Tarmizi Taher, a former Indonesian Minister of Religion, is calling for the country's two major Muslim organizations to initiate dialogue about the need for condoms and clean needle use. But he acknowledges, "you have to use the right sentences to persuade people." "We call it an emergency, because under Islamic law if there is an emergency you can change the rules," said Taher.

*Posted by SEA-AIDS. 29/6/03*

## Egypt: homosexual prosecutions overturned: internet arrests, harassments continue

The acquittal by a Cairo appeals court of eleven men earlier convicted of consensual homosexual conduct is a step forward, but arrests and harassment of men who have sex with men continue in Egypt, Human Rights Watch said today. The appeals court overturned the convictions on July 20.

"Men remain imprisoned in Egypt for private acts, in a continuing crackdown which violates international law," said Scott Long, a researcher for Human Rights Watch. "What is needed is to repeal the provisions of a law which invite repressive enforcement."

The men were among sixteen who had been charged in February 2003, when police tapped the phone of a private apartment in the Giza district of greater Cairo after an informer reported that the owner was visited by other men. Police arrested the men whose recorded conversations suggested that they had engaged in homosexual acts. They were charged with the "habitual practice of debauchery," punishable by up to three years imprisonment under Law 10/1961.

Debauchery [fujur] in the law is understood to criminalize consensual, non-commercial homosexual sex.

The men were tortured in detention. One told Human Rights Watch that they were held in isolation for fifteen days in the women's section of the Giza police station; there, guards beat them three times daily, at every change of shift.

Thirteen men eventually appeared at trial; three more in hiding were tried in absentia. Only two were acquitted by the trial court April 17, 2003; the rest received sentences of from one to three and a half years' imprisonment.

While overturning the sentences of the eleven men who appealed, Judge Moazer al-Marsary said, "We are so disgusted with you, we can't even look at you. What you did is a major sin, but unfortunately the case has procedural errors and the court has to acquit all of you."

"We welcome the acquittals," said Long, "but judges have a duty to affirm the rights of the accused rather than engaging in prejudicial rhetoric and hiding behind technicalities."

Activists in Egypt report that official solicitation and arrests of suspected gay men over the Internet have continued in recent months.

Appeals courts have a record of overturning 'debauchery convictions in Egypt, when based on flimsy evidence or official solicitation.

However, some appeals fail. Human Rights Watch is concerned by the continuing imprisonment of Zaki Saad Zaki Abd al-Malak, a 23-year old resident of Ismailia who was solicited by police over the Internet in January 2002. After corresponding with a man through an MSN chatroom, Malak came to Cairo to meet him: at their prearranged meeting place, Vice Squad officers arrested him. He told human rights activists that police beat him daily during two weeks of detention in the Agouza Police Station. At one meeting with his lawyer, dried blood still crusted his face.

On February 7, 2002, Malak was convicted of the "habitual practice of debauchery," as well as advertising "against public morals" and "inciting passers-by ... to commit indecent acts." He was sentenced to three years' imprisonment, followed by three years' police supervision. The sentence was upheld on appeal. A further appeal is pending before the Cassation Court, Egypt's highest judicial review body. Meanwhile, Malak is being held in Borg al-Arab prison near Alexandria.

On February 17, 2003, a Cairo appeals court upheld a penal sentence against Wissam Toufic Abyad, a 26-year-old Lebanese citizen. Police arrested Abyad on January 16 in Cairo's Heliopolis district after he had arranged to meet with a "Raoul," whom he had met through a gay personals-advertisement site on the Internet. Undercover police and informants have used the nickname "Raoul" in several other cases to solicit suspected homosexual men.

The Heliopolis Court of Misdemeanors sentenced Abyad on January 20 to one year and three months' imprisonment, under the same three charges used against Zaki Saad Zaki Abd al-Malak. Abyad remains imprisoned, and is also appealing to the Cassation Court.

"It is time to end the arrest and torture of men suspected of homosexual conduct in Egypt," said Long

*Press Release from the Human Rights Watch – <http://www.hrw.org>, 22/07/03*

## Scientists document increasing HIV superinfections

Evidence is growing that "superinfection" with more than one strain of HIV may be more common than previously thought, which could complicate efforts to make a vaccine, experts said at an international AIDS conference in Paris. Scientists reported on Monday that three new cases of HIV infected people who initially were doing well without drugs but became sick years later after contracting a second strain of HIV. "Superinfection is sobering," said Dr Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, the chief US AIDS research agency. He was not involved in the studies.

"That means that although you can mount an adequate response against one virus, then body still does not have the capability to protect you against new infection, which tells you that the development of a vaccine is going to be even more of a challenge."

Dr Fauci said is too early to tell how big a problem superinfection will become but that he does not believe superinfections are the reasons patients on treatment can suddenly deteriorate. None of the patients in the three cases discussed at the conference were being treated for HIV, which can become resistant to drugs over time.

At the meeting, Dr Luc Perrin, a professor of clinical virology at the University of Geneva in Switzerland, reported finding superinfections in two Swiss intravenous drug users.

In the study, Dr Perrin followed 136 drug users with HIV and

found that the amount of HIV in the blood of five patients suddenly shot up after years of control without drugs. Test confirmed that two of the five had superinfection, Dr Perrin said. "I think superinfection most of the time is transient and is not detected," he said. "It may be that you are more frequently infected than you think but that frequently you are able to take care of it."

In another study, Dr Harold Burger of Albany Medical College in Albany, New York said genetic tests on a superinfected woman showed the two viruses mixed and produced a hybrid that took over the original virus.

Although the development of a hybrid was not surprising – scientists estimate there are 14 mixed strains circulating – the report is the first documented case of two HIV strains, or subtypes, combining in one person to form a third strain.

"The issue is can you get a vaccine that will cover all subtypes?" said Dr Anton Pozniak, an AIDS specialist at Chelsea and Westminster hospital in London, who was not connected with the research.

"Say you do. Imagine somebody with a subtype 'C' has sex with some with subtype 'A' and the two viruses then, circulating in the blood, combine in some way and suddenly some vaccine, because the infection is an 'A/C,' won't work," he said. "Or, perhaps 'A/C' is more virulent and will attack the immune system in a much more aggressive way than either 'A' or 'C' – these are theoretical possibilities."

*Asia Age, 16/07/03*

## Helping Others To Help Themselves

*Working with male sexual and reproductive health in Bangladesh*

Bandhu Social Welfare Society  
2<sup>nd</sup> National Consultation and Capacity-Building Meeting  
22<sup>nd</sup> – 25<sup>th</sup> August 2003  
Dhaka, Bangladesh  
Sponsored by USAID/FHI IMPACT, Bangladesh  
Technical Assistance by Naz Foundation International

### ABSTRACT

There is growing evidence that indicate significant levels of males who have sex with males as well as the existence of substantial numbers of male commercial sex workers in Bangladesh. With this are the high levels of sexual activity and multiple partners by many of these males, significant levels of sexual access to females by many of these males including their wives, low levels of condom use and safer sex practices, with the concomitant high risks for HIV and STI transmission from these males to their sexual partners. Further, many young males (both pre-adolescent and adolescent) are also involved in these activities. Such sexual behaviours are exacerbated by poverty, gender segregation, economic, age and gender power differentials, adult male ownership of social spaces, low levels of knowledge of STIs/HIV, and adult male sexual privileges.

At the same time male to male transmission of STIs and HIV is largely invisible because of the issues of shame which produce low levels of testing by such males, as well as the lack of anal and oral STI testing in many clinics, and further because such sexual behaviours are often denied by the males and females themselves.

Over the last seven years, Bandhu Social Welfare Society has been providing sexual health services in Dhaka, Chittagong, Syhlet, Mymensingh and Comilla, where services include educational outreach, condom promotion, counselling, community building, and drop-in services.

In November 2001, BSWs held its first National Consultation Meeting on male sexual and reproductive health, bringing together some 80 representatives from different BSWs projects across Bangladesh as well as from its own networks.

The 2<sup>nd</sup> National Consultation and Capacity-Building was an outcome of the first and continues building on the strength developed from that meeting.



### SCOPE AND PURPOSE OF THE MEETING

The Conference brought together representatives from all the BSWs projects working in the field of male sexual health issues, as well as participants from ODPUP (another male sexual health project), as well as providing access to a number of technical experts on the issues of concern.

Nine one day workshops were held during the meeting that provided capacity and skills building so as to enhance the city projects service capacity.

### OBJECTIVES OF THE MEETING

1. to discuss and develop appropriate strategies to address the sexual health needs of males who have sex with males and their sexual partners in Bangladesh.
2. to encourage the development of information sharing mechanisms and develop models of good practices in providing local culturally appropriate sexual health promotion strategies amongst males who have sex with males and their sexual partners of whatever gender identification.
3. to provide skills building workshops in a number of areas of service delivery and so enhance the capacity of individual projects.
4. to explore human rights concerns regarding males who have sex with males and develop appropriate mechanism to address these concerns.
5. to look at training needs specifically addressing issues concerning sexual health needs for males who have sex with males and the development of appropriate sexual health services.

### METHODOLOGY

Over the three days of this meeting, a series of one day training workshops and discussions were held on a range of issues of concern for the agencies and projects.

#### *Workshops*

- \* fieldwork methodologies
- \* community mobilising strategies
- \* social marketing of condoms

*continued on page 14, col. 1*

## Bandhu's 2nd National Consultation and Capacity-Building Meeting

continued from page 13, col.2

- \* developing BCC materials
- \* living with HIV/AIDS - care and support
- \* counselling
- \* female partners of MSM
- \* monitoring and evaluation
- \* writing a project proposal

These workshops were conducted through group sharing of experiences and discussions on different approaches to the issues.

Special speakers included:

Shivananda Khan, Executive Director, Naz Foundation International

Charles E. Llewellyn, Team Leader, Population, Health & Nutrition, USAID, Bangladesh

Robert Kelly, Deputy Director, FHI IMPACT, Bangladesh

Dr. Neil Squires, Senior Programme Advisor, DFID Bangladesh

Dr. Tasnim Azim, Head, HIV/AIDS Programme, ICDDR,B

Dr. Yasmin H Ahmed, Country Director, Marie Stopes Bangladesh Ltd



A Meeting report will be produced shortly. For those interested please get in touch with Bandhu Social Welfare Society directly on [bandhu@bdmail.net](mailto:bandhu@bdmail.net)

## Naz Foundation India Trust

### [Indian] Govt not to legalise homosexuality

The Centre told the Delhi High Court that homosexuality cannot be legalised in India as the society disapproves of such behaviour.

In its reply to a petition challenging the Constitutional validity of Section 377 of the Indian Penal Code (IPC), the Government said "deletion of the said section can well open the flood gates of delinquent behaviour and be construed as providing unbridled licence for the same."

According to Section 377 of IPC, whoever voluntarily has sex against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to ten years.

Naz Foundation [India Trust], an NGO working for the welfare of AIDS patients, has challenged the validity of this provision and sought to legalise homosexuality on the grounds that due to fear of police action, consenting adult males having sexual relations between them, were not coming forward to disclose it though they were more prone to HIV infection.

"Indian society by and large disapproves of homosexuality and disapproval was strong enough to justify it being treated as a criminal offence even when the adults indulge in it in private," it said citing Law Commission's 42<sup>nd</sup> report.

The Government also questioned the NGO's locus standi to approach the court on this issue, saying "no one except those whose rights are directly affected by the law can raise the question of its constitutionality". A Division Bench of the Chief Justice B C Patel and Justice A K Sikri fixed December 10 for further hearing after the

NGO sought time to prepare a rejoinder to the Government affidavit filed through its counsel Aman Lekhi.

Justifying the penal provision against homosexuality, the Centre said "the purpose of Section 377 of IPC is to provide a healthy environment in the society by criminalising unnatural sexual activities against the order of nature".

It submitted "the studies of the criminal jurisprudence of Section 377 of IPC reveal that in India it has been basically used to punish sexual abuse of children and to compliment lacunae in the rape laws. It has rarely been used to punish homosexual behaviour".

The Centre said "Law does not run separately from society. It only reflects the perception of the society. Public tolerance of different activities changes and legal categories get influenced by those changes".

"The public, notably in the UK and the USA, have shown tolerance of a new sexual behaviour or sexual preference but it is not universally accepted behaviour.... Objectively speaking, there is no such tolerance to practice of homosexuality/lesbianism in Indian society", it submitted.

Earlier, the court had taken a serious view of Centre's inability to spell out its stand on homosexuality and asked the Attorney General to give his opinion as to whether the provision of law making it a penal offence can be abolished.

The issue could not be just brushed aside on the grounds of social morality, the court observed.

*Sify News: posted by lgbt India, 8/9/03*

## Extending support: NFI providing technical assistance

Apart from providing the framework for Bandhu Social Welfare Society's 2nd National Consultation and Capacity-Building Meeting held in Dhaka this past August and the training for the Meeting facilitator's, we have been busy elsewhere.

In conjunction with Bamon Development Consultants we worked with Blue Diamond Society in Katmandu, Nepal to assist them in developing their Human Resources Manual and a Strategic

Development Plan for increasing coverage of sexual health services for MSM across Nepal. Along with this we also conducted an NFI Training of Trainers course with them as a key component for the scaling up plan.

A visit to Myanmar to review PSI Myanmar's sexual health

*continued on page 15, col, 1*

## NFI providing technical assistance

*continued from page 14, col.2*

promotion work with MSM in Yagon and Mandalay was also conducted in August. The visit has led to a series of recommendations for enhancing and extending PSI's current activities with MSM in the country with a strategy for implementing an adapted NFI service model for self-identified MSM and working with other vulnerable males.

This work is leading NFI to extend its capacity beyond South Asia into the South-East Asian region as well. Working with a couple of members of our Technical Advisory Network NFI is now developing a Concept Note to provide technical and institutional support for sexual health initiatives in that region. ARMAN (Asia Regional MSM AIDS Network) is growing.

This expansion of the area in which NFI will work in the future is integral to its plans for "upscaling" and "upstreaming" its work on providing institution and technical support for working with vulnerable male populations. We now see NFI working across Asia in ensuring that MSM have access to appropriate prevention, care and support services, where self-help organising is central in such developments.

## Terms and terminology

Recent policy reflections, concerns and fears regarding "sensitive" issues in the light of the Bush presidency in the US have led to a lot of rumours as to what language is now acceptable and what is not in the field of sexual health. These concerns have been highlighted by recent decisions by USAID and CDC in the States to cut funding of from "offending" agencies.

In this Bush universe, NFI is also exploring language, and in the light of the Indian Government's statement on homosexuality, it becomes every more pertinent.

Thus:

MSM = vulnerable male populations or

MARS - males at risk

MSM sexual health project = male reproductive and sexual health programme

Perhaps you have your own terms that you could share with us.

If so email NFI on london@nfi.net with your suggestions.

## International cost limits treatment of HIV in India

*by Julia Angwin*

Munuswamy Suresh used to be a middle-class Indian. He owned a 2,000-square foot house with three bedrooms, two bathrooms and a garage. But since last year, he has been on the verge of poverty. Mr. Suresh, his wife and his parents have been sharing a rented three bedroom, one bathroom house with two other families. He has sold his television, camera and all of the family's land and jewelry. The reason for his family's financial fall: the high cost of buying antiretroviral AIDS treatment medication to keep the one wage-earner in the family, Mr. Suresh, alive. The plight of HIV-infected Indians such as Mr. Suresh is of particular concern today, as it becomes increasingly clear that this country of about one billion people has a growing AIDS problem. Last week the Indian government disclosed that the country's number of HIV/AIDS cases had jumped 15% in 2002, raising the total number infected to 4.58 million, or about 0.5% of the population. The absolute number is!

the second highest in the world after South Africa, where an estimated 4.8 million, or 11% of the population, is infected, according to the Nelson Mandela/HSRC study released in December. Most experts say the Indian government's estimate is likely to be too conservative. In June, two researchers from the University of California, Berkeley, published a paper in the British Medical Journal saying the AIDS epidemic in India is following the same pattern as that of sub-Saharan Africa in the 1980s, with the potential to be just as devastating. The researchers, Malcolm Potts and Julia Walsh, predict that by 2010, as many as 25 million Indians could be infected with HIV. According to the World Bank, studies in Africa have shown that when more than 8% of a country's population is infected with HIV, the country loses about 0.8% GDP growth every year. Researchers are divided about the best way to address India's AIDS epidemic.

Some philanthropists, such as the Bill and Melinda Gates Foundation, are focused entirely on preventing the epidemic from spreading. The foundation has pledged to spend \$100 million in India during the next 10 years, starting with efforts to convince truck drivers to practice safe sex. The epidemic is nearing a tipping point where "there is a window of time to work on prevention before the numbers will swamp us," says Ashok Alexander, the project's director. Others say it is foolish to focus on prevention alone. "You cannot separate care and prevention," says Dr. Suniti Solomon, director of Y.R.G. Care, the private AIDS clinic that is treating Mr. Suresh. The Global Fund to fight AIDS, Tuberculosis and Malaria

has pledged to spend \$100 million for AIDS care in India, which the government says it will use to provide antiretroviral drugs for pregnant women and newborns.

Both sides agree, however, that much more needs to be done to prevent the epidemic from spiraling out of control. The Indian Health Ministry's AIDS policy division says its annual budget for prevention and treatment was just \$50 million in the fiscal year 2002-2003. And even though Indian manufacturers make cheap AIDS treatment drugs that they sell to the rest of the world, the Indian government says it can't afford to buy those drugs for its people. The generic antiretrovirals cost less than \$1 per patient per day. So, for now, India's private AIDS clinics struggle to provide treatment on an extremely limited basis. The Swiss nonprofit Francois-Xavier Bagnoud has convinced the Indian

state of Rajasthan to buy antiretroviral drugs for 10 of its 315 patients. The Naz Foundation in New Delhi provides drugs for six orphaned children and to pregnant women during their last two months.

The Freedom Foundation in Bangalore provides drugs for 120 of its 3,000 patients. "It's very difficult to choose" who will get the drugs, says Dr. Nirmula Skill, who runs the Freedom Foundation clinic. "I look at who really needs it the most: Are there people depending on them? Have they been abandoned by their family?" R. Ravi Kumar, 34, a soft-spoken man with an easy smile is one of the chosen ones. When his family discovered he was sick with HIV four years ago, they threw him out. He arrived at the Freedom Foundation clinic semi-comatose, suffering from tuberculosis. Now, the clinic pays for his medicine and he works as an attendant in the clinic. "Now I can work, I have no tiredness," he says. "If it wasn't for the drugs, I wouldn't be here today."

Even Dr. Solomon's clinic, Y.R.G. Care, in Chennai, which is among the best known and best-funded in the country with a \$773,000 annual budget, only doles out the drugs to about 10% of its more than 5,000 patients. Only pregnant mothers receive the drugs free; relatively affluent patients like Mr. Suresh can buy the drugs at a discount rate negotiated by the clinic. But Mr. Suresh will soon run out of money to pay for the drugs. When he is feeling well, he can earn 3,000 rupees a month (\$65) as an air-conditioner repairman. The medicine costs 1,600 to 2,000 rupees per month, not including the expensive viral load tests that are required every few months. So he doesn't always buy his medicine. "When I have money, I will purchase some little bits of medicine," he says. *The Wall Street Journal*, 28/7/03

## Emerging HIV-1 epidemic in China in men who have sex with men

Kyung-Hee Choi, Hui Liu, Yaqi Guo, Lei Han, Jeffrey S Mandel, George W Rutherford

China is currently undergoing a serious HIV-1 epidemic in intravenous drug users, sex workers, and former plasma donors. Little is known, however, about HIV-1 risk in Chinese men who have sex with men. In this study of seroprevalence in such men in Beijing, we recorded 15 (3.1%, 95% CI 1.8-5.1) of 481 men infected with HIV-1. Overall, 238 (49%) of participants reported unprotected anal intercourse during the previous 6 months. HIV-1 seropositivity was independently associated with being older than 39 years and having had more than 20 male sexual partners. Most men older than 39 years had been married. Our findings suggest the potential for spread of HIV-1 between men who have sex with men and to their heterosexual partners. (Lancet 2003; 361: 2125-26)

In June, 2002, the UN warned that China could face a "catastrophe [involving] unimaginable human suffering" without swift action to control the spread of HIV-1. By December, 2001, Chinese authorities reported 30736 HIV-1 infections. However, the UN estimated that by the end of 2001, between 800000 and 1.5 million were already infected, and that the number of infections could reach 10 million by 2010. Although about 75% of current HIV-1 infections are attributable to intravenous drug use and transfusion of HIV-1-infected blood and blood products, sexual transmission might become the predominant mode of HIV-1 transmission, as the virus spreads from drug users and sex workers into the general population.

Men who have sex with men in China are believed to number between 2 and 8 million, and might have an important role in spreading the HIV-1 epidemic to heterosexually active people. However, infection rates among such men are unknown. China's national HIV/AIDS sentinel surveillance is restricted to five at-risk groups: drug users, female sex workers, truck drivers, pregnant women, and patients with sexually transmitted diseases (STDs). Data are not being obtained for sexual orientation. The few studies that have been done in men who have sex with men have been restricted to estimation of the prevalence of HIV-1 risk behaviour. We have assessed both HIV-1 prevalence rates and levels of risk behaviour in such men in Beijing, the Chinese city with the largest recorded number of HIV-1 infections in these men.

From September, 2001, to January, 2002, we recruited potential study participants through informal social networks and in bars, parks, and bath-houses frequented by men who have sex with men (ie, convenience sampling). Recruiters hired from among the target population approached potential participants to determine their study eligibility, which were: age 18 years or older, same-gender sex (ie, ever had sex with another man), and residence in Beijing. Of the 501 men screened, 489 were eligible for study participation, and 482 provided oral informed consent. The study was approved by the committee for human research of the University of California, San Francisco, CA, USA and by the institutional review board, Beijing Association of STD/AIDS Prevention.

Three female health-care workers, who were trained as interviewers, administered a 20 min face-to-face standard questionnaire followed by pretest counselling and collection of oral mucosal transudate samples that were later tested for HIV-1. After specimen collection, participants were given HIV-1-prevention information and prenumbered cards showing appointment dates (usually for 1 week later) for post-test counselling. When a sample tested positive for HIV-1, participants had their blood drawn during the post-test counselling visit, and were asked to return for confirmed results on a third visit.

Oral mucosal transudate samples were obtained with the OraSure HIV-1 oral-specimen collection-device (OraSure Technologies, Bethlehem, PA, USA). All samples were tested twice for HIV-1 with an ELISA by the Beijing municipal STD clinic (Vironostika HIV-1 Microelisa System, bioMérieux Inc, Durham, NC, USA). If the

second test was positive, the serum sample was confirmed by a Western blot (Genelabs Diagnostics, Singapore).

For data analysis we calculated HIV-1 prevalence and did bivariate and multiple logistic-regression analyses to identify factors associated with HIV-1 infection. We modified multivariate models through backwards elimination that removed explanatory variables with *p* values greater than 0.20.

Of 481 participants who had sufficient oral-fluid samples for HIV-1 testing, 15 (3.1%, 95% CI 1.8-5.1) tested positive (table). Overall, 238 (49%) participants reported unprotected anal intercourse with men during the 6 months before the study, and 107 (22%) had unprotected anal or vaginal intercourse with women during the same period. Mean age was 27 years (median 25, SD 8). Multivariate analyses showed that age older than 39 years and more than 20 male sexual partners were associated with HIV-1 infection.

Our data suggest that there is low but significant HIV-1 prevalence in men who have sex with men in Beijing. However, in view of high rates of unprotected sex in such men, HIV-1 infection rates will continue to rise unless prevention measures are implemented. Our results for HIV-1 prevalence are close to those recorded in Chinese men in other high-risk populations. For example, in patients from STD clinics in Guangdong, Yunnan, and Guangxi provinces, which have the highest number of sexually transmitted cases, HIV-1 prevalences were 1.3%, 2.0%, and 2.7%, respectively.

Prevalence of infection was 4.5 times higher for men older than 39

*continued on page 17, col. 1*

### China launches 'sex website'

China has launched what is believed to be the first website aimed at giving young Chinese people advice on sexual health. The interactive service, You and Me, is supported by the United Nations and aims to encourage young people to discuss openly their sexual relations and other sexual matters. Correspondents say most Chinese people have limited access to accurate information about sex, and the government is worried about the spread of AIDS and other sexually-transmitted diseases. Leading experts on infectious diseases say China and India - the world's two most populous countries - are facing a potential AIDS disaster. China says it has at least a million people with AIDS, but the UN estimates this could reach 10 million by the end of the decade. Shared use of intravenous needles by drug users and infection through contaminated blood donations account for about three-quarters of current cases in China. The new website is supported by the non-profit organisation Marie Stopes International China (MSIC). The United Nations Population Fund (UNFPA) representative to China, Siri Tellier, said the website would also serve to "allow young people to connect with each other even across the national borders". "Although young people in general are healthier than other age groups, they have specific risks that are related to their behaviour," Ms Tellier said. Young people were now more at risk because there was "a wider gap between puberty and marriage" and "increased sexual activity outside marriage", according to Liu Liqing, the MSIC China representative. Unwanted pregnancies and unsafe abortions are also a problem the new website seeks to tackle. Early this month, the director of the US Centers for Disease Control and Prevention, Julie Gerberding, said the AIDS situation in China and India was akin to what Africa experienced a decade ago. She said: "If we don't intervene in those environments we will have a catastrophe of a very, very profound increase in the number of cases. "We are truly globalised and if one person in a country is vulnerable, every one is vulnerable. If one country is vulnerable then the world is vulnerable." *Posted by JVNet 15/7/03*

## HIV infects 3 percent of MSM in Beijing

continued from page 16, col. 2

years than in those aged 39 or younger, irrespective of number of male sexual partners in their lifetime. 293 (64%) of the older men had been married, compared with only 53 (11%) of the younger men. These findings suggest that men who have sex with men could potentially serve as a sexual bridge between high-risk men and low-risk women, and that this sexual mixing pattern might contribute to the sexual transmission of HIV-1 to heterosexually active adults. To some extent, this pattern has been seen in other Asian countries, notably India.<sup>5</sup>

Our estimates of HIV-1 prevalence might have been affected by the selection bias due to convenience sampling. Rigorous investigations with systematic sampling are needed to obtain accurate and reliable estimates of HIV-1 prevalence in Chinese men who have sex with men. Our data suggest that these men, at least in Beijing, are part of an emerging HIV-1 epidemic. Efforts are urgently needed to prevent further spread of infection both in these men and to their heterosexual partners.

### Acknowledgments

We thank Ying Liu and William Stewart for support, and Li Zhen, Fen Ding, Qin Zhang, and Ying Shao for research assistance. This research was supported by National Institute of Mental Health (NIMH grant MH42459 [Center for AIDS Prevention Studies]). The funding source had no role in the study design, data collection, data analysis, data interpretation, or writing of this report.

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### Held on gay deaths

Police have reportedly arrested a 24-year-old Chinese man wanted for murdering seven homosexuals he lured to their deaths after arranging to meet them via the internet according to local media reports yesterday in Beijing. The man, from northwestern Xinjiang province, also admitted murdering a 15-year-old classmate in 1994. The suspect reportedly told investigating authorities he had gone on a killing spree after the classmate, who had been his former lover, spurned him and left him with a broken heart.

Bangkok Post, 10/8/03

### Living well with HIV/AIDS

A manual on nutritional care and support for people living with HIV/AIDS published by FAO is available at <http://www.fao.org/DOCREP/005/Y4168E/4168E00.HTM>

*And twenty years on...*

## Policemen get AIDS awareness from those who are unaware

The protectors of society too need protection, Or so had thought the organisers of a concert to educate 6,000 policemen on HIV/AIDS

Concert For Life, held at Talkatora Stadium (New Delhi) on Wednesday night, was meant to spread awareness about the disease. But when "informed" speakers prescribe holidays, not condoms, ignorance may no longer be bliss.

Consider this: Sudhir Sharma, chairman of the Delhi Labour Welfare Board, telling the audience that AIDS is a foreign phenomenon. "Indians are so pure these foreigners will never understand our culture," he said, suggesting ingenious ways of tackling HIV/AIDS: "If the constables are given holidays, all the pressure will be taken off them. And then I promise, no disease will touch them."

Not that many would have realised how unrealistic the idea was. Constables admitted that they were unaware of the disease or its threat. Said from Bengal Police: "I and my colleagues don't know anything. We came to just watch the concert."

A constable of Central Reserve Police Force (CRPF), who is stationed at Kalkaji, said he had heard about the virus, but that was all. And considering what the speakers had to offer, others like him would have been hardly enlightened by the end.

The function opened with a performance by pianist Brian Silas with the song Woh subah kabhi to sayegi. Sreerupa Mitra Chaudhary, president of organisers Coalition for Rural Empowerment (CORE) said: "AIDS is not a disease. It is a phenomenon that makes us evaluate our culture. I request you to take our message forward to your states and battalions."

While Dennis Lazarus, deputy resident representative of United Nations Development Programme (UNDP) in India, called "HIV/AIDS everyone's concern", S. Rathore did speak about the disease and its causes.

Rathore, Joint Director of National AIDS Control Organisation (NACO), said: "The young in the defence and the paramilitary are extremely vulnerable. They belong to the age group that is most susceptible to AIDS. More than 80 per cent of the cases in India are because of unprotected sex. Until there is sex education in schools and society broadly, we cannot control the disease."

Asked what he had understood, a Delhi Police constable, said he now knew that AIDS must be contained but was not sure about the symptoms or how to take precautions.

The speeches were followed by theatrical portrayals on the agony of AIDS victims [sic]. First by Bharatnatyam exponent Geeta Chandran and her troupe followed by Komal Gandhar, a 22-member group of prostitutes and their children who have been rehabilitated.

The function came to an end with a fusion music and contemporary dance performance by Creation Group. Whatever happened to HIV/AIDS? *The Indian Express*, 6/9/03

### 'Shame' threat

Police in a town in central Vietnam have announced they will name and shame hotel customers if they are caught having affairs, having sexual encounters with prostitutes or using and dealing drugs, according to local media. Mu Hang district – the largest coastal resort town of Danang – has reported a recent rise in "social evils", said police chief Lieutenant-Colonel Tran Din Thich. "Those who are caught having illegal relations will be fined and have their name told to their employers and have their name publicised in the mass media, regardless of whether they are high ranking officials, state employees, or ordinary people," Col Thich said yesterday.

Bangkok Post, 10/8/03

## AIDS begins to widen its reach in India - disease spreading beyond high-risk groups to general population

By John Lancaster

On a packed-earth lane known as Bangaraman Temple Street, a resident leads a macabre house tour, ticking off the names of the dead and the doomed.

Here is the tiny concrete hovel where Beeraka, the tea seller, died of AIDS last Saturday, leaving behind an 8-year-old son and a wife who almost certainly is infected with the disease. Three doors down, on the opposite side, is Budavarthi, 40, a mother with HIV who lost her truck-driver husband to AIDS three years ago. Around the corner is Rekha, 28, who was infected by her late husband and transmitted the virus to her son, now 6 years old.

And coming up an alley in the arms of her aunt is Devi, a solemn 3-year-old in a patterned cotton shift. She lost both her parents to AIDS — her mother died in April — and is infected with the virus. Her aunt says the disease has prevented Devi from learning to walk.

“So many people are sick in any neighborhood,” said the tour guide, Bhavani Senapathi, 25, who works as a nurse in a nearby support center for AIDS victims. Her husband is bedridden with the disease, and she has HIV. “We have people dying every day.”

Such scenes are increasingly common in parts of India, signaling the start of the long-awaited breakout of the disease from traditional high-risk groups such as prostitutes and drug users into the general population. Infection rates still pale compared to those of sub-Saharan Africa. But AIDS experts say that is changing.

Blood-test data from pregnancy clinics, considered a reliable cross-section of society, show infection rates as high as 5 to 8 percent in some localities in southern India, according to state AIDS control agencies and independent researchers. A September 2002 report by the CIA’s National Intelligence Council predicted 20 million to 25 million AIDS cases in India by 2010, more than any other country.

“In some parts of India, particularly the states that are reporting the higher prevalence, the tipping point is long past,” Richard Feachem, executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, said in a telephone interview from Geneva. “I think there is absolutely no doubt that the virus is moving into the general population.”

Despite efforts by private charities and some government health agencies, particularly at the state level, the national response to the disease has been spotty at best, according to AIDS specialists from international donors as well as Indian and foreign nonprofit groups. They cite, among other things, resource constraints, cultural barriers to AIDS-prevention campaigns - including resistance to discussing condom use - and bureaucratic obstacles such as a federal budget rule that caps the amount foreign donors can contribute to fighting AIDS.

“There is a fairly widespread view among educated people and opinion leaders in India that HIV-AIDS is primarily an African problem and that Hindu and Muslim culture will protect India from the most serious consequences of the virus,” Feachem said.

As in other countries, “there has been a resort to the mythology of cultural immunity - it can’t happen to us because we’re different,” added Feachem, who toured the country this year on behalf of the fund, a quasi-U.N. agency that acts as a conduit for public and private funds. “I found on my visit a persistent tendency to minimize the current scale of the epidemic and the potential future growth.”

Officials from India’s Health Ministry and the National AIDS Control Organization, which coordinates federal and state prevention efforts, did not respond to repeated telephone messages and faxes seeking comment for this article.

By most reckonings, the AIDS epidemic in India is still at a relatively early stage, with an overall infection rate among adults estimated at 0.9 to 1.4 percent; the adult infection rate in the southern African nation of Botswana, by comparison, is about 35 percent.

AIDS experts warn, however, that unless more is done to arrest the spread of the disease, the window of opportunity could soon slam shut, creating a far bigger problem down the road.

The disease is already exacting a high toll. As always in India, the problem is sheer numbers: In a country with a billion people, even a 1 percent prevalence rate among adults translates into 4 million infected people, according to U.N. statistics, which means that India has more HIV carriers than any country except South Africa. Many of those lives could be prolonged with antiretroviral drugs, which cost just \$350 per year in India, far less than in the West. But even that is well beyond the reach of all but a tiny fraction of patients.

India can hardly be accused of turning a blind eye to the disease. Prime Minister Atal Bihari Vajpayee has delivered several speeches on the topic, and the government has orchestrated multiple ad campaigns promoting awareness and prevention. Here in the southeastern state of Andhra Pradesh, one of the hardest-hit areas, the state AIDS agency has been especially forthright, once inflating a giant condom outside the state legislature to dramatize its campaign.

In general, however, Indian officials have played down the threat.

For example, India’s Planning Commission, a government body that sets spending priorities for the country, says in its 2002-2007 economic plan that the disease is likely to “plateau” in 2010 and has caused “only a small reduction in expected improvement in longevity.” Government spending on AIDS has remained flat for the last several years. And government officials have reacted angrily to suggestions by outside experts that the disease is getting out of hand.

The National Intelligence Council prediction, for example, was denounced as “completely inaccurate” by Shatrughan Sinha, then the health minister. He subsequently accused Microsoft Chairman Bill Gates of “spreading panic” when Gates warned during a trip to India last fall of the potential for an AIDS explosion in the country; Gates had traveled to India to announce a \$100 million grant for fighting the disease.

As in any country, cultural attitudes have shaped the national response. Last December, the communications minister, Sushma Swaraj — a senior leader of the Hindu-nationalist Bharatiya Janata Party that heads India’s governing coalition — pulled the plug on a television campaign stressing the protective benefits of condoms; conservatives had complained that the ads encouraged promiscuity.

The ads have since been retooled to emphasize abstinence and faithfulness, in some cases avoiding any mention of condoms. One recent spot, for example, shows a village councilwoman warning other women about the dangers of AIDS and urging them to be faithful — but says nothing about how they should protect themselves if their husbands fail to follow the same advice. Swaraj, who is now the health minister, told the Times of India this month that she favors a “holistic” approach to AIDS prevention.

One significant constraint on India’s ability to marshal resources against the disease is bureaucratic.

For the most part, the government insists that money contributed by foreign donors flow through its coffers, rather than directly to private groups (it made an exception for Gates). The problem, according to officials with donor agencies, is that the Planning Commission sets annual ceilings on the amount of money - government or otherwise — that can be spent on various programs, including those related to AIDS. That puts India in the seemingly bizarre position of refusing some of the money that donors are eager to give.

“Donor commitment and available resources are greater than the plan ceilings allow,” said Tim Martineau, the senior health adviser

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## Spreading HIV

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for Britain's foreign aid agency in New Delhi. "I believe that some states could absorb more resources and that ideally resource allocations should reflect the epidemiology of the disease." Indian officials defend the system. They say it is up to them and not foreign donors to set the health care agenda in a country where AIDS is one of a number of chronic diseases — such as malaria and tuberculosis — that claim thousands of lives each year. "If the government gives free rope to one sector, then the other sectors will suffer," said N.N. Kaul, a Planning Commission spokesman. "What is the priority of the central government? What is the priority of the state government?"

"AIDS is clearly a priority in Andhra Pradesh, a coastal state where the rate of infection among prostitutes in some cities approaches 50 percent, according to a 2001 study funded by the British government. Many prostitutes have passed on the disease to their clients, who infected their wives, who infected their children. By all accounts, the state has moved aggressively to combat the disease, both through public education and more practical initiatives such as distributing free condoms to prostitutes.

"I don't go anywhere without them," said Mani Devaradi, 25,

pulling a foil package from her sari as she waited for customers at a busy intersection in the coastal city of Kakinada recently. Kasaraneni Damayanthi, who directs the state program, said in a phone interview from the state capital, Hyderabad, that as a result of such efforts, infection rates have begun to stabilize in some areas. But she added: "We need much more than what we've been getting, because the problem is really massive. It has very much gone into the general population."

That much is clear from a visit to this sweltering farming town roughly 700 miles southeast of New Delhi.

Parvathi Vorra, a somber, slender woman in a blue sari, got the virus from her husband and then passed it on to her son, 3-year-old Sunil. She knows nothing of antiretrovirals and couldn't afford them anyway. Now her husband is too ill to work, and she has taken over his job as a sweeper in a local cinema, despite fevers that sometimes last for days.

"I don't have any fear for myself," Vorra, 20, said during an interview at St. Paul's Trust, a local charity that provides her with food and medicine to treat secondary infections associated with the disease. "I only want my husband and child to be happy."

*Washington Post Foreign Service 11/06/03*

*A posting from SEA-AIDS ([sea-aids@healthdev.net](mailto:sea-aids@healthdev.net))*

## Masturbation 'cuts cancer risk'

*men could reduce their risk of developing prostate cancer through regular masturbation, researchers suggest*

They say cancer-causing chemicals could build up in the prostate if men do not ejaculate regularly.

And they say sexual intercourse may not have the same protective effect because of the possibility of contracting a sexually transmitted infection, which could increase men's cancer risk.

Australian researchers questioned over 1,000 men who had developed prostate cancer and 1,250 who had not about their sexual habits.

They found those who had ejaculated the most between the ages of 20 and 50 were the least likely to develop the cancer.

The protective effect was greatest while the men were in their 20s.

Men who ejaculated more than five times a week were a third less likely to develop prostate cancer later in life.

### Fluid

Previous research has suggested that a high number of sexual partners or a high level of sexual activity increased a man's risk of developing prostate cancer by up to 40%.

But the Australian researchers who carried out this study suggest the early work missed the protective effect of ejaculation because it focussed on sexual intercourse, with its associated risk of STIs.

Graham Giles, of the Cancer Council Victoria in Melbourne, who led the research team, told *New Scientist*: "Had we been able to remove ejaculations associated with sexual intercourse, there should have been an even stronger protective effect of ejaculations."

The researchers suggest that ejaculating may prevent carcinogens accumulating in the prostate gland.

The prostate provides a fluid into semen during ejaculation that activates sperm and prevents them sticking together.

The fluid has high concentrations of substances including potassium, zinc, fructose and citric acid, which are drawn from the bloodstream. But animal studies have shown carcinogens such as 3-methylchloranthrene, found in cigarette smoke, are also concentrated in the prostate.

### 'Flushing out'

Dr Giles said fewer ejaculations may mean the carcinogens build up.

"It's a prostatic stagnation hypothesis. The more you flush the ducts out, the less there is to hang around and damage the cells that line them."

A similar connection has been found between breast cancer and breastfeeding, where lactating appeared to "flush out" carcinogens, reduce a woman's risk of the disease, *New Scientist* reports.

Another theory put forward by the researchers is that ejaculation may induce prostate glands to mature fully, making them less susceptible to carcinogens.

Dr Chris Hiley, head of policy and research at the UK's Prostate Cancer Charity, told *BBC News Online*: "This is a plausible theory.

She added: "In the same way the human papillomavirus has been linked to cervical cancer, there is a suggestion that bits of prostate cancer may be related to a sexually transmitted infection earlier in life."

Anthony Smith, deputy director of the Australian Research Centre in Sex, Health and Society at La Trobe University in Melbourne, said the research could affect the kind of lifestyle advice doctors give to patients.

"Masturbation is part of people's sexual repertoire.

"If these findings hold up, then it's perfectly reasonable that men should be encouraged to masturbate," he said.

*BBC News, 16/07/03*

## No condom ads please, we're eating

Vietnam has banned television and radio from airing advertisements for condoms, sanitary pads and other products at dinner time.

Advertisements for such products are "unaesthetic and unsuitable to Vietnamese psychology and traditional customs", said a statement issued this week by the Ministry of Culture and Information, which is in charge of censorship.

The ban, effective immediately, also covers advertisements for toilet paper and drugs to treat skin diseases.

There was no word why the ban was to be in operation only from 6 p.m. to 8 p.m., but that is peak viewing time and also the time most people in the country eat dinner.

"This is a sensible thing to do, it is unappetising to see these ads at dinner," said Tran Huyen Trang, a businesswoman in Hanoi.

*Posted by JVNet, 23/7/03*

## Loving men

*The changing face of marriage, manhood and masculinity*  
by Dalip Daswani

*Neither a lofty degree of intelligence  
nor imagination go to the making of genius.  
Love, love, love, that is the soul of genius.  
Wolfgang Amadeus Mozart*

*Zen is to have the heart and soul of a little child.*  
Takuan

Times are a-changing. Today we have the "Metrosexual Male". Not just the softer, gentler man (in spite of all the body building). But the more androgynous male proud of his 'feminine' side – shopping for sarongs and spouting jewellery and sindoor - things that men have adorned their bodies with for hundreds of years. The difference being that now, queer fashion designers are making this into a libidinous fashion statement. Maybe that is why some like Anil Thakraney (article in Sunday Midday dated 28 Aug 2003), suspect this to be part of a "brilliant gay conspiracy" hatched by "twisted" queers to "multiply our tribe exponentially".

The bigotry of Mr. Thakraney and his ilk aside, today we also find youngsters, more and more questioning traditional Family Values and the institution of marriage itself changing shape. A few months back I performed a play the central theme of which was marrying oneself. Last month there was a front-page article on a woman who exchanged marriage vows with herself on her 40<sup>th</sup> birthday. "And why not?" As for conventional marriage, well heterosexual divorce is fast becoming a parallel existence together with the nuclear and traditional family, even in small town India.

Of the divorced men I know, ranging in age from the mid thirties to the early fifties, some have made it good. Symbols of wealth occupy much of the physical and emotional space in their homes. No wonder they speak about feeling suffocated. These men wear an expression of having been wronged. They are lonely, but will never say so. That would be unmanly.

Others amongst these divorced men, collect mental data banks on all kinds of aspects of life. Many date heavily, sometimes several simultaneously; adept in their conspiracy. They make good gigolos but rather consider themselves to be gentlemen. Their intellectual prowess has answers to everything. Why a failed marriage? Well the woman of course and they will give you a foolproof, finely honed argument on that.

Where there are sons, of whatever age, involved in these broken marriages, the men seem to feel a strong need to be the primary guardians and providers. This desire to protect their sons from the whims of their ex-wife and other evils being in some way a salvation against the blemish of divorce on their manhood.

When listening to some of these men I come out feeling hollow and empty. They are arrogant, self-righteous, terrified of intimacy, and of loving again, if they ever loved in the first place.

How different is it in the 'differentness' of the world of homosexual men? We pride in being able to wear our emotions on our sleeve, falling in and out of love as often as we change our underwear. But are we really shorn of the masks all men are so practised at wearing? Do we model our relationships any different to the heterosexually-based romantic notion of monogamy and coupledness? Are we any less terrified of the demands that true love makes? I'm not talking about lust, bedroom antics and "erotic peccadilloes" – what we so often confuse love with. And, are we any less 'divorced' from our inner selves than the divorced men I describe earlier?

At the Masculinity Workshop conducted at the NFI Conference in April this year, it was significant that we all - queer men: gays, homosexuals, kothis, queens, etc. – unanimously saw ourselves as men. Not as effeminate or 'feminine' men; nor as lesser than men.

But men. We learnt to see and understand how masculinity was a socially, culturally and religiously defined construct. That normative masculinity was essentially defined by a set of socially sanctioned behaviours, and that the 'normal man' was merely a commonly accepted role for the male by a majority. That there is no one 'proforma' for the masculine, or the feminine for that matter. But rather a range of masculinities and femininities which are contextualised performances, or roles, specific not to a biological sex, but rather to the context.

The Masculinity Workshop concluded with all participants beginning to see how we queer men must seek out those positive attributes that we, each of us, has, and focus on these, building upon them towards a personal sense of growth and achievement, at the same time taking personal responsibility and "ownership" for our own lives and relationships.

In this connection, I share here a set of truths offered by Franklin Abbott, a poet, author, activist and psychotherapist from an article of his.

**The right and need to defend the gains we have already won legally, socially, spiritually and personally.**

We, who live as homosexuals, are survivors. But do we want to simply survive or do we want to be able to do more? The greater openness that we enjoy today, the number of groups we have, are thanks in large part to those who have risked so much to challenge the status quo. Every step forward has been hard-earned by a very few for the many. How can we each, at our own pace, contribute to this growing 'freedom'?

**Our human right to love whom and how we please so long as we bring no harm to another.**

We owe it to ourselves to go beyond the singular model presented by the straight world over thousands of years, which is progressively proving to work less and less. Being homosexual is so much more than sexual orientation. We fail to understand this, and trap ourselves into a vicious pattern hunting for bigger, harder and more, rather than working to affirm and celebrate our ability to expand our loving spirit beyond convention and stereotypes.

**The need to honour and embrace our unique position in human society; to give ourselves credit for the beauty and balance we bring to the world.**

Franklin Abbott says it most succinctly: "Genetic altruism has put 5 to 10% of all men on the outside of the procreative imperative. Nothing we are sexually drawn to do, will co-create another human being. Nature was smart enough to create a group who, since childless, could direct their energies in other ways. As gay men our contributions to the arts, to healing and teaching, to social change and ecological well-being must be seen by us as connected with our being homosexual. For that is where truly our 'differentness' lies.

**Our ongoing right to participate in the larger society as equals and form alliances with those who share our desires for liberation.**

Our 'twilight ghetos' only increase our own sense of alienation. There are many who share our experience with prejudice. They may not all be homosexual but they are our supporters. Some of them may still be conditioned by homophobia. But is that not true for many of us in the queer world as well? Are not so many of us biased about married gay men, queens, man-boy love, etc. How many of us are free of racist, sexist attitudes and other forms of prejudice?

**Our need for separate space**

"A space where we may become more vulnerable and wise with each other and experience the awe of what our daring to love one another makes manifest."

**Our right to grief**

We all, queer men, suffer tremendous losses along the way: dreams, careers, family, a sense of safety, security, touch. It is important to grieve.

**Our right to growth**

It is important to grieve but not to give up hope by hardening our

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## Loving men

*continued from page 20, col. 2*

hearts or dimming our wits to chronic self abuse or fear. We have got to move on and open ourselves to each other's healing love and to the exuberance of nature and life.

I recently read Antoine de Saint-Exupery's "The Little Prince". It's a story I would recommend every queer person to read. I posted a copy to my current 'boyfriend'. We celebrated - no shared - a first 'anniversary' in July. I have never been more ardent than I have in my wooing of this young man. We spent one night together in my hotel room; me under the blanket, he above it. We spent a night together on the same berth on an overnight train journey. The next morning he said I make a nice bean-bag. My past 'sleep-buddies' always likened me to a soft dunlop mattress. On the last night I spent in his home, he re-joined the two single beds in his bedroom. Was it an invitation? I don't think so. I was rather touched by this gesture of trust. I have been asking him for a kiss and I received one some days ago... by email: "Keep It Simple Stupid... is my kiss to you my friend. with love.....". (K.I.S.S. being the acronym for the First Principle in "Rich Dad Poor Dad" which he is currently reading). It is also the first time he used the word love with me. We have not made love and, most likely we never will. But we are loving every day. In recent months I have let go of him and grieved only to find the feeling in my heart stronger, the love in my soul ever more joyous. It is a love I do not understand, for it is so very different from the times before,

and there have been many times before. I asked him once "Why do I love you so much?" He had no answer but I got one the very next morning in the newspaper. There were two quotes that caught my eye:

***If you have a friend worth loving, Love him. Yes, and let him know that you love him, ere life's evening tinge his brow with sunset glow. Why should good words never be said of a friend till he is dead?***

*Daniel W. Hoyt*

***What is a friend but a single soul in two bodies.***  
*Aristotle*

This love is a gift from the Gods to the Little Prince inside of me. I am not responsible for this love, but, I know I am fully accountable for what I do with it. My friend is straight; I am gay. And how does it matter... really? For I am loving again, a man, who is loving me, in his own way, in his own time... I experience the ecstasy of 'making love' with him whenever I need to, without it being necessary that I sleep with him. It is a beautiful relationship bringing me joy and energy, pain and humility too.

*Dalip Daswani, potter, ceramic artist and designer, amateur actor, director and writer may be contacted at ddalip@vsnl.net*

## Open Closet: as more liberal attitudes sweep across Bengal, gays and lesbians no longer need to mask their sexuality

*By Labonita Ghosh*

A few years ago when Kolkata-based dance outfit Sapphire Creations staged *Alien Flower*, a ballet about homosexual love, they had a pretty bad time. Posters for the play were torn to pieces by angry protesters and organisers at the auditorium where the ballet was being performed insisted Sapphire take down their "provocative" banner. Troupe leader Sudarshan Chakraborty had to endure threat calls at home for weeks. "There was nothing provocative about the posters or the banner," he says, "It was simply the tag line—Celebrate Your Sexuality—that seemed to have bothered people. We had not used the words homosexual or same-sex love anywhere in our publicity material." Last week, when he finally reprised it, Chakraborty deliberately added a teaser: an onstage, lip-to-lip kiss between two of the male protagonists. This time, there wasn't a murmur from the audience.

Sapphire members say they felt emboldened by the new consciousness sweeping Bengal, where lesbians and gays have begun to find greater acceptance. Now a sudden burst of activity among the state's gay community is forcing a change in the way they were looked upon till now. Last month, Kolkata's first-ever gay march commemorated Pride Week along with the rest of the world. As over 100 homosexual men and women took to the streets, the state Government which would have normally frowned on such events, gave them unprecedented police protection. On June 2 Sappho, the only lesbian group in the state, organised a meet on 'Gender and Sexuality' where controversial topics like sexual orientation and femininity were discussed in detail. The participants included members of the state human rights commission, writers, playwrights and other 'moral guardians' of society. In September the professor of a well-known north Kolkata college (he doesn't want to be named till the work is finished) will come out with a 'potentially explosive' study on gay identity in Bengali literature, particularly in the works of Rabindranath Tagore and poet Jibananda Das.

How come this sudden acceptance? According to Rafiqueel Haque Dowiah of Integration Society which organised the Pride March, while earlier generations in the gay community mainly focused on issues of health, the younger lot are expressing their sexuality through cultural events and human rights assertions. Last week, when Xpose organised a play about two men in love a much publicised event, there were no protests outside the auditorium about the explicit dialogues.

Another group, Pratyay is now drafting a play named Brihannala, a modern-day take-off on the Mahabharata episode where Arjun spent a year in drag. Recently eight Kolkata-based groups who work with male sex workers formed Manas Bengal, a forum for transgender men in the state. "The new boldness might make Kolkata overtake Mumbai as the country's gay capital," says Dowjah.

The numbers are certainly swelling. A 2002 study in Kolkata showed that there were over 5,000 MSM (Men who have Sex with Men) who could be contacted any time. The number of gay-support groups has also gone up to about 10 in the state, from three in 1999. And this is not just an urban phenomenon.

Amazingly, the districts of Hooghly and Lalpaiguri have their own network of gay associations under two very active clubs at the district headquarters - Amite in Chandannagar and Mitju in Siliguri.

In 2000, after an article was published in the local newspapers, Integration received over 1,800 letters from men all over Bengal wanting to become part of the homosexual rights movement. Integration has now set up eight support groups outside Kolkata to organise programmes and monthly meetings for the "still-closeted" homosexuals, Sappho, which operates a telephone helpline two days a week, says it receives as many as 70 phone calls in two hours, and about 25 per cent of these are from women in mofussil towns, All sure signs that the homosexual rights movement has taken deep roots in the state. *India Today*, 11/08/2003

# Risk of HIV/AIDS follows some migrants home

Zofeen Ebrahim

"I call him my failure," Dr Ashraf Memon said of Mohammad Wali, "because even after seven years we have not been able to persuade him to bring his family for testing."

Wali (not his real name) is 32 and has AIDS, for which he has been consulting Dr Memon, of Karachi's Sindh AIDS Control Programme, since 1996.

That was the year Wali's world began to fall apart. He was just 25, had a job in Dubai, the United Arab Emirates, in a pipe fabrication unit, and looked forward to meeting his two young children and wife. Then he was found to be HIV-positive and deported.

"I just can't brace myself to tell my wife that I have AIDS," said the thin, forlorn young man who complained of suffering from "bouts of stomach problems, body aches and fever".

Ironically, his wife is a teacher who has also done a nursing course and, admitted Wali, "she very well knows what AIDS is".

Economic migration, particularly to regions like the Persian Gulf, has long been an attraction for the young and ambitious in Pakistan.

Yet the repatriation of much-needed foreign exchange from the Gulf countries to Pakistan also conceals the risks being borne by families at home and their earning members abroad.

As a study conducted by the Ministry of Health and the United Nations Programme on HIV/AIDS (UNAIDS) concluded, "a substantial number of the reported HIV infections in Pakistan have occurred among men who have worked in other countries".

In January 2003, there were over 3.1 million Pakistanis officially documented as working abroad, according to the Overseas Pakistanis Foundation (OPF). The number includes both skilled and unskilled labour, technicians and professionals.

"The very people who are most likely to become infected with HIV/AIDS in Pakistan are the younger members of society, the group that represents economically the most productive segment of the country's population," said the Ministry-UNAIDS report, which was released in 2000.

For Pakistani migrants, factors like the unfamiliar setting, loneliness, isolation, possessing a disposable income and the freedom of being away from home and family can and do contribute to engaging in high-risk behaviour.

Mohammad Nazir is only too aware of the risks, for he ran them and suffered the consequences. He had worked in Jeddah, Saudi Arabia, for eight years as a bookbinder. "I had the skill and was at the right place at the right time" he recalled. "Things could not have been better. For the first time in my life I had enough to spend even after sending a major chunk to my parents."

Until the day he fell unconscious and was taken to the hospital. The doctors, he said, told Nazir he had "tuberculosis of the brain" and he was deported, still bewildered about what he was told had happened to him. "When I arrived here I discovered why I was sent home," he said.

That was 18 months ago, and at home in the northern Pakistani city of Lahore, Nazir struggles every day with the treacherous turn his life has taken, for he is only 28. He talked about wanting to learn the Koran. "When problems weigh you down, turning to religion provides you with solace and comfort," he added sagely.

Nazir calls his time in Jeddah "an expensive adventure". He acknowledges his own faults, but also blames the society he left and has now returned to. With the help of New Light AIDS Control and Awareness Group, a non-governmental organisation (NGO) that spreads awareness of the issues confronted by people living with AIDS, he now holds group sessions in his hometown.

"It's not easy as people don't want to accept that it can happen to them," explained Nazir. "Most of them dismiss me completely by saying extramarital sex does not happen in our society. But when I tell them I'm from the same society, it hits home and they begin to listen. That is when I tell them about other modes of transmission and how

to prevent contracting HIV."

Nazir did not return to Pakistan as composed as he is now. "I came back loaded with problems," he said. "I was so troubled I wanted to commit suicide. I still have the skill, but no money. When you suddenly find yourself with so much money and the freedom of being away from home, you lose perspective."

According to Mushtaq Ahmed, general manager (for Sindh) of the OPF, around 80 to 90 percent of HIV/AIDS cases involve high-risk behaviour by migrant workers.

"It is imperative that host countries pitch in if we are to control the spread of HIV/AIDS further. By and large, when the illiterate migrant is sent back because of having contracted HIV/AIDS, he has no idea that it is. He then becomes a carrier and comes home and unknowingly spreads it within his family."

Ahmed believes the migrant should be allowed to continue work in the host country, as the condition does not lead to debilitating illnesses in the early stages of infection. "Once the host country decides there is no choice other than sending the migrant home, he should be counselled and told how he can prevent its spread further," he said.

Dr Farrukh M Ansari, senior programme officer at UNAIDS, wants to see more interaction with NGOs working in the health sector in the host countries. "If we can train people from NGOs to become counsellors and to hold one-to-one pre-departure briefings for migrants, we can overcome some of the problems."

Ahmed of OPF however pointed out that from his experience he finds "such briefing sessions are not very useful".

The trauma of sudden departure, he said, makes it difficult for the migrant to attend such a session, and even were he to, the interaction with a technical person in a language that is not native would only add to the sense of hopelessness and despair.

Source : <http://www.ipsnews.net/interna.asp?idnews=19881>  
Posted by Sea-AIDS, 8/9/03

To often AIDS prevention programmes believe that distributing condoms and education materials amongst "at risk groups" will prevent the spread of HIV/AIDS. If this were true no one would be smoking!

Six primary conditions need to co-exist in order to empower risk reduction.

- The power to change
- The desire to change
- The will to change
- The skill to change
- The knowledge to change
- The social context to change

Sexual behaviours are not isolated individual events. They occur between persons with differing psychosocial frameworks and histories and embedded within specific sociosexual contexts.

A personal and social enabling environment needs to exist for sustainable behaviour change to occur and such change.

## AIDS in India could become as dire as in Africa

By Sarah Yang

The epidemic of HIV/AIDS in India is following the same pattern as that of sub-Saharan Africa in the 1980s, and it could become just as devastating unless preventive action is taken now, according to researchers from the University of California, Berkeley, in a paper to be published Saturday (June 21) in the *British Medical Journal*.

"In hindsight, opportunities were missed to stem the explosive growth of AIDS in Africa," says Dr. Malcolm Potts, professor of population and family planning at UC Berkeley's School of Public Health and lead author of the paper. "It would be a tragedy if we don't apply the lessons learned from the failure to control the spread of HIV in Africa to the current situation in India. It is very painful to watch history repeating itself."

According to the Joint United Nations Programme on HIV/AIDS, 20 percent of people over 15 in some sub-Saharan African countries are HIV-positive, and 70 percent of them will eventually die from AIDS.

Recent estimates indicate the HIV prevalence rate in India, which has a population of 1 billion people, is less than 1 percent, but the low rate belies the looming pandemic on the horizon, according to the paper's authors.

Part of the change comes from the shifting demographics of India over the past few decades. Like in Africa, large numbers of men in rural areas are migrating to the cities for work and being exposed to changing cultural values, the researchers say.

"Certain sexual practices that were inhibited in a village suddenly become easier with the anonymity that comes with living in a large city," says Potts. "Men also start earning more money, so they have disposable income. And because the ratio of men to women is so low, the men spend their money on prostitutes, which contributes to the spread of HIV."

A report from the CIA's National Intelligence Council projects that the number of people infected with HIV in India will jump to 20-25 million by 2010. There is already evidence that, in some parts of India, HIV infection is moving from the core high-risk groups of prostitutes and intravenous drug users into the general population, the researchers say.

"In sub-Saharan Africa, not enough resources went towards effective prevention programs in these core high-risk groups," says Potts. "The situation in India today parallels that of Africa 15 years ago."

The authors are part of the Bay Area International Group (BIG), a family planning and reproductive health research group at UC Berkeley. Based upon an extensive literature review, original economic analyses and personal experience working in the fields of HIV prevention and international finance, the researchers concluded that current efforts to target high-risk groups in prevention programs fall far short of what is needed.

The paper notes that the public health expenditures for both India and sub-Saharan Africa fall below 6 percent of the gross domestic product. "Both India and Africa face similar challenges in that a large proportion of the population lives in poverty, and limited resources are available to help them," says Dr. Julia Walsh, UC Berkeley adjunct professor of maternal and child health, co-author of the paper, and a co-director of BIG. "In India, the government spends a total of \$12 per year per person on health care. Per capita, you're lucky if you get \$1 per year spent on AIDS."

"Investment in AIDS prevention has been a story of too little, too late," says Potts. "The U.S. earmarked a mere \$35 million globally for AIDS prevention in the mid-1980s. If we had had \$200 million dedicated to AIDS prevention in Africa in the 1980s, the region would not be in the shape it is in now."

With limited resources, it becomes even more important to use

AIDS funds wisely, the researchers said. Yet, scarce funds are being wasted on a large number of small AIDS prevention pilot projects that cannot be scaled to the larger population and on large scientific meetings that have become "platforms for non-evidence based lobbying" rather than a forum for an exchange of ideas and collaborations, the authors say.

Moreover, funding for prevention efforts is in direct competition with funding for anti-retroviral (ARV) drugs. The researchers found that 60 percent of \$378 million in grants from the Global Fund to Fight AIDS, Tuberculosis, and Malaria went towards HIV projects, and that 21 of 28 countries receiving those grants will use the money to purchase ARV drugs.

"With the exception of preventing mother-to-child transmission during birth, ARVs are difficult to use and are expensive in developing nations, even when drug companies greatly reduce the price," says Walsh. "The most compelling lobbyists for extending ARV treatment to poor countries are infected individuals in rich countries. But evidence shows that focusing efforts on prevention rather than drug treatment can avert more infections and deaths from AIDS in developing nations."

Another mistake made in the early years of the AIDS epidemic in Africa was the failure to act quickly on scientific evidence that sexually transmitted diseases (STDs) contribute to the spread of HIV by widely distributing condoms and subsidizing the use of antibiotics.

"We know these work, we just have to do it," says Walsh. "Developing programs that helped those at highest risk for HIV transmission means dealing with groups that are marginalised in society: the prostitutes, IV drug users and men who have sex with men. There is still a traditional culture in India, but political leaders must be willing to acknowledge the need to commit more resources to these core groups if they are to slow the spread of HIV."

Evidence also has led the authors to recommend programs run by faith-based organizations, such as those in the Islamic, Christian and Hindu religions, that encourage sexual abstinence and a reduction in the number of sexual partners.

Another avenue of prevention advocated by the researchers is for HIV prevention programs to offer circumcision to Hindu men, who are generally not circumcised. This is based upon increasingly strong evidence that uncircumcised men are at significantly higher risk of becoming infected from an HIV-positive partner compared with circumcised men.

"We have a moral obligation to use the lessons learned from Africa to prevent a similarly catastrophic spread of HIV in India," says Walsh. "This involves coordinated efforts from national governments, large agencies and donor groups. To do anything less is unethical."

The Fred H. Bixby Endowment, the Bill and Melinda Gates Foundation and the William and Flora Hewlett Foundation provided funding for this research.

posted by AIDS-India egroup 24/6/03

You start from where people are at, however they define themselves and whatever significance they give to their sexual acts, whether they see this as integral to who they perceive themselves to be, or whether it is *maasti*.

Imposing labels, identities, beliefs upon those we work with just disempowers them in their own voyage of self-discovery and opportunities for change.

## The attention of the international community is being diverted from the hard work of primary prevention

By P J Feldblum, M J Welsh and M J Steiner

The 2002 international AIDS conference highlighted tremendous clamour for antiretroviral therapy, while little attention was paid to primary prevention by behavioural intervention. The international community seems diverted from the hard work of primary prevention, but progress on treatment access must not come at the expense of prevention by behaviour change, including condom promotion. Condoms are effective for HIV prevention. Targeted condom programmes can be extremely cost effective. The provision of condoms to those most in need remains hindered by multiple hurdles, including provider bias, ready physical access, and myth/rumour. Still, hopes for better access to HIV treatment in the future cannot divert us from the prevention needs of the present. We urge donors to do more now to learn how best to promote condoms as part of a package of comprehensive primary HIV prevention through behaviour change.

About 3.5 million new HIV infections occurred world wide in 2001. The number of HIV infected people in Africa has approximately doubled since 1996. How should we assign priorities in our response to the pandemic? At the 2002 international AIDS conference in Barcelona, the greatest clamour was for antiretroviral therapy (ART); the loudest advocacy was that lack of access to ART in resource poor settings must change. Little attention was paid to primary prevention by behavioural intervention. Using the CD Rom of all conference abstracts we found that a mere 3% of the presentations focused on condoms and interventions (searching for the terms "condom" and "intervention"), whereas 15% of the presentations focused on ART (using the terms "antiretroviral therapy" or "HAART"). While the life saving benefit of ART is undeniable and treatment is an essential element of comprehensive HIV/AIDS programmes, we are concerned that the attention of the international community is being diverted from the hard work of primary prevention. Progress on treatment access must not come at the expense of prevention by means of behaviour change, including condom promotion.

### Condoms work

As documented by solid epidemiological studies, condoms are effective for HIV prevention. Consistent condom use by HIV serodiscordant couples results in near zero transmission rates to the seronegative partner. Condom manufacturing and packaging processes have improved to the point that the initial quality of most devices is no longer questioned. Moreover, population level data from Thailand show the magnitude of health impact that can be achieved with targeted condom programming. During 1989–93, when reported condom use increased from 14% to 94% of commercial sex acts, cases of five STIs in men fell 79%. Reductions in HIV incidence and prevalence in Uganda have resulted from a suite of behavioural changes including partner reduction, delayed onset of intercourse in youth, and increased condom use, all of which have moved in salutary directions. Similar changes seem to be under way in Zambia. Some high risk groups in Asian countries, including Cambodian military and policemen and Indian truckers and factory workers, report fewer partners and more condom use during the past 5 years. Although it takes more than distributing condoms to reduce HIV incidence, and the relative contributions of different kinds of behaviour change cannot be assigned precisely, condom promotion has been a critical component of all population level HIV success stories to date.

### Condoms are cost effective

Condom distribution programmes can operate on a fairly large scale in resource poor environments with affordable programme costs, as attested by the widely reported successes of social marketing of condoms around the world. Population Services International (PSI), one of the world's largest and most successful condom social marketing programmes with over 330 million devices sold in 2001,

reports that the cost per condom sold in sub-Saharan Africa is less than US\$0.12, including procurement, promotion, distribution, and overheads (John Berman, personal communication of 1997–2001 PSI sales data, 2002). Furthermore, condom programmes targeted at high risk people can be particularly cost effective. On the basis of disability adjusted life years, a combination of condom distribution and STD treatment for sex workers has been shown by mathematical modelling to be two orders of magnitude more cost effective than ART. Distribution of plastic female condoms, more costly than latex male devices, also appears to be a relatively inexpensive intervention. Condom cost effectiveness holds even at the current lower cost of generic ART drugs of about US\$1 per person per day.

### Obstacles to condom use persist

Unfortunately, the provision of condoms to those most in need is hindered by several continued hurdles. On the supply side, bias against condoms and negative attitudes towards STI clients can be widespread among healthcare providers themselves, which serves to limit access during clinical contacts. In a simulated client study of men presenting with urethral discharge in pharmacies in Accra, Ghana, only 6% were counselled to use condoms.

Secondly, physical access to condoms remains a key impediment in many places. It is estimated that two thirds of the world's population has ready and easy access to condoms. But that sort of gross geographic treatment ignores gaps in availability at important delivery points. For example, in western Kenya clients of sex workers indicated they do not have access to condoms in the places where sexual encounters are arranged. In KwaZulu-Natal, South Africa, condoms were not available at half of the non-clinical outlets pharmacies, groceries, bars, truck stops checked. A review of survey data from eight African countries found that non-availability of condoms at the time of sex is one of the main reasons for non-use. Unfortunately, not nearly enough condoms reach that region, hardest hit by HIV. The number of condoms procured by leading donors has diminished over the past 5 years, and was no greater in 2000 than it was in 1990.

Thirdly, these supply-side hindrances are compounded on the demand side by stigma, myth, and rumour surrounding condoms, ultimately resulting in low uptake and inconsistent use in many areas. Researchers repeatedly hear that condoms are ineffective; laden with holes; laced with pathogens; liable to become stuck in women; and cause promiscuity. Overall, too few coital episodes with a risk of STI transmission are protected by condoms. The best way to attack these problems is still unclear, given conflicting research results from behavioural interventions that are in any event so intensive as to be irrelevant to the problems of developing countries.

### Conclusions

Promoting condoms is undeniably difficult, yet hopes for better access to HIV treatment in the future cannot divert us from the prevention needs of the present. Vast numbers of adolescents and young adults enter the sexual and reproductive arena annually. Condoms are efficacious and, broadly speaking, currently available. We can and must make rapid progress on the fundamental necessity for making condoms readily available when and where people need them. Reaching men with effective condom promotion messages is key in communities where sexual decision making is male dominated. High risk groups must remain a key target in nascent, concentrated, or generalised epidemics, even as we make strides to eliminate barriers to use in the general population. To strike a better balance between prevention and treatment, we urge donors to do more now to learn how best to promote condom use as part of a package of comprehensive primary HIV prevention through behaviour change. *Sex Transm Infect* 2003; 79:268-269, BMJ Publishing Group Ltd.

## “Recent herpes simplex virus type 2 infection and the risk of Human Immunodeficiency Virus Type 1 acquisition in India”

By Steven J. Reynolds; Arun R. Risbud; Mary E. Shepherd; Jonathan M. Zenilman, Ronald S. Brookmeyer, Ramesh S. Paranjape, Anand D. Divekar; Raman R. Gangakhedkar; Manisha V. Ghate; Robert C. Bollinger; Sanjay M. Mehendale

Herpes simplex virus type 2 (HSV-2) infection is the most common cause of genital ulcer disease in both developed and developing countries. A clear relationship has been established between genital herpes and HIV acquisition, but almost all studies have evaluated prevalent genital herpes infection. In the current study, researchers assessed the impact of prevalent and incident HSV-2 infection on the acquisition of HIV-1. HIV-1-seronegative patients attending three referral STD clinics and a reproductive tract infection clinic were enrolled in a prospective study of HIV infection in Pune, India, from May 1993 through April 2000. The study population represented a mix of male patients with STDs, female partners of male STD patients, female commercial sex workers, and women with reproductive tract infections.

Of 2,732 persons enrolled, 2,260 were male, 9 were hijra (eunuchs), and 463 were female; 1,175 participants (43 percent) had HSV-2 antibodies. Median duration of follow-up was 10.7 months, and the median number of follow-up visits was three. During the study, 217 participants seroconverted to HSV-2 positive, resulting in a crude HSV-2 incidence rate of 11.4 cases/100 person-years. Risk factors for HSV-2 in the unadjusted analysis included earlier calendar period of follow-up (1993-1996), younger age, female sex worker, lower education level, living away from family, lack of condom use, genital lesion at the current or a previous visit, and coincident HIV-1 infection. Independent predictors of incident HSV-2 infection included the presence of a genital lesion at a previous clinic visit, a current visit, and both visits. When the group of male STD patients was used as a reference in the multivariate model, hijras and female sex workers had significantly higher HSV-2 incidence rates.

The unadjusted rate ratio of HIV acquisition among participants exposed to prevalent HSV-2 infection was 2.07. Of

the 224 participants with incident HIV-1 infection, 28 were found to have both incident HSV-2 infection and incident HIV-1 infection during the follow-up period. For the majority (n=22), serologic evidence of these two infections was detected simultaneously. The unadjusted rate ratio of HIV-1 acquisition among participants exposed to remote incident HSV-2 infection was found to be 2.08; among participants exposed to recent incident HSV-2 infection, the rate ratio was 6.26. The adjusted HR of HIV-1 acquisition increased with relative timing of HSV-2 infection, from 1.67 among those exposed to prevalent HSV-2 infection to 1.92 among those exposed to remote incident HSV-1. Exposure to recent incident HSV-2 infection conferred a 3.81-fold increased hazard of HIV-1 acquisition. Of the 217 incident HSV-2-infected participants, 51 (23.5 percent) had a genital lesion documented at the same visit at which seroconversion was demonstrated. A presence of asymptomatic HSV-2 infection (no clinically apparent or self-reported genital ulcer) conferred an adjusted HR for HIV-1 infection of 2.14. Symptomatic prevalent HSV-2 infection conferred an adjusted HR of 5.06.

“Individuals with serologic evidence of recent incident HSV-2 infection in our study had the highest HIV-1 incidence (adjusted HR, 3.55) when the analysis was controlled for other sexual risk behaviors, which illustrates that incident infection with this common sexually transmitted virus is independently associated with HIV-1 acquisition,” the authors concluded. “...The elevated risk of HIV-1 acquisition... provides a strong argument for the prioritization of HSV-2 vaccine development and other HSV-2 prevention strategies as key components of the current global HIV prevention research agenda.”

*Journal of Infectious Diseases (05.15.03) Vol. 187; No. 10: P. 1513-1521; Posted by Saathii on 11/06/03*

## Rise of Internet Fuels Fears of AIDS Resurgence

Today in Atlanta, two new studies presented at the 2003 National HIV Prevention Conference noted that online chatrooms and Web sites are replacing gay bathhouses and sex clubs as the most popular meeting points for arranging high-risk sex. The findings come amid growing evidence of an apparent resurgence of HIV and syphilis in men who have sex with men. New HIV diagnoses among gay and bisexual men have jumped more than 17 percent since 1999, CDC reported this week.

“It’s clear we need to reach gay and bisexual men with appropriate messages, not only in traditional high-risk settings but also online,” said Dr. Ron Valdiserri, deputy director of CDC’s National Center for HIV, STD and TB Prevention.

A California Department of Health Services survey showed 23 percent of gay and bisexual men with syphilis admitting having met sexual partners on the Internet. Twenty-one percent had met partners in bathhouses.

A study by the Center for AIDS Prevention Studies at the University of California-San Francisco interviewed gay and bisexual males online. Thirty-nine percent of the interview subjects admitted having unprotected anal sex with someone they had met on the Internet during the previous two months.

And yet, the Internet can also be a tool to deliver HIV prevention and safe sex messages to high-risk groups. AIDS experts have reported success raising HIV and STD prevention issues with gay and

bisexual males online, using banner ads, one-on-one outreach sessions and chatroom discussions on Web sites.

Educators say the anonymity of the Internet allows them to address issues some might feel reluctant to discuss in clinics. They also cite a need to increase HIV awareness among minority groups and teenagers.

Research presented at the conference showed about 20 percent of blacks and Latinos were unaware that antiretroviral drugs had revolutionized the AIDS fight since the early 1990s. “Information about these treatments must be communicated more effectively....” said Valerie Mills, associate administrator for HIV/AIDS at the Substance Abuse and Mental Health Services Administration.

*SAATHI posting 01/08/03*

### FIGHT AGAINST

DENIAL  
IGNORANCE  
PREJUDICE  
INVISIBILITY  
STIGMATISATION  
HARASSMENT  
VIOLENCE  
SOCIAL EXCLUSION  
MARGINALISATION

# Community groups step in where the Indian government fears to tread

by Nicole Rajani

## An Urgent Need for Risk Reduction Among MSM

Homosexual relations in India are largely hidden, and men who have sex with men remain at high risk for HIV infection. A remnant of British colonial law, Section 377 of the Indian Penal Code, bans homosexual behavior. Though rarely applied except when minors are involved, Section 377 and other prohibitions against obscenity and "public nuisance" are a source of blackmail and harassment of men who have sex with men (MSM). India's National AIDS Control Organisation only recently acknowledged the high prevalence of homosexual activity in India and the urgent need for HIV prevention programs targeting MSM. The national response is lagging behind a few innovative programs initiated by community-based organizations.

Focusing on Mumbai's Underground Culture In 1990, Ashok Row Kavi decided to start the first openly gay publication, Bombay Dost. The first issue of the magazine was on the stands the following year. The publication spread rapidly through the gay network and had a snowball effect. After three years, Kavi and others decided to use the subscription base of the magazine to convene a conference on the status of Indian men who have sex with men.

Kavi registered the Humsafar Trust in 1994 as one of the first nongovernmental organizations working with the men who have sex with men. The organization first set up a community center. "There were cruising places all over the city, but this could be a nonthreatening place, where you could talk about and be what you wanted," said Kavi. The center started Friday workshops to discuss healthcare, beauty and other lifestyle issues. Drop-ins could raise their own issues, too. The workshops grew from an initial attendance of just four people to an average of 100 people every week.

Humsafar quickly became a major MSM resource and research center. It received a government grant in 1998 to survey MSM activity in the city – the first such grant to an openly gay organization.

Kavi recalled, "We insisted that men having sex with men, and self-identified gay men, would really be a huge radiation zone for HIV and STDs. For a very obvious reason, this type of sex is not called sex, and it is free in many cases." His group created a diagram grouping MSM based on behavior and vulnerability.

"The reason we deconstructed this is for public health reasons," Kavi explained. "Public health officials have never believed that there are so many men having sex with men. So what we've done is deconstructed it, so then it becomes visible. That's the way we've increased credibility with the government."

In 1999, Humsafar received a National AIDS Control Organisation grant for a pilot project to promote safer sex among men who have sex with men in the Mumbai metropolitan area. It selected six MSM sites and began urging a reduction in sexual partners, greater condom use and healthier behavior overall. Humsafar also conducted an epidemiological survey and found an HIV prevalence of 13%.

Funding for Humsafar's work continued for the next three years. In 2002, the organization reported that the proportion of MSM using condoms had risen from 43% to 83%. Humsafar's peer outreach program distributed 600,000 condoms to nearly 58,000 MSM in 2002. The average number of sex partners among MSM had gone from 11 to six per year by 2002. More men were requesting HIV tests and their overall health-seeking behavior had improved, Humsafar also noted.

Kavi estimates that there are about 350,000 MSM in Mumbai. Although sex among men has always occurred in Indian society, he points to the scarcity of women as a prime reason for contemporary increases in homosexual relations. "Even if men wanted to have sex with women, they couldn't.... There's a falling gender ratio," he said. India's 2001 national census found that the number of girls

under six declined from 945 for every 1,000 boys in 1991 to 927 girls for every 1,000 boys. According to UNICEF, there are 50 million "missing" females in India, mainly due to modern ultrasound technology that allows parents to learn the sex of their babies early in pregnancy. They can fulfill the customary desire to have sons by aborting female fetuses.

The shrinking female population has also affected Humsafar's work with the community. Kavi claims that 20% to 25% of "bar girls" are actually boys in drag. "They're more vulnerable because the women in bars usually have local pimps; they are well guarded; the gatekeepers are in place. But there's no such thing for the boys. There's no protection, and there's a lot of sexual violence."

Humsafar targets this vulnerable population by going to local bars, talking with the boys about HIV/AIDS and giving out condoms. Once the boys feel comfortable and gain confidence, they start visiting the center.

Kavi explained, "When a woman takes to sex work, she may be a mother, she may be brilliant, she may have a Ph.D. in literature, but her primary identity is always as a prostitute – that's what she becomes, that's the label given to her. But a male sex worker can hide under many labels. He can be a model, masseur.... It's very interesting how with these groups, you have to pass various barriers and stigmas to get at what they really do."

Humsafar has been highly successful in attracting MSM to its voluntary counseling and testing center, where it has tested 28,000. Their follow-up rate is 65%, which Kavi claims is one of the highest, even better than at traditional STD clinics. "Basically it comes from the idea of a safe space; when people feel safe, they will come in." Besides pre- and post-test counseling, Humsafar offers support services for people living with HIV/AIDS. The group focuses on traditional health and nutrition approaches. Kavi is known as a "Hindu revivalist" for his promotion of time-honored alternative treatments.

Kavi said, "We have a separate nutrition department because we refuse to take part in any HIV treatment till we are promised sustainability, and not before.... If I get in, I must be able to sustain it." Care and support programs concentrate on more basic needs like potable drinking water. They distribute 70 to 80 bottles of water a day to transgenders and male sex workers, many of whom live in huts near train stations. The dietary program includes utilizing proteins to their maximum benefit – such as mixing soy and wheat flour to make chapatis (Indian flat breads) more nutritious – and eating only fruit in the morning to remove toxins from the body.

"We're having amazing results. They're gaining weight without any recourse except to keep away opportunistic infections and managing their diet," Kavi said. "We have a tradition of 3,000 years. I don't say all of it is good...but I'm not throwing out the baby with the bathwater. In the next three years...when we sign the [World Trade Organization patent] agreement, even simple antidiarrhea drugs are going to cost 10 times as much. Where are you going to get the money?"

The organization also has founded the Humsafar Parivar Credit Society, which will eventually be used to provide staff members and others with anti-HIV treatment. It has already raised 200,000 Rupees (\$4,200) as core capital and will approach funding agencies for matching grants.

Humsafar has negotiated with the Indian generic drug manufacturer Cipla. It managed to bring down the monthly cost of HIV treatment to 1,340 Rupees (\$28). Including tests, the total monthly cost will be 1,500 Rupees (\$32). Patients will pay half this amount, with the credit society covering the remainder.

Kavi described Humsafar's approach to public healthcare: "The vision statement of Humsafar Trust is that we will not replicate anything that is already there in the public health system. Our job is to increase the capacity of the public health system and demand as citizens that they understand our problems."

An important component of the program is sensitizing healthcare providers in the public sector. Humsafar is contacting public healthcare staff and strengthening the personnel's ability to care and treat MSM with HIV and other STDs. For example, it conducted training at Sion Hospital in north Mumbai to advise doctors on how to ask questions about MSM activity. MSM contact tracing increased from 2% to 23% within a year.

Finally, Humsafar advocates for MSM rights and sensitizing the police to the needs of MSM. Lawyers give educational workshops every three months to MSM about their rights. Humsafar also holds regular workshops at police stations. If it hears that a particular station is very repressive, it arranges a meeting with the top authorities. Kavi said, "Among policemen, we demand that these rights are given to everybody. We agree that sex in public places is wrong, but we make them understand that that's the only place that allows gay men to be with other gay men."

### Recognizing Sexual Diversity in Tamil Nadu

Diagonally across the subcontinent in Tamil Nadu's capital, Chennai (Madras), the organization Sahodaran has also made significant efforts to safeguard the health and well being of MSM. Sunil Menon and Lalitha Kumaramangalam started the organization in 1998. Kumaramangalam had been running programs for other marginalized communities, such as truck drivers and slum-dwellers, and realized the dire need to spread HIV awareness to the MSM community. Self-identified gay men had begun to form more vocal communities in the major urban centers, but homosexual activity remained largely underground, and there was little knowledge of the vast scope of MSM behavior in India. Menon received a World Health Organization grant in 1992 to research homosexual behavior. He recalled that when he presented his findings to India's National AIDS Control Organisation, "they were really shocked; suddenly I was talking about MSM activity that transcended barriers of identity, behavior patterns. It was very shocking and disturbing for certain people."

Menon says that the variety of MSM behavior in India is vast and presents a range of challenges for HIV prevention programs. "MSM have not been studied properly in India – they have not been understood. The few groups that exist have been working in small urban areas, around the big metropolises, and that's not enough – from an HIV standpoint that's not enough. The scope of their work is limited to upper-middle class, English-speaking, educated, literate, economically independent male adults who know exactly what it means to be 'gay.' They identify with the word."

Sahodaran aims to reach out to those who may not fall into this category, including the many Indian men who engage in homosexual as well as heterosexual activity, and those who feel the strong sociocultural pressure to get married. Some of the men who come to Sahodaran are married, and they have formed their own peer group.

Sahodaran targets MSM behavior rather than solely gay-identified or homosexual men. "We work with the more visible, feminized males, who are called kothis. But that's a very small group and is the tip of the iceberg," said Menon. Many men could "go either way" and are neutral in appearance; they are neither markedly feminine nor masculine. There are also the panthis – the heterosexual men who seek out men because they have no access to women.

Menon observed that aside from the artificially skewed sex ratio, the strong emphasis on marriage and premarital virginity greatly increases the likelihood that many nominally heterosexual men will engage in homosexual activity. He said, "You have to get married to have sex with women, or you have to pay for it. Even if the men have girlfriends, their girlfriends are hanging onto their virginity till they get married – because God forbid this boyfriend doesn't marry her, and she's not a virgin, she'll get hell from her [future] husband. MSM

activity is easier, more practical; it's quicker and cheaper – and you can do it in any corner or dark alley. That's why there's so much MSM activity happening."

Sahodaran's outreach field officers work in 14 major "cruising areas" for MSM, including parks, beaches and railway stations throughout Chennai. Each field officer covers a particular area and has two assistants, who are locals. The assistants know the people in the area and introduce them to the field officer, who offers counseling, HIV/AIDS information and condoms. The field officers document their work and the following day report on how many people they met, which category they were (kothi, panthi, etc.), what they spoke about, how the men responded, and how many condoms and information pamphlets they handed out. "With the new people we meet in the field, we give them our cards, and ask them to come over to the center, we tell them there's a safe space for you," said field officer Anto James.

Sahodaran's drop-in center has 30 to 40 MSM coming in every day for counseling, healthcare referral and information, as well as other activities, like yoga, cooking and dance. They also have literacy classes, in Tamil and English, as well as income-generation activities like candle making and pottery. "Some are shy to come at first. But once they come in here, they are satisfied. They see people like themselves," said James. "They can't be very open in the house, with their neighbors, and their straight friends, but here they are very happy. They're much more open about their identity."

### Finding Validation in Religious Tradition

For two weeks each year in April-May, the festival at the Koothandavar temple in the southern Tamil Nadu village Koovagam draws thousands of transgenders and MSM from all over India. According to Hindu mythology, the warrior Aravanan had to be sacrificed in order for the Pandavas to win the Mahabharata war. Aravanan agreed, but he did not want to die a virgin. He asked to wed prior to the sacrifice, but no father would allow his daughter to lose her virginity for a one-night marriage. Taking pity on Aravanan, the Lord Krishna assumed the female form of Mohini and wed the warrior before his death.

Many of the transgendered and cross-dressing festival participants come in honor of Mohini, with whom they identify. They tie a string on their wrists to symbolize their marriage to Aravanan, and the next day, the string is pulled off to signify their widowhood.

Other male attendees believe they are fulfilling the role of Aravanan. Menon said, "There is a lot of MSM sexual activity [at the festival], and it's part of the mythology. So we've been doing a lot of prevention work around that because there's a lot of unprotected sex there."

The transgenders, or hijras, who dominate the Koothandavar festival are considered a "third gender" and have long held a place in Hindu religion as dancers and singers. While some hijras are born hermaphrodites, the vast majority are biological males who have been castrated in religious ceremonies. Traditionally, they were believed empowered by the mother goddess to either bless or curse others. Hijras accordingly collect money at weddings and births. In the past, they were commonly greeted with respect, but now they often arouse annoyance and scorn. They live on the fringes of society in their own communities and have increasingly resorted to commercial sex work to make a living.

Sahodaran's main MSM clientele in the cities, the feminine kothis, strongly identify with hijra lifestyle and culture even though they are not hijras themselves. The hijras embody a tradition that Indian MSM adapt when defining their identity. Menon noted, "We all borrow heavily from the hijra, the transgender community. Our language and most of our rituals are borrowed from, similar to, or part of the transgender community." As India faces its AIDS epidemic, learning that language and ritual will be critical to reducing MSM's vulnerability.

Source: amfAR;

Posted by SAATHII Electronic Newsletter, 30/06/03

## Sexual abuse in madrasas

Seventeen-year-old Abid Khan Tanoli is a tragic figure as he sits all alone in the Patel Hospital in Karachi. At least 50 per cent of his body is covered with acid burns. He has lost his eyesight and his face is completely disfigured for life.

Young Abid's ordeal began last year when he refused to have sex with his teacher, Qari Amin, in a Karachi madrasa (a school for Islamic instruction). The teacher had been harassing him for quite long. "He threatened to ruin me for life," narrates Abid, "but I didn't take him seriously. I stopped going to the school instead. I didn't tell anyone because I was ashamed."

A few days later, Abid was playing with his younger siblings at home, when Amin, accompanied by three men, broke into his house and threw acid over his body. "This should be a lesson for life," Amin told Abid.

"I was unable to see anything," recalls Abid. "My whole face was burning. I felt as if I was on fire.

"It would have been better if they had just killed my son," says 40-year-old Resham Jan, Abid's mother. "I cannot believe he has been reduced to such a sorry state."

Though the incident took place in 2002, it was only in July 2003 that it came to light when Abid's family approached some NGOs for support.

This is the first time that a local religious leader has been accused of sexual violence, though there have been many instances of sexual assault and rape of children and adolescents in Pakistan. According to a report compiled by Madadgaar, a joint project of Lawyers for Human Rights and Legal Aid (LHRLA) and UNICEF, over 1,615 cases of violence against children were reported in the national and vernacular press in Pakistan in the year 2002. Out of these, 340 children were raped, 287 were sodomised and 53 children were murdered after being sexually abused, stated the report.

According to a 2002 survey by the Ministry of Interior Affairs, Pakistan has 15,000 madrasas in which two million students, mostly

boys, seek religious education. "Sexual abuse of children is always a major issue in segregated societies all over the world, and the hundreds and thousands of religious schools which exist in Pakistan are no exception," believes Manzoor Baloch, a local sociologist.

The president of LHRLA, Zia Ahmed Awan, says that though there are several instances of child abuse in madrasas, they are hushed up or sorted out within the confines of the school. Sometimes parents are pressurised not to report them to the media, as it would give religion a bad name.

Abid's father, Mohammed Abid Tanoli, a cab driver, was also asked to keep quiet when he took up his son's case with the clergy. He was threatened when he refused to back down. "I despise hypocrites who sport huge beards in the name of religion and hinder the passage of justice in the name of Islam," says Tanoli.

Abid's attackers even forced the local hospital, to which he had been rushed immediately after the acid attack, to discharge the boy before his treatment had been completed. Tanoli then contacted local human rights organisations and managed to get his son admitted to a private hospital where he is now being treated free of charge. He also reported the case to Mominabad police station. He was offered Rps 500,000 (\$8300 US) as bribe if he were to withdraw the case. But Tanoli was determined to get justice for his son. The police finally arrested Amin and two of his associates. But the trial continues and so does the pressure on Abid's family

*(The Kathmandu Post, 28/7/03)*

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