



Shivananda Khan, founder and Chief Executive of Naz Foundation International with his Order of the British Empire medal, awarded for his work with MSM in South Asia, standing in the inner quadrangle of Buckingham Palace, after he was invested by his Royal Highness, The Prince of Wales on June 8th, 2005.

Shivanand stated that "this award is not only for me, but also for all those who are working so hard towards ensuring that all males who have sex with males have access to appropriate HIV/AIDS services."

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

Vision

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

Mission

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

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

Naz Foundation International's Ethical Policy

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

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

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

Pukaar

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

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

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

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Hard Choices: rationing antiretroviral therapy for HIV/AIDS in Africa

Sydney Rosen, Ian Sanne, Alzanne Collier, Jonathan L Simon
The Lancet 31/12/04 (online), forwarded by Laurent De Danois

As the world intensified its fight against the global AIDS epidemic, African countries have begun to develop large scale and prevention and treatment programmes. A combination of funds from Africa governments and international donors are paying for drugs, diagnostics, clinic and laboratory infrastructure, and medical personnel.

Although these funds, which reach into the billions of dollars,¹ will pay for antiretroviral therapy for many thousands of HIV-positive Africans, there is almost no chance the African countries will have the human, infrastructural, or financial resources to treat everyone who is in need, at least in the early years. The numbers of patients targeted for treatment are ambitious, but they are only a small fraction of those who are eligible for antiretroviral drugs on even the most conservative medical grounds. In Zambia, for example, the first year target for treatment is 10,000 patients; 100,000 Zambians have already reached the clinical threshold of a CD4 count below 200, and thousands more become eligible each year.² Ghana is targeting 12,000 patients for therapy in the first two years³ - 58,000 are believed to be medically eligible now.⁴ Kenya's target is 50% coverage,⁵ as is the global target of WHO's 3x5 initiative.¹

Economists call any policy or practice that restricts consumption of goods a rationing system.⁶ As used by economists, rationing is value-neutral, i.e., it does not imply intent to deprive people of a good resource, but rather describes the allocation of scarce resource. In the market place, rationing is based on price. Non-market goods, such as free medical care, are rationed in other ways. Ambitious targets for treatment of HIV/AIDS still represent only a few of those in need; therefore, the rationing of treatment services is inevitable. Rationing of antiretroviral therapy for HIV/AIDS will be necessary as long as demand exceeds supply.

What are the options?

The most accepted criterion for rationing antiretroviral therapy is disease progression. WHO guidelines and many national guidelines in Africa call for treating only patient with a CD4 count below 200, or an AIDS-defining illness.⁷ These criteria affects demand dramatically: researchers doing a study in South Africa found that if treatment programmes applied the guidelines of the US Department of Health and Human Services, which call for starting treatment at a CD4 count of 350 rather than WHO guidelines, the proportion of HIV-positive people eligible for therapy would increase from 9.5% to 56.3%.⁸

Even if health-care providers use WHO's conservative guidelines for when treatment should begin, medical criteria alone will not avert the need to ration antiretroviral therapy. Socioeconomic criteria will also be needed. In some countries, government will set explicit criteria for who will be eligible for antiretroviral therapy first or at lower cost. In other countries, implicit rationing systems will arise. To help to clarify the differences among the various rationing strategies that might be adopted, we have defined four general types of systems. Two are explicit and two are implicit.

Some policies and programmes use explicit socioeconomic criteria to define the populations that have priority. The most widely adopted example of a programme that explicitly targets specific population is MCTC-Plus, a programme that makes antiretroviral therapy preferentially available to HIV-positive mothers of new infants to stop mother-to-child transmission.⁹ Skilled workers also could be targeted, because they produce goods and services and generate economic growth. Governments can preserve human capital by giving treatment priority to doctors, nurses, teachers, judges, police

officers, or postsecondary students, among others. Kenya, for example, has indicated that it will target health-care workers.¹⁰ Some programmes priorities poor people for treatment because they have the lowest probability of being able to afford private medical care, and many people believe poor people should have preferential access to publicly funded programmes.¹¹

Governments can also make rules for access that explicitly favour certain individuals or groups, without specifying particular socioeconomic target populations. One obvious way to ration treatment is to restrict it to those who live in specified geographic areas. These targeted areas can be distributed equitably throughout the country, concentrated in regions with high rates of HIV infection, or sited in urban centres of politically important regions. Another way to ration treatment is to require patients to make co-payments. If programmes require patients to contribute even a small share of the cost of the payment, the number of people with access to therapy probably will fall dramatically.⁵

Other conditions limit access implicitly. For a patient to have access to treatment, he or she must be identified as HIV-positive and medically eligible, have the means to reach a treatment site, be seen by a health-care professional, and received the prescribed medications within a period that is both medically and economically feasible. Programmes can limit access at each step in this process. If HIV test or CD4 counts are not available

In a particular area, it will curtail demand for treatment. For some patients, transport costs pose an insurmountable obstacle. Most facilities probably will treat everyone who is medically eligible on a first-come, first-served basis until they run out of drugs or expertise. Patients who arrive after that happens might be asked to return later, sent to another facility, or simply sent away. Other patients will wait in a queue outside the clinic or pharmacy door. Patients will not get treatment if their jobs, child-care responsibilities, or other obligations prevent them from waiting the hours or days needed to reach the front of the queue.

All the rationing systems mentioned above results from formal policies, rules, or procedures. Rationing can also be based on informal, and often illicit, arrangements that favour specific groups or individual implicitly. In countries where enforcement of rules tends to be weak and informal arrangements common, members of the social, economic, or political elite who believe they need therapy will get it. A high degree of queue jumping, which allows certain groups or individuals to move to the front of the treatment line, should be anticipated. Black markets for antiretroviral drugs,¹² which allows low price medications to be resold at higher prices to those who can afford them, have already been reported in Zimbabwe, "Swaziland,"¹³ and other countries.

Evaluation of the systems

Different ways to ration antiretroviral therapy will have different social and economic consequences for African populations. Understanding these outcomes is important if the decisions made about resource allocation and programme design are to help a nation accomplish its goals for fighting HIV/AIDS and sustaining economic development. We have identified seven criteria for assessment of rationing systems and we provide an example of how each criterion might be applied.

First, does the rationing system produce a high rate of successfully treated patients? Requiring patient copayment could improve medical effectiveness by favouring highly motivated,

continued on page 4, col.1

Rationing of ARVs

continued from page 3, col. 2

and therefore adherent, patients. Investigators in Botswana, however, report that patients most commonly stop therapy because they cannot afford the copayment.¹⁴ Second is the cost per patient treated low, compared with other approaches? Queuing is an inexpensive rationing strategy from the perspective of the public-health system, but it imposes a substantial opportunity cost on patients in the form of waiting time. Third, are the human and infrastructural resources needed to implement the programme available? If programmes limit the number of sites at which they deliver treatment, they will use expertise, distribution systems, and laboratory capacity efficiently; however, providing access only to patients who live within the site's designated catchment area might not be feasible because of the administrative and ethical difficulties of excluding patients who live elsewhere.

Fourth, to what extent does the system of distributing treatment reduce the long-term effects of the HIV epidemic on economic development? Preferentially treating skilled workers, for example, strongly supports the preservation of human capital—the accumulated, skill, knowledge, and expertise of workers¹⁵ — whereas queuing favours those whose time has the least economic value—ie, the unemployed.

Fifth, do all medically eligible patients have equal access to treatment? A rationing strategy that targets mothers, such as MTCT-plus, is generally supported by those who favour a social-justice definition of equity, which argues for preferential access for poor or disadvantaged subpopulations. But under a narrower definition of equal access, MTCT-plus is highly inequitable because it excludes all men and the woman who are not currently bearing children. Sixth, can the system be sustained? Targeting poor people is an attractive strategy while donor funding lasts, but it could become an unaffordable luxury when donor support ebbs. Last to what extent does treatment reduce the rate of HIV infection? Preferentially targeting core transmitters, such as sex workers or truck drivers, might have the greatest effect on HIV infection rates.

There is no single rationing system, or combination of systems, that will be optimum for everyone. Other criteria could be considered. African societies will place different weights on the values inherent in goals, such as equity and efficiency. Rationing systems that are efficient—targeting skilled workers, for example—are generally inequitable. Those that seem equitable, such as first-come, first-served, are highly inefficient. Hard choices are unavoidable.

Who will decide?

Decisions about rationing will be made at many levels of society. International funding agencies express their priorities through the amounts and conditions of their grants. Legislation might govern the allocation of resources at the national level. Ministries of health, local department of health, and managers of treatment facilities will all create guidelines. Once a facility becomes a treatment site, the frontline health-care professionals who work there—doctors, nurses, and counsellors—will be forced to ration access according to their clinic's criteria or even their own.¹⁶

At each level, politicians, interest groups, influential individuals, and patients will bring pressure. At each decision-making level, it will be easier to use implicit systems of rationing than to make and enforce hard choices.

Because access to antiretroviral drugs is a matter of life or death for AIDS patients, choices about rationing systems matter deeply. African governments can ration deliberately, on the basis of explicit criteria, or they can allow implicit rationing to prevail. Without analysis and debate about public policy, people will make arbitrary decisions about access to treatment, and implicit rationing will foster both inequity and inefficiency. We believe the governments that make deliberate choices about rationing antiretroviral therapy, and then explain and defend those choices to their constituencies, are more

likely to sustain economic development and social cohesion and secure a socially desirable return from the large investments now being made.

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Sexual health:

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

Source: WHO Draft working definition, October 2002

Trafficking of boys

Sunil Pant

Blue Diamond Society, Kathmandu, Nepal

After seven years of Divya Thapa, Meta (Feminine Male) had not only brought himself/herself to the Blue Diamond Society but along with him he had brought his devastating story of torture and deception.

He began working at a very early age at a guesthouse cum restaurant called Deurali in Pokhara, his hometown in Nepal, from his early teenage. He had two brothers, a mother and a father to support. While working at the restaurant he befriended a guy named Manoj Thapa Magar, about 30-32 years old and who said he was from Butwal, made him an offer he couldn't resist. Manoj asked him if he wanted to earn more money and when Ditya answered yes to this, Manoj said that there was more money working in India's restaurants. He said that he knew a few people there in Mumbai who could give Ditya a job. Ditya willingly agreed to go and earn more money so that he can help his family and himself. Manoj lived few years in Mumbai before he started working in Pokhara.

They went together to Mumbai and Ditya was taken to a Haveli (a brothel run by Maharani, another name for traditional Hijra brothel owner) called Rani Haveli in Mumbai's Kumatipura. There Manoj told Divya that Divya can live and eat there while he worked and earn a lot of money. He left Ditya and went out of the room saying he'll be back in a while. Ditya waited and waited for Manoj to come back but in vain because Manoj never came back, instead later late night the Maharani (Brothel's owner) came to him and said that Divya can work there and that his friend Manoj had already left. Ditya had no idea of what the days to come were going to be like.

Divya was then forcefully taught to wear different dresses including sarees, jewelries and he got vigorous training in how to walk and talk like a girl. If he made a mistake he was beaten severely. Then they taught him how to beg for money, which is a common trait in India for the hijara (castrated males). He was tortured everyday by the owner who brought more than 20-25 clients a day who had forced sex with Ditya. They didn't even agree to wear condoms; according to Ditya there are about 50-60 Nepali *Metas* only in that *Haveli* since they are in demand and many more in Mumbai. She said that the brothel also has Indian *Metas* (known as *Kothis* in India) and other both Indian and Nepali women who are forced into trafficking. After a while Ditya was sent with a few other hijaras wearing sarees to beg in different houses and even on the train. Divya said that it was really humiliating since he'd rather earn a hard days' work than beg.

Divya said that on the days that he couldn't bring much money Maharani didn't give him any food so he had to go to bed hungry. If he even made one small mistake he was beaten severely, he has scars, burnt marks, and stitches of these atrocities. After working there for two years the brothel owners tried to castrate him forcefully since most of the males brought there, eventually, are castrated but when Divya forcefully denied, they circumcised him since the brothel owner, Maharani, was a Muslim, saying it's a Muslim brothel Divya had to become Muslim. The clients who seemed to be from high class to the middle class were never good to Divya and other *Metis*, they always made sure that they brutalized *metis*.

According to Divya, they had a monthly health checkup and if anyone were found to be HIV positive they were kicked out of the brothel with no money. Ditya said that a lot of Nepali and Indian *Metas* kicked out after they were found HIV+ and he also says that there are a lot other Neplais with similar fate who are in India. He said he knows about few more other brothel, which also has 50-60 Nepali *metis* in each.

After he had been there for two years his father and his brother who found out about his whereabouts from Divya's one client who also happened to be from his home town, Pokhara. That was the only time he found out that he had been sold when the owner of the brothel asked them for IRs. 80,000 (about US\$ 2000) if they were to take him back. His father and brother were threatened and they had no other

choice but to leave. Maharani also told his father and his brother that their son had already been castrated and if they took him back he'll bring shame to the whole family.

Finally one day after seven years of every day's torment and torture Ditya heard about Blue Diamond Society through TV and newspapers. He had never thought about escaping because he feared that nobody in Nepal will support him but when he saw that there was indeed an organization in Nepal for people like him his courage grew and he knew that support will be there. One day on a usual routine of begging he escaped with the help of two other hijaras of India. He collected some money from begging and got on the train and came to Nepal.

His first destination was his home but when he got there he found out that he hadn't been able to keep his words given to his father of coming to see him because his father had already passed away. After few days staying in Pokhara with mother he left for Blue Diamond Society to Kathmandu as it was getting increasingly difficult for him to stay longer with the family as the society already talking about him and his other relatives also disowned him.

Now BDS is working at his rehabilitation and making sure that everyone knows that it's not just the girls who are sold but the males and boys too. We are trying to make sure that the culprit is caught and punished. There are still a lot of others in India who are still suffering from everyday torture and we hope to bring justice to all of them and pray that we can do that soon. We also will try to catch the network of these PIPMS here in Nepal and the brothels owner in India, who are selling not only women but also males in large scale. We will be working with organization working cross boarder to reduce the Human Trafficking.

We are very concern and denounce all kind of human trafficking and call government and all other parties to work together to stop human trafficking whether its girls, women, boys or males.



On the Nepali New Year's Eve night of April 13th, following a celebration by Blue Diamond Society, the local MSM HIV/AIDS project, local police in Kathmandu beat up some *metis* who were on walking towards Thamel from the BDS office. Using batons, gun butts and sticks, one *meti* (see above) was also threatened at gun point, beaten in thr stomach, and when he fell down was kicked all over. Nine *metis* were beaten that evening.

This type of systemic violence not only happens in Nepal. They happen in Bangladesh, India, and Pakistan as well. When the dominant masculinity is outraged by femininity, when recourse to justice is not seen as a priority issue, and when *metis*, *kothis*, *zenanas*, and *hijras* are disempowered and silenced, how can we speak of social justice and HIV/AIDS prevention, and an empowering environment?

Amid the shadows, Pakistan's third sex faces HIV threat

On a sultry summer's night, men crowd into a tent on the edge of Lahore's red light district. They silently eyeball the slinking female figure on stage before them. She flirts, pouts and bats an eyelid, rolling her hips and running a suggestive finger across the lips.

But beneath the tottering heels, smeared mascara and sequinned shalwar kameez the curvaceous woman is, biologically speaking, a man.

She is a hijra, part of south Asia's ancient and secretive community of transsexuals, hermaphrodites and eunuchs. Once influential in the Moghul Empire's courts -, serving royalty or commanding legions of soldiers - the "third sex" now live in the shadows of Pakistani society, as dancers, beggars or sex workers.

The enigmatic group emerges during the summer fair season. Some dance at mafia-run fairgrounds with blaring Punjabi music and illicit gambling dens. Others work the "wall of death" whirling around as a motor-bike roars around them and men shower them with money.

Now they are faced with a very real prospect of death.

Although HIV levels in Pakistan are low - an estimated 100,000 of its 150 million people are infected, compared with about 5 million in neighbouring India - experts warn that hijra are part of a small but high-risk group that could trigger an "explosive" rise in the disease.

A new survey by Family Health International (FHI) has uncovered a concentrated epidemic among drug addicts, one quarter of whom tested HIV-positive in Karachi.

Just 2% of hijra were infected. But the prevalence of sexually transmitted disease - some 60% have syphilis - woeful public health systems and ignorance about AIDS "give warning of serious HIV epidemic potential in Pakistan," claims the study.

Interactions between high-risk groups compound the danger. Addicts frequently buy sex from female sex workers and hijra, who in turn sleep with truckers and married men. "The hijra infection rate is low for now, but the risk is high," said Naseer Nizamani of FHI. "And it could easily spread into the general population."

Ambiguous attitudes to the hijra complicate the struggle.

Many Pakistanis believe the hijra possess supernatural powers. Parents pay them to bless their newborn sons - fearing they may otherwise be cursed - or hire them as wedding dancers. But they are also scorned, taunted by homophobes and victimised - and sometimes raped - by police.

"Our parents disown us, our friends desert us and it is impossible to find a partner for life," mourned Madame Henna, a cigarette-twirling hijra at a brothel in the Hira Mundi red light district.

The close-knit community has its own language, laws and leaders. Some hijras have links with organised crime.

Hijras who first emerged in 12 century Muslim courts, remain loyal to Islam and worship at dedicated hijra shrines. They have a tradition of burying their dead secretly, under the cover of darkness.

But secrecy carries a cost. FHI found that more than 40% of hijra had never heard of HIV and only 9% use condoms. "Nobody wants to use one," said Gori Shermi, a 30-year-old hijra peer educator.

Mr Shermi works for the AIDS Prevention Association of Pakistan, one of a handful of small NGOs working with hijra. Volunteer workers build links by offering gifts, said its director, Muhammad Ranif. "Only then they will listen to us," he said.

Stigmatisation started under the British Raj, which passed the first laws against "sodomites". Today the practice of forced castration has faded and most hijra are transsexuals. Many are sponsored by "husbands" - married men leading double lives torn between family and a homosexual relationship.

In India, hijra have starred in Bollywood films and contested local council elections. But mullahs and other powerful conservatives hold sway in Pakistan.

Inside the dancing tent the thrusting hijra paused her act as the wail of a mullah started from a nearby mosque.

"This will be the last song for now," announced a crackling voice on a loudspeaker. "Then we will take a break for evening prayer." *The Guardian*, 9/6/05

Gay rights in Pakistan

Sitting on a bench in the shade of the cool palms of Lahore's Lawrence Gardens, Tariq thought carefully over what to say next. For years he had kept his sexuality a secret, knowing all too well the risk of revealing himself as gay.

"My life is a lie and I know it," the 24-year-old fine arts student told IRIN. "But this is the reality of Pakistan and this is the reality I have to live."

For thousands of gay people in Pakistan today, that reality is repeated again and again. The idea of 'coming out' has never been an option for him, Tariq stressed. Like most people interviewed by IRIN, he declined to use his real name. Part of the 'lie' is living up to family and societal norms, with Tariq himself conceding he has recently agreed to a marriage arranged by his family.

Living with denial

With denial as their constant companion, gay Pakistanis live in constant fear of being 'outed' in this staunchly conservative society, which is largely ignorant and intolerant of sexual minorities. The vast majority of gay people just do what is expected of them and remain quietly in the shadows, a way of life common throughout this South Asian nation of 140 million. To act in any way effeminately is a sign of weakness and a blemish on one's own masculinity in this most 'macho' of societies. To be gay is to be deviant, an aberration against God's will which gay men in Pakistan go to great lengths to disguise.

Gay men living in the larger cities such as Lahore, Karachi or the capital, Islamabad, fare slightly better in the mildly more tolerant

atmosphere of urban areas. Here they enjoy higher levels of education and many hold well paid professional jobs. Those living in impoverished rural areas remain closeted together fearing the extreme conservatism of their villages.

"I live in two worlds," Umjad, a 28-year-old marketing executive for a major multi-national, told IRIN at a friend's upscale apartment in Karachi's Clifton Beach area. "Sometimes I feel like a Hollywood actor. I'm always trying to balance both lives." In an effort to do just that, each week Umjad and his friends gather informally at a friend's house in what undoubtedly is their only chance to be themselves.

"Sure it's difficult. You can't be openly gay if you want to be accepted or if you want to have a good job," Itfan, Umjad's 42-year-old friend remarked candidly, his friends nodding with approval. "But there is a greater sense of solidarity amongst gay people in Pakistan now than ever before." Though low by Western standards, part of this solidarity came with the evolution of the internet which revolutionised opportunities for gay Pakistanis to meet each other and discuss issues impacting them.

"I used to feel so alone. Now I know there are lots of people like me," Zubair, a slender 24-year-old added.

"It changed my life," another quipped.

Homosexuality and Islam

Yet for most gay people in Pakistan, having to wrestle with one's own sexuality and being constantly concerned about being discovered, life remains a constant battle. Can you be true to yourself, while

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adhering to the strict Islamic morals the country prides itself on?

“The issue of ‘homosexuality’ is sensitive and is not publicly discussed but there is, at the same time, a level of acceptance amongst men,” Hina Jilani, a leading human rights activist and lawyer, told IRIN in Lahore.

That tacit acceptance can be best seen in Pakistan’s North West Frontier Province (NWFP), where ethnic Pashtun men are well known for taking young boys as lovers, a practice now deeply embedded in the local culture and an obvious consequence of the strict segregation of women there. But according to a Boston Globe report published in July 2004 entitled “Open Secret”, homosexuals in Pakistan walk a fine line between harsh legal and cultural prohibition and a form of unspoken social acceptance.

“Islamic tradition frowns on but acknowledges male-male sex and this plays a role in permitting clandestine sex so long as it is not allowed to interfere with family life, which is of paramount importance,” San Francisco-based sociologist Stephen Murray was quoted as saying in his 1997 collection of scholarly essays entitled “Sociological Control of Homosexuality: A Multi-Nation Comparison”. Cultural and religious tradition keeps such relationships largely hidden in Pakistan, he wrote, adding there is no gay life in the Western sense of the word, and any sexual relationships between men have to be concealed and managed behind the context of marriage to a woman.

Further complicating the matter, Murray noted that the most common form of male homosexuality in Pakistan was pederasty, whereby an older man entices or coerces a younger male into sex, sometimes using physical force. Such incidents serve only to blur the issues of homosexuality and exploitation, the Boston Globe report said, making it even more difficult for gays to be open about their sexuality and assert their need for rights. This drives them further underground.

“Many organisations who have tried to work on the rights of gay people have really used HIV/AIDS programmes to approach the subject and cannot [do so] openly,” Jilani maintained.

In the shadows

One local NGO responding to a request for an interview by IRIN underscored the concern people working to tackle the subject face.

“This is a critical issue in our society. We have to be careful for that. Please let us know how many persons will be with you,” asked the NGO employee warily, inquiring whether any journalists or anyone from the authorities would be present at the proposed meeting. “Human rights activists like us struggle for the rights of people including gays and other youngsters. If you want to find a person who is campaigning openly for gay rights only, the answer is NO,” he said adamantly, going on to describe homosexuality as a harshly punishable sin and a crime.

“Some religious persons may kill the person who talks about gay rights,” he warned.

A voice abroad

Even so, while activists on the ground may prefer to keep a low profile on the issue, those abroad are more vocal.

“The lack of proper democracy and the lack of respect for internationally set standards of human rights makes the lives of LGBT [lesbian gay bisexual and transgender] people in Pakistan more difficult,” Kursad Kahramanoglu, who heads up the International Lesbian and Gay Association (ILGA), the oldest and only membership-based LGBT organisation in the world, told IRIN from London.

ILGA often receive requests from LGBT people in Pakistan for help in receiving political asylum in western countries, he said, noting that because of a lack of resources they are unable to deal with individual cases.

“However, I can tell you one of the active members of the ILGA organisation now lives in London because it was not possible to live as an open gay man in Pakistan,” Kahramanoglu said.

With regard to members in Pakistan, he replied: “We cannot for reasons you can appreciate give their contact details,” explaining it was precisely this issue of confidentiality which has been used against the ILGA at the United Nations in the past.

Official line

The government in Islamabad has never hidden its intolerance towards the issue of gay rights. In April 2003, a UN vote on homosexual human rights was derailed at the last minute by an alliance of disapproving Muslim countries, including Pakistan, which introduced amendments designed to kill the measure.

The amendments removed all references to discrimination on the basis of sexual orientation, rendering the resolution meaningless, a 25 April 2003 Guardian report said. The resolution, was sponsored by Brazil with support from 19 of the 53 member countries of the UN Human Rights Commission. It called on member states to promote and protect the human rights “of all persons, regardless of their sexual orientation”.

“Pakistan, which prides itself on being the land of civilised, educated, humane people, cannot do anything else but see the truth. At present they are in denial,” Kahramanoglu charged. “They say homosexuality does not exist in Pakistan and that if it does it must be the corrupt effect of these degenerate Western infidels! And yet they admire and work hard to achieve most other things from the West. What will the Pakistani government do if and when the Netherlands or Canada appoints a legally married gay Ambassador to Pakistan with his lovely partner? Cut diplomatic ties with the Netherlands or Canada?” the ILGA official asked.

Such questions might best be put to the country’s lawmakers, with Pakistan reportedly being one of the few countries in the world where homosexuality is punishable by death. According to ILGA, Pakistan is one of only eight countries today still retaining capital punishment for homosexuality. Others include Mauritania, Sudan, Afghanistan, the Chechen Republic, Iran, Saudi Arabia and Yemen. The situation with regard to the United Arab Emirates is unclear.

According to Jilani, while homosexuality is an offence under Pakistan’s Penal Code (PCC), the law does not specifically refer to homosexuality.

“In the Pakistan Penal Code the provision defining the offence and prescribing the punishment for it is titled “unnatural offences”, she said, noting that while there were several convictions under this statute each year, it is not possible to give precise statistics.

Under section 377 of the PCC, whoever voluntarily has carnal intercourse 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 [shall not be less than two years nor more than] 10 years, and shall also be liable to a fine, she explained.

Yet such ambiguity in the law makes the challenge of changing society’s perception of homosexuality all the more difficult. For there to be any hope of progress for the gay community, it will be necessary for the attitudes of ordinary people to change. Meanwhile, for men like Tariq, whose hope for progress remains minimal, the precarious balancing act of living two lives continues.

“People here are not ready to talk about homosexuality so they are certainly not ready to talk about gay rights,” he said in a matter of fact manner. “They tell me it’s a sin to be gay. But the real sin is not being allowed to be who I am.”

Source: IRIN - <http://www.irinnews.org/> - *The United Nations Integrated Regional Information Networks*, 10 May 2005

Ministers debate dropping VAT on condoms to encourage safer sex

Health ministers are in talks with the treasury about dropping VAT on condoms to make them more affordable.

The government has been accused of "taxing sex" and discouraging people from having safer sex by charging 17.5% VAT on condoms.

Around 30p from every £1.99 pack of three condoms goes to the Treasury, and since some GPs have stopped giving out free condoms, sexual health campaigners have been calling for the levy to be dropped.

A Department of Health spokeswoman confirmed that it was asking the Treasury to revisit the issue.

"We have held discussions with the Treasury on this issue and gathered a good deal of, research and information. We are planning to revisit the topic with the Treasury shortly," she said.

A spokesman for the Treasury said talks were ongoing. "We will consider the Department of Health's point of view and actively engage with them. It's not something that ministers will take lightly," he said.

Condoms are rated as "luxury" items by the treasury and therefore incur the highest rate of VAT.

The chancellor has the option of applying a 5% tariff on a series of items approved by the EU, including condoms. But to drop VAT on condoms entirely would require a new EU directive.

A discussion within the EU about what items should be eligible for reduced or zero rates of VAT is expected later this year.

The Treasury made it clear that it was planning to lobby for reduced VAT in four areas, including the upkeep of places of worship and the cost of making buildings more energy efficient. But condoms are not currently on that list.

The moves are understood to be in response to the government-commissioned Independent Advisory Group on Sexual Health and HIV which last October called for VAT on condoms to be lifted and for more free condoms to be available on the NHS.

The group argued that the cost of condoms meant that those in at-risk groups, in particular young people, did not always use them.

Government figures for teenage pregnancies in 2003, released last week, revealed that 8,000 girls under the age of 16 became pregnant in England and Wales in that year, meaning that its drive to halve the number of underage conceptions by 2010 has stalled.

Baroness Joyce Gould, the chairwoman of the advisory group, welcomed moves to examine the issue of VAT on condoms. She said: "The price of condoms is prohibitively high. They are certainly not a luxury; they are a health necessity."

The NHS spends about £4.3m a year on condoms and last year it gave away 38m condoms in England.

But it is up to individual GP surgeries whether they give, out free condoms or refer patients to a chemist.

A spokeswoman for the Family Planning Association said: "We would welcome a reduction in the price of condoms. But price is only one factor. We would like to see more free condoms from GPs, too."

Lisa Power, head of policy at the HIV/Aids charity the Terrence Higgins Trust, said: "The cost savings are clear - the small amount gained by the Treasury in VAT on these items is dwarfed by the cost of treating poor sexual health. Each new case of HIV in the UK costs the country between £250,000 and £500,000.

The chemist Superdrug last week launched a campaign for VAT on condoms to be dropped with an online petition and a letter to the health secretary, Patricia Hewitt, claiming that the levy amounted to a "stealth tax on sex [which] is a rip-off". The company has reduced the price of condoms in its stores by 17.5% for the duration of its campaign. *The Guardian*, 7/6/05

Indian genes quicken HIV progression

Indians infected with HIV develop AIDS faster than their counterparts in the West, and researchers now have a clue as to why this happens. The immune response to HIV among Indians is weaker because they possess more gene variants that accelerate the progression of HIV to AIDS, according to a study done at the All India Institute of Medical Sciences (AIIMS).

AIIMS researchers studied two sets of genes that are involved in the body's immune response to foreign bodies: the human leukocyte antigens (HLA) and chemokines. Gene variants among these set of genes explained why the HIV virus is more rapidly lethal in some people, while in others it takes decades to cause AIDS.

The HLA are proteins on the surface of white-blood cells and other tissues in the body. They play a key role in the immune system's response towards viruses and other foreign invaders.

"The HLA-B*35-Px gene that has been linked with rapid progression to AIDS is 2.5 times more common in Indians than the HLA-B*35-Py gene, which is a protective gene," says Dr N.K. Mehra, head, Department of Transplant Immunology and Immunogenetics, AIIMS, who led the study. In comparison, Caucasians (white populations) have higher numbers of the Py variant as compared to Px.

Mehra and his team studied 2,000 healthy and 200 HIV-positive people over the past two years. The study has been reported in *Nature Medicine* this year.

He also found that a protective variation of chemokines (intracellular messenger molecules that attract immune cells to sites of infection) was absent in Indians. "Global studies have shown that the 'CCR5-delta-32' mutation protects against AIDS," says Dr Mehra. "It is absent in Indians."

Again, in the same gene type, another variant associated with rapid AIDS progression, CCR5-0202, was found to be very common while its protective cousin, CCR5-0201, was almost absent.

"Our recommendation is to start treating HIV-positive people in India more aggressively as compared to western populations," says Dr Mehra.

Hindustan Times, April 4, 2005

Aussie tourist jailed over gay sex

A Fiji court has jailed an Australian tourist for two years for what the judge called a "shameful" and "disgusting" homosexual act.

Retired university lecturer Thomas Maxwell McCoskar, 55, and a Fijian man had pleaded guilty to having sex in the city of Nadi over the Easter period and asked the court for leniency, the Fiji Times reported.

Gay sex is illegal in Fiji, a nation of conservative Christian values, and carries a jail sentence of up to 14 years.

In sentencing the pair yesterday, Magistrate Syed Muhktar Shah said the crimes committed by McCoskar, from Victoria, and Dharendra Nandan, 23, were "something so disgusting that it would make any person vomit".

Mr Shah said McCoskar's actions bordered on pedophilia.

"If you wanted to have fun, you should have stayed in Australia instead of trying to come to Fiji and exploit our young boys," he said.

"With you being a former lecturer, you should have known that such indecent acts are illegal."

The newspaper reported that the pair told the court there was nothing wrong with what they did and Nandan threatened to commit suicide if jailed.

But Mr Shah told Nandan he should have thought of the "shamefulness of the crime" before associating with McCoskar.

<http://ntnews.com.au> report; 6/4/05

Singapore bans AIDS concert

By Fayen Wong

Singapore has rejected an application for a concert by a local AIDS support group, citing concern over its gay performers following a spike in HIV cases.

Los Angeles-based Christian gay pop musicians Jason and deMarco were the planned feature performers for the April 3 Action for AIDS event organised by Christian group Safehaven.

"Based on the duo's website and reports of their performances in the United States, it is assessed that their performance will promote a gay lifestyle which would be against the public interest," said the Media Authority of Singapore in a statement.

The ban follows comments this month by a Singapore government minister who said a gay and lesbian festival in August last year may have led to a surge in the number of local AIDS cases, a remark that outraged gay activists.

Although Singapore has one of Asia's lowest levels of HIV infection, the number of new infections hit a record high of 311 cases in 2004, up 28 percent from 2003. A third of the newly diagnosed cases were gay men.

Gay activists say many the remaining two-thirds appeared to be heterosexual men who caught the illness from prostitutes in nearby

Southeast Asian regions such as Indonesia's Batam island just an hour's boat ride from Singapore.

Safehaven said the concert had aimed to raise funds for AIDS programmes and increase awareness about HIV among gay people.

"We invited Jason and deMarco because they are a monogamous couple for the past 5 years and we wanted to send forth the message to the gay community that a monogamous relationship and responsible attitude towards sex should be the approach to take," said Peter Goh, a coordinator from Safehaven.

"We did not intend, and still do not intend, for this to be a gay concert," he said.

Singapore's gay community has only recently enjoyed greater freedoms and after former premier Goh Chok Tong announced in 2003 that homosexuals were now employed in the civil service, a low-key policy shift aimed in part at fostering a creative class.

He said homosexuals could hold key positions without fear of discrimination - a move once unthinkable in a country where oral sex even between men and women is still technically illegal and punishable by up to two years in jail under current laws.

"It is unfortunate that the authorities rejected the license. These people had good intentions, they wanted to do something for its community and help us as well to give funds to our prevention efforts," said Brenton Wong, a spokesman for Action for Aids.

Posted by Jan de Lin van Wijngaarden, 2/4/05

Surplus men, sex work, and the spread of HIV in China

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Source: AIDS. 19(6):539-547, April 8, 2005.

Abstract:

While 70% of HIV positive individuals live in sub-Saharan Africa, it is widely believed that the future of the epidemic depends on the magnitude of HIV spread in India and China, the world's most populous countries. China's 1.3 billion people are in the midst of significant social transformation, which will impact future sexual disease transmission. Soon approximately 8.5 million 'surplus men', unmarried and disproportionately poor and migrant, will come of age in China's cities and rural areas. Meanwhile, many millions of Chinese sex workers appear to represent a broad range of prices, places, and related HIV risk behaviors.

Using demographic and behavioral data, this paper describes the combined effect of sexual practices, sex work, and a true male surplus on HIV transmission. Alongside a rapid increase in sexually transmitted disease incidence across developed parts of urban China, surplus men could become a significant new HIV risk group. The anticipated high sexual risk among many surplus men and injecting drug use among a subgroup of surplus men may create bridging populations from high to low risk individuals.

Prevention strategies that emphasize traditional measures - condom promotion, sex education, medical training - must be reinforced by strategies which acknowledge surplus men and sex workers.

Reform within female sex worker mandatory re-education centers

and site specific interventions at construction sites, military areas, or unemployment centers may hold promise in curbing HIV/sexually transmitted infections. From a sociological perspective, we believe that surplus men and sex workers will have a profound effect on the future of HIV spread in China and on the success or failure of future interventions.

Posted AIDS-Asia, 11/4/05

Scientists discover new strain of HIV virus

Scientists at the Jawaharlal Nehru Centre for Advanced Sciences at Bangalore, one of the laboratories doing frontline molecular virology research on AIDS in India, have now stumbled upon a recombinant virus strain in HIV infected persons in South India.

This has raised fresh concerns about HIV-AIDS infection in India.

Viral proliferation has been one of the major challenges before the global scientific community developing the AIDS vaccine.

So far it was known that epidemics in India were dominated by subtype-C virus of HIV-1, however according to the recent study scientists have now identified a novel B/C recombinant virus in a sample survey done on primary infections in all four southern states in India.

"We identified just three recombinant viruses in a small subset of 115 samples. To find out whether really it is a problem for India depends on what is the predominant virus," said Dr. Ranga Uday Kumar, Faculty, JNCASR, Bangalore.

The B-C recombinant virus is a new strain of virus for India. The strain is common in China but the scientists rule out that route for spread of the infection.

"No, it is not coming from China. Initially that is what we thought because B-C recombinants are known only from China, so we thought probably they are infiltrating from China to India but our analyses at the marker level showed that they are of a different nature," said Dr Kumar.

The discovery of the unique B-C recombinant virus in southern India throws up fresh challenges for the treatment of HIV-AIDS in India. In fact with the AIDS graph spiraling, there is an urgent need for a more broadbased study on this subject.

NDTV, March 26, 2005

Over 15% HIV+ patients resistant to drugs

Tests conducted on a random group of HIV positive people in Chennai have revealed that that nearly 15 per cent of them are already resistant to drugs.

A sample size of 50 persons was chosen in Chennai to conduct a study on drug resistance, headed by Dr P Balakrishnan.

A new danger

He found that over 14 per cent, that is, seven people of the HIV positive group are resistant to the drugs, even before consuming the medicines. It's a small percentage, but doctors are seeing it as a warning sign.

"Exposure to therapy is increasing. So far it's okay, the problem has just begun. We can expect those alarming statistics very soon," said Dr P Balakrishnan, Lab Manager, YRG CARE.

The reason for this doctors say is simple. Though HIV medicines are becoming cheaper, they remain unaffordable for the vast majority of HIV patients in India.

So a new problem seems to be emerging - drug resistance.

Ideally an HIV positive patient would have to take these medicines throughout his life.

But often, many patients do not continue with the therapy leading to the development of newer strains of the virus that make them drug resistant.

Warning signs

Dr Suniti Solomon who had detected the first HIV positive case in India says, it's time to start worrying.

"I think any drug resistance in India I would be very alarmed and more so with HIV because we have only a few drugs for HIV and if our strains of virus become resistant to it, which we have already started seeing, it's going to be dangerous," said Dr Suniti Solomon, microbiologist.

So it's the same story with HIV as well. Microorganisms develop resistance to old drugs sending us in search of new drugs.

"These viruses are very smart viruses, since they generate resistant mutants during the course of their application.

The enzyme of this virus does not have proof reading capacity as a result of which mutants are generated in each generation. The mutant virus becomes resistant to the drug and these are therefore picked up. This is called the mutant virus," said Dr Pradeep Seth, Head of Microbiology, AIIMS.

Combating resistance

So far all doctors can advise is that the way to combat resistance is never to discontinue the medication because the minute the patient stops ? the virus mutates.

With this new turn of events, a nation-wide resistance surveillance study is soon going to be conducted by the National Aids Research Institute in Pune.

That study could change the way the battle against AIDS is fought. *NDTV.com, March 27, 2005.*

To get federal funds, groups that fight AIDS overseas must sign pledge

By Steve Sternberg
USA TODAY

In a major policy shift, the Bush administration on Thursday notified U.S.-based AIDS organizations that get taxpayer funding for work overseas that they must pledge that they oppose prostitution and sex trafficking.

This is the first time U.S. AIDS groups have been required to accept such a condition in exchange for federal funds.

"What applied to foreign organizations will apply to U.S. organisations, too," says Kent Hill, head of Global Health at the U.S. Agency for International Development (USAID).

Hill says administration officials are doing what Congress required when it passed the five-year, \$15 billion President's Emergency Plan for AIDS Relief (PEPFAR) in Africa, Asia and the Caribbean two years ago.

Critics say what they call the anti-prostitution "loyalty oath" may violate their free-speech rights and hinder their work with prostitutes, a crucial risk group.

"It's ideological blackmail. It's like a loyalty oath," says Paul Zeitz of the Global AIDS Alliance.

"No one endorses prostitution and sex-trafficking. We cannot stop AIDS if we lose the trust of people most at risk of HIV infection and undermine effective, lifesaving programs," he said.

In February, 13 charitable organizations, including Save the Children, CARE and International Rescue Committee, relayed the same criticism to Global AIDS Coordinator Randall Tobias. The groups said, "Contributing to the stigmatizing of populations that are at risk, infected or affected by HIV/AIDS greatly undermines the success of AIDS prevention, testing and care efforts."

The law authorizing PEPFAR formally required federally funded groups to promise that they won't use those funds to promote prostitution, the legalisation of prostitution or sex trafficking. The law also required foreign groups that get U.S. funds to declare opposition to prostitution, pledging allegiance to U.S. policy.

The law was amended last year to exempt multinational groups that get funding from the USA, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as United Nations agencies that channel money from the USA and other donors to grass-roots AIDS organisations.

The federal government channels about \$550 million in global AIDS funds through USAID and \$488 million through PEPFAR. In 2006, the balance will shift: \$361 million will go through USAID programs and about \$1.8 billion through the president's plan.

One legal expert says the pledge violates the organizations' and their employees' constitutional right to free speech.

"It's a first amendment problem," says Ira Lupu, a professor of constitutional law at George Washington University in Washington, D.C. "You're asking (the organizations) in exchange for federal grants to limit their activities under the grant: to sell off their rights to engage in politically committed expression in support of other activities."

Posted by Paul Hollerbach, AED, 10/6/05

New opinions are always suspect, and usually opposed without any other reason, but because they are not already common.
John Locke, 1690

The true personal identity is revealed in the process of living, and is experienced as fluid, of being born anew each moment.
Shivananda Khan, 1987

Supreme Court, Delhi: Centre get notices on gay rights

Sparking off yet another round of debate on the questing to legalise all forms of sex, including homosexuality, the Supreme Court on Friday issued notices to the Delhi government and the Centre.

It seems the petitioner NGO – Naz Foundation – is not allowing dust to settle on the question to legalise homosexuality under Section 377 of the IPC. After the Delhi high court last year dismissed their petition, the NGO moved a special leave petition before the apex court. Perusing their SL, the bench has issued notices to the state, Union of India, Delhi Police commissioner, Delhi state AIDS control society; National AIDS control Society besides others. The petition filed before the apex court has sought challenging the constitutional validity of Section 377 of the IPC, which makes any kind of unnatural sex a punishable offence. Naz Foundation, a well-known NGO working for HIV/AIDS awareness, had approached the court ‘for a declaration that Section 377 of IPC to the extent applicable to and penalise sexual acts in private between consenting adults is violative of articles 14, 15, 19(1) (a) to 19 (1) (d) and 21 of the Constitution’

In September last year, the Delhi high court reaffirmed that “Indian society by and large disapproves of homosexuality.” The division bench comprising Chief Justice B C Patel in their judgment had ruled, “Since there is no cause of action, a petition cannot be filed just for testing the validity of legislation.” The bench taking a strong view of the fact that the petitioner has challenged the said law, without being an aggrieved party, in the absence of any cause of action, dismissed it. Upholding the Centre’s view, the high court found “no merit” in legalising the said section 377 of the IPC, whoever has sex against the order of nature with any man, woman or animal, shall be punished with imprisonment for life.” *The Asian Age, April 1, 2005*

Fighting AIDS behind bars

The United States will never contain deadly diseases like AIDS and hepatitis C until it prevents them from spreading behind bars, where infection levels are many times as high as in the world outside and the diseases spread easily, thanks in part to unprotected sex among inmates. Routine testing and education programs in prison are a must. But so are common-sense programs that distribute condoms behind bars. These programs have long since been standard operating procedure in prison systems abroad, but are unavailable in about 95 percent of this country’s prisons.

This situation has persisted despite studies showing that same-sex encounters behind bars are more common than prison officials care to admit, and despite warnings from public health officials, who have pointed out time and again that the highest AIDS rates are typically found in the communities where the largest numbers of ex-offenders live. But a condom distribution bill recently passed by the California State Assembly could well be the beginning of a more sensible policy – not just in California, but in the country as a whole.

Pushed through the Assembly by Paul Koretz, a Democrat from West Hollywood, the bill has yet to clear the Senate. If it does, it will require California’s corrections system, the nation’s largest, to allow public health and nonprofit groups to distribute condoms to inmates. The Assembly wisely rejected the spurious argument that distributing condoms would promote sex in prison - understanding that sex among inmates is common and will continue no matter what lawmakers say.

The Assembly, which is the more conservative of California’s two legislative houses, passed the bill thanks to strong support from medical, civil rights and law enforcement organizations, all of which have watched the AIDS epidemic with growing alarm. The bill deserves to be passed by the State Senate and to be widely emulated. After all, the country needs all the tools it can get in the fight against AIDS. *Posted by Paula Hollerbach, 10/6/05*

Virgin syndrome: China women opt for surgery

Ms Liu Ying, a 23 year-old Chinese bride, will never forget her wedding night, not only because of the wedding itself, but because of the white sheet laid in the bed by her mother-in-law.

Her mother-in-law examined the sheet early next morning with a smile as she saw the blood on it, which testified to Ms. Liu’s virginity. Ms Liu felt a sense of relief. Later she made a call and expressed her gratitude to the surgeon, who had used modern technology to artificially restore her hymen, report Xinhua.

Ms. Liu, who grew up in the suburb of Zhengzhou, capital of central China’s Henan province, is open-minded and lovely. Before meeting her husband she had another boyfriend with whom she had physical relations. For the fear of being exposed as a non-virgin bride and the ensuing troubles that might follow, Ms. Liu secretly went to a local hospital and underwent hymen repair surgery.

The surgery cost her more than 1,400 Yuan (some \$170), but it helped her to escape unwanted scrutiny about her past.

Ms. Liu’s experience is unusual, as the ancient practice of suing a white sheet to determine the presence of absence of a bride’s hymen has been discarded by most Chinese people.

But the value of hymen – a membranous fold of tissue that covers the external vaginal orifice – still prized in the country, even among young Chinese. A survey by Sina.com, a popular Chinese web portal, reveals that only 17.5 per cent of male Chinese do not care about the virginity of their girlfriends.

It shows that virginity in girls is still valued by most young men, despite the fact that today’s Chinese youngsters are more open than ever regarding sexual relationships. Premarital sexual relations and cohabitation are prevalent among young Chinese. The contradiction serves to explain why more Chinese women prefer undergoing hymen reconstruction surgery, or hymenorraphy.

Ms Jing Song’en, director of the vagina plastic surgery centre Zhengzhou Oriental Women’s Hospital, says that the surgery has doubled in the past several years.

Most of them are under 25, with the youngest 16 and the oldest 38, Jing says. About 95 per cent of them say they are having the surgery to improve their marriage prospects.

Most come alone, secretly, and some them linger outside for a long time before mustering the courage to walk into the clinic, Ms Jing acknowledged. And many of names and addresses they provide are fictitious.

But Ms. Jing says she is very sympathetic with these girls. It is understandable that they come here to perform hymenorraphy as a solution to heavy social pressure, she says.

The Asian Age, April 2, 2005.



An HIV/AIDS awareness workshop conducted for kathoey in Vientiane, Laos by PSI Lao.

Female orgasm all in the genes

Women who are unable to have orgasms during sex may be genetically programmed to weed out unreliable men who are a flop between the sheets, according to new research.

Scientists who have studied the ability of thousands of women to climax say it is largely written in their genes - the most compelling evidence so far that the female orgasm has a biological role.

The findings suggest the failure of some women to have orgasms regularly is not a dysfunction, but a sophisticated mate-selection strategy that evolved during prehistoric times.

Tim Spector of St Thomas's hospital in London, who led the research, said: "The theory is that the orgasm is an evolutionary way of seeing if men can prove themselves to be likely good providers' or dependable, patient and caring enough to look after the kids:'

Women who reach orgasm very easily may be more likely to be satisfied with poor quality men. "Perhaps women who had orgasms too easily weren't very good selectors," Professor Spector said. "It paid women to be more fussy and this is one way of doing it. The simple fact is that it takes women on average 12 minutes and men two and a half minutes to reach orgasm. Adjusting to that imbalance is a test."

His team used a national register of twins to ask 4,037 women, aged 19 to 83, about their sex lives and to compare their DNA. About half were identical twins, who share all their genes. The others were non-identical twin, who do not. Assuming twins are brought up in similar environments allows scientists to tease out the differences that are down to genes.

Thirty-two per cent of the women said they never or infrequently experienced an orgasm during sex, and 21% during masturbation. Only 14% said they always had an orgasm during sex.

Genetic comparisons showed that 34% of the variation during intercourse was inherited. In the case of masturbation, 45% of the difference was down to genes. The findings appear today in the Royal

Society journal *Biology Letters*.

Prof Spector said these were low estimates because they were based on answers to intimate questions. In reality, genes are probably the greatest single factor involved in whether women have an orgasm or not.

The genes could work on a physical level, perhaps causing variations in the G-spot, the angle of the vagina, or the clitoris. They could work psychologically, to alter a woman's confidence or mood, or they might vary the activity of enzymes or hormones.

"It's likely to come from the mother's side but we can't say that it doesn't come from the father, if, for example, it's a psychological state rather than purely anatomical," he said.

The research opens the door to further studies to identify the relevant genes and perhaps develop treatments to help more women reach orgasm. "If the motivation and funding were there you could find a number of the genes involved within a few years. Each of those would show you a new mechanism that, in theory, you could make drugs to interact with. But there's so little research, it's really a taboo area."

The genetic control over how easily women experience an orgasm during sex shows it is subject to evolutionary pressure, which means it must confer a biological advantage.

One theory is that orgasms promote fertility. Studies have shown that women are slightly more likely to have an orgasm when they are ovulating. There is also evidence that the uptake of sperm is increased when a woman climaxes. But if this were the only explanation, all women would have orgasms.

"The theory I prefer is the mate selection theory," Prof Spector said. "If a man is considered powerful enough, strong enough, or thoughtful enough in bed or in the cave, then he's likely to hang around as a long-term partner and be a better bet for bringing up children:' *The Guardian*, 8/6/05

Can the latest female orgasm theory really hold up?

Yvonne Roberts

Imagine the scenario, five or 10 years hence. 'Did the earth move for you, darling?' 'No.' 'Well, keep on taking the medicine. It's bound to work one day.' Where puritanism and Darwinian science have already gone before, Professor Tim Spector of St Thomas' Hospital, London now follows: female orgasm, he says, is all in the genes.

To come or not to come is out of a woman's hands or, for that matter, her partner's. It's all been decided by nature; biology rules that some women will never enjoy what the family planning pioneer Marie Stopes described as 'wonderful tides'. But given sufficient research, Professor Spector suggests, a drug may eventually be found to 'cure' the non-orgasmic.

The medicalisation of women's sexuality rolls on apace, once again relieving many struggling men of the worry that they just haven't been trying hard enough, while females are left high and dry - metaphorically and physically - because of their rotten choice in partners.

According to Spector's speculations, women who reach orgasm easily are more likely to be satisfied with poor-quality men who love and leave. Males who are good enough to hang around long enough for a female to climax (12 minutes) have passed the evolutionary test which says they are likely to be 'dependable, patient and caring enough to look after the kids'. (Lust, libido and childcare aren't often mentioned in the same sentence.)

Spector's team used a national register of twins to ask 4,037 women about their sex lives and to compare their DNA. Half were identical twins who share genes. Some 32 per cent of the total said they never or infrequently experienced orgasm; only 14 per cent said

they had an orgasm during intercourse. Genetic comparisons showed that 34 percent of the variation during intercourse was inherited, and the difference was down to genes. According to Spector, genes could work on a physical level, for instance, causing differences in the angle of the vagina or the clitoris. They may also have a psychological effect, varying the activities of hormones.

Spector's research is undoubtedly impeccable, but what kind of study is able definitively to disentangle biology from social construction? Or, to put it another way, perhaps in questioning women only about their sex lives and not their lives in general, a major piece of the puzzle has been left out?

In the US, female sexual dysfunction (FSD) is already big business. The quest is on for the female equivalent to Viagra and entry to a business allegedly worth more than £2 billion. Recently, the *New York Times* reported on the success of sex therapist Laura Berman who runs the Berman Centre in Chicago. She prescribes low-dosage testosterone cream, 'the fuel of love', to women, a treatment not approved by the Food and Drug Administration. Leonore Tiefer, associate professor of psychiatry at New York University, says that long before reaching for testosterone (the long term effects of which are unknown) a therapist ought to assess a range of issues.

"The first is political, cultural, social, relational, psychological and then medical. You can have a perfectly good sex life, even if you don't have any genitalia, if you are in a relationship and feel good about yourself. A uniform model of sexuality doesn't exist."

continued on page 13, col. 1

Female orgasm theory

continued from page 12, col. 2

You can also, of course, be perfectly happy in a relationship having no sex at all but the general impression today is that everyone is at it. As sociologist Professor Carol Smart has said, sex has moved from sin and procreation 'into a major part of our quest for identity'. If sex has ceased to be what we do and become the measure of who we are, then the results of Professor Spector's study may tell us as much about the power of conditioning as the versatility of science.

One in three women in the Spector survey said they rarely or never had an orgasm during sex. In Kinsey's survey in 1953, 55 per cent rarely experienced orgasm. By the Seventies, in a study by the Playboy Foundation, the figure had dropped to 48 per cent. In another 30 years, general satisfaction may well have spread across the (female) land.

Or perhaps not. A brief gallop through the history of sex makes it clear that it is a miracle inhibitions are being shed at the rate they apparently are. Female sexuality, as defined by men, has moved from dangerously and insatiably predatory to officially non-existent. In Victorian times, a woman who revealed a lusty appetite (unless she was paid) was in danger of being treated for hysteria or subjected to

the surgical removal of her clitoris, the only organ designed entirely for pleasure and omitted from many 19th-century anatomy books. (As late as 1948 in the US, a five-year-old had her clitoris removed to 'cure' her enthusiasm for masturbation.)

'Nice girls don't - except in times of war' is burned so indelibly on the consciences of many baby-boomers that 'free love' and the Sixties debate on the vaginal versus the clitoral orgasm passed them by. ('I'll take both' is probably today's consumerist response.)

In the Seventies, the question shifted from where it happens (or not) to what makes it happen. In California, Eleanor Stephens, author of *Our Body, Ourselves*, ran courses optimistically entitled 'pre-orgasmic workshops', which taught women how to reach orgasm through masturbation. Four months later, 50 percent were reaching orgasm in inter-course. And, no, the workshops no longer run.

Today, of course, we have a paradox. Anyone, in theory at least, is free to 'go the whole way', as it was once quaintly worded... except that competitiveness, greed, individualism, stress, exhaustion, null-points lovers and the time squeeze, added to the urge to do it 'right', mean that, as Professor Spector has discovered, sex for some is anything but a pleasure.

But, Doc, it can't all be about biology.
The Observer. 12/6/05

An important comment from Ashok Row Kavi of Humsafar Trust

An extract from a posting by Ashok Row Kavi on the e-forum AIDS-India.

"A gently remind the readers on this list to glance at the new budgetary guidelines drawn up by NACO in close consultation with NGOs, CBOs, PLWHA groups and finance people.

This exercise took over 18 months after intense haggling in open sessions in Delhi.

What is startling is that all three "CORE" groups which have to be compulsorily funded by every SACS before "other vulnerable" groups can be funded are: (In their relative importance)

- 1) Sex Workers (female and male/transgendered).
- 2) IVD-users.
- 3) Men-Having-Sex-With-Men (MSM).

Now as somebody who took great pains through advocacy at every layer of government and health bureaucracy to convince both the Family Welfare and Health Ministries and NACO to have MSM included into the core sector, I suddenly realised that ALL THREE CORE GROUPS mentioned above are CRIMINALISED groups who cannot be engaged without serious systemic changes in the legal, social and health sectors.

For example, till the Prevention of Immoral Traffic Act (PITA) is drastically changed you cannot possibly work with female/male sex workers. Simple things like soliciting become a criminal act.

Till Section 377 of the IPC is changed, even outreach amongst MSM becomes "an accessory to abetment of Section 377" which is punishable on its own. Hence, outreach to MSM is criminalised and de facto impossible. This is reflected in fact sheets brought out by the International Gay and Lesbian Assn.(ILGA)

Without drastic changes in the Narcotic Control Acts even possession of small amounts of drugs like opium, charas can lead to imprisonment and heavy fines.

So please tell me how on earth does one work with whole populations who are criminalised and driven to the margins of society for their every action and livelihood.

Ashok Row Kavi
Humsafar Trust
Mumbai Metro

Posted AIDS-India 29/4/05



NFI Sexual Health Resource Centre

The Naz Foundation International, Regional Office Documentation and Library Centre in Lucknow, India, on genders, masculinities, sexualities and HIV/AIDS, has over 3000 books, documents and videoa. A range of facilities are also available, including internet, photocopying, and a comfortable study space.

The Resource Centre aims to increase knowledge and scholarship on issues of masculinities, sexualities and sexual health, with a focus on male-to-male issues in the Asia region.

To find what is available in our Centre, please review the book and documentation lists available on our website www.nfi.net, which are regularly updated as new documentation is obtained.

This facility is available for students, researchers, advocates, and activists, to spend a quiet time studying and researching in the issues of their concerns.

For further information and access to the Centre please contact Kaushik Das, Information and Resource Centre Coordinator on kaushik@nfi.net.

Story of 'Simple Simon' from Cochin.

Thirty four year old Simon is a peer educator at an NGO in Cochin, which works for the legal rights of sexuality minorities and sex workers. He also moonlights as a sex worker.

On a Sunday afternoon in February 2005, outside the Nehru Park in Cochin Simon was approached by a friend, who asked him if he would be interested in doing a television interview, for a regional TV station that was doing a story on the lives of gay sex workers in the city. After repeatedly turning down his friend's offer Simon was approached by the show's producer who was waiting for the response in a vehicle parked nearby.

She offered to pay Simon Rs800 if he agreed to do the interview and promised him the footage was for a documentary, which would only be shown at foreign film festivals. Tempted by the offer Simon gave in.

He was asked questions about the kind of sexual favours his clients demanded, to which he responded that most of his customers were looking for oral sex. They also asked him what were the major problems he faced being a sexworker in the city, he answered, "the constant harassment of police and local thugs".

He was given a sari and women's undergarments and asked to change into it and strut around in front of the camera. Simon went along with the producer's requests, as by this point in time he was fully convinced the footage was only going to be screened at foreign film festivals. After the shoot was done Simon was paid Rs800 and asked to sign a receipt that said he received the promised amount.

After collecting the signed receipt the producer asked Simon if he would lend her Rs600, which she would return promptly. The simpleton fell for it and the producer and her crew drove away leaving him with Rs200 in hand.

At this point I have to add that Simon has not yet declared the truth about his sexuality to his family (which consists of his mother and younger brother). Simon's mother is a single woman who works as a maid and his brother works at a welding shop.

On the 14th of February, about a week after Simon's interview with the TV crew, his landlord came knocking at his door. He brought the news to Simon's mother that her son was on TV. He took her to his house and had her watch Simon's interview that was being aired on TV. Simon was asked to leave his home and had to spend the next couple of days and nights outside.

At 11 PM on the 23rd of February 2005, Simon walked out of a cinema, after watching the 9 PM screening of a regional language film. He made his way down Banerji road (in the heart of the town), to a street vendor in front of the St Anthony's church, at Kacheripady (about half a kilometer from the cinema). He was about to get himself something to eat, when a police jeep intercepted him.

There were two cops in the jeep; one was the driver and the other an officer. The officer came out and grabbed him by the collar and asked the driver "isn't this the Fellow who talked about us on TV?" Without waiting for a response he forced Simon in the back of the Jeep. Meanwhile Simon replied, "Yes when they asked me what my problems were I said it's the harassment from cops and thugs."

They then took Simon to the Ernakulam north police station. It took another 15 hours and 45 minutes for him to be finally released. During his hours under police custody Simon was brutally assaulted by two cops, one was the officer who brought him in; the other was another cop who was working the night shift.

He had upon his release six bruises on his back, one big one on his right shoulder, four bruises on his upper left arm, two more on the top of his left palm.

His pinky and ring finger of the left hand were broken. They taunted him saying things like "You looked real hot prancing around in the sari.

Heard you say, you give your clients oral sex." He then overheard

the officer tell the other cop "I was at home entertaining guests this evening when this guy was on TV saying cops harass him". Apparently the TV station had been airing the program all week long.

Simon was kept under police custody till 2.45 PM the next day. All the while the police did not inform him of the reason for his arrest, nor was he made aware of his right to bail. There was no information sent to his family or friends about his arrest. He was not fed proper food or water; he was most certainly not treated with dignity nor offered medical treatment.

He was finally released at 2.45 PM the next day, after he informed the police the NGO he worked for was organizing a meeting at 3 PM and he would be missed.

The meeting, the police were kind enough to drive him to, was the discussion organized in the city on the 24th of February, on the rights of sexuality minorities against police harassment. It was a part of the nationwide campaign to repeal section 377 of the IPC.

One of the chief guests at the meeting was a prominent psychiatrist of the community and a member of the centre for Torture Prevention. He had Simon admitted at the hospital where he practices. Simon recuperated at the hospital for the next five days and left on the 29th.

His hospital bill was taken care of by the Torture Prevention Centre and a complaint was filed on his behalf by the NGO he works for. The complaint was filed at the office of one of the assistant police commissioners.

The assistant commissioner who received the complaint had the circle inspector of the same police station where Simon was assaulted, look into the matter. The circle inspector sent police constables to Simon's house to have him report to the station. Though reluctant to go at first, on the insistence of his lawyer Simon went.

The circle inspector had the lawyer who accompanied Simon wait outside, and questioned Simon about what he was doing out in the streets at 11 PM of the night in question. Simon recounted how he was returning from the movie and heading toward the street vendor when he was picked up. The circle inspector then told Simon how Simon himself was to blame for soliciting customers, and he should not have been out in the street, that late into the night. He also told Simon he ought to know better than to listen to the advice of his lawyer, who would preach human rights, but in the end it would be Simon, who would have to face the heat.

Simon dropped his complaint and returned to his daily life. What else can he do? Trust the same system that interrogates him (the victim), to conduct a fair and impartial investigation? Or go to the sleazy press, which put him in this situation in the first place.

Posted on AIDS-India, 14/4/05

NFI booth at the 6th ICAAP, October, 2001, Melbourne Australia



See you in Kobe, Japan

NFI will be hosting a booth for its partner agencies (Booth 49) at the 7th ICAAP in Kobe, Japan, 1st - 5th July 2005.

Find out more about NFI and its work across South and South-East Asia.

Nosy parkers! Gay men have a nose for gays

Steve Connor in London

The human nose can sniff out a suitable sexual partner, working especially well for gay men, according to the first study of how body odours are linked with sexual orientation.

Gay men showed a strong preference for the body odour of other gay men in the scientifically controlled test of how the natural scent of someone's body can contribute to the choice of a partner.

Although previous studies have shown that body odour plays a role in making heterosexual men or women attractive to members of the opposite sex this is the first study that has investigated its role in sexual orientation. Charles Wysocki of the Monell Chemical Senses Centre in Philadelphia, a non-profit research institute, said that the findings underline the importance of natural odours in determining a sexual partner whatever the sexual orientation of the person involved.

"Our findings support the contention that gender preferences has a biological component that is reflected in both the production of different body odours and in the perception of and response to body odours," Dr Wysocki said. The study involved 24 heterosexual and homosexual men and women who for about nine days were subjected to a "wash-out" period when they used scent-free soap and shampoo and refrained from eating strongly flavoured food containing garlic, cumin or curry. After this period of odour cleansing they were asked to wear sterile cotton pads under the armpits for day which were then collected and stored to use as a bottled source of their body odour. A panel of 82 heterosexual and homosexual men and women, who were not the donors of the armpit pads, were then asked to sniff each bottled body odour and evaluate its pleasantness according to a rigorous set of criteria.

In a study published in the journal *Psychological Science*, the scientists found: "Heterosexual males and females preferred odours from heterosexual males relative to gay males; gay males preferred odours from other gay males.

"Heterosexual males and females and lesbians over the age of 25 preferred odours from lesbians, relative to the odours from gay males; gay males preferred the odours of other gay males relative to lesbians," they say.

Dr Wysocki said that the strongest finding from the study was that gay men prefer the smell of other gay men and that lesbians responded differently to body odour compared to heterosexual women. "The overall conclusions are that the body odour you most prefer or least prefer does not depend on where it comes from but it also depends on who you are - in other words your sexual orientation," Dr Wysocki said.

Gay men preferred the odours from gay men and heterosexual women, whereas odour from gay men were the least preferred by heterosexual men and women and by lesbians, he said.

Previous studies have shown that body odour is linked with a set of genes involved in the body's immune system called the major histocompatibility complex - and that all men and women have their own set of these genes.

One theory is that this could be an evolutionary mechanism to avoid inbreeding. The latest study suggests that the gene in body odour may play a role in sexual orientation, Dr Wysocki said. "The bigger picture is that body odour is determined in part by gender orientation which is not something we can have predicted. And it's possible that the genes involved in body odour are also involved in later life in gender orientation," he said.

The Statesman, New Delhi, 11/5/05

Editor's note: But what about learning and practice?

Easy sex and slow politics tip Japan towards AIDS crisis

Beautiful, single and sexually active, Emi is the sort of person who causes nightmares among Japan's health ministry bureaucrats. At 20, she says she has had more than a dozen sexual partners in relationships that sometimes lasted just a few days. She admits that condoms are not always high on her list of priorities. "Japan is pretty safe that way," she says.

Such complacency is part of a potentially lethal cocktail of freewheeling sexual habits and slow-moving government that is pushing this traditionally safe, healthy society towards an AIDS crisis, claim medical experts. "I think we're looking at an AIDS explosion in the very near future," says Dr Kunio Kitamura, the head of Japan's Family Planning Association. "This is the only G7 country where the disease has continually expanded since 1993."

Japan has just over 10,000 official cases of AIDS, well below rates in most other countries. But in contrast to the UK, where the epidemic peaked in the mid-1990s and the disease remains largely confined to well-defined categories, the epidemic is growing sharply in Japan - a record 1,165 new cases in 2004. And the rate is doubling every four years.

More worrying still is the profile of the victims. Many AIDS sufferers in Japan are heterosexual and drug-free and they are getting younger - the welfare ministry says 40 per cent of all Japanese newly infected with HIV are in their teens or twenties. Other sexually transmitted diseases are rising even faster. A conference in December last year heard that one in 10 Japanese teenagers had chlamydia. "We know from studies in the US that where chlamydia goes, HIV often follows," said Dr Kitamura. "It shows a lot of youngsters are engaging in unprotected sex."

The key to tackling the looming crisis is changing Japan's sexual habits, say experts, especially among teenagers: a recent poll found that nearly 40 percent of senior high school students have had sex, rising to nearly 50 percent for girls, and condom use is falling. "The figures might not seem especially high compared to other countries, but it is an enormous leap compared to what it was 20 or even 10 years ago" said Masako Kihara, a government researcher at Kyoto University.

"What worries me most is the complacency. There is a lot more awareness of AIDS now but teenagers don't think it has anything to do with them. The children don't know they're engaging in risky behaviour so they don't wear condoms."

The situation is worsened by some of the highest rates of prostitution in the advanced world; Dr Kihara claims more than 10 per cent of Japanese men pay for sex, and thousands of high school girls looking for extra pocket money are contacted by middle-aged men who use internet dating sites. Critics say the government must do more to crack down and spend more on combating AIDS. But they say testing centres are in short supply, anti-AIDS budgets in many cities are falling, and sex education in schools is inadequate.

The Independent, 9/6/05

When I deny the integrity and self-worthiness of another, I deny my own. I commit violence against myself and that other person.

Who are the masses? For when we speak of the masses, we lose sight of the person.

Shivananda Khan, 1987

Indian Government bureaucracies kill off people living with AIDS

by Richard Stern

While hundreds of millions of dollars in assistance for AIDS pour into India from international donor sources including the Global Fund, only 5,000 people living with HIV/AIDS (PLWA) are receiving anti-retroviral treatment through the public sector. Incredible negligence on the part of the National AIDS Control Organization (NACO) and the Health Ministry combine to systematically create a form of "bureaucratic genocide," contributing to the deaths thousands of PLWA who need treatment now.

According to the World Health Organization (WHO), 700,000 people in India urgently require treatment. About 100,000 die each year, nearly 300 each day.

As of this moment, all public sector treatment in India is provided by government funds, channelled through NACO. Yet \$122 million in additional funds for ARV access has been available for nearly a full year from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), but not one dollar has been disbursed from Geneva to India for Anti-retroviral access.

While the money remains in the bank, Mumbai's JJ Hospital is the only publicly funded facility in that city where PLWA currently receive free treatment. A staff of two overworked counsellors tries to see 180 patients each morning, who come to the clinic. Counsellors must deal with adherence and other issues for the 1,350 PLWA now receiving free treatment at this hospital. Yet hospital staff have indicated that, as of April 1st no more PLWA can be placed on treatment. The Mumbai AIDS Control Centre has decided that the JJ program is saturated.

Mumbai is India's largest city with a population of 16 million. Experts agree that at least 30,000 people in Mumbai need treatment now. The government will supposedly begin providing free treatment at three additional hospitals, called "medical colleges," in the near future but the cap for each of these hospitals will be 500 patients, meaning that a total number of 2,800 people, could be placed on treatment by the end of 2005 in Mumbai, leaving 27,000 or 90% still without ARV access. Of these 27,000 an estimated 8,000 will die during the year.

No treatment for children with AIDS

Although Mumbai AIDS Control Centre staff acknowledged that 1,500 children are known to need treatment, and despite a thriving low cost generic manufacturing industry, incredibly there are no paediatric AIDS suspensions available. Children over 13 are given pills for adults but there is no treatment for children under 13. The WHO representative for Mumbai, Dr. Dilip Vasvani informed me that there are "plans" to begin providing treatment for children at a facility in Northeast Mumbai that already provides medical services for children but he would not be specific about a date.

Few if any of the PLWA we met in Mumbai had any information about the Global Fund or the reason for the delays in disbursement. In India's first AIDS related Global Fund project approved in round two, over two years ago, \$100 million was made available to India by the Fund. Incredibly, India's "Country Coordinating Mechanism" (CCM) only asked for funds to treat 5,000 people over a five-year period. At current prices, treatment for 5,000 people represents only about \$800,000 out of the total approved of \$100 million, less than one percent. However, it is a mute point, since none of the people who could be treated with Global Fund money have even been placed on treatment as of this date. Global Fund projects are "country driven" meaning that the Fund does not mandate that a country ask for funds for treatment in their proposals. A year and a half later, in the fourth round, India did ask for funds for treatment access, but the grant agreement has never been signed.

WHO's Dr. Vasvani acknowledged that he himself knows little

about the Global Fund roll-out in India. He indicated that ARV roll-out would be slow at first to assure quality of care, but could not explain why the "cap" of 2,800 had been placed on Access for Mumbai for the year 2005, when so many are urgently in need of treatment. In all of India 5,000 people are on treatment in six major centres, but NACO had originally announced that treatment would be available 100,000 by the end of 2005. In early February, the NACO estimate was dramatically lowered, in spite of available funds, and the goal is now to have 100,000 people on treatment by the end of 2007, a decision that defies logic given the resources available to the government from donor sources.

For most questions I posed regarding the Global Fund and general ARV policy, Dr. Vasvani referred to me Dr. Alka Gogate, Director of the Mumbai AIDS Control Centre, the local branch of NACO which is responsible for Maharashtra state.

In spite of a confirmed appointment that I had made directly with Dr. Gogate for Tuesday March 29th, at 3 pm she failed to appear and left no note or message relating to the cancellation of this meeting. Although I never spoke with Dr. Gogate, documents provided by NGO's, indicated that in March of 2004 she had announced that medications for children would be a priority in Mumbai. She also indicated in the same report that in Mumbai, no one would receive treatment unless they had a "responsible accompanying person" to insure adherence. I had no chance to ask her if she is aware that this policy is against all "best practice" policies that entitle a person with AIDS to confidentiality.

Global Fund Money Still Not Released

However information available on the Global Fund website reveals that \$37 million has been available since the fourth round AIDS project was approved in June of 2004 for ARV treatment access to be provided at several major sites throughout the country, during a two year period, with an additional \$85 million available for the following three years. However, the grant agreement which would release these funds has still not been signed, and there is still no specific information about when it will actually be signed. According to the website, the \$37 million would provide treatment for 44,300 PLWA during the first two years of the project.

Informed sources claimed that the delay in signing the contract and disbursing the funds are due to a range of issues related to internal government and health ministry approvals and other "bureaucratic" problems. The Department of Economic Affairs of India is the "Principal Recipient" for the grant and would implement the project. It is astounding and disheartening that \$37 million has been available to provide treatment for nearly a year, and could potentially have saved 45,000 lives, yet the CCM and Principal Recipient have not been able to complete the requirements needed in order to receive the funds and begin implementation of treatment. More perplexing is the fact that NACO has been able to complete requisites for the small government financed treatment access roll-out, but not for the Global Fund roll-out which will cost the government nothing at all.

The Global Fund claims that it is trying to use partner Agencies including WHO and UNAIDS to speed up this process, but obviously the outcome remains lethal.

The total amount available over the entire five year project for scaling up from the 4th Round HIV grant would be about \$122 million, with a goal of placing 137,000 people on treatment during a five year period. Yet, according to our own calculations based on current medication prices, for every \$10 million dollars available, about 50,000 people should be able to receive treatment.

Ironically, a fourth round grant agreement was signed just weeks ago for \$4.2 million, with a Consortium of five Indian NGO's. But

of this money, over \$1.9 million is allocated for “infrastructure, human resources, and planning and administration,” while only \$62,000 is for drugs, in this case drugs for Opportunistic Infections.

Informed sources in Geneva indicated that India’s various GFATM grants could be cancelled due to lack of follow up as the two year review process approaches for the Round Two grant, and implementation is still bogged down in delays due to bureaucracy.

The reality for PLWA in the streets and hospitals of Mumbai, is that the windfall of resources available in Geneva and New Delhi is being delayed by a small army of paid bureaucrats, while those who need treatment simply find a place to die.

Hospices in Mumbai

Nestled in the far Northeast corner of the city, six kilometres from the end the Mumbai railroad line is the Niramay Niketan AIDS Hospice. The day I visited about 50 PLWA were living there, but none had access to ARVs.

“Not all of them are terminal” said Frank Furtado, Director of the program. “For those who can be treated for their OI’s, we try to get them out in 15 days.” Still, Furtado acknowledged that about 150 PLWA die each year at the Hospice and an unknown quantity after they have left. Furtado himself expressed scepticism about placing hospice residents on ARVS unless sustainability was guaranteed.

Founded in 1885 as India’s first Leper Hospital, Niramay Niketan still houses 40 people suffering from leprosy. The stigma and suffering of untreated AIDS patients draws interesting parallels to earlier leper and TB Sanitoriums, while today, despite the fact that cheap and effective remedies exist, 98 percent of India’s AIDS patients in Mumbai and throughout the country are abandoned and left to die.

The Neketan AIDS program began in 2002 in a new building constructed with donations obtained by Furtado, and the entire project including leprosy as well as AIDS functions on a budget of US \$5,000 per month.

Furtado, although he has directed the project since it’s opening, was completely unaware of the Global Fund or the money sitting unused in Delhi and Geneva. Nor had he been told about the possibility of applying for a 5th round grant.

Furtado mentioned that there is a great shortage of staff at the Centre but indicated that part of the problem is that there are not enough qualified nurses who are willing to work with PLWA.

Since my visit occurred during lunch, nurses and assistants were busy serving ample portions of food to the residents. Two wide eyed, but emaciated children, perhaps 5 years old stared at the pale-faced intruder.

Each of the five AIDS units has its own TV and the centre is immaculately clean, in spite of the staff shortages. Furtado proudly mentioned that his institution has always been willing to accept “eunuchs” as transgendered people are known in India.

Sex workers condemned to death

Interestingly, at the JJ Hospital Centre treatment program, only 4 women out of 600 enrolled in the program are sex workers, even though Mumbai’s infamous Red Light District is just three kilometres from the Hospital. An estimated 8,000 Sex Workers are HIV+. According to one source, when sex workers begin to be ill, the men who run the brothels send them back to their home villages to die. They would avoid sending them to the Hospital for fear that authorities could obtain information about illegal activities from the sick women.

In another AIDS hospice, Jyothis Terminal Care, 50 kilometres North of Mumbai, The Director, Mrs. Bede informed me that all 73 available beds are filled. Only 4 of 73 PLWA have ARVs, those four as a result of donations made to the Hospice, Mrs. Bede confirmed that Hospice records showed that of 800 persons who were admitted to the Hospice during the past five years, 400 are known to have died, but no information is available on several hundred others who eventually left the hospice. Less than 100 are known to be alive.

I asked Dr. Vasvani why no attempt was being made to utilize the hospices for disbursement of ARV’s, given the fact that both Jyothis

and Neketan have Physicians and nurses on staff. He replied that, “you have to move slowly with these kinds of things.” In fact, in Mumbai there seems to be no shortage of infrastructure available in the Health Care system, an issue frequently referred as an obstacle in Sub-Saharan African countries and rural areas. But in Mumbai, doctors and clinics abound and with the funds that should be flowing, could be enlisted in ARV roll-out programs.

While I was in India, a large paid advertisement appeared in one of Mumbai’s English language newspapers (Mid-Day) soliciting proposals from NGOs for the fifth round of Global Fund projects, but no such announcement appeared in any Hindi papers. It is estimated that 95% of PLWA in India speak no English, but many NGO directors as well as most government officials are fluent in English. No mention was made in the ad for proposals related to care and treatment. Global Fund projects are country driven, according to Global Fund Board mandates, so there will be no intervention by the Fund to mandate proposals that would focus on access to ARV’s for PLWA. With all the delays in disbursement of Funds in previously approved grants, it is questionable why India would even be applying for a Fifth Round grant.

Country Coordinating Mechanism fails PLWA

Obviously the CCM in India is a lot better at writing lucrative proposals than at implementing them. One wonders if the CCM should not be devoting its efforts to implementing current proposals, and what the real motivation is for soliciting Fifth round grants from a plethora of NGO’s. Perhaps the promise of money strategically delivered to some leading NGO’s by the CCM may actually discourage meaningful activism, because some NGO’s become reluctant to place pressure on the various Agencies involved for fear of losing their funding.

Whereas most NGO directors we spoke to tended not to be overly critical of the AIDS treatment roll-out, one PLWA told me through an interpreter. “You are in India, but you don’t understand. To the Indian government, people with AIDS are unwanted. They would happily be rid of us.”

India has long been a centre of international activism as a result of various Indian generic companies which produce ARV’s that are exported throughout the world at cheap prices. While I was in India the new Patent act was passed over the strong protests of Indian as well as international activists. This law may have significant long-range impact on the exportation of these drugs. There was major coverage in the Press regarding the Patent Act. But, over the years with all the attention focused on the Indian generic companies little or no attention has been focused on the fact that 98% of all Indians themselves lack access to the inexpensive ARVs that are manufactured by numerous companies in their own country.

I obtained the detailed minutes of the regular monthly ARV scale up meeting held in New Delhi on February 3rd of this year, and attended by WHO, and NACO employees, as well as many international donor sources and civil society groups. Even as government representatives were explaining, the newly reduced goals in terms of scaling up, no mention appears anywhere in the minutes of the untapped Global Fund resources.

Lethal GFATM Policies

The Global Fund’s own “country driven” orientation, which mandates only minimal intervention in National decision-making regarding Fund implementation is inextricably linked to the “genocidal” bureaucracy that is occurring in India. It is clear that neither the CCM nor the Principal Recipient in India are concerned about the fact that nearly 100,000 people may have died of AIDS since the 4th round grant was approved. But the Global Fund does not intervene, (because of its “Board Policies”), to implement project safeguards that would stop the deaths of the Indian PLWA and get treatment to them. So the Indian CCM and Principal Recipient feel little or no pressure from its funding source to fulfil its obligations in a way that

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Does “CNN” (Condoms, Needles, Negotiation) work better than “ABC” (Abstinence, Being Faithful and Condom Use) in attacking the AIDS epidemic?

By Steven W. Sinding
International Family Planning Perspectives
Volume 31, Number 1, March 2005

After more than two decades of HIV/AIDS, we have learned a great deal about how it is transmitted, care and treatment options, its global impact, its developmental roots, and what preventive measures are most feasible and effective. Yet it sometimes seems as if these science-based lessons are lost in the cacophony of ideological, religious and political rhetoric that surrounds discussion of HIV/AIDS today. The uproar about ABC (abstinence, being faithful, condom use) is an excellent case in point, for the narrow manner in which this model of prevention is being interpreted may be undermining the global response.

On the face of it, few would argue with the basic premise of ABC. It is epidemiologically and programmatically sound - a tiered approach to prevention that is appropriately calibrated to levels of risk. Indeed, as implemented in Uganda and other places, the ABC approach has been successful and effective in reducing the rate of new infection and deserves the support and the praise it has received.

But it's not that simple.

Marriage as a risk factor

The reality of AIDS in Sub-Saharan Africa - still the region bearing the overwhelming share of the global AIDS burden - is that marriage (and the illusion of fidelity among supposedly HIV-negative couples) is increasingly seen as a risk factor. As health providers, we see that married, monogamous women are highly vulnerable to HIV infection due to their lack of rights within marriage, difficulties negotiating safer sex, extended partner absence and domestic violence.

In Sub-Saharan Africa, the majority of newly HIV-positive women are contracting the virus within marriage from their husbands.¹ This pattern is reflected around the world. In Cambodia, prevalence is falling among sex workers but rising rapidly in married women: Fifty percent of all married women who contracted the virus in 2002 were infected by their husbands.² Furthermore, in one recent study, more than 80% of HIV-positive women were monogamous,³ and in a study in Rwanda, 25% of women who were HIV-positive said they had had only one sexual partner in their lifetime.⁴ These women had complied with the prevention messages they were given, and yet doing so failed to protect them. Promoting abstinence or faithfulness as the only

ways to prevent HIV transmission will leave millions of people without the ability to protect themselves from infection.

Improving women's status and negotiating skills are thus key areas for any prevention strategy. Women are increasingly vulnerable to HIV infection.⁵ In 1997, women made up 41% of people living with HIV; by 2002, this figure had risen to almost 50%. In 2003, UNAIDS estimated that five million people were newly infected and 40 million people were living with HIV/AIDS. Half of those infected were women.

Condom stigma

Another critical issue is condom stigma - the association in many people's minds between condoms and illicit sex. Many women and men feel shame about using - and frequently refuse to use - condoms within marriage. A tremendously important goal must be the desensitization of condom use, the removal of the taboo on this method and, indeed, on communication between partners about condom use. The genius of Senator Mechai in Thailand and, early on, President Museveni of Uganda was their ability, as political leaders, to create an environment in which open discussion of HIV transmission permitted discussions about sexuality - at the community, family and couple levels. Once options were discussed, real behaviour change occurred. In Thailand, this resulted in phenomenal changes in condom use, and in Uganda it resulted in a more multidimensional, but nonetheless highly effective, behavioural response.

Indeed, effective condom use is real behaviour change. It has been said that past programs were primarily focused simply on providing condoms and hoping people would use them correctly. But for many years, IPPF has been teaching people how to use condoms correctly and serious efforts have been under way for several years to help young people understand how to use condoms properly. By promoting condoms as part of a standard package of prevention measures, we can help to destigmatise and normalize their use.

It comes down to this: Serious efforts at behaviour change communication may succeed in delaying sexual debut and limiting the numbers of partners. But among HIV-positive people - the majority of whom may be unaware of their status - sex is an undeniable reality and, in the absence of any other technology to protect sexually active people from the risk of infection, prevention messages must stress correct and consistent use of condoms.

Evidence that condoms work

What is the evidence that condoms are an essential part of the battle against AIDS? First, a recent position statement from WHO, UNAIDS and UNFPA reads, in part:⁶

“The male latex condom is the single most efficient available technology to reduce the sexual transmission of HIV and other sexually transmitted infections. Condoms will remain the key preventive tool for many, many years to come.”

According to a meta-analysis commissioned by UNAIDS, condom use is 90% effective in preventing transmission, and condom use has been a key element in reductions in HIV prevalence in many countries.⁷ In Thailand and Brazil, for example, where transmission has primarily been within the commercial sex trade, condom promotion has been especially effective.

But, where the epidemic is largely heterosexual and widespread, evidence on the effectiveness of condom programs has been more mixed and less clear. In Uganda, while it is clear that condoms have

Indian Government bureaucracies

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would be congruent with the life or death urgency of the situation. Ultimately it is the Global Fund as well as the National AIDS program that are failing the multitudes of poor Indians who need treatment.

One of only three Civil Society Global Fund board members worldwide works in New Delhi at a large international agency, but even her presence at the heart of where the struggle should be, seems to have generated little or no impact.

The Global Fund continues to describe itself as a Funding Source only, and also as more of a “bank” than an implementing Agency. This is distressingly accurate. Just the interest on \$140 million dollars sitting in a Swiss bank for a year, (at a 6 percent interest rate), would yield about \$8 million, enough money to purchase ARVs for 40,000 PLWA for one full year at current prices.

posted by Sherry Joseph, Futures Group, AIDS India, 11/4/05

played a role in lowering infection rates, reducing the number of sex partners appears to have played at least as large a role. In other words, condoms should not be seen as distinct from other strategies but as an integral part of comprehensive strategies that also counsel abstinence and reducing the number of sexual partners. This view is also expressed in the 2004 UNAIDS Report on the Global AIDS Epidemic.⁸

Furthermore, the effectiveness of condoms in preventing disease transmission (and unwanted pregnancy, for that matter) lies not in the inherent quality of the product but in its *effective* use. Evidence from family planning programs over many years makes it abundantly clear that the condom is a safe and relatively effective method, but that compliance in its use is difficult to achieve with consistency over extended periods of time. For this reason, family planning fieldworkers often recommended other methods of birth control over condom use, although condoms were always known to be the best and, indeed, one of the only forms of prevention of STIs.

Needle exchange

There is a good analogy between moralising against condoms and moralising against needle exchange programs. In both cases, the moralisers wish to deny human nature and behaviour. A 2004 evidence assessment by the Cochrane Collaborative Review Group on HIV Infection and AIDS shows that clean needles, methadone substitution for injecting drug use, and condom use by injecting drug users are effective in reducing the spread of HIV.⁹

Of course, rehabilitation and detoxification efforts must continue, and we must search for ways to make them better. One way to do this is by providing not just one, but a suite of care services that recognise the reality of injecting drug users' lives. Just as abstinence and fidelity are not substitutes for condom use, so rehabilitation and detoxification are not substitutes for clean needles.

Distorting the ABC model

Abstinence for younger adolescents, faithfulness in marriage and condom promotion have a place in international HIV/AIDS programs. Unfortunately, by twisting the ABC concept important international voices - the U.S. government and the Vatican, in particular - have made ABC controversial. The actions of these major political actors are not only regrettable; given their influence over millions of people around the world, they represent a serious setback to efforts to bring HIV/AIDS under control.

Conservative U.S. government officials have made clear the Bush administration's preference for abstinence-only approaches and have registered strong misgivings about the moral and ethical advisability of providing condoms as part of AIDS prevention programs, arguing - incorrectly - that condoms may encourage early sex and sexual promiscuity. In addition, U.S. officials have removed scientifically accurate information about condom use effectiveness from the Web sites of several federal agencies and have questioned whether or not condoms provide protection against STIs, including HIV.

This issue of abstinence-only programming needs to be addressed head on. No only are there question marks over exactly what defines abstinence and what makes it sustainable; there is no clear evidence that it works.

As the largest international funder of HIV/AIDS programs, the attitude and recommendations of the U.S. government have far-reaching consequences for the health of people across the world. The "ABC" approach is a central prevention component of the new U.S. Global AIDS Strategy, yet the government channels one-third of all HIV prevention funding to abstinence programs, particularly those that counsel abstinence until marriage.¹⁰

To date, however, there is no conclusive proof that abstinence-only programs have been successful in any country in the world in reducing HIV transmission.¹¹ In a recent review of abstinence programs in the United States by DiCenso and colleagues, pregnancy rates among the partners of the young male participants were no lower than those among the partners of nonparticipants.¹²

Similarly, the effectiveness of abstinence as a long-term strategy - particularly for young people - was refuted by a study presented at

the annual meeting of the American Psychological Society that reported that not only was the "virginity pledge" broken by more than 60% of the pledgers, but 55% who reported keeping their virginity admitted to engaging in risky forms of nonvaginal sex.¹³

For its part, the Vatican has conducted a global campaign of disinformation about condoms. Not only has the Vatican echoed the Bush administration's concerns about the effect of condoms on Christian morality, but many in the church hierarchy have denigrated condoms as flawed products.¹⁴ In 2003, the president of the Vatican's Pontifical Council for the Family, Cardinal Alfonso L'opez Trujillo, told a BBC Panorama program, "the AIDS virus is roughly 450 times smaller than the spermatozoon. The virus can easily pass through the 'net' that is formed by the condom."¹⁵ In countering the Vatican's claims, WHO and IPPF were supported by research from the U.S. National Institutes of Health, which concluded that "intact condoms are essentially impermeable to particles the size of STD pathogens, including the smallest sexually transmitted virus."¹⁶

In other words, the HIV prevention approach we are talking about here is not ABC in its pure form but rather ABC as it has been perverted by the religious conservatives who wield such strong influence within the Bush administration and the Vatican.

Science, not ideology

We live in a world that is complex and diverse. Many things in addition to the ABC approach are necessary to control the epidemic: Voluntary counselling and testing - a cornerstone of the WHO "3 by 5" initiative - needs to be linked to treatment access; destigmatisation campaigns are required to promote a better environment for those seeking prevention and treatment; and increased efforts need to be made to improve the status of women and young girls. The UNAIDS Global Coalition on Women and AIDS provides an excellent platform to revitalize our global prevention agenda. And while the ABC approach will form part of the response, it should be firmly grounded in science, not ideology.

Instead of debating CNN vs. ABC, we must recognize the complexity of sexual relations, which embrace every facet of our lives, including issues of culture, tradition, power and status. We must acknowledge the unequal power relationships between men and women, especially older men and younger women, and we must design interventions that provide realistic choices. Above all, we must resist efforts to impose a particular morality on individuals. We must respect the individual and find ways of giving people realistic and effective options. We must not deny men and women access to information or technologies that enable them to protect their health and even their lives. Forty years of experience in family planning and reproductive health has shown us that empowering individuals to make informed choices is the only approach that really works.

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Brazil refuses \$40M in U.S. AIDS grants to protest policy requiring groups to condemn commercial sex work

Brazilian officials at the end of April said that the country has refused \$40 million in U.S. AIDS grants because of a Bush administration requirement that HIV/AIDS organizations seeking funding to provide services in other countries must pledge to oppose commercial sex work, the Wall Street Journal reports (Phillips/Moffett, Wall Street Journal, 2/5). Under the Bush administration policy, even groups whose HIV/AIDS work in other countries has nothing to do with commercial sex workers have to make a written pledge opposing commercial sex work or risk losing federal funding. In addition, the Bush administration might refuse to fund HIV/AIDS groups that do not accept Bush's social agenda on issues such as sexual abstinence and drug use. The new policy stems from two 2003 laws, one involving HIV/AIDS funding and another regarding sex trafficking (Kaiser Daily HIV/AIDS Report, 28/2). Brazilian officials last week wrote to USAID to explain its decision to refuse the remainder of a \$48 million HIV/AIDS grant that began in 2003 and was scheduled to run through 2008. According to some HIV/AIDS advocates, Brazil has been a "model" for combating HIV/AIDS with its "accepting, open" policies toward commercial sex workers, injection drug users, men who have sex with men and other "high-risk" groups, the Journal reports. Brazilian authorities said that the Bush administration requirement that groups receiving funding must condemn commercial sex work would hinder the country's efforts to fight the disease, according to the Journal. "We can't control (the disease) with principles that are Manichean, theological, fundamentalist and Shiite," Pedro Chequer, director of Brazil's AIDS program and chair of the

national commission that decided to refuse the grants, said, adding that the commission - which includes cabinet ministers, scientists and AIDS advocates - viewed the Bush administration policy as "interference that harms the Brazilian policy regarding diversity, ethical principles and human rights."

Brazilian Strategy

Brazil's national AIDS program, which is considered to be one of the most progressive in the world, includes HIV/AIDS prevention, care and treatment services. The program manufactures and distributes generic versions of antiretroviral drugs, providing them at no cost to all HIV-positive people in the country (Kaiser Daily HIV/AIDS Report, 16/3). Although Brazil's HIV/AIDS prevention strategy emphasizes abstinence and sexual fidelity, it focuses more on condom education and distribution, according to the Journal. Commercial sex work is not a crime in Brazil, and advocates for commercial sex workers have been "among the most active" in the country's fight against HIV/AIDS, according to the Journal. The U.S. grants were to include \$190,000 for eight groups that advocate for commercial sex workers in Brazil, according to Gabriela Leite, coordinator of the Brazilian Network of Sex Professionals. Leite said that she had "lengthy" discussions with USAID to assure U.S. officials that the grant money received only would be used for HIV/AIDS education and prevention and not for commercial sex worker rights issues, according to the Journal. However, despite a 50-page agreement between USAID and Leite's group, talks "broke down" when Leite's group refused to condemn commercial sex work, according to the Journal. "Why should we adopt a different orientation if we have been successful for the more than 10 years?" Sonia Correa, a Brazilian AIDS advocate and co-chair of the International Working Group on Sexuality and Social Policy, asked. Although experts in 1992 estimated that 1.2 million HIV-positive people would live in Brazil by 2002, the country's epidemic has been "far less serious" because of its prevention efforts, and by 2002 there were only about 660,000 HIV-positive people in the country, according to the Journal.

Reaction

"Obviously, Brazil has the right to act however it chooses in this regard," Sen. Sam Brownback (R-Kan.), who has been a leader for "conservative cause[s]" in Congress, said, adding that he hopes the grants can be redirected to other countries with policies that are in line with the Bush administration, according to the Journal. "We're talking about promotion of prostitution, which the majority of both the House and Senate believe is harmful to women," Brownback added. USAID spokesperson Roslyn Matthews on Sunday said that the agency is "still reviewing" Brazil's decision, adding, "We are in the process of determining next steps." The U.S. grants were only a "small part" of the amount Brazil spends on HIV/AIDS programs, and Chequer said the Brazilian government will increase spending on the programs to make up for the lost funding, according to the Journal *Wall Street Journal*, 2/5/05 - Kaisernetwork.org

CNN versus ABC

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Acknowledgments

This viewpoint is based on a panel debate at the 15th International AIDS Conference, Bangkok, July 11-16, 2004.

posted by JVNet, 26/4/05

I don't mind if my panthi beats me up. It only shows how manly and powerful he is.

When my parik ("husband") beats me, I feel as helpless as a woman. Since I want to be a woman, it actually makes me feel good.

**Quotes from kothi-identified males.
What does this say about the way dominant masculinity is constructed?**

Men who have sex with men in Shenzhen, China, rarely use condoms to prevent spread of HIV

Only 20% of men who have sex with men in Shenzhen, China, use condoms each time they have sex, according to a survey conducted by the Shenzhen Disease Prevention and Control Centre, the *South China Morning Post* reports. Shenzhen - a town in Southern China - is a popular place for MSM because of its location near the border of Hong Kong, strong job market and "relatively tolerant attitude toward" homosexuality, according to the *Morning Post*. In the survey of 220 MSM in Shenzhen, 33% of respondents said that they "never or seldom" use condoms, 61% said they engage in anal sex, 7% said they engage in oral sex and 74% said they have had sex with strangers. To fight the spread of HIV, health officials have placed posters in some areas of the city to promote condom use. "The use of condoms has increased dramatically in those (areas) where intervention measures have been taken," Cai Wende of the Shenzhen DPCC said, adding, "But we are facing difficulties in enlarging these pilot programs, even though they have proved to be very efficient." The survey also showed that the low percentage of condom use among MSM might pose a threat to women because about half of the MSM surveyed said they sometimes have sex with women, according to the

Morning Post (Cui, *South China Morning Post*, 5/23).

HIV prevalence among male sex workers

A separate DPCC survey of 116 male commercial sex workers in Shenzhen showed that 5.17% of the respondents were HIV-positive, a rate nearly four times the HIV prevalence among MSM nationwide, according to the *Morning Post*. "The prevalence will get out of control unless immediate preventative measures are taken," Cai said, noting that there are more male commercial sex workers in Shenzhen than in Hong Kong and some people travel to Shenzhen to find male commercial sex workers. "People from Hong Kong can spread the epidemic, but we lack the necessary finances and personnel to monitor them," he added (*South China Morning Post*, 5/23). MSM account for 11% of mainland China's HIV-positive population (Cui, *South China Morning Post*, 5/23). The Chinese government estimates that there are 840,000 HIV-positive people in the country and that 80,000 of those people have AIDS. However, international experts and advocates say that the actual number of HIV-positive people in China probably is between one million and 1.5 million
Kaiser Daily HIV/AIDS Report, 19/5/05

More soldiers killed by AIDS than bullets in India's northeast

Indian defence authorities sounded a health alert with scores of soldiers engaged in anti-insurgency operations in the country's troubled northeast struck by HIV, the virus that causes AIDS.

"The time has come to wake up with HIV infection among our troops assuming serious dimensions. Now we find more soldiers dying to HIV- AIDS than to bullets fired by militants," Lieutenant General Bhopinder Singh, Director General of Assam Rifles, said in Meghalaya state capital Shillong on Friday.

"We have a challenge at hand and we need to tackle it sensitively," he told AFP at the force headquarters.

The Assam Rifles is a premier paramilitary force of 55,000 troops deployed in the rugged jungles of the northeast against some 30 guerrilla groups waging insurgencies for independent homelands or greater autonomy.

The first HIV-positive Assam Rifles soldier was detected in 1992.

Since then, 32 Assam Rifles soldiers have died of AIDS and 180 more are in serious condition at two treatment camps in the region.

After random blood screening, Assam Rifles doctors sounded the alert saying the number of soldiers infected with HIV was alarming.

Doctors with army and other paramilitary and police units in the northeast also say they are concerned but have not carried out the random blood screening that has revealed the extent of the spread of HIV among the Assam Rifles.

While the percentage of soldiers suffering from HIV/AIDS is in line with the less than half a percent of India's total population, experts say soldiers deployed in the region are still ignorant about how the illness spreads.

"We find awareness levels about how HIV spreads very low among soldiers," said S.I. Ahmed, an AIDS specialist from Assam's main city of Guwahati.

The Assam Rifles held a day-long HIV-AIDS awareness campaign Friday in Shillong with a host of celebrities, including actor Shilpa Shetty and former Jammu and Kashmir chief minister Farooq Abdullah, taking part.

As part of the drive, Assam Rifles soldiers were being given free condoms.

One paramilitary soldier, who asked not to be named, said he was

devastated when doctors told him last weekend that he had tested HIV- positive.

"I was traumatized," he said.

Promiscuity explains the spread of HIV.

"We're invariably stressed out and monotony sets in working in isolated and hostile terrain for a long period," the soldier said. "So the easy way to relax is to go for casual sex. And I also did that without really knowing the consequences."

"In most cases we have found the soldiers mingling with the locals and then going for unprotected sex to fight stress and fatigue," one Assam Rifles doctor said. "Life away from families for a longer duration is one of the reasons."

The New Delhi government has strongly disputed claims by an international anti-AIDS group that India has outstripped South Africa as the country with the highest tally of people living with HIV-AIDS.

Officially South Africa has 5.3 million infected people and India 5.1 million.

However, the executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Richard Feachem, said the official statistics were wrong and India had overtaken South Africa.

India's northeast has been declared as one of the country's high-risk zones with close to 100,000 people infected with HIV.

Source: *China AIDS Survey - Digest Number 269*

Posted on *Sea-AIDS* 26/4/05

Those who deny freedom to others, deserve it not themselves.

Abraham Lincoln, 1839

No man is good enough to govern another man without that other's consent

Abraham Lincoln, 1854

AIDS epidemic still outpacing response

Report by UN Secretary-General calls on governments to expand access to HIV prevention and treatment

United Nations, New York, 2 June 2005

Despite encouraging signs that the AIDS epidemic is beginning to be contained in a small but growing number of countries, the epidemic continues to expand worldwide, according to a report released by UN Secretary-General Kofi Annan.

The report was prepared for a high-level UN ministerial gathering today that will assess progress towards meeting the targets set four years ago at a historic UN General Assembly Special Session on HIV/AIDS.

"We are seeing real signs of progress in tackling AIDS at the community level, but it is still not enough," said UN Secretary-General Kofi Annan. "It is time for Governments to translate commitment into concrete action. In September, world leaders will meet at the United Nations to assess progress in implementing the Millennium Declaration, and to chart the road ahead. How we fare in the fight against AIDS is crucial. Halting the spread is not only a Millennium Development Goal in itself; it is a prerequisite for reaching most of the others."

While progress has been made, the report emphasizes the need for an increased global response in order to meet the 2005 goals agreed to by all UN Member States at the UN Special Session in 2001. These goals, contained in the Declaration of Commitment on HIV/AIDS, focus on the rapid expansion of HIV prevention, care, treatment and impact alleviation programmes. They are a vital foundation to achieving the UN Millennium Development Goal of halting and reversing the epidemic by 2015.

For example, one of the goals is that by the end of 2005, HIV prevalence among young men and women aged 15 to 24 in the most affected countries should be at least 25% lower than in 2001. The reality is that young people continue to represent one half of all new HIV infections worldwide, and often do not have access to life-saving prevention services.

"The AIDS epidemic has entered a new and critical phase, and so must the response," said Dr Peter Piot, UNAIDS Executive Director. "The only way we will get ahead of the epidemic is if there is universal access to HIV prevention and treatment. This needs to be the world's immediate goal."

UN Member States participating in today's General Assembly High-Level Meeting on HIV/AIDS will review progress made towards achieving the UN goals, and will outline solutions and policies needed to meet the targets and roll back the epidemic.

According to the Secretary-General's report, progress has been made on several fronts since 2001. Worldwide, the number of people receiving counselling and testing services has doubled over the past four years. The number of women accessing services to prevent mother-to-child HIV transmission has increased by 70%, and the number of young people who have received AIDS education has doubled.

Funding for AIDS in developing countries has also increased dramatically – from US\$2 billion in 2001 to an estimated US\$8

billion in 2005. But resources still fall short of what is needed to effectively turn back the epidemic.

Despite encouraging signs, the report also outlines serious challenges that need urgent attention in order to achieve the intended goal of reversing the epidemic. Access to HIV treatment and prevention services remains low. As of end 2004, only 12% of the 6 million people who need HIV treatment worldwide had access to it. Globally, only one in five people has access to prevention services. And targeted prevention services in 2003 reached only 16% of sex workers, 11% of men who have sex with men, 20% of street children, and less than 5% of the world's 13 million injecting drug users.

The report makes specific recommendations for scaling up prevention and treatment efforts, expanding services to orphans and children made vulnerable by AIDS, ensuring gender equality, and mobilizing additional resources for fighting AIDS. These include making HIV testing services more widely available, integrating HIV prevention into treatment scale up efforts, promoting universal free education for boys and girls, and combating violence against women.

About the UN Secretary-General's Report

The report of the UN Secretary-General presented to the General Assembly today is based on country data from various sources, including national data on key AIDS indicators from 17 countries in Africa, Asia, the Caribbean and Eastern Europe, other national surveys, commissioned studies and evidence-based estimates of coverage for key AIDS interventions. In 2006, the UN Secretary-General will release a more comprehensive report on meeting the 2005 goals based on end 2005 data on all global and country indicators. The indicators measure the progress towards implementing the targets and goals of the Declaration of Commitment on HIV/AIDS. The indicators are broken down as follows:

- **Global-level indicators** (e.g., international spending, policies and advocacy efforts)
- **National commitment and action indicators** (e.g., domestic government spending; country-level policy development and implementation)
- **National programme and behaviour indicators** (e.g., access of vulnerable groups to key services; risk behaviour changes)
- **National impact indicators** (e.g., rate of new infections among young people, high-risk groups and infants born to HIV-infected mothers)

For more information, please contact Annemarie Hou, UNAIDS, New York, mobile (+41 79) 500 2123, Jonathan Rich, UNAIDS, New York, tel. (+1 212) 532 0255, Dominique De Santis, UNAIDS, Geneva, (+41 22) 791 4509 or Newton Kanhema, UN Department of Public Information, New York, tel (+1 212) 963-5602. The Secretary-General's Report and information on the General Assembly High-Level Meeting on HIV/AIDS can be accessed on the UNAIDS website, www.unaids.org.

India plans law to stop discrimination against AIDS

India, which has the world's second largest HIV/AIDS population, plans to introduce a law to stop discrimination against people infected with the deadly virus, the health minister said on Monday.

A huge stigma is attached to people who are HIV-positive in India and many of the country's 5.1 million people with AIDS face severe discrimination because of widespread lack of awareness about the illness.

Activists say many employees of hotels, factories and textile firms have lost jobs after testing positive. They are either forced to quit,

given early retirement or declared unfit to work.

"We have finalised draft legislation to end discrimination against AIDS patients," Health Minister Anbumani Ramadoss told an AIDS conference.

"It has gone to the law ministry and will be presented to parliament."

India's HIV problem has assumed serious proportions despite health programmes to halt its spread. Over the years, HIV/AIDS has

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Statement at the General Assembly High-Level Meeting on HIV/AIDS

New York, 2 June 2005

by Dr Peter Piot

Excellencies, distinguished delegates, colleagues and friends:

We have heard the Secretary-General emphasize in his speech the dramatic change in global action against AIDS since this august Assembly adopted the Declaration of Commitment on HIV/AIDS four years ago.

But, equally, as the Secretary-General and His Excellency Monsieur Jean Ping have said, we have not turned back the epidemic. In fact, given the quantum worsening in the epidemic in the past years, the gap between need and action remains enormously wide and may even grow.

Looking back over the past four years, two disquieting facts become evident. One is that AIDS is an unprecedented global crisis – there is simply no other example of this kind. The other is that until and unless we control this epidemic it will continue to expand and worsen – for decades – killing unbelievably large numbers and wrecking entire societies.

Ladies and Gentlemen:

These two facts require us to make a quantum leap in our commitment, in our goals and in our action on tackling this terrible epidemic. These two facts show that this epidemic will defeat us unless there is an exceptional response from the world's leaders and publics.

Our response will be equal to this challenge only when several milestones have been met.

The first and foremost milestone is that AIDS get the same level of attention and concern by the world's leaders as they give to global security – not an iota less. In every key policy-making body, the AIDS epidemic needs to be taken up as regularly and with as much scrutiny as the most urgent security threats and crises are.

The second essential milestone is that we must ensure universal access to both HIV prevention and HIV treatment. It has become obvious in the space of the past years that nothing less than universal access to effective HIV prevention and treatment will be sufficient if we are to keep this epidemic from engulfing the next generations. And for universal access to become a reality we must immediately close the huge funding gap of many billions. Yes, there has been remarkable progress since 2001, notably because of the creation of the Global Fund called for the General Assembly in the Declaration of Commitment. But the shortfall is widening.

A third milestone is that we must make the money work for people on the ground. For the money to work effectively all actors and funders need to support nationally led strategies through the 'Three Ones' principles, which have been endorsed by governments, civil society and donors worldwide since 2004. And for the money to work the rights and needs of women and of the most vulnerable and marginalized people – particularly sex workers, men who have sex with men, and injecting drug users – must be accorded the highest priority in practice. And, equally, people living with HIV have to be

accorded their rightful leadership role at every level.

Ladies and Gentlemen:

A fourth milestone towards a response that is truly equal to the threat is that we fully incorporate a long-term horizon into our planning and in our actions. We must move from the reactive to the active and strategic. This is an imperative because the AIDS epidemic is a long-term one, it will not somehow disappear one fine day. Consequently, at the same time as we work on an emergency footing to make universal access to HIV prevention and treatment a reality, we have to achieve several other things too. We have to put in place the systems that are needed to realize longer-term solutions, such as an HIV vaccine and microbicide. We have to tackle the fundamental drivers of this epidemic, such as lack of education, gender inequality, poverty and discrimination. And we have to overcome the enduring obstacles to development created by the epidemic itself, such as the orphaning of generations of children and the stripping of human and institutional capacity. In other words, we need to plan for exceptional action on the things that will make a difference in one year and in five years – as well as in 10 years and 20 years. We must make this conceptual leap in our planning and actions.

Mr President, I can assure you of the commitment of the 10 UNAIDS Cosponsoring organizations and myself to working hard to reach these four milestones. We have come a long way since the creation of UNAIDS, the Joint and Cosponsored UN Programme on HIV/AIDS – but it is not enough. As a UN system we need to maximize our collective effectiveness by pooling our efforts in every country as a fully joint UN team and programme on AIDS. This is nothing less than UN reform in action for the benefit of the people.

Ladies and Gentlemen:

The Declaration of Commitment adopted in 2001 was a brave and great leap forward – but it is self-evident today that success against this epidemic requires that almost every country execute a far stronger plan, far stronger action, and clear targets that go beyond 2015.

If we invest now on the right scale and in the right manner in tackling this epidemic, we could free up scarce resources desperately needed for development much sooner than we think. Resolve the AIDS crisis and we remove a major hurdle to achieving the Millennium Development Goals.

My respectful call to you is that when this Assembly meets a year from now that it will not be to discuss what has not been done on AIDS, but to agree on action to address the material and dare I say political obstacles in the path of universal access to HIV prevention and treatment. We cannot afford to rest before this is achieved.

Thank you.

Discrimination and AIDS

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moved beyond traditionally high-risk groups such as prostitutes, drug users and homosexuals.

Experts say the number of those infected could quadruple by 2010 and the World Bank has warned the disease would become the single largest cause of death in the world's second-most populous country unless there is progress on prevention.

“People living with HIV/AIDS face stigma and discrimination

and, therefore, care and support to such patients needs to be mainstreamed through general health services,” said a health ministry statement.

The virus is spreading into families, infecting mothers and children, and many people do not even know they are infected.

Experts say the most alarming trend is the spread of the disease to villages, with rural India accounting for 59 percent of infections compared with 41 percent in cities.

Reuters, April 4, 2005.

ARVs in Pune, India

By Durga Chandran

Suresh Sawant is the 600th-odd HIV-positive patient listed in the register of those applying for free anti-retroviral therapy at Pune's largest public hospital. He has been camping on the footpath outside the hospital with his family. But, as of now, only 86 of the hundreds applying are receiving the free therapy

Thirty-year-old Suresh Sawant (name changed) from Shevgaon village in Ahmednagar district, Maharashtra, is HIV-positive. Frail and undernourished, Suresh, a daily wage labourer, has been unable to work for the last couple of months. He complains of acute and persistent diarrhoea; he can't eat much. This is his third visit to the Sassoon General Hospital, Pune, one of four centres in Maharashtra identified by the National AIDS Control Organisation (NACO), the nodal agency for implementing the HIV/AIDS prevention and control programme in India, and the World Health Organisation (WHO) for free anti-retroviral therapy (ART) to people living with HIV/AIDS (PLHA).

Suresh has been camping on the footpath outside the hospital for the last three days, with his 75-year-old mother and elder brother. Despite being told repeatedly by the counsellor that his name had been entered in the record book and that he was the 600th-odd patient on the waiting list for the free ART programme, Suresh stands there pleading for some medicine to relieve him temporarily of his ailment. Besides the physical pain, there's fear lurking in his eyes as he wonders if he will survive the long months before the free drug is actually made available to him.

It's evident from the steady stream of people queuing up outside the old OPD of the Sassoon General Hospital (Room No 60) - where patients are being screened for free ART - as well as from the already overflowing register that there are many like Suresh who cannot afford to buy the expensive anti-retroviral drugs (costing around Rs 1,100 a month) and are awaiting their turn for the free therapy after undergoing the initial screening.

Of the 700 or more PLHA who have been screened since January 5, 2005, around 86 patients were enrolled in the free ART programme in Pune as of February 9, 2005. They are getting a fixed dose combination of three drugs - Stavudine, Lamivudine and Nevirapine. According to the hospital authorities, the number of patients receiving the free drugs has been arrived at on the basis of NACO guidelines.

The NACO guidelines, called 'Programme Implementation Guidelines for a Phased Scale-up of Access to Antiretroviral Therapy', were drafted following the Indian government's decision in 2003 to place 100,000 AIDS patients in India on structured anti-retroviral therapy by the end of 2005, and 15-20% additional AIDS cases each year thereafter for a period of five years. The guidelines spelt out a detailed implementation of anti-retroviral drugs to people living with HIV/AIDS.

Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu are the six high-prevalence states where the drugs, procured through the WHO, are presently being administered. In Maharashtra, the drug is being administered in regions with a high prevalence of PLHA — like Mumbai, Sangli and Nagpur, besides Pune.

According to statistics supplied by the Maharashtra State AIDS Control Society (MSACS) involved in the implementation of the National AIDS Control Programme in the state, Maharashtra has around 128,011 people who have tested HIV-positive (between August 1986 and February 2004). The MSACS' AIDS surveillance report further reveals that as of February 2004 there have been 9,569 AIDS cases in Mumbai alone, 2,507 in Sangli, 1,026 in Pune and 636 in Nagpur.

Considering the growing number of HIV/AIDS cases in the state, the MSACS, in coordination with NACO, decided on a specific number of patients to target at each regional centre. The guidelines set

a target of free drugs for 150 patients for Mumbai's JJ Hospital, BYL Nair Hospital and KEM Hospital, but the enormous number of patients who queued up to receive the drugs forced the government to increase the number from 150 to over 960. In Sangli too the number was raised from 150 to 240.

In Pune, the BJ Medical College and Sassoon General Hospital were given the target of enrolling 75 patients, a number arrived at in keeping with drug supplies made available to the centre. "We have extended the number to 86 as the entire drug stock for the year has arrived and we can cater to a few additional patients. I have also written to the MSACS requesting an increase in drug supplies so that we can extend the free ART programme to benefit more patients in and around Pune," says Dr Kakrani, professor and head of department of medicine in charge of supervising the free ART programme at Sassoon.

The screening was based on three essential criteria — an ELISA test to confirm the HIV-positive status of patients, CD4 count blood test, which measures the strength of the immune system after a diagnosis of HIV infection, and, most important, ascertaining the patient's willingness to adhere to the prolonged treatment. Among those screened, WHO class III patients (those who exhibit weight loss of more than 10% and symptomatic diarrhoea/ fever for longer than a month) and class IV patients (who exhibit symptomatic AIDS-Wasting syndrome and severe opportunistic infections) or those with a CD4 count below 200 were given preference.

Although the introduction of the ART programme in the fight against HIV/AIDS has led to a dramatic decline in AIDS-related morbidity and mortality, the effectiveness of the programme depends mainly on the patient's adherence to the lifelong regime; therefore patients with regular follow-up rates were included in the programme.

Dr Sanjay Pujari, director HIV project, Ruby Hall Clinic, Pune, in his article 'Anti-retroviral therapy in India: Some cautions', published in the Indian Journal of Medical Ethics says: "Adherence is critical for the long-term success of anti-retroviral therapy. Patients need a lot of encouragement and support to achieve more than 90% adherence to their regimes. Education and support by physicians, coupled with a commitment by patients to continue despite side-effects and inconvenience, is a critical component of successful treatment."

The role of the counsellor becomes extremely important in this regard. It is left up to the counsellor to talk to patients and their families and make them realise the importance of taking the medicine regularly.

"The government guidelines required the centre to administer the drug to patients within a 50 km radius of Pune as it would be easier for them to visit the hospital every month to collect their pack of the free medicine. But the centre has been receiving patients staying 300-400 km from Pune. Most of the patients cannot afford the trip to the city every month," says Vaishali Gaikwad, the newly appointed counsellor for the free ART programme at Sassoon Hospital.

According to hospital sources, although NACO's guidelines were kept in mind, most of the 86 patients were chosen on a first-come-first-serve basis and belonged to rural pockets of Pune, Ahmednagar and Marathwada. Children and pregnant women were not being administered the drug. "The saddest part about anti-retroviral therapy in India is the unavailability of paediatric formulations of these drugs," says Dr Pujari.

The male to female ratio of ART drug recipients in Pune is 70:30. "This is reflective of the ward admission in our hospital too, where very few women from rural backgrounds or otherwise come forward for treatment, especially if it involves sexually transmitted diseases," Dr Kakrani adds. It is also interesting to note that there are no commercial sex workers receiving the drugs; a reason for this could be lack of information about the programme or their unwillingness to come forward and identify themselves.

The fear and social stigma attached to the disease together with

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ARVs in Pune

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lack of awareness about the programme are resulting in many patients rushing to private practitioners, some of whom are taking advantage of the situation. "We were taking the anti-retroviral drug from a hospital near our home for the last one year. Every month we had to pay Rs 800 for the drugs and Rs 100 as consultation fees, but there was no remarkable difference in our health," say Seema and Rajesh Naik (names changed), who are now waiting for the free treatment at Sassoon.

"The test to check our CD4 count was done just once at the beginning of the year, so we had no way of knowing the efficacy of the drugs on our immune system. Only after attending the counselling session at Sassoon Hospital did we find out that the tests should be repeated two to eight weeks after starting the therapy and then every three or eight months. We lost a lot of money," says Seema.

Although the free ART programme has brought hope to a lot of people living with HIV/AIDS and their families, there are still several missing links in the programme. It is important to remember that for the 86 who have been included in the programme in Pune, there are 700 others who are yet to receive the treatment. And that number could be just the tip of the iceberg.

"I have been coming to Sassoon since January this year hoping to get the free treatment but they have told me to wait since my CD4 count is not below 200. Do they have to wait till my condition worsens and then treat me? With a meagre salary of Rs 2,500 to run my household, I cannot afford to come to the hospital often," says 40-year-old Asif (name changed) who works in a bakery to support his wife and children. The frustration of someone who is aware of the availability of the free drug at such close quarters and is unable to avail of it is palpable.

InfoChange News & Features, April 2005

<http://www.infochangeindia.org/features260.jsp>



Building Networks, Sharing Knowledge, Helping Ourselves

Gay, kothi, zenana, bakla, hijra, waria, kathoey, fa'fa'fina, other? Working with others like yourself in HIV/AIDS prevention, treatment, care and support in the Asia Region?

Would you like to share your experiences with others?

The why not write to Naz Foundation International about your or your organisation's work, self-help organising, outreach activities, and any other news you think might be of interest to others, sharing knowledge, skills and information.

Send us your news, stories, and images to Kaushik Das on kaushik@nfi.net for possible inclusion in a new e-newsletter ARMAN News, which will be electronically distributed on a number of e-groups and forums, as well as on the NFI website.

Don't forget to send us your contact details.

Free AIDS tests offered to gay men

South China's Guangdong Province recently began providing free and confidential access to AIDS and HIV tests to gay men.

The move will last one month and is designed to be an annual event.

Between May 10 and June 10, local homosexuals including foreigners can provide blood samples in anonymity by mail to the AIDS Prevention and Treatment Institute of the Guangdong Provincial Centre for Disease Control for AIDS and HIV tests, an official from the centre said yesterday.

Meanwhile, gay men who arrive at the centre can speak face-to-face to doctors there.

Confidentiality is a priority, with examination results not to be leaked, said Jin Jianxing, a centre official.

In addition to mail-based services, examinees can receive test results via the Internet if they do not wish to travel to the centre, Jin said.

The move is aimed at helping the province study and research the spread of AIDS and HIV among the province's gay population and to tackle the spread of the fatal disease in Guangdong, which borders Hong Kong and Macao special administrative regions.

The number of gay men makes up between 2 per cent and 4 per cent of Guangdong's total population, Jin said.

And the odds of gay men passing on HIV and AIDS are usually five times greater than lesbians.

Shenzhen Special Economic Zone alone is now estimated to have more than 100,000 homosexuals living within the area.

Meanwhile, the centre also offers free examinations for hepatitis, syphilis and other infectious diseases for gay men during the one-month period, Jin told China Daily yesterday.

To help fight AIDS and HIV in Guangdong, where AIDS has quickly spread in recent years, authorities are planning to establish a special anti-AIDS working committee to focus on preventing and tackling the illness.

The committee will consist of senior doctors and other experts who will try to establish files for all AIDS patients and HIV carriers in the province.

It is expected to be officially established before the end of the year and will seek out international co-operation and overseas financial support over the next few years.

And Guangdong provincial government will surely expand the government's investment in combating HIV and AIDS, while importing advanced equipment and technologies to help test and treat patients.

An official from Guangdong Provincial Bureau of Public Health has promised to further improve his province's testing and treatment standards.

Guangdong's total number of AIDS patients officially numbered 5,051 at the end of last year.

But the official predicted that the prosperous province likely had as many as 30,000 underground AIDS patients and HIV carriers.

Last year alone, a total of 191 people were diagnosed as having contracted AIDS in Guangdong.

With Guangdong's opening up drive advancing, the province's number of AIDS patients and HIV carriers will continue to grow in the future, doctors predict, becoming a serious health threat to the province.

Guangdong now has the fourth greatest number of AIDS patients and HIV carriers in China.

Yunnan Province in Southwest China is the worst HIV/AIDS hit region. It is followed by the Xinjiang Uygur Autonomous Region and Guangxi Zhuang Autonomous Region.

China Daily 05/18/2005

Sexual minorities in Pakistan

Tahir Khilji, *Vision, Pakistan*

Founder of *Nayab Health Project* in Lahore, working with *zenanas* and HIV/AIDS

This article is primarily based upon experiences of the work that Vision has been doing in partnership with zenanas (males who identify as females) community for the past seven years.

Visibility in the media

The question that at the very onset needs to be answered is that who are the sexual minorities in Pakistan? Logically, I would assume that sexual minority anywhere in the world would comprise of those people who do not conform to the norms and practices of sexual mainstream in the society.

In other words if heterosexuality is a norm and the only accepted mode of relationship in a society then those who have homosexual relationships will obviously not be conforming to the norms set by the society and thus would be considered and treated as a minority.

Once declared a minority (sexual or otherwise), the community, group, or an individual, faces a series of challenges. One major challenge is that of co-existence with the mainstream. One of the factors that is essential for this co-existence is to understand the perception of both the groups towards each other i.e. majority group towards minority and similarly minority groups towards majority.

There could be several ways of gauging this perception and one of them may be to see how each group projects the other because it is the projection and visibility that one allows the other in their respective worlds that enables each to start a dialogue with the other and agree upon the dynamics of co existence.

Thus, using this as a paradigm what do I see happening in Pakistan? For this, let us first examine the mainstream sexual groups' perceptions towards sexual minorities.

Predominantly, and interestingly, any perception that emerges through different mediums such as literature (both classic and popular), drama, mainstream cinema and journalistic reports reflects on relationships between two men and does not touch upon emotional and sexual relationship between two women.

If one is to look at the literature before 1947, there are references to relationship between two women in both classic and popular literature (Vanita, Kidwai: 2001) but the only carried forward of that literature post partition are Ismat Chughtai's story "Lihaf" (the quilt) and Tehri Lakeer (the crooked line).

In comparison there is plenty in both classic as well as popular literature that sheds light on relationship between two men pre and post partition.

To mention a few here I would refer to following, Shaukat Siddiqui's novel "Khuda Ki Basti" (God's Own Land), Sadat Hassan Manto's short story "Mummy", Hameeda Sultan's Rang Mahal (colored Palace), Josh Malihabadi's "Yadoon ki Barat" (The Wedding Party of Memories) and many more that reflects upon male to male relationship.

From the entire list of the books that I am referring to in my preceding paragraph, it is probably Josh who remembers his sexual encounter with another male fondly, otherwise most of it has been written and reflected upon from a more negative and judgmental point of view.

The popular literature provides a whole range of books that have cashed upon the myths surrounding male-to-male sexual relationships. In most of these books sexual content takes both center stage as well as periphery¹. Mostly stereotypes are reinforced and there is hardly any effort to explore male sexuality and its different dimensions.

On both stage and television again there is a total silence on relationship between two women. However, male-to-male sexual relationships forms an integral part of popular theatre's comic relief. Mostly it is demeaning and derogatory, especially when there is a subtle reference to a person who would be getting penetrated in the sexual act. One can clearly draw parallels between the role of women

and these specific men in popular theatre (the treatment reserved for both is not any different in these so called "stage plays").

The other space provided to male-to-male relationship in the popular theatre is more in context of *zenanas*. They are made the butt of each joke where each gesture is vulgarised and demeaned. Generally their exit from the stage is unceremonious and in form of pushing and getting kicked or beaten by another all male character, and where the *zenana* character is supposed to be enjoying such treatment.

Mainstream Pakistani cinema has mostly followed the pattern of popular theatre where male-to-male sex is generally referred to in derogatory terms². Once again, *zenanas* are projected as 'creatures' who deserve to be treated in and obnoxious and abusive manner. If any positivism is conceptualised for their characters it is more where they end up dying in order to save the life or honour of the female lead or the life of the male lead. The dialogues at the time of dying mostly reflect their uselessness in the society and how this good deed i.e. saving the honour or life of the main leads, would provide them a place in heavens.

Parallel cinema and documentaries³, in recent times have highlighted the issues of sexual minorities (although once again they are focused on men who love men) in a context that provides a take off point for discussions and reflection on person's right to make a choice regarding his sexual orientation.

Vernacular press has shown a tendency of sensationalism while reporting news on sexual minorities. Again whatever is reported is mostly about males. Female sexual minorities are once again invisible in print media.

The English press appears to use a more balanced approach in reporting news on such male, though here too, there is an absence regarding women. At the same time, the English press is still at a preliminary phase of addressing the issues of male sexual minorities, and is trying to identify the different groups that form the larger population of male sexual minority.

Thus, one can conclude from this that a very limited visibility of sexual minorities is permitted by the society in Pakistan, and even during this process the mainstream society reserves the right to project sexual minorities in derogatory and abusive ways.

Physical visibility in public spaces

The only physically visible group from the larger male sexual minority is the population of *zenanas* and *hijras*. This is due to their performative presence in the public domain through dress, make-up, and actions.

Masculinity in Pakistan has very strict parameters. Clothing, selection of colours, body language, and topic of conversation would be some of the factors that would determine the expression of manliness in a male.

A new term that has been coined for the young male social elite is "Mummy Daddy Type". These "Mummy Daddy Types" are generally educated, aware of recent trends in fashion, are willing to experiment with colours and fabrics, and may or may not have a same sex orientation.

If they do have a same sex orientation, they are very well insulated and hidden from the larger society because of their social status, taking their social responsibilities seriously. They are aware of the package that comes along with maintaining the status quo and so they carry the entire baggage of family honour, maleness, and their desire for being with another man in a nicely wrapped up heterosexual marriage. Their visibility as a male sexual minority is restricted to totally protected private spaces and to a few close like-minded friends

from a similar class structure and who have same stake in keeping things anonymous.

As a consequence, any perception of a male sexual minority towards the mainstream sexual majority are the voices of *zenana/hijra* communities as they are the only visible group and have no inhibition in reflecting upon their feelings.

Briefly, they feel harassed, violated, humiliated, and cheated by the mainstream. With their own support systems they do not generally interact with mainstream, which is usually limited to sexual encounters where again they feel short changed. Their spaces are segregated and they restrict themselves to "cruising" areas where it is easy for them to get a client/partner⁴.

Current legal structures

The current legal structure in Pakistan is a British legacy. Ordinances, amendments and legal acts complement the inherent legal structure and also reflect the process of law making since the inception of Pakistan. The current constitution of Pakistan was drafted and approved by the then elected assemblies in 1973.

As in any other country, the constitution of Pakistan provides protection to all its citizens so the protective clauses are part of the constitution of Pakistan and to invoke any clause, a writ has to be filed in one of the provincial high court (depending upon the jurisdiction). However, there is not much of a history of Public Interest Litigation in Pakistan, but this does not mean that there is no room for such an exercise.

Sexual minorities and legal protection

The needs of sexual minorities would generally emerge from the visibility factor and how that visibility affects the mainstream society. If such visibility is non-threatening then there may not be much legal protection required. However, if this visibility is threatening then the nature of the need would correspond to that threat.

In Pakistan's case, right now such visibility is non-threatening. Mainstream society is not losing its sleep over the existence of several thousands of *zenanas* in a population of approximately 150 million (estimates year 2000). Rather a tacit approval of their existence is justified through history (Jaffery: 1998). Thus, on surface there is not much hope of a confrontational situation between the law and the rights of sexual minorities.

However, if one scratches the surface, it is evident that the need is there and has to be addressed immediately. The entire process of marginalisation and stigmatisation has been done so overtly that the community has internalised their status in the society and consider themselves to be destined to live this life.

A confrontational situation may arise if the community is further stigmatised and is considered to be a major source of spreading disease such as HIV/AIDS (it is already being called one of the most at-risk groups in Pakistan). In such a situation the community faces two major problems; one is of their bodily exploitation by those who are collecting data and collating numbers for HIV/AIDS figure in Pakistan, as this is one of the most powerless and visible at-risk sub-populations from the larger MSM population in the country. Testing for HIV can be done forcibly without using appropriate informed consent protocols and there is ample evidence that this has happened in the city of Lahore, Pakistan⁵.

If this is a beginning, there is much more that can follow within the garb of HIV/AIDS. Thus, we are looking at a very vulnerable community that is part of the larger male sexual minority but right now stands in isolation and has to safe guard its own interest as well as act as catalyst for starting some kind of movement for other male sexual minorities.

Article 25 of constitution of Pakistan reads as under:

Equality of citizens

- (1) All citizens are equal before law and are entitled to equal protection of Law.
- (2) There shall be no discrimination on the basis of sex alone
- (3) Nothing in this article shall prevent the state from making any special provision for the protection of women and children

This Article, when read with Article 36 and Article 38 of the constitution can be invoked for the protection of sexual minorities. While Article 36 is on *protection of minorities*, it is Article 38 that talks about promotion of *social and economic* well being of people.

Article 38 states that: The state shall secure the well being of the people, irrespective of sex, caste, creed or race.

This means that if *zenanas* are defined as a minority, then the *zenana* community (or for that matter any other sexual minority) can use this article for its protection. Thus if the state provides protection to *zenana* community and each individual of the community then the state is not only acknowledging the existence of the community but is assuring that each individual will enjoy all those rights that any other citizen of Pakistan enjoys.

This admission by the court of law would be ground breaking and would initiate a series of protections for the community, such as protection against police violence at police stations, a common practice of arrest without warrants from living spaces, and searching the living space without search warrants.

The challenge, however, remains that both the state as well as thuman rights groups in the country, has to disassociate the act (survival sex or consensual sex with another man) from the person. Thus unlawful acts do not mean that a criminal does not get those rights that are promised to him under the constitution of the country.

Future course of action

It is essential that a future course of action should be designed keeping in mind the ground realities of Pakistan. If the Constitution of Pakistan provides certain protections, there are other laws in place that directly threaten sexual minorities, specifically *zenanas*, both as an individual and as a community.

One such law is the section 377 of Pakistan Penal Code (PPC). It reads as under:

Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment of either description for a term which (shall not be less than 2 years nor more than) ten years, and shall also be liable to fine.

Explanation: Penetration is sufficient to constitute the carnal intercourse necessary to the offence described in this section

I believe that any demand to abolish section PPC 377 may be considered a radical move, and may meet not only strong resistance but can have volatile reaction that may eventually lead to a counter productive situation for all involved. Thus, one has to look at other strategies that would start to dilute the section and decrease its damaging aspects.

It is true that there have been very few cases that have actually been registered under this section, but it remains a very potent tool in the hands of law implementation agencies, such as police, to harass the *zenana* community. Thus, what one can currently ask for is to bring in certain distinctions and introduce more clarity to existing structure of the section.

As there are many grey areas in the section, I believe that there is enough space to manipulate and manoeuvre the situation. Age remains one the areas that need to be clearly negotiated. Male child sexual abuse needs to be distinguished from consensual sex.

What happens when age is defined?

Currently two males involved in the sexual act become culpable if they are either 18 years of age or they have attained puberty, whatever happens earlier. Case law clearly reports that there has been evidence of puberty at the age of 15 and below.

What perhaps could be advocated initially is that two male having sex should only be brought under the purview of this law if they have attained the age of voting i.e. 18 years of age. Anything before that should be considered male child sexual abuse and should be tried under the laws that already exist for child protection and should also follow the same procedure that is provided under such laws. Currently

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Sexual minorities in Pakistan

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there is no such law. The Juvenile Justice Ordinance (JJO) has been abolished early this year (2004).

What benefit does it have in the long run?

Male children who reflect characteristics that are considered feminine by the society are prime targets of sexual abuse, and if they are caught having sex with an adult, it is generally the child who is taken to the police station while the adult is able to bribe or talk his way through with the police official. At the police station, the child is not only mentally and physically brutalised, but if young and good looking, would be kept in custody for extended periods of time and would also be sexually exploited. A cut off point in age would be the first step in this situation.

Similarly the word "rape" or forcible sex is not part of the legal lexicon. Lawfully, male on male rape does not exist. Non-consensual sex between two males should also be brought under the purview of the law.

Taking these initial steps, I believe, can lead to a process where spaces can be developed for the legitimisation of consensual adult male-to-male sex.¹ Jismanay by Khalid Arman, Jinsi talookat by Muaz Hassan, Humjins parasti by Imam Alludin Shehbaz. Darmayanay by Saif ur Rehman Rana.

References

² Heer Ranjha (1974), Salah Sahib (1982), Shora tay jawai (1981) Shama (1980)

³ World Ka Center (2002), Listen To MY Voice (1998), Madhu The Mystic (2003)

⁴ Listen to My Voice, 1998

⁵ Vision versus National AIDS Control Program of Pakistan, Ministry of Health, Family Health International. Writ filed in the Lahore High Court Lahore. Status: litigation pending. Year of filing; 2003



Sahodaran, the MSM sexual health project in Chennai is conducting a series of street theatre programme exploring HIV/AIDS, masculinities and sexualities.



International Gender Transient Affinity (IGTA)



Founded in 1989, IGTA is the British based human rights and research organisation for and by the world's transgendered. Its overall goal is the achievement of recognition for the equal rights of a nation alive within all nations, called by many names but identified from western sources as the transgendered.

IGTA recognises all branches of same, irrespective of race, creed, colour, politics, or gender, sex and sexuality. IGTA also works with and for all other sexualities and identities in human rights and liaises with Amnesty International and ILGA, among others.

It operates agents in a cell system, not unlike the secret services of the world, establishing routes for safer travel and escape from oppression, safe houses, and observation points from which ground-situation reportage can be filtered back to the west, for address by Amnesty, et al.

It also gathers empirical evidence and data on the social anthropology, archaeology, history, art and culture of transgenders worldwide into a museum/gallery project, which it uses for publication in order to educate the wider world.

In a polarised world where gender and sex are tied into a binary and hierarchal system of male and female, transgender provides the challenge and the opportunity to deconstruct such a system, creating a world where all humans, irrespective of their own gender definition can find peace and self-worth.

IGTA therefore represents all and any kind of transgender, no matter how they see themselves, male to female, female to male, as children of the Mother/Father Goddess, the world's earliest deity, also known as Nature.

IGTAs agents have established a world wide network and continue to pursue contact with all TG communities. They have helped in the change of laws in Russia and the People's Republic of China for transsexuals and the clinicians who help them, in the change of laws in Brazil, in support of the Turkish and Greek TG movements, and in forming contact organisations within socially and politically hostile countries, notably inside the Slav civil war.

The organisation is looking for more direct contact through India and the rest of Asia.

For more details please write to:

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