Pukaar
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October 2007

Developing the Asia Pacific Coalition on Male Sexual Health

The October 2007 edition of Pukaar (number 59) is focusing on the development of the Asia Pacific Coalition on Male Sexual Health, a history-making development in the region with a one year gestation period. APCOM brings together MSM[1] community-sector representatives, donors and the government sector, along with the technical support of UNAIDS, UNDP and UNESCO, to address the appalling lack of investment in HIV prevention, treatment, care and support services for MSM, and the concomitant and extraordinary lack of service coverage. The consequence of course is not hard to predict – ever increasing HIV epidemics among differing sub-populations of MSM in the different countries of the region.

Pukaar has consistently highlighted these disheartening issues of concern over the years, and despite fine words by key international institutions and donors, very little has changed, where even in Thailand, despite all the trumpeting of the supposed success of it's "100 percent condom use" campaign, HIV prevalence among MSM reached over 28% in 2005, when it was just over 17% in 2003!

The increasing HIV prevalence only goes to show the high levels of denial, stigma, discrimination and social exclusion that MSM face across the region, and where that old slogan from the eighties in the United States, "silence equals death" still has meaning and significance for us.

One of the consequences of these facts has been that MSM community organisations often find themselves on the opposite side of the wall of indifference where we tend to fight over breadcrumbs, rather than coming together with one voice. And when do come together, we find ourselves arguing with donors and governments about our needs. Evidence-informed programming? For many of us this rings hollow.

The development of APCOM hopes to change that mind-set and develop a coalition of forces that will make a real difference. It joins in partnership with that global initiative – The Global Forum on MSM and HIV that evolved from the pre-satellite meeting at the International AIDS Conference in Toronto, Canada in August 2006.

Between July and September 2007, key developments have occurred that we hope will make a difference, where APCOM held is first Governing Board meeting, and was launched at the 8th International Congress on AIDS in Asia and the Pacific.

This edition of Pukaar is dedicated to highlighting these developments.

[1] 'Men who have sex with men' (or MSM) is an inclusive, public health term to define the sexual behavior of males having sex with other males, and does not refer to an identifiable community or gender identification. Within this context it is understood that the word 'man'/'men' is socially constructed; as well, within the framework of male-to-male sex, there are a range of masculinities along with diverse sexual, gender and transgender identities, communities and networks.

Missing

Shivananda Khan OBE
(This was written just prior to the 8th ICAAP)

As the 8th International Congress on AIDS and the Pacific looms ever closer, where some 3000 people will gather together in Colombo Sri Lanka to share, discuss and learn from each other's experiences in confronting the challenge of HIV in the region, one stark fact stands out. Male-to-male sex, risk and vulnerability often seems to be conspicuous by its absence in national AIDS plans, an invisible population, where we are facing an often unacknowledged public health crisis. A soon to be published report from UNAIDS (Men who have sex with men – the missing piece in national responses to AIDS in Asia and the Pacific, Joint United National Programme on HIV/AIDS, 2007) points out that, while it is conservatively estimated that there are at least 10 million males having sex with males (usually identified by the acronym MSM which includes gay identified men, other men and feminised males who are involved in male-male sex, and transgendered male-to-female persons who have sex with men) in the Asia and the Pacific, and despite having higher infection rates than the general adult population, investment in supporting HIV prevention, care and support services focusing on the health needs of MSM is usually abysmally low in national AIDS programmes is usually between 0% to 4%. Further, the report goes on to say that only about one in ten MSM in the region, have access to any sort of HIV services.

All across the Asia and the Pacific region there are a number of concentrated HIV epidemics among MSM, but spending on HIV prevention care and support does not match need. Thus, in Thailand, which reported an enormous growth of HIV infection among MSM from 17% in 2003 to 28% in 2005,[1] investment in MSM HIV programming was just over 1% of the total national plan spending.[2]

At the drop-in centre in Yangon, Burma (programme operated by PSI Myanmar)

If anything this mismatch between need and reality is a clear indication of the stigma, discrimination and social exclusion, confounded by the often harsh victimisation by the state and individuals that are meted out to those visible MSM, particularly so when many countries have laws that make adult consensual same sex behaviours illegal creating social environments that not only impede the development of appropriate HIV services for MSM, but also impede access to them. For example, in India, in 2001, four people were arrested for 'promoting homosexuality' when in fact they were involved in providing HIV prevention services for MSM. This conflict between public health needs and the law

continued on page 3, col.1

Naz Foundation International is a development agency specialising in providing technical, institutional and financial support for the promotion of the sexual health, welfare and human rights 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 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 sexually transmitted infections 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 sexual responsibility of their male partners.
6. Encouraging communication of sexual health information between sexual partners and promoting partner notification of sexually transmitted infections and 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 services for infected female partners of males who have sex with males.

Pukaar

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

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

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

Send all material to ***Pukaar***, **Naz Foundation International**, 9 Gulzar Colony, New Berry Lane, Lucknow 226001, India

visit our website

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enforcement agencies is common throughout the Asia and the Pacific.

At the same time many males who have sex with males are married, while many also access female commercial sex workers. 42% of the respondents in a survey of MSM in Andhra Pradesh, India were married (Dandona et al., 2005). A sample of 482 men who had sex with men in Beijing (Gibson et al., 2004) found that nearly two-thirds had sex with a woman, 28 % of them within the past six months. Many MSM also sell sex, as well as buying it from, women, and may well be married also.

To add to the complexity of the whole issue of male-to-male sex and HIV, sex between males may happen because it is what is immediately available, for example in prisons or amongst truck drivers (Khan and Hyder, 1998). Those who engage in it also may not think of themselves as homosexual, or even MSM, and in other situations will have sex with women. Along with this, are males who are injecting drug users and also have sex with other males (a double jeopardy here in terms of HIV).

The reality is that denial, invisibility, stigma, discrimination, social exclusion and illegality, create an environment where there is little public acknowledgment of the issues that MSM face, which feeds into a framework of a lack of understanding of the diversity of male-to-male sex, risks and vulnerability, and the lack of data, both epidemiological as well as ethnographic, on which effective programmes can be developed, funded and implemented.

If the situation is left as it is, then any hope of addressing the challenge that HIV presents to the health of the nations in the Asia and the Pacific region is lost. MSM are not a separated and isolated sub-population from the general population. They are an integral part of the citizenship of each country. What they do is not isolated from the general pattern of male sexual behaviours in these countries, it is integral a part of the general male sexual behaviours, and creates increasing risks of a spreading epidemic.

Of course, developing effective responses to the wide diversity of social classes and groups, gender identities, marginalized and hidden populations, and behaviours encompassed by the term MSM, will present policy makers and donors with a complex challenge.

A special consultation meeting focusing on this specific question was held in New Delhi, India in September 2006, called Risks and Responsibilities: Male Sexual Health and HIV in Asia and the Pacific. This meeting was jointly hosted by the National AIDS Control Organisation, India and the Naz Foundation International, with technical assistance and support from UNAIDS, and financial assistance from a range of donors.[3]

The meeting brought together some 80 people representing government national AIDS programmes, donors, and MSM themselves, from 30 countries, and agreements were reached on collaboration, principles of good practice, and forming an advocacy coalition between government, donors and MSM working on HIV.

The principles of good practice developed at this meeting included a proactive approach to address the societal, cultural and legal impediments towards implementing, and accessing, HIV services for males who have sex with males, such as reviewing, repealing, or amending laws that criminalise adult consensual same-sex behaviours, and addressing the constant discrimination and harassment that many MSM have to face. Along with this, would be a rapid scaling up of investment in supporting a range of HIV risk-reduction strategies among MSM, that includes outreach education programmes, MSM friendly STI clinics, distribution of condoms and water based lubricant,

At the drop-in space in Secunderabad, India, operated by Mithrudu Trust

access to safe spaces where MSM can meet and socialise without harassment, and access to voluntary HIV counselling and testing, support, care and treatment services for MSM who are infected with HIV, based on experience that have shown that HIV interventions are more effective if MSM fully participate in programme design and implementation.

While HIV epidemics continue to grow among MSM, where for many countries may too late to prevent such epidemics, it is time to act to ensure that these epidemics do not continue to spiral out of control, and where epidemics are just beginning, and where MSM populations are extremely vulnerable to HIV infection, there is an urgent need for governments, donors and non-government organisations working in the field of HIV to clearly recognise the need to ensure that all MSM can have access to quality HIV prevention, treatment, care and support services, if we are to fulfil the laudable goals of universal access to HIV services.

Governments across the region need to recognise the critical role that they play in addressing social, cultural and legal impediments to accessibility of appropriate HIV services, while donors need to recognise that increasing investment in MSM is critical to successful HIV programming in the region. At the same time, if there is good will to work together in ensuring that more MSM do not need to become ill and die, and that a social and HIV service environment encourages MSM to address their own health concerns, then MSM themselves can be supported to join in this effort taking responsibility for their own lives. But to ask for such responsibility without addressing their own rights, we stand no hope to reverse the current trend of HIV affecting and infecting MSM populations across Asia and the Pacific.

References

1. (Van Griensven F, Thanprasertsuk S, Jommaroeng R, Mansergh G, Naorat S, Jenkins RA, Ungchusak K, Phanuphak P, Tappero JW and Bangkok MSM Study Group., Evidence of a previously undocumented epidemic of HIV infection among men who have sex with men in Bangkok, Thailand. AIDS 2005, 19:521-526.)

2. (HIV expenditure on MSM programming in the Asia-Pacific region, Constella Futures, 2006, Constella Futures)

3. Donors were Australian Agency for International Development (AusAID), Canadian International Development Agency (CIDA), Centre for Disease Control, USA (CDC), Department for International Development, UK (DFID), Ford Foundation, Humanistisch Instituut voor Ontwikkelingssamenwerking (HIVOS), International HIV/AIDS Alliance, Swedish International Development Agency (SIDA), TREATAsia (American Foundation for AIDS Research-amfAR), and the World Bank. Along with this support were Constella Futures Health Policy Initiative, Family Health International, the International HIV/AIDS Alliance, Pact and Population Services International who also sponsored delegates to this meeting. For more details please see www. risksandresponsibilities.org).

The Asia Pacific Coalition on Male Sexual Health

Interim Governing Board meeting

26-27 July 2007, Bangkok, Thailand

With an open and transparent governance solidified by the adoption of the draft constitution of APCOM with a number of amendments agreed and incorporated, the meeting was convened by the Interim Chairperson, Shivananda Khan.

Representing the MSM sector from the various sub-regional configurations were Dede Oetomo, Manvendra Singh Gohil, Siam Arayawongchai, Sunil Babu Pant, and Zhen Li, along with Sittiphan Boonyapisomparn (transgenders), Dr Chansy Phumphachan (government sector), Edmund Settle (UNDP), Geoff Manthey (UNAIDS) and Jan Wijngaarden (UNESCO). Aditya Bondyopadhyay (Secretariat Coordinator) provided the reporting and Paul Causey (Executive Management Consultant) managed the logistics. Philippe Girault (FHI) attended as observer.

The Board reviewed and adopted the long-term goals of APCOM along with its objectives, as well as accepting the subregional configurations and criteria was developed for APCOM organisational membership. A draft two year work plan and budget with amendments were also accepted.

Along with this, Aditya Bondyopadhyay was reaffirmed as Coordinator of APCOM Secretariat, and Shivananda Khan of Naz Foundation International reconfirmed as the Interim Chairperson., with Siam Arayawongchai of Purple Sky Network appointed as Vice-Chairperson, pending approval of the PSN Technical Board. Paul Causey was appointed as the Executive Management Consultant to support the Chairperson and the Secretariat.

Our thanks and appreciation goes to HIVOS for financially supporting this meeting.

APCOM FAQs

1. What is APCOM?

APCOM stands for Asia Pacific Coalition on Male Sexual Health.

2. Is APCOM a community network?

No. It is a coalition formed by bringing together MSM community networks, government and donor representatives, along with technical support and assistance from UN agencies as equal partners.

3. Why was APCOM formed?

A clear need for sustained advocacy around increasing financial investment and service coverage in terms of MSM and HIV prevention, treatment, care and support in the Asia Pacific region was articulated at the Risks and Responsibilities consultation in New Delhi in September 2006. This was expressed as the Asia Pacific Coalition on Male Sexual Health taking on this role adopted at the meeting.

4. What are the broad areas of activity that APCOM will undertake?

APCOM will focus on the following main activities:

- Advocacy
  - For increased funding for MSM HIV services across the region
  - For increased coverage of MSM HIV prevention, treatment, care and support interventions
  - For implementing the "Guidelines for Good Practice" developed and adopted at the Risks and Responsibilities meeting
  - For community driven MSM HIV services
  - Fostering a rights based approach that create an enabling environment for MSM HIV services
- Good quality knowledge generation and management
- Convening
  - Strategic partnerships
  - Sub-Regional and national networks
  - Meetings of stakeholders
- Capacity development by leveraging technical assistance
- Intervention in crisis situations.

5. Who Governs APCOM?

APCOM is presently governed by an Interim Governing Board (IGB) that has representatives of MSM communities, government sector, UN agencies, funders, and technical experts. This IGB is transitional and will be in office for the next 24 months, within which time elections would be held to the first Governing Board. This new Board will then take over the governance of APCOM.

6. Who selected the IGB?

MSM community representatives from the sub-regional configurations of the Asia Pacific region were selected on the basis of acknowledged leadership from these sub-regions. Most of community representatives on the IGB were also Steering Committee members of the Risks and Responsibilities Consultation, and continued on in the IGB. The transgender and government sector representatives, the technical experts, and the funder/donor representatives were selected on the advisement of and after consultation with the UNAIDS Regional Support Team in Bangkok.

With regard to the Pacific sector MSM representative, the Secretariat Coordinator attended (funded by UNESCO) the first Pacific Islands MSM networking meeting in Apia, Samoa in August 2007 and was able to discuss APCOM with the participants, who selected their own representative. Likewise, the MSM HIV+ve representative was nominated based on internal discussions in APN+ and the newly formed APN+ MSM network.

7. What determines the governing structure of APCOM?

The governing structure of APCOM is determined by the Constitution of APCOM that was adopted by the IGB in its meeting of the 27th July 2007. "Terms of Reference" (TOR) of APCOM have been developed, based on its constitutional structure. A website is under construction and these TORs, along with the constitution will be uploaded soon,

8. Would APCOM be membership based?

Yes, community representation within APCOM shall be membership based. Only organisations and networks working on the issue of MSM and HIV with community involvement can become members of APCOM. Community representatives on the APCOM Board shall be elected by members of APCOM.

9. Would APCOM have a secretariat? If so where?

Yes, there will be a permanent Secretariat, as detailed in the constitution.

The Secretariat of the Risks and Responsibilities Consultation, based in New Delhi, has now become the Secretariat of APCOM for the interim period of 2 years. After the first Board of APCOM takes over from the Interim Board, they shall decide where the permanent secretariat of APCOM would be located.

10. Does APCOM replace, conflict or duplicate the work of other regional coalitions and networks such as AP Rainbow, 7-Sisters, or even the Purple Sky Network?

No. APCOM is not network, but a coalition of different stakeholders with a shared vision, along with an emphasis on partnership and synergy of work and goals. It will work closely with other networks and coalitions towards achieving the objective of increasing coverage of HIV prevention, treatment, care and support services for MSM across the region.

APCOM - sub-regional configurations and Interim Governing Board

Sector	Countries	MSM representative
China	People's Republic of China	Zhen Li
Developed Asia	Japan, Hong Kong Special Administrative Region, Macau Special Administrative Region Singapore, South Korea, Taiwan, *and Australia**	Masao Kashiwazaki
Greater Mekong	Cambodia, Lao PDR, Myanmar, Thailand and Vietnam	Siam Arayawongchai *(pending)*
India	India	Mavendra Singh Gohil
Pacific Region	Cook Islands, Easter Federated States of Micronesia, Fiji, French Polynesia, Guam, Kiribati, Marshall Islands, New Caledonia, Niue, Palau, Papua New Guinea, Pitcairn, Samoa, Solomon Islands, Tongo, Tuvalu, Vanuata, *and New Zealand**	Joey Mataele
South Asia *(not India)*	Afghanistan, Bangladesh Bhutan, Maldivdes, Mongolia, Nepal, Pakistan, Sri Lanka	Sunil Pant
South-East Asia *(without GMS countries)*	Brunei, East Timor, Indonesia, Malaysia, Philippines	Dede Oteomo

** In regard to the positioning of Australia and New Zealand in the above configurations, it is proposed to create a permanent Observer sub-region called Australasia, which will consist of these two countries.*

Background

The 2006 Risks and Responsibilities Consultation Meeting was organised around these configurations with agreement and feedback by the community participants:

1. Developed Asia: The socio-economic dynamics in these countries and areas are very different from other Asia-Pacific countries and require addressing MSM and HIV issues around resource allocation and coverage differently
2. Greater Mekong: The Greater Mekong sub-region in terms of response to HIV among MSM was formed in 2005 because of cultural similarities.
3. India and China: India and China are seen as separate sub regions because of their population and geographical sizes

For more details of APCOM, its constitution, organisational membership, terms of reference for the different representatives, and work plan, please contact the Secretariat at apcom@msmasia.org

Other sectors	Representatives
transgender networks	Sittaphan Bunyapisomparm, Thailand Lenny Sugiharto, Indonesia
MSM +ve	Raphael Meyer, Singapore
Government	Dr Chansy Phimphachanh *(pending)* *2nd representative pending*
Donor	Phillippe Allen, AusAID Clifton Cortez, USAID
UN	Edmund Settle, UNDP Geoff Manthey, UNAIDS Jan Wijngaarden, UNESCO

Secretariat Coordinator	Aditya Bondhyoadhyay
Executive Management Consultant	Paul Causey
Media Advisor	Roy Wadi
Interim Chairperson	Shivananda Khan
Interim Vice-Chairperson	Siam Arayawongchai *(pending)*

You can be assured of the support of the United Nations family in your common endeavor to win the battle against HIV among MSM and transgender communities.
If nobody is there for you - we are here!

Dr. Nafis Sadik Special Advisor to the United Nations Secretary-General and special envoy for HIV and AIDS in Asia and the Pacific New Delhi, 26th September 2006

Why we must work with male-to-male sex and HIV prevention, care and support

Because:

- It is the right thing to do on humanitarian grounds
- It is the right thing to do epidemiologically
- It is the right thing to do from a public health perspective

Males who have sex with males (MSM) whether their self-identity is linked to their same sex behaviour or not, have:

- The right to be from violence and harassment
- The right to be treated with dignity and respect
- The right to be treated as full citizens in their country
- The right to be free from HIV/AIDS

MSM who are already infected with HIV have the right to access appropriate care and treatment equally with everyone else, regardless of how the virus was transmitted to them.

APCOM long term goals and objectives

Long term goals

1. Increased investment from governments, donors and civil society groups and communities in appropriate research, and interventions for HIV prevention, treatment, care and support for males who have sex with males and transgenders in the Asia Pacific region
2. Scaled-up programmatic, geographic and comprehensive coverage of HIV prevention, treatment, care and support interventions for males who have sex with males and transgenders in the Asia-Pacific region
3. Strengthened the evidence-base for advocacy, policy development, programming and the reducing societal, legal, and institutional obstacles for the above

Objectives

1. Advocacy: Conduct targeted advocacy with governments, donors, research agencies, civil society organizations and UN bodies for an improved HIV policy framework, increased investment, scaled up programs, reduced stigma and discrimination and the promotion of individual rights of MSM
2. Convening: Convene and strengthen sub-regional and national networks and communities of MSM and their organisations, particularly those with fewer resources and within disproportionately adversely affected communities, as well as governments, researchers and donors to collaborate in initiating or expanding comprehensive responses to prevent and treat HIV and improve sexual health in Asia and the Pacific.
3. Strategic information: Identify, collect, produce and share strategic information, with community involvement as far as feasible, to support effective and efficient program design as well as targeted advocacy efforts at the sub-regional and country level, and monitor and evaluate the deliverables for their quality, coverage and effectiveness.
4. Technical assistance: Identify and facilitate the provision of technical assistance to sub-regional and national networks, governments, and civil society, working to improve the sexual health and reduce the burden of HIV among MSM.
5. Organisational support: Nurture and support transgender groups and organisations, and involve them in all activities as equal partners. It shall be the endeavour of APCOM to help transgender groups form their own networks and coalitions to address their own issues and concerns.

APCOM workplan goals and objectives

***Goal 1 – APCOM structure and operations:* To establish democratic and transparent systems to create and support a functional APCOM infrastructure.**

Objective 1 – APCOM structure: Develop policies, procedures and systems for APCOM governance.

Objective 2 – Daily operations: To establish a secretariat including systems for daily operations and communication.

Objective 3 – Communications: To establish and increase greater communication and information sharing and increase community participation in APCOM through the development of appropriate systems and means of external and internal communication.

Objective 4 – Transgender networking: To develop an Asia Pacific network of transgender groups, organisations and institutions.

***Goal 2 – Advocacy:* To support scale up and increase of attention to the needs of MSM and HIV issues.**

Objective 1 – Visibility: To increase inclusion of and greater visibility for the needs of MSM and HIV issues in regional and worldwide advocacy efforts.

Objective 2 – Resource Mobilisation: To mobilise resources to achieve rapid scale up and/or increased HIV services, research and advocacy for MSM in Asia Pacific.

Objective 3 – Policy and Planning: To assure that international, regional, sub-regional, national and local policies and planning include MSM and HIV issues.

Objective 4 – Media: To increase the mass media knowledge, understanding, coverage and sensitivity of MSM and HIV issues in Asia Pacific.

Objective 5 – Legal Reforms – To improve legal situations that are barriers to service delivery for HIV interventions for MSM.

Objective 6 – Research: To increase research needed to scale up, increase and improve HIV interventions for MSM in ways that are community-endorsed and involved.

***Goal 3 – Partner, network and community development:* To strengthen and develop networks, partnerships and communities in and between groups working to improve the situation of HIV among MSM.**

Objective 1 – Partnerships: To strengthen and assist in development of networks and partnerships.

Objective 2 – Technical Assistance: To leverage existing and new technical assistance and support for partners especially for MSM HIV community groups.

Objective 3 – Crisis resolution: To assist in the resolution of crises that arise in working with MSM and HIV in communities.

***Goal 4 – Strategic Information:* To increase the amount and quality of information on MSM and HIV in Asia and the Pacific.**

Objective 1 – Scorecard: To assess the response to HIV and MSM in every country in Asia Pacific.

Objective 2 – Good practice: To promote understanding and knowledge of 'good practices' for delivering services.

Beach party at ICAAP

The Asia-Pacific Coalition on Male Sexual Health at the 8th ICAAP

(supported by HIVOS and UNAIDS)
19th - 23rd August, 2007, Colombo, Sri Lanka

At the 2nd International Congress on AIDS in Asia and the Pacific held in New Delhi, India, 1992 marginalisation and exclusion appeared to be the order of the day in regard to MSM and HIV issues. Only one session on "alternate sexualities and HIV" was held, and when a request was made for space to host a break-out session for MSM, it was refused.

Not to be daunted, a small group of activists and interested persons went ahead and held our meeting - in a park across from the meeting venue.

Since then, there have been a range of seminars, conferences, and meetings, focusing on the needs of MSM and the ever increasing HIV prevalence amongst them. And the struggle to ensure greater representation and visibility at the ICAAPs continued.

The 8th ICAAP was a significant turning point in this struggle. Not only were there a significant number of oral presentations on MSM and HIV (some 49 MSM-related sessions out of almost 200 sessions, about 5% of the total*), but also a number of satellite sessions and symposia were also held that ensure that the voice of MSM was heard.

Whether it was listened to is another matter, and another story.

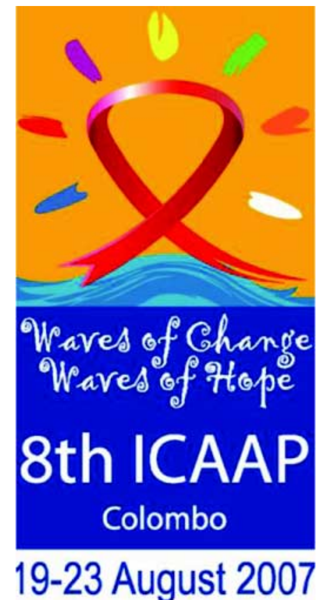
It was here that the Asia-Pacific Coalition on Male Sexual Health was officialy launched.

* *these presentations are available on www.icaap8.lk*

Press Release

Prioritizing Male Sexual Health in Asia Pacific

Region-wide coalition addressing HIV and AIDS among men who have sex with men launched



22 August, Colombo - A groundbreaking coalition aiming to build, strengthen, and increase interventions addressing HIV-related vulnerabilities of men who have sex with men (MSM) in the Asia and Pacific region was launched at the 8th International Congress on AIDS in Asia and Pacific (8th ICAAP).

The Asia Pacific Coalition on Male Sexual Health (APCOM), an autonomous, regional coalition of civil society groups, government sector representatives, donors, technical experts and the United Nations system, plans to conduct targeted advocacy with stake holders, including governments and donors to improve the HIV policy framework, increase investment and evidenced-based research, scale up programs, as well as the promotion of individual rights of MSM and transgenders.

Despite evidence establishing male-to-male sex as one driving force of HIV transmission in Asia and Pacific region, relatively few MSM interventions strategically focus on prevention, treatment, care and support for MSM and transgender populations. It is estimated by many groups, including UNAIDS, that targeted prevention programmes reach less than 8% of MSM although up to one third of all HIV cases in the Asia Pacific region are transmitted via sex between males.

Furthermore, almost half (45 per cent) of countries have laws in place that actually hinder the access of most-at-risk groups to HIV prevention and treatment services. And, analysis of National AIDS budgets indicates that even countries with concentrated epidemics often fail to allocate meaningful resources to programmes that specifically address the needs of the populations at highest risk of HIV infection.

"How long can we remain silent spectators in the face of such neglect, particularly when the population at risk is so big in number?" asked Prasada Rao, Director, UNAIDS Regional Support Team in Asia. "Male to male sex is being treated as if it does not exist. The reality is male to male sex occurs in all countries and cultures."

Aiming to strengthen sub-regional and national networks, and communities of MSM and their organizations, particularly those with fewer resources and within disproportionately adversely affected communities, ACPOM will also identify and facilitate the provision of technical assistance, as well as convene governments, researchers, donors and civil society organisations to collaborate in initiating or expanding comprehensive responses to prevent and treat HIV, improve sexual health, and reduce stigma and discrimination in Asia and the Pacific.

"We can only truly address the challenge of HIV, as well as confront stigma, discrimination, violence and social exclusion of MSM and transgenders, if we all work together in our collective, region wide struggle to reduce the personal, medical and social burden of HIV our communities and societies face," stated Shivananda Khan, APCOM interim Chair and CEO of Naz Foundation International.

Opened to regional and sub-regional networks, as well as national networks and individual organisations, APCOM will be governed by a 19-member Governing Board comprised of community representatives from 7 sub-regions of Asia Pacific, including the Pacific (including New Zealand), South Asia (including Mongolia and excluding India), greater Mekong sub-region (GMS), South East Asia (excluding GMS), Developed Asia (Japan, South Korea, Singapore, Taiwan, Hong Kong and Australia), China and India. In addition, the board will consist of representatives from the transgender community, government sector, donors and a communication advisor. UNAIDS, UNDP and UNESCO will support APCOM as technical advisors.

APCOM is a direct outcome of the Male Sexual Health and HIV in Asia and the Pacific International Consultation held in New Delhi in late 2006. This 3-day consultation brought together community members, government officials, policy makers and researchers to provide an opportunity to inform and develop strategic advocacy initiatives on key policy issues concerning MSM and the transgender community.

Chaired by Shivananda Khan and Edmund Settle (UNDP), speakers were members of the Interim Governing Board.

The International Humanist Institute for Cooperation with Developing Countries (HIVOS) and UNAIDS have provided initial support for APCOM.

The APCOM at the 8th ICAAP

Leading up to the official launch of APCOM were two other APCOM events introducing the urgent need for a development such as this. One was where Shivananda Khan as a plenary speaker presented on *Risks and Responsibilities: Preventing HIV epidemics among gay men, other MSM and transgenders in Asia and the Pacific*. The other was a Symposium - *The missing piece: MSM and national responses to AIDS in Asia and the Pacific*. This Symposium was co-chaired by Mr J.V.R. Prasada Rao, Director, UNAIDS Regional Support Team, Asia and the Pacific, Sherman de Rose, Director, Companions on a Journey, Sri Lanka, and Shivananda Khan.

Symposium presenters were:

- Dr Carol Jenkins - The evidence: male-to-male sex in Asia and the Pacific - an overview
- Dr Frits van Griensven - The growing epidemic among MSM in Asia and the Pacific
- Brad Otto - The investment and coverage: HIV expenditure on MSM programming in Asia and the Pacific
- Swarap Sarkar - Bridging the gap

(To download copies of these presentation, visit the 8th ICAAP website, www.icaap8.lk)

While Dr Jenkins presented evidence indicating the existence of the diversity of male-male sexual behaviours, practices and gender performance in all the countries of the region, Dr van Griensven presented the latest information on the increasing HIV prevalence among MSM in many of the countries, where MSM are actually bearing a significantly higher burden than the general male population. Brad Otto, representing Constella Future's study on expenditures on MSM and HIv programming demonstrated that there was a gross underinvestment in HIV prevention, care and support and that there was an urgent need to rapidly scale up such investment if there was to be any significant impact in reducing HIV rates in the countries of the region.

Buddha at the entrance of conference venue - Bandaranaika Memorial International Conference Hall

Finally Swarap Sarkar spoke of how governments and donors need to bridge the gap between need and service coverage through increased investment and service coverage.

UNAIDS also launched their new paper on MSM and HIV also entitled *The Missing Piece* at this Symposium.

Jan Wigngaardenof MSM-Asia reports on two sessions during the first day

Session: Same sex partnerships, stigma and discrimination

Mr Xu Jie, Chairman of the National Chinese MSM working group, presented a model for collaboration between MSM communities and the local and national Government of China. He suggested that the development of a National Framework for MSM and HIV can be useful to mobilize and involve MSM communities. The development of the framework was also useful in establishing, for the first time, contact between Government officials and MSM community representatives.

Ms Jane Koerner of the University of Japan presented qualitative research on the information, social and sexual networks of young MSM in rural and urban Japan. She concluded that homosexuality is a difficult issue to identify with for many men; many held separate networks of gay/MSM friends and straight friends, and almost none had told their families about their differing sexual preference.

Lorraine Yap presented research on HIV positive prisoners in Australia. Some of them were gay identified. It appeared that the policy of providing single cells for HIV positive people led to suspicion and discrimination by fellow inmates, based on their fears of HIV and/or other diseases.

The discussion following the session discussed, among other things, the role of governments and civil society in addressing stigma and discrimination of MSM. It was concluded that while governments must provide a proper policy framework, it was up to civil society to push for this. A delegate from Australia noted that personal level advocacy with key decision makers can be a powerful tool for changing their mindset, which in turn can help in improving the policy environment.

Session: Advancing a research agenda for HIV prevention for MSM in Asia and the Pacific

Dennis Altman started off the session saying that a lot if known about men who have sex with men, but what is known is not always acknowledged. He noted that the president of Sri Lanka had not mentioned MSM in his opening speech, and nor had other officials during the opening ceremony yesterday. He urged delegates to stop talking about identity labels and focus on human sexuality, and the risks it implies for HIV transmission. Many MSM do not base their identity on their sexual behavior; they do not feel addressed by labels like Gay, Queer, etc.

Challenge for advocacy and research: we also we have to talk about how people develop identity based on sexual behaviour.

Frits van Griensven provided an overview of the epidemiology of HIV in the region. He noted that before 2000, in Southeast Asia and China virtually no data was available. This has changed dramatically, and there is a clearer picture now of the epidemic among MSM.

He pointed at the limitations of current data:

1. They are all cross-sectional; there is no data on incidence of HIV, only on prevalence
2. Sampling frames are often based on convenience and referral sampling. However, some new methodologies, like Respondent Driven Sampling and Time Venue Sampling, are addressing this limitation
3. Much of the data is clinic-based, not truly community-based
4. Most research data we have is descriptive; there is limited knowledge of factors that drive vulnerability and risk behaviors among MSM
5. Usually studies are done as a single point in time; methodologies change over time and populations change over time; this decreases comparability, making the identification of trends difficult or impossible
6. MSM data are scattered, without an overruling framework or coordination

Future needs for a research agenda:

1. Longitudinal studies needed (cohort studies, pre- post test studies to assess HIV incidence and evaluate the effect of interventions
2. Research into access and evaluation of HIV and STI services, treatment an care (coverage) and adherence of anti-retrovirals
3. Impact of anti-retorvirals on perception of HIV as a disease and on

risk behavior.

Masao Kashiwazaki of the Japanese Foundation for AIDS Prevention noted that 63.6% of HIV cases in Japan is through homosexual contact and 36.8% of AIDS cases (2005). Knowledge is good but only 70% use condoms consistently. Several interventions are taking place. He suggested the following priorities for research:

1. Data on sexual (risk) behavior among MSM;
2. Determinants of risk behaviors;
3. Social networks and how they influence risk behaviors and information dissemination;
4. Social marketing and its use for promoting condoms and lubricants among MSM;
5. Program evaluation, and what works and what does not work in HIV prevention;
6. Assessment of how local Governments and NGOs can work together.

Nay Oo Lwin of PSI Myanmar gave a presentation of the Targeted Outreach Programme of drop-in and outreach work in Myanmar. He noted that there is a lack of reliable prevalence data. He did not focus on priorities for a research agenda.

Roy Chan of Singapore, presented the results of an internet based survey, showing decreased incidence of risk behaviors among MSM.

Jeffrey Grierson of Latrobe University noted that reasons for research can be diverse; planning, intervention testing, advocacy, policy development, social change, to test assumptions, to evaluate; this needs to be taken into account when determining a research agenda. The level of analysis can be individual (behavioural surveillance, qualitative research on individuals, service access, perceptions, attitudes, knowledge, needs of individuals), it can be social/relational (couples studies, peer group research, focus group dicussions, group interviews, network studies, telling us about how groups react, how peers communicate, how group structures operate), or they can be structural (policy, systems, economic research, telling us about power and influence, structures that hinder or help us in our work).

People have to make research fit; does the research fit the need? Fit the action? Will it convince the right people? Can the research translate into action? Can it be done?

Bruce Parnell, who was in the audience, noted that programs fit communities, but many men do not belong to these communities. Many interventions are not based on what we know from research. Jeffrey answered that the power of research is to construct or describe communities. How people use social categories and link this to their sexual behavior should be a focus. Aditya Bondhyopadhyay of the Asia Pacific Coalition on Male Sexual Health, added that people who do not identify with an identity are people who dissolve into "mainstream masculinity"; they can not be reached by regular MSM intervention work. One way is to work through communities that identify as something, they can reach their partners who may be those "unidentifying" men. Jeffrey added that network research can tell you where those people sit in the social structure, and how you can reach them.

Edmund Settle of UNDP noted that most research is on tracking the epidemic, and for advocacy purposes. He said that this is fine, but that it shows that what we are doing is not working. If we find the epidemic growing and we track that, our interventions may not be working. We need information on what approaches for HIV prevention work, what factors determine condom use etc. Nobody is talking about monitoring programs, coverage. There should be a session on monitoring and coverage. Dennis Altman responded that we need to encourage innovative prevention programs that will provide evidence that needs to be monitored and evaluated. They are not separate. Frits van Griensven added that he concludes that research is working. It has brought the epidemic among MSM out in the open, without research and without data there would have been no progress and no programs. The data caused the denial to disappear.

Gay sex laws to stay in Singapore

By Fridae News Editor

Despite efforts to lobby against the retention of gay sex laws in the city-state's first major penal code amendments in 22 years, the gay community will have to bear double the insult as the laws will sit between proposed laws against necrophilia and bestiality.

Under a Bill introduced in Singapore's parliament on Monday, current laws criminalising sex between men will be retained although laws criminalising oral and anal sex between heterosexuals will be repealed.

Singapore adopted the Indian Penal Code in 1871 when the city state was then part of the Straits Settlements which was part of the British Empire.

Britain, the former British colony of Hong Kong and Australia have since repealed laws prohibiting sex between men in 1967, 1991 and 1997 (in the state of Tasmania, the last Australian state to do so) respectively. In Asia, only Malaysia and India, both of which are former British colonies, continue to criminalise sex between men.

The proposed amendments, which was made available to the public since November 9 last year, will see no change to Section 377A which provides fora jail sentence for up to two years should a man is found to have committed "an act of gross indecency" with another man, either in public or private.

The Penal Code (Amendment) Bill, which was read the first time in Parliament on Monday, codifies the existing Section 377A "Outrages on decency " between the new Section 377 "Sexual penetration of a corpse" and Section 377B "Sexual penetration with living animal."

In April, the Law Society of Singapore said in its official feedback to the proposed amendment of the Penal Code that "the retention of s.377A in its present form cannot be justified" and recommended the section to be repealed. The Ministry of Home Affairs (MHA) was quoted as saying in the Straits Times today that public feedback on the issue had been "emotional, divided and strongly expressed," with the majority calling for the section to be retained.

"MHA recognises that we are generally a conservative society and that we should let the situation evolve," MHA said.

Ms Indranee Rajah, former chairman of the Government Parliamentary Committee for Law and Home Affairs, reiterated the MHA's "assurance" that it would not actively prosecute people under that section. "But in recognition of the fact that there is still quite a strong majority uncomfortable with homosexuality, the section must stay," she said.

In April, Minister Mentor Lee Kuan Yew surprised many when he questioned the city-state's ban on gay sex. "If in fact it is true, and I have asked doctors this, that you are genetically born a homosexual - because that's the nature of the genetic random transmission of genes - you can't help it. So why should we criminalise it?" he told a youth rally.

In a recent International Herald Tribune interview, Minister Mentor Lee Kuan Yew said: "China has already allowed and recognised gays, so have Hong Kong and Taiwan. It's a matter of time. But we have a part Muslim population, another part conservative older Chinese and Indians."

Other advocates of repeal include Member of Parliament Baey Kam Kengand Nominated Member of Parliament Siew Kum Hong who both spoke against keeping Section 377A on the books at a public forum on the issue in July.

MSM-Asia, 21/9/07

NYC research shows impact of school bullying on gay and lesbian kids

Nine percent of young people in a New York City study of lesbian and gay youth meet the criteria for post-traumatic stress disorder (PTSD). The research found that for nearly one in ten of the young participants, experiences growing up lesbian or gay are linked to the same condition that affects many adults who are the victims of violent crime or are in an accident or natural disaster.

"These results join the growing body of data suggesting that violence directed at young people who are lesbian, gay or bisexual has a significant negative effect on their mental health," said Robert-Jay Green, PhD, executive director of the Rockway Institute, a national research and public policy center located at Alliant International University. "Many adults overlook such abuse, considering it an expected, normal part of childhood teasing. For the targets of this kind of aggression, however, it can be associated with serious psychological harm."

The study was conducted by Anthony R. D'Augelli and Michael Starks of Penn State University and Arnold Grossman of New York University and published in the Journal of Interpersonal Violence in November 2006.

The research examined 528 New York City area youth aged 15 to 19 who were victimized based on their sexual orientation or whether they appeared to their peers to be "sissies" or "tomboys." Participants were interviewed three times during a two-year period.

Three-fourths of the youths said they felt different from their peers as they were growing up. On average, the realization they were different occurred at about age eight. Parents noticed these differences, and few reacted positively to the possibility that their child was gay. Youths typically delayed "coming out" to their parents until age 14 or 15. Nearly one-third of youth who were called "sissies" or "tomboys" by their peers said their parents tried to encourage traditional sex role behaviours.

Nearly 80 percent of the young people reported verbal taunts, some beginning as early as age 6. The average age that this gay-related verbal abuse started was 11 for males and 14 for females. More than 70 percent of these verbal incidents occurred at school. Nearly three-quarters (73 percent) said they were very or extremely upset by the verbal victimization.

Fourteen percent of participants reported physical attacks, some as young as age 9. Males were most victimized by other males, while females were victimized almost equally by males (53 percent) and females (47 percent).

Violence occurred most often at school (56 percent) or in a public setting (25 percent). Most participants (89 percent) said they were very or extremely upset by the physical victimization.

For nine percent, the victimization was sexual. Incidents occurred earlier for males (age 13) than for females (age 16). All of the attackers were male, and the most likely setting was at home (34 percent). Nearly all of the young people (97 percent) said they were very or extremely upset by the sexual victimization.

The study found that earlier victimization, the perception of these early experiences as highly upsetting, and the lifetime accumulation of victimization events are factors that can create long term psychological distress. Overall, the study found nine percent of participants met the criteria for post-traumatic stress disorder (PTSD) as defined by the diagnostic manual of the American Psychiatric Association. Of those who had been called "sissy" or "tomboy," the figure was 12 percent. PTSD was associated with increased physical victimization and with the degree of upset experienced. Thus, concluded the researchers, youth who are less gender typical in childhood and who are victimized may have elevated mental health and trauma symptoms, and some may have PTSD.

Overall, the study found 70 percent of verbal victimization and 56 percent of physical victimization occurred in schools. Noted Green, "These data again point to an urgent need for training school administrators, teachers, and counsellors to stop the bullying of lesbian and gay youths. Every child has a basic right to a safe learning environment free from verbal harassment and physical violence. Nobody, regardless of his or her political views on gay issues, wants to see these children hurt. It's high time that school officials and shapers of education policy ensured safety for all of our children."

About Rockway Institute: The nonpartisan Rockway Institute promotes scientific and professional expertise to counter antigay prejudice and improve public policies affecting lesbian, gay, bisexual, and transgender (LGBT) people. The Institute's view is that public opinion, policies, and programs should be shaped by the facts about LGBT lives, not by political ideology. A primary goal is to organize the most knowledgeable social scientists, mental health professionals, and physicians in the United States to provide accurate information about LGBT issues to the media, legislatures, and the courts. The Institute also conducts targeted research projects to address the nation's most pressing LGBT public policy concerns.

Website: http://rockwayinstitute.org; Gaybombay, 9/8/07

Guidance on gay bullying issued to UK schools

The Department for Children, Families and Schools has issued guidance to schools in England and Wales on how to tackle homophobic bullying.

The new guidance from the government gives teachers, head teachers, school governors and support staff practical advice on how to recognise, prevent and respond to homophobic language and physical abuse.

It follows on from Stonewall's wide-ranging study into homophobic bullying published in June this year, entitled The School Report.

Nearly two thirds of LGB students reported instances of homopbobic harassment.

That figure jumps to 75% of young gay people attending faith schools.

The survey of more than 1,100 young people found that only 23% of all UK schools explicitly condemn homophobic bullying.

92% of gay, lesbian and bisexual pupils have experienced verbal abuse, 41% physical bullying and 17% have been subject to death threats.

30% of pupils reported that adults have been responsible for incidents of homophobic bullying in their schools.

Nearly every interviewed student had heard phrases like, 'You're so gay', and remarks like 'poof' and 'dyke' in UK schools.

Kevin Brennan, Parliamentary Under Secretary of State for Children, Young People and Families, told PinkNews.co.uk in July that the government wants to eradicate homophobia in education.

"The guidance is strong, it has got the full force of the government behind it," he said.

"We are committed to making sure that every school implements the guidance.

"We don't like to simply put bureaucratic requirements on schools without the evidence that that is needed so at this stage it remains guidance. We will be monitoring its implementation."

The Department for Children, Families and Schools also launched an online cyberbullying campaign today.

To view the government guidance on homophobic bullying, click: http://www.teachers.gov.uk/_doc/11911/HOMOPHOBIC%20BULLYING.pdf

Discrimination, violence against MSM, WSW in Uganda hindering HIV prevention, treatment efforts, Human Rights Watch says

Human Rights Watch on Thursday in a statement said that Ugandan President Yoweri Museveni's promotion of homophobia and violence against men who have sex with men, as well as women who have sex with women, is hindering the country's efforts to fight HIV/AIDS, *Reuters* reports. HRW urged Museveni to repeal a law against sodomy and to end his "long record of harassing" lesbian, gay, bisexual and transgender people (Cawthorne, *Reuters*, 8/24). In addition, HRW called on the government to integrate sexual orientation and gender identity issues into Uganda's HIV prevention and treatment programs (HRW statement, 8/23).

Juliana Cano Nieto, a researcher in HRW's LGBT program, said that the government's promotion of homophobia is "undermining Uganda's efforts to combat the spread of HIV/AIDS." HRW said that the government harasses gay organizations, promotes discrimination and raids the homes of advocates, according to *Reuters* (*Reuters*, 8/24). Scott Long, director of HRW's LGBT program, in a letter sent to Museveni on Thursday said that the government's actions against MSM and WSW place the "health of all Ugandans" at risk "amid the HIV/AIDS pandemic." Long added that the government's "determination to silence any discussion of sexual orientation" is "devastating" to the fight against HIV/AIDS (Letter text, 8/23).

HRW's announcement came one week after Sexual Minorities Uganda, a coalition of four LGBT organizations, launched a campaign titled "Let us Live in Peace." The group at a press conference in Kampala, Uganda, condemned discrimination and violence against MSM and WSW, as well as the "life-threatening silence about their sexualities in HIV/AIDS prevention programs." Martin Ssempa - pastor of Makerere Community Church, which has received funding from the President's Emergency Plan for AIDS_Relief - on Aug. 21 organized a rally to protest the press conference, during which he called for continued action against MSM and WSW (HRW statement, 8/23). Ugandan officials were not available for comment, according to *Reuters* (*Reuters*, 8/24).

Kaisernetwork.org, 21/8/07

Experts in Senegal Concerned About Effect of Male Circumcision Studies on Sexual Behavior of MSM

HIV and AIDS experts are warning men who have sex with men in Senegal that male circumcision alone does not prevent HIV transmission and are urging MSM to use other methods to protect themselves against the virus, *IRIN News* reports. According to *IRIN News*, the warning comes after research indicated that circumcision could help prevent HIV transmission; however, the research was conducted among heterosexual men (*IRIN News*, 8/8).

According to final data from two NIH-funded studies - conducted in Uganda and Kenya and published in the Feb. 23 issue of the journal *Lancet* - routine male circumcision could reduce a man's risk of HIV infection through heterosexual sex by 65%. The results of the Uganda and Kenya studies mirrored similar results of a study conducted in South Africa in 2005. In response to the findings, the World Health Organization and UNAIDS in March recommended the procedure as a way to help reduce transmission of the virus through heterosexual sex (*Kaiser Daily HIV/AIDS Report*, 6/22).

According to the French Institute for Applied Medicine and Epidemiology, about 21.5% of Senegalese MSM are HIV-positive, compared with 0.7% of the general population. HIV/AIDS experts are concerned that the study's findings could confuse MSM and lead to more risky sexual behavior, as well as a higher HIV prevalence among the population. A 2003 study conducted by Cheikh Niang of the Cheikh Anta Diop University in Senegal's capital, Dakar, found that 23% of MSM used a condom during their most recent sexual encounter. In addition, many Senegalese MSM also have wives or girlfriends to be accepted by society - placing more people at risk of contracting HIV - *IRIN News* reports.

According to some observational research, male circumcision could reduce the risk of HIV among MSM by about 50%. However, Bertran Auvert, an author for the 2005 South Africa study, said that because the studies were observational, they "prove nothing." Auvert added that experts "can merely suppose" that circumcision offers a "certain level of protection."

Jean-Louis Rodriguez - former executive secretary of And Ligeey, a Senegalese association that promotes the rights of MSM - said experts do "not want to encourage people to hide behind the idea that circumcision completely prevents the transmission of HIV." Rodriguez added that HIV prevention messages "must always be targeted" toward MSM. Khoudia Sow, WHO's HIV/AIDS director in Senegal, said that targeting HIV prevention messages at MSM is "not a question of revising all our prevention techniques," adding that "circumcision could play a part in the range of existing measures, but in no instance would it substitute them" (*IRIN News*, 8/8).

Kaisernetwork.org, 10/8/07

Wealthy men, not poverty, fuelling AIDS in Asia: study

The HIV/AIDS epidemic in South Asia is being fuelled by the sexual behaviour of wealthy men and not by poverty as is widely believed, says a new study by UNAIDS and the Asian Development Bank

Rich men who often have unprotected sex with commercial sex-workers are behind the spread of the HIV/AIDS epidemic in Asia, according to a revolutionary new study that reports that HIV does not necessarily spread under conditions of poverty.

"Clients of sex-workers account for most HIV cases in Asia. Typically, they are wealthy men," said Ross McLeod, an economist, while presenting the findings of the study to delegates at the Eighth International Conference on AIDS in Asia and the Pacific (ICAAP) held recently in Colombo, Sri Lanka.

In Cambodia, for instance, 12% of the richest men in the country were responsible for spreading the HIV virus, says the joint study by UNAIDS and the Asian Development Bank (ADB).

The study pinpoints men who have sex with multiple partners, including sex-workers, and do not use condoms.

McLeod added that HIV infections among wealthy Asian women too were on the rise. "Seventy per cent of cases in Asia are male, but this is beginning to change."

The multi-nation study has important lessons for many governments in Asia that victimise consenting adults, many of them underprivileged, who practise safe sex, while several wealthy men are passing the virus on to their unsuspecting wives.

The study also turns the long-held and widespread belief that poverty fuels HIV/AIDS on its head. "Poverty does not seem to increase the risk of infection in the first place. But AIDS increases the

continued on page 12, col. 1

Wealthy men, not poverty, fuelling AIDS in Asia: study

continued from page 11, col. 2

risk of poverty," says Jacques Jeugmans of the ADB.

A number of UN health experts told the conference that a majority of HIV-positive women in the region are married women who have only had sex with their husbands, leading them to conclude that these women contracted the virus from husbands who had had unprotected sex outside marriage. This is certainly true in a country like India, which has the third highest HIV caseload in the world and the highest one outside Africa.

Indian epidemiologist Swarup Sarkar, regional director of UNAIDS for South Asia, says that although the joint UNAIDS-ADB study is an ongoing project it already holds out major policy implications for the way HIV/AIDS ought to be tackled in Asia.

For instance, one important new finding is about the way the virus has spread in countries — it usually started among Injecting Drug Users (IDUs) in the 1990s, moved on to sex-workers, and from there to male clients and their faithful wives. Homosexuals and men who have sex with men were infected well before the epidemic took root among the general population.

"Therefore, early intervention among IDUs is essential," says Sarkar, pointing out that Bangladesh, Malaysia and Pakistan were now at the stage where they could benefit from making such an intervention, whereas the priority group for a country like Cambodia would be commercial sex-workers.

"But resource allocation (funding) is disproportionate," says Sarkar. Whereas "condoms and clean needles avert most infections," money from a US presidential fund for AIDS - known by its acronym PEPFAR, which is the largest such channel of aid to fight HIV/AIDS - was going into programmes to promote abstinence and faithfulness.

Compounding the problem is the fact that far from adopting focussed health initiatives, many countries in the region - including India - instead criminalise sex-workers, drug users and people with alternative sexual orientations.

http://southasia.oneworld.net/article/archive/1867

Police assault *metis* at Ratna Park for carrying condoms

Sunil Pant, Blue Diamond Society, Nepal

On the night of July 14, 2007, police in Kathmandu carried out an assault on *metis* (effeminate males or transgender people), beating, stripping, and in some cases sexually abusing them. The next day, the officer responsible for the assaults acknowledged to Blue Diamond Society as well as representatives of Human Rights Watch that such beatings are regular police practice - and said that carrying condoms is evidence of illegal acts.

In Ratna Park, in the heart of Kathmandu, 5 *metis* (Sanya, Sandhya, Simmi and two others) gathered to talk at around 8:30 p.m. According to their reports:

In Ratna Park, the *metis* saw three policemen (including sub-inspector Pradeep Chand from Janasewa Police station) approaching around 8:30 PM. From a distance the police warned the *metis* to stop on sight, otherwise they would shoot them. One managed to escape. 4 *metis* were caught; police started randomly beating with batons, slaps, and kicks. The police also searched their pockets and when they saw about 200 RS they began abusing them verbally: "You *chakkas* and *hijras*, motherfuckers, you make this money by anal sex and prostitution". Sanya told the police she had heart problem and begged them not to beat her harshly. Though police relented slightly, they were very harsh with other *metis*.

Police told the *metis* to take their clothes off so officers could check for signs of sexual intercourse. Police sexually abused the *metis* by demanding they pull their foreskins back to check for sperm, using their mobile phone lights to check the *metis'* genitals.

They also searched the *metis'* bags, and, when they found unused condoms, demanded why they carried them. When the *metis* told police they used them themselves in sex, police started beating them up for carrying condoms, saying the *metis* practicing unnatural and illegal sexual behaviour.

Simmi managed to walk out of the park, saying she would try to find another friend who had run away when police entered the park. Simmi saw Alex, an HIV/AIDS worker for the Blue Diamond Society and explained what's going on inside the park. Alex (whose *meti* name is "Juli") called the emergency police number, 100, for support. Two police nearby (from Durbar Marg Police station) accompanied Juli into the park. Instead of assisting, they watched the assaults.

Three police (including Sub-Inspector Pradeep Chand) were still beating the *metis*. The Sub-Inspector recognized Juli and caught her by the hand. He rummaged through her bag, and started beating up her by kicks, and batons on her back, leg and face. Juli also asked abused verbally and accused of practicing immoral and illegal behaviour - as she was also found carrying condoms in her bag. The two police from Durbar Marg Police station didn't react at all. They were just silent spectators of the abuse and beating against *metis* by the three policemen from Janasewa police station.

Alex told the police "not to beat any of us here: rather, take us if we have committed any crime." The Sub-Inspector Pradeep Chand told Juli not to misbehave with police, and not to try to "act smart." So Chand told the two policemen from Durbar Marg Police station to take Juli and Simmi to the jail. After that Juli and Simmi were taken to the van waiting outside Ratna Park. Yet these police did not take them to Durbar Marg Police Station - saying "Ratna Park is not in our duty area, so get off".

Juli and Simmi decided to go to Durbar Marg Police Station anyway to file the complaint, but Juli was told "you can't file a complaint as you need a 5 rupees stamp".

The rest of the other 3 *metis* were taken by a Janasewa Station police van for a time - then forced to run away to three different directions.

At Janasewa Police Station the human rights activists and *metis* spoke to Police Inspector U. P. Chaturbedi; Sub-Inspector Pardeep Chand; the driver of the van; and another policeman involved in the previous night's abuse who was called. Sub-Inspector Pradeep claimed that illegal and immoral behaviour goes on in the park, asserting that police have to control such illegal and immoral behavior. Scott Long from Human Rights Watch asked what evidence he had of illegal acts. The Sub-Inspector said, "We found *metis* carrying condoms, and the *metis* also told us that they use condom while having anal or oral sex. So it's our regular campaign to control *metis* inside the Ratna Park and elsewhere".

Blue Diamond Society denounces such kind of systematic brutal attack against the marginalized community of *metis* in Nepal and condemns the degrading action of the Nepal Police who are supposed to protect the citizens. Criminalising *metis* for carrying condoms and using condoms is a devastating signal of police attitudes and behaviour. It will have a very negative impact on sexual health and preventing HIV/STI amongst *metis* and homosexuals in Nepal.

Blue Diamond Society calls on the Nepal Police, Government and other national and international human rights organizations to take action against the Nepal police so that police officers who are supposed to protect the citizens of the country cannot commit such acts with impunity from the law they are here to uphold. Our (sexual and gender minorities) rights for protection from HIV and STI must not be violated.

2.5 million people in India living with HIV, according to new estimates

UNAIDS press release: Improved data from more sources gives better understanding of AIDS epidemic in India

The new 2006 estimates released today by the National AIDS Control Organization (NACO), supported by UNAIDS and WHO, indicate that national adult HIV prevalence in India is approximately 0.36%, which corresponds to an estimated 2 million to 3.1 million people living with HIV in the country. These estimates are more accurate than those of previous years, as they are based on an expanded surveillance system and a revised and enhanced methodology.

As part of its continuing effort to know its epidemic better, the Indian Government has greatly expanded and improved its surveillance system in recent years and increased the population groups covered. In 2006, the government created 400 new sentinel surveillance sites and facilitated National Family Health Survey-3, which is a population based survey.

Launching the third phase of the National Programme, Dr. Anbumani Ramadoss, Union Minister for Health and Family Welfare said, "Revision of estimates based on more data and improved methodology marks a significant improvement in systems and capabilities to monitor the spread of HIV, a sign of the progress we have made in understanding the epidemic better. This is welcome progress. Unfortunately, the new figures still point towards a serious epidemic with the potential to trigger off if the prevention efforts identified in the NACP III are not scaled up rapidly and implemented in the desired manner. We must remember that India has nearly 30 lakh[1] people living with HIV. These are people facing stigma, discrimination and irrational prejudice everyday of their lives and need all our support and understanding." The Minister called upon his colleagues in the medical profession and civil society organizations to fight stigma and discrimination.

Resulting from a more robust and enhanced methodology, the revised estimates will be used to improve planning for prevention, care and treatment efforts. "While it is good news that the total number of HIV infections is lower than previously thought, we cannot be complacent. The steady and slow spread of the HIV infection is a worrying factor. The better understanding of India's epidemic has certainly enabled us to have more focused HIV prevention and treatment strategies and more effective deployment of resources," said Mr. Naresh Dayal, Secretary Health and Chair of the National AIDS Control Board.

The new methods developed for the revised estimates has also been used to "back-calculate" the prevalence for years since 2002 based on the new set of assumptions and measures. These figures allow a fair comparison of year-on-year trends in HIV prevalence. They show an epidemic that is stable overtime with marginal decline in 2006.

Commenting on the new estimates and guarding against their misinterpretation, Sujatha Rao, Additional Secretary and Director General, National AIDS Control Organization said, "The calculation of figures for several years, using the new model helps us understand that the new lower estimates do not mean a sharp decline in the epidemic." Cautioning against an easing off the momentum of the HIV response she added, "Using a similar methodology led to downward revision in estimates in some countries such as Zambia and Rwanda. We will convince all stakeholders to stay energized and to retain the hard-fought gains of the last decade."

Showing confidence in the commitment of the Indian leadership, Dr. Denis Broun, UNAIDS Country Coordinator said, "The trends evident from the latest estimates validate India's national AIDS strategy. Taking encouragement from the new lower estimates the national authorities should increase the strength of their HIV programmes. We must scale-up efforts to reach universal access to HIV prevention, care and treatment. Though the proportion of people living with HIV is lower than previously estimated, India's epidemic continues to be substantial in numbers. Despite the lower prevalence estimate the cost of prevention efforts required to control the epidemic remains the same."

WHO Representative, Dr. Salim Habayeb commended the vision of the Government of India in the last 15 years for addressing the HIV epidemic. He also commended the efforts of the states, civil society, partner agencies as well as the valuable role of the media in facilitating the creation of an enabling environment. "The HIV burden remains substantial. India's efforts, especially those in prevention, are noteworthy and should be further scaled up along with provision of Universal Access to treatment for those who need it."

HIV prevalence shows signs of slight decline among general population

While overall, the HIV epidemic shows a stable trend in the recent years, there is variation between states and population groups. The good news is that in Tamil Nadu and other southern states with high HIV burden where effective interventions have been in place for several years, HIV prevalence has begun to decline or stabilize.

New pockets of high HIV prevalence identified

HIV continues to emerge in new areas. The 2006 surveillance data has identified selected pockets of high prevalence in the northern states. There are 29 districts with high prevalence, particularly in the states of West Bengal, Orissa, Rajasthan and Bihar.

HIV prevalence continues to be high among vulnerable groups

The 2006 surveillance figures show an increase in HIV infection among several groups at higher risk of HIV infection such as people who inject drugs and men who have sex with men. The HIV positivity among Injecting Drug Users (IDU) has been found to be significantly high in metro cities of Chennai, Delhi, Mumbai and Chandigarh. Besides, the states of Orissa, Punjab, West Bengal, Uttar Pradesh and Kerala also show high prevalence among IDUs.

While data does suggest that HIV prevalence levels are declining among sex workers in the southern states, overall prevalence levels among this group continue to be high, necessitating a scaling up of focused prevention efforts among these groups.

"Only by controlling the epidemic among the vulnerable groups can the dynamic of the epidemic be broken," said Sujatha Rao, Additional Secretary and Director General, NACO.

[1] 1 lakh=100,000

MSM populations have several times higher HIV prevalence than the general population

	MSM HIV rate	HIV rate in general population
Chennai India	6 times	0.9
Jakarat, Indonesia	4 times	0.5
Bangkok, Thailand	16 times	1.6
HCM City, Vietnam	6 times	1
China	15 times	0.1

Source: (UNAIDS, 2006a; UNAIDS, 2006b; FHI, 2006)

The looming Asia Pacific HIV pandemic

Bill Bowtell

Contemplating the appalling mismanagement of the global political response to the emergence and early years of the HIV/AIDS pandemic, it is hard not to come to the conclusion that the greatest enemy of rational public policy making is not, as might have been expected in the case of AIDS, nihilism and paralyzing despair.

Rather, the staggering inability of the global community to prevent the long, relentless march of AIDS from its African origins to the shores of the Asia Pacific owes a great deal to the limitless capacity of human beings for invincible optimism. Time and again, evidence that the HIV virus was a dangerous threat requiring decisive pre-emptive containment action was ignored or discounted.

Cultural taboos and the AIDS pandemic

For fear of offending cultural taboos, confronting uncomfortable truths about sexuality, or just in the blind hope that something would turn up, the world simply did nothing much at all to stop AIDS before it became the greatest public health crisis of our times. In creating AIDS policy, faith, hope, groundless optimism and simple stupidity time and again trumped evidence, science and reason.

The greater the accumulation of evidence that simple, cheap and easily engineered changes in risky behaviors could largely prevent transmission, the greater the attachment to pursuing expensive and fanciful policies that directly contributed to the rapid expansion of the global HIV caseload.

In the 25 years of the AIDS pandemic, some 65 million people have been infected with the HIV virus. Twenty-five million have died from AIDS caused by HIV infection. Forty million people are presently living with HIV/AIDS. In 2006, 4.3 million people were newly infected with HIV and 3 million people died from AIDS. In 2006, half of all new HIV infections occurred in people under the age of 25.

World and Africa HIV/AIDS statistics

While the preponderant caseload remains in sub-Saharan Africa, the HIV virus is now present in every region of the planet, and in almost every country and territory. The global HIV caseload is growing at about 10% per annum, which means that the present global HIV caseload may double in about a decade or less.

The HIV virus is an orthodox product of evolutionary biology. But the AIDS pandemic is a creation of politics. In some quarters, it was once fashionable to describe the advent of HIV and its relentless spread around the world in terms of a divinely-ordained act of God. This pernicious nonsense implied that AIDS was therefore something about which nothing much could be done. But this was never the case. HIV is not Ebola, or even influenza.

Preventing AIDS

The HIV virus is a blood-borne virus that is relatively hard to transmit. It is very susceptible to simple measures and technologies that easily prevent its transmission between humans. At almost any time in the decade or so following the first identification of the HIV virus in 1981, the use of simple prevention measures by at-risk populations could have greatly impeded the spread of the HIV virus and contained the problem.

In 2007, the global AIDS pandemic is so large because the wrong policy decisions were taken in the early years of the emergence of the problem. Rather than squarely face up to the fact that the transmission of HIV was closely linked to sexual and drug-taking behaviors among young people in particular, many governments denied that the problem was ever likely to become a serious threat to their populations. They hoped instead that medical science would shortly fashion a vaccine, treatment or a cure that would relieve them of the need to acknowledge the great variety of risky behaviors indulged in by humankind.

In the 1980s and 1990s, only a few countries dealt openly and honestly with the policy consequences of HIV/AIDS and its transmission vectors. These countries generally fashioned a suite of prevention policies that involved distribution and promotion of condoms to all sexually active people, widespread availability of information about HIV/AIDS, universal access to testing and treatments and, most significantly of all, distribution of clean needles and syringes to the users of illicit drugs.

The countries that adopted these policies were generally rewarded with sustained low and therefore manageable rates of HIV and AIDS infections. Over two decades, an immense volume of evidence accumulated that these simple policies were effective in containing HIV/AIDS. These simple harm reduction measures were everywhere much more successful in preventing the spread of HIV/AIDS than containment policies that required young people to abandon sex and drug use.

AIDS and prohibition

The idea that HIV/AIDS could be beaten by the prohibition of these pleasures proved to be as counter-productive as the prohibition of alcohol was in the United States in the 1920s. As was the case with Prohibition, the laws and policies that were introduced ostensibly to control the problem ended up contributing to its spread. Heterosexual and homosexual sex, the consumption of illicit drugs through injection, ritual scarification and tattooing practices, and prostitution are, for better or worse, ineradicable elements of the human condition.

It is neither possible nor desirable to base effective HIV containment policies on the assumption that people will abandon them. They will not. The incontrovertible evidence of the last 25 years of the global response to AIDS is that the best that can be done is to inform people of the risks involved in such practices and to persuade them to make the minimal changes in behavior that reduce the risk of HIV transmission while indulging their propensity for pleasure. This approach is mature and sensible. Above all, where it has been tried it has broadly worked while the other approaches based on pious moralizing; faith-based optimism and stern proscription have been unmitigated disasters.

In the early years of the pandemic, especially in the United States, rational policy-making was overwhelmed by the explanation of AIDS as a form of divine punishment for the sinful trinity of homosexuality, prostitution and drug use. For political reasons, attempts to mitigate the spread of HIV by introducing needle and syringe exchanges, promotion and distribution of condoms and safer sex information and generally approaching the problem in a mature and considered way, were deeply opposed by the forces of religious reaction. In the United States, these forces compelled the federal government to abandon its attempts to introduce a coordinated national HIV response based on prevention principles. However, the irrational vilification of AIDS in these quarters began to moderate somewhat after new therapies and treatments became available in the mid-1990s.

While opposition remained high to workable prevention policies, the pressing and urgent need to deal with the rising numbers of HIV infected people led the United States Congress and others to greatly increase funding for these expensive new therapies. Over time, this has led to a more nuanced view of AIDS within the United States Congress that might best be summarized as “hate the sin, love the sinner”. So while the obstacles to provision of care and treatment have, in principle, begun to crumble, the greatest obstacle to the provision of sensible prevention policies remains the conflation of the HIV virus and “sin”.

It is extraordinary that the public health response to a single disease, HIV/AIDS, has been entangled in an endless, spurious and mendacious debate about how to suppress vice and promote virtue. The fight against AIDS has been gravely hampered by its politicization by those engaged in the great religious revival that has swept the world in the last several decades. There is no meaning to be found in

the coming of the AIDS virus nor can it be suppressed by any measures other than those based on sound science, empirical observations and the accumulation of evidence about what does and does not work to persuade people to make small changes in risky behaviours.

After two decades, the evidence is completely clear that the promotion and use of condoms, and the use of sterile needles and syringes are key factors in reducing HIV transmission in those at greatest risk of infection - that is, young people. Of course, these technologies have to be made widely available, disincentives to their use have to be removed or reduced, and information about HIV/AIDS has to be made widely available if the maximum preventive effect is to be obtained. Providing these technologies also assumes that the public health authorities accept the realities of sexual behavior and diversity, and of the consumption of often illicit drugs.

These assumptions will, by their nature, conflict with those who wish to restrict and contain sexual expression and activity, and suppress the trade in illicit drugs.

In most jurisdictions, however, there is no evidence to suggest that the availability and use of condoms or clean needles and syringes has increased the rates of sexual or drug-taking activity. Unfortunately, the HIV pandemic is not able to be legislated away. The resort to "tough measures" that "send signals" in relation to sexuality and drug use has been a failure in terms of containing the spread of HIV/AIDS. It is beyond time to actually take tough decisions to implement effective HIV prevention policies rather than simply talk tough.

Looming AIDS pandemic in the Asia Pacific

The chequered history of the political response to the AIDS pandemic should be borne in mind as we survey the sobering outlook for the potential spread of the pandemic into the Asia Pacific region, the world's most populous and economically vibrant and dynamic region. Asia Pacific policy makers would do well to regard the present situation with none of the misplaced optimism that has failed so spectacularly to contain AIDS in the other regions of the world. Rather, they should learn from the litany of errors that has brought about the present catastrophe, and resolve not to repeat them.

UNAIDS reports the overall rate of HIV infection in the region for 2006 at less that 0.1%. However, this overall figure marks wide intra-regional disparities, very significant disparities in infection rates and histories within individual countries, and very different risk profiles for different states and territories within the region.

The numbers of HIV/AIDS cases in China and India have been notoriously difficult to report, and both have been the subject of intense attention and study. It seems clear that earlier assumptions that large numbers of HIV infections were unreported in both countries were wrong. India now reports an adult HIV prevalence rate of 0.36%. China reports that something less than a million of its citizens are HIV positive. However, when the population of both countries is in excess of one billion people, the consequences of even small increases in the prevalence of HIV infections could be significant. Other countries in the region, such as Thailand and Cambodia, have large and long-standing HIV epidemics, although both have been diligent inapplying harm-reduction policies.

In a globalized world, with large numbers of people travelling for leisure and business, there is an increasingly greater risk of HIV transmission between countries.

As we move in to 2008, it is clear that the global HIV pandemic has not been brought under control. Strategies to contain the HIV virus have so far failed to curb its spread into new countries and regions of the globe, notably the Asia Pacific. Without major changes in strategy and significant increases in funding for behavioral prevention programs, the HIV outlook for 2008 and beyond is very grim. There is little prospect that an HIV vaccine, much less a cure for AIDS, will be developed or become broadly available within the foreseeable future.

Antiretroviral therapies for HIV infection (ART) have generated greatly improved outcomes for HIV-positive people by delaying the onset of AIDS and suppressing many debilitating consequences of earlier HIV treatments. While of undeniable benefit to individuals, the advent of ART has created a large, increasing pool of HIV positive people requiring indefinite access to costly treatments that are complex to deliver. The size of this caseload will have increasingly severe economic and systemic consequences. There is little prospect that sufficient funds can be found to ensure universal treatment access for the present global HIV caseload, let alone one that is likely to double within the next decade or so. There are also clear indications that in the wake of the HIV pandemic new strains of virulent tuberculosis are emerging. Tuberculosis is more contagious than HIV. It poses severe health risks to HIV-positive people, as well as to otherwise healthy individuals.

In short, the HIV pandemic has not responded to the strategies so far employed to contain it, and is poised to enter a new period of rapid and dynamic growth in the Asia Pacific region, with highly unpredictable consequences. There is a real, but rapidly shrinking, window of opportunity to avert the worst-case outcome in the Asia Pacific region.

The preponderant HIV caseload remains in sub-Saharan Africa but the disease is expanding rapidly into Russia, east and central Asia and eastern Europe. Between 2004 and 2006, in eastern Europe and central Asia there was a 70% rise in new HIV infections. China has an estimated HIV caseload of about 600,000, which is probably still incompletely reported. However, in 2006, the overall prevalence of HIV infection in east and south-east Asia remains at less that 0.1%, indicating there is still a window of opportunity for effective preventive action to be taken in the region as a whole.

The impact of the HIV pandemic in the Asia Pacific region varies widely between and within countries. Of particular concern is the rapid spread of HIV infection in Papua New Guinea Some 1.8% of the adult population of Papua New Guinea is infected with HIV and prevalence in urban areas may be as high as 3.5% which is comparable to the situation in sub-Saharan Africa. Rates of new HIV diagnoses in Papua New Guinea have increased at about 30% per year since 1997. The very high level of HIV infection in Papua New Guinea raises concerns about the potential for the rapid onset of HIV infection of neighboring Melanesian societies, including West Papua, East Timor, Solomon Islands and other Pacific Island states. Recent, anecdotal and other reports suggest that HIV prevalence in some parts of West Papua and Irian Jaya may be approaching those in Papua New Guinea.

AIDS in Papua New Guinea

The provision of universal access to HIV/AIDS care and treatment remains one of the major, sensible and relevant goals of the United Nations HIV/AIDS grand strategy. The realization of this goal is life-saving and transforming for people with HIV/AIDS. Under PEPFAR and United Nations and other programs, the pharmaceutical industry is being subsidized to produce ever-increasing quantities of new and improved ART treatments. The short-term benefits are obvious. But in the rush to do the right thing, no thought has been given to the fundamental question "Who pays?"

Size matters

It is increasingly clear that the world cannot afford, or will not meet, the real costs of treating even the present HIV/AIDS caseload. This caseload exists because of the failure to prevent the spread of HIV/AIDS infection through harm reduction and behavioral prevention measures. The sheer size of this caseload is transforming the threat posed by the HIV/AIDS pandemic. The present and projected global caseload threatens to impose immense new financial costs on national economies and the international system. The costs of providing ART therapies to even a significant proportion of a global caseload that may number 80 million people within a decade are staggering. The costs of providing genuine universal access to necessary HIV treatments for the entire global HIV caseload do not seem to have

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been fully assessed even in the most recent actuarial calculations.

Assuming, conservatively, that each course of ART therapy requires an investment of $US1,000 per person per year, the cost of providing ART to a caseload of 40 million is $US40 billion per year. These costs take no account of the expanded human and capital infrastructure required to deliver such treatments, or the opportunity costs involved in treating HIV/AIDS cases at the expense of other priorities. Notwithstanding the good intentions of the United Nations, the political reality is that these direct costs of ART treatment are beyond the capacities of governments and donors to fund without diverting resources from other critical development areas and/or recourse to increased levels of taxation and coercive measures.

The escalating costs of providing HIV treatment access to its 600,000 HIV-positive citizens was a crucial factor in the Thai government's decision in January 2007 to break the patent on the HIV/AIDS drug Kaletra to produce a generic alternative. In announcing the decision, Thai Public Health Minister Mongkol said that as Thailand had a budget of $US112 million for the treatment of HIV/AIDS patients, it could only afford to provide medicine for 108,000 patients at the price charged for Kaletra by its manufacturer Abbott Pharmaceuticals. Under similar pressure from rising HIV caseloads, many other governments will be tempted to follow the Thai example

A large and growing caseload also increases the threat that the HIV virus will both increases its resistance to drug therapies and facilitate the spread of new strains of dangerous pathogens, especially highly drug resistant tuberculosis. These new strains of tuberculosis are dangerous to people with HIV/AIDS and risky to otherwise healthy individuals. Already, outbreaks of extremely drug resistant (XDR) tuberculosis have been reported in South Africa, South Korea and the United States of America. In Cambodia, which has brought its rate of new HIV infections under some control, some 53% of people living with HIV/AIDS also have tuberculosis of one form or another. It is a sad fact that there seems to be an inverse correlation emerging between success in prolonging the lives of HIV/AIDS-infected people, and the emergence of new, virulent forms of tuberculosis.

The paradoxical spiral

We are caught in a paradoxical spiral: the size of the global HIV/AIDS caseload demands that available resources be applied to care and treatment at the expense of prevention. But the less emphasis there is on prevention, the faster the global caseload will expand. In a perverse way, the commitment to universal access to ART therapies and treatment has therefore made matters worse, rather than better.

This spiral can only be broken if new and adequate resources are devoted to prevention rather than to the care and treatment of those with HIV/AIDS. If adequate resources cannot be applied to both effective behavioral prevention and to the achievement of the universal access to treatment objective, then logic and morality dictates that the commitment to universal treatment access should be subordinated to the imperative need to cap the caseload through advocating behavior change.

Two HIV and AIDS pandemics: The actual and the potential

There is not one HIV/AIDS pandemic but two. Current international HIV/AIDS strategies fail because, in practice, they recognize and respond only to the historical pandemic and not to the looming one.

The actual HIV/AIDS pandemic is the one that emerged in the last 25 years, predominantly in sub-Saharan Africa. This pandemic is an "after the event" pandemic, largely concerned with the care and treatment of those infected with the disease. It is more about AIDS than HIV. Its needs have led to the development of effective but expensive treatments and political consensus around devoting the resources necessary to deal with a large, but inherently manageable, caseload. As devastating as its impact has been on the 65 million people so far infected with HIV/AIDS, for the past quarter-century the impact of HIV/AIDS has fallen mostly on individuals in small and impoverished countries without the resources and structural depth to contain the pandemic. Until now, this has meant that the pandemic has not had global, systemic effects. The response to the pandemic has been characterized by humanitarian concern and charitable intentions. The toll of dead, dying and infected from HIV/AIDS has been great, but clearly insufficient to precipitate effective action.

The second HIVAIDS pandemic is the one that looms in the Asia Pacific region. This pandemic is potential rather than actual. It is, in 2007, more about HIV than AIDS. It is being driven by a massively large pool of present infections that is spawning new and virulent co-infections. Because those who are infected will not die from AIDS provided treatments are made available, the potential epidemic will have great financial implications that will strain the budgets of even the most prosperous and largest regional economies. The looming pandemic will appear first in the most vulnerable social groups and countries. In the Asia Pacific region, these first affected societies are scattered throughout the region. They are connected to adjacent societies by links of trade and tourism and by large legal and illegal migration and refugee flows. It is only a matter of chance and time before HIV spreads across the region from the areas that were first affected by it.

But to prevent the potential pandemic becoming an actual one, Asia Pacific policy-makers must face some uncomfortable truths. Behavioral prevention remains the best, cheapest and most viable strategy for averting the spread of HIV/AIDS in the Asia Pacific region. There must be much greater emphasis and funding given to primary prevention.

The HIV/AIDS strategy promoted by the United Nations and accepted as orthodoxy by the international community is an unwieldy and unsatisfactory compromise. Despite heroic efforts by UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, there is as yet insufficient political support and funding to both treat the present and projected HIV caseload, and to implement effective behavioral change programs. It is time for a more sophisticated, flexible and appropriate set of strategies to meet the challenges of containing HIV/AIDS in the Asia Pacific region.

Despite immense efforts, medical science is not on the verge of developing, in any time frame that matters, an effective HIV vaccine, cure for AIDS or useful biomedical prevention measures such as vaginal microbicides. However, the armory of primary prevention measures to contain HIV/AIDS may even be augmented by recent findings that male circumcision may greatly improve resistance to HIV infection Even in the welcome event that new therapies emerge, the burdens of cost, complexity and controversy will be immense.

In recent decades, Asia Pacific policy makers have clearly demonstrated their preference for sound, pragmatic and non-ideological economic policy-making. As they now contemplate the looming threat of HIV/AIDS and its associated miseries, they would do very well to apply these principles to in the fields of public health and social policy as well. They reject the failed HIV containment policies of the past two decades and embrace only those that can be demonstrated by evidence and experience to have worked to contain HIV/AIDS.

Bill Bowtell is Director, HIV/AIDS Project of the Lowy Institute for International Policy, Sydney Australia. See his recent article, Deadly Failure of Nerve. He wrote this article for Japan Focus. Posted on the internet, September 20, 2007.

237 reasons why people have sex

Scholars in antiquity began counting the ways that humans have sex, but they weren't so diligent in cataloguing the reasons, humans wanted to get into all those positions. Darwin and his successors offered a few explanations of mating strategies - to find better genes, to gain status and resources - but they neglected to produce a Kama Sutra of sexual motivations.

Perhaps you didn't lament this omission. Perhaps you thought that the motivations for sex were pretty obvious. Or maybe you never really wanted to know what was going on inside other people's minds, in which case you should stop reading immediately.

For now, thanks to psychologists at the University of Texas at Austin, we can at last count the whys. After asking nearly 2,000 people why they'd had sex, the researchers have assembled and categorised a total of 237 reasons - everything from "I want to feel closer to God" to "I was drunk." They even found a few people who claimed to have been motivated by the desire to c have a child.

" The researchers, Cindy M. Meston and David M. Buss, believe their list, published in the August issue of *Archives of Sexual Behavior*, is the most thorough taxonomy of sexual motivation ever compiled. This seems entirely plausible.

Who knew, for instance, that a headache had any erotic significance except as an excuse for saying no? But some respondents of both sexes explained that they'd had sex "to get rid of a headache." It's No. 173 on the hit list. Others said they did it to "help me fall asleep," "make my partner feel powerful," "burn calories," "return a favour," "keep warm," "hurt an enemy" or "change the topic of conversation." The lamest may have been, "It seemed like good exercise," although there is also this: "Someone dared me." Dr Buss has studied mating strategies around the world - he's the oft-cited author of *The Evolution of Desire* and other books - but even he did not expect to find such varied and Machiavellian reasons for sex. "I was truly astonished," he said, "by this richness of sexual psychology."

The researchers collected the data by first asking more than 400 people to list their reasons for having sex, and then asking more than 1,500 others to rate how important each reason was to them. Although it was a fairly homogenous sample of students at the University of Texas, nearly everyone of the 237 reasons was rated by at least some people as their most important motive for having sex. The best news is that both men and women ranked the same reason most often: "I was attracted to the person." The rest of the top 10 for each gender were also almost all the same, including "I wanted to express my love for the person," "I was sexually aroused and wanted the release", and "It's fun."

No matter what the reason, men were more likely to cite it than women, with a couple of notable exceptions. Women were more likely to say they had sex because, "I wanted to express my love for the person" and "I realised I was in love." This jibes with conventional wisdom about women emphasising the emotional aspects of sex, although it might also reflect the female respondents' reluctance to admit to less lofty motives.

The results contradicted another stereotype about women: their supposed tendency to use sex to gain status or resources. "Our findings suggest that men do these things more than women," Dr Buss said, alluding to the respondents who said they'd had sex to get things, like a promotion, a raise or a favour. Men were much more likely than women to say they'd had sex to "boost my social status" or I because the partner was famous or "usually 'out of my league'."

Dr Buss said: "Although I knew that having sex has consequences for reputation, it surprised me that people, notably men, would be motivated to have sex solely for social status and reputation enhancement." But then, men were also more likely than women to say they'd had sex because "I was slumming," Or simply because "the opportunity presented itself," or "the person demanded that 1 have sex,"

If nothing else, the results seem to be a robust confirmation of the hypothesis in the old joke: how can a woman get a man to take off his clothes? Ask him.

To make sense of the 237 reasons, Dr Buss and Dr Meston created a. taxonomy with four general categories:

PHYSICAL: "The person had beautiful eyes" or "a desirable body," or "was good kisser" or "too physically attractive to resist." Or "I wanted to achieve an orgasm."

GOAL ATTAINMENT: "I wanted to even the score with a cheating partner" or "break up a rival's relationship" or "make money" or "be popular." Or "because of a bet."

EMOTIONAL: "I wanted to communicate at a deeper level" or "lift my partner's spirits" or "say 'thank you'." Or just because "the person was intelligent."

INSECURITY: "I felt like it was my duty" or "I wanted to boost my self-esteem" or "It was the only way my partner would spend time with me."

Having sex out of a sense of duty, Dr Buss said, showed up in a separate study as being especially frequent among older women. But both sexes seem to practise a strategy that he calls mate-guarding, as illustrated in one of the reasons given by survey respondents: "I was afraid my partner would have an affair if I didn't." That fear seems especially reasonable after you finish reading Dr Buss' paper and realise just how many reasons there are for infidelity. Some critics might complain that the list has some repetitions - it includes "I was curious about sex" as well as "I wanted to see what all the fuss was about" - but I'm more concerned about the reasons yet to be enumerated.

For instance, nowhere among the 237 reasons will you find the one attributed to the actress Joan Crawford: "I need sex for a clear complexion." (The closest is "I thought it would make me feel healthy.")

Nor will you find anything about gathering rosebuds while ye may (the 17th-century exhortation to young virgins from Robert Herrick). Nor the similar hurry-before-we-die rationale ("*The grave's a fine and private place/But none I think do there embrace*") from Andrew Marveil in *To His Coy Mistress*.

Asian Age, 1/8/07

Sexual Health

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absense of desease, dysfunction or infirmity. Sexual health requires a positive 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.

Sexual rights

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence.

Culture-specific approach needed to issues of sexuality and health

Vidya Shah, India

The diversity of South Asia has been celebrated by Indian culture for many centuries and has been woven into art and cultural expression in a beautiful, almost seamless, way. But all this seems to be changing.

A recent case, involving the jailing of a young art student in Western India for painting 'obscenities' and the rustication of a college dean who defended him on grounds of freedom of expression, indicates the addition of shame and guilt to discourses on diversity. Today, sexual and cultural identities are consistently politicised by right-wing forces in Indian society aiming to reinforce social divisions and hierarchies. One example of this is the banning, on moral grounds, of sex education in four Indian states.

This bigotry is perhaps the most visible aspect of the resistance to sexual diversity in the subcontinent. Much of the resistance is focused on rejecting male-to-male sexual behaviour, not just in India, but across South Asia. The non-acceptance of this sexual preference is evident in the way the rights of men who have sex with men are perceived and violated.

Most South Asian social analyses on sexuality discuss the topic in an exclusively heterosexual context. In most South Asian cultures, the marriage of a man to a woman is obligatory, irrespective of personal preference and choice. The vast majority of marriages are still arranged by the bride and groom's families. For same sex desire to be understood in these cultures it will be necessary for people to first accept that there are homosexual as well as heterosexual members of their community.

Societies have always tried to create the ideal 'good person', who lives their life in a 'good community' to a set of standards called 'good conduct'. But this practice can be described as an attempt to create an idealised uniformity to iron out differences and diversity in society.

Those who wield power in South Asia have constantly tried to reinforce the ideal of uniformity using a variety of often violent methods. Many men who have sex with men, and even project staff providing HIV services, face harassment, sexual violence and rape perpetrated by law enforcement agents, fellow students and colleagues and people in positions of trust, such as relatives, neighbourhood elders, older friends and teachers.

Gang rape is not uncommon, often resulting in internal injuries, and increased vulnerability to HIV infection. A study conducted among men who have sex with men in South Asia showed that 42 percent of respondents reported that they had been sexually assaulted or raped, with many of those respondents saying they were attacked by groups of thugs or policemen.

The issue of HIV has brought the tremendous complexities of male-to-male sexual relations to the surface of social discussions. But simplified, black and white labels such as gay, straight, heterosexual and homosexual are insufficient when tackling these complexities. Male-to-male sexual behaviour in Bangladesh and India often does not fit the heterosexual versus homosexual oppositional paradigm that is so commonly used when discussing same-sex sexual behaviour in the West. This paradigm is not invalid, but it does not necessarily apply within the South Asian context.

The tendency to deny the existence of diverse sexualities in both Western and South Asian cultural discourses has had a central impact on the conceptualisation and understanding of identities. Traditional family, marital and reproductive matrixes further limit understanding. South Asia has some of the world's highest rates of HIV infection and the realisation of this has given new lease to debates on sexuality, sexual identity and gender construction in the past two decades. If appropriate prevention, treatment and care strategies are to be developed, it is important that the dynamics of sexuality and sexual behaviour within certain cultural contexts are understood.

The tendency to write off behaviour as either acceptable or unacceptable has compounded the problems surrounding HIV and risk behaviour. Any attempt at a reductionist analysis would result in the denial of the tremendous diversity of sexualities and gender identities in South Asia, and would prevent our engagement in effective HIV and AIDS prevention efforts among men who have sex with men.

HDN 2007

Mods note: Vidya Shah, the Key Correspondent who has written the below article, also co-authored a publication which was released recently (My body is not mine; stories of violence and tales of hope: Vidya Shah and Aditya Bandopadhyaya: 2007). This was published by DFID, NFI and CMAC. Thanks]

Heavy drinkers living with HIV have lower CD4 counts

HIV-positive people not taking antiretroviral treatment who are heavy drinkers have lower CD4 counts than moderate drinkers or those who never drink. However, the same difference isn't true for people taking antiretrovirals, and alcohol consumption doesn't affect viral load, researchers from Boston report in the Journal of Acquired Immune Deficiency Syndromes.

The difference, of around 50 cells/mm3, may place some heavy drinkers at earlier risk of developing opportunistic illnesses, but the study was not designed to assess how quickly people developed clinical illnesses related to HIV infection.

Nevertheless, the findings imply that someone who consistently drinks heavily would be quicker to reach the point at which treatment is recommended than someone who is teetotal.

The study reviewed CD4 cell counts and viral load in 595 people with HIV in Boston, USA, recruited into cohort studies on alcohol and HIV disease progression between 1997 and 2006. Participants were recruited through hospitals and the community (including a homeless shelter and a methadone clinic) and were predominantly non-white (66%) and injecting drug users (54%).

Fifty-nine per cent were abstinent from alcohol at study entry, but 30% were classified as heavy users, having reported consumption of either 14 or more drinks a week in the past month, or five or more drinks on a single occasion for men, and seven or more drinks in a week, or four or more drinks on a single occasion for women and men aged 66 and over.

Heavy drinkers averaged seven drinks per day, although the median number of drinks per day among heavy drinkers was 2.6, with an interquartile range of 0.8 – 6.8. This implies that the sample included a small number of very heavy drinkers, and a large number who regularly drank at least two drinks per day, or who binge-drank on several occasions each week.

Once recruited to the study participants had CD4 count and viral load assessments every six months, together with an assessment of recent alcohol consumption. Participants were followed for a median of approximately four and a half years.

continued on page 19, col. 1

Heavy drinking and CD4 counts

continued from page 18, col. 2

The study found that after controlling for age, race, HIV risk behaviour, homelessness, depression, adherence and duration in the study, heavy drinkers not taking antiretroviral therapy had CD4 cell counts that were, on average, 48.6 cells/mm3 lower than those of untreated HIV-positive people who did not drink. Moderate drinkers did not show any significant difference from abstinent people. Viral load was not significantly affected by alcohol consumption.

In people taking antiretroviral treatment there was no significant difference in CD4 cell count according to alcohol consumption. However, heavy drinkers were more likely to be non-adherent at baseline.

When they looked at the CD4 cell percentage, researchers found no difference between heavy drinkers and abstinent individuals, implying that the effect of alcohol is not specific to the CD4 cell population but instead reduces the lymphocyte population across the board.

In settings where high alcohol consumption is common, such as Russia or South Africa, the researchers say that the findings could have major public health consequences.

The CD4 cell difference between heavy drinkers and teetotal people – around 50 cells – is the equivalent of one years-worth of CD4 cell loss, if compared with calculations of CD4 cell loss in asymptomatic people with HIV in the UK.

The findings imply that people with HIV with levels of alcohol consumption that may appear modest by the standards of some countries or communities may already be closer to the threshold for starting treatment by the time they are diagnosed with HIV, and that if alcohol consumption increases after diagnosis and stays high, it will moderately affect disease progression.

Reference

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Source:aidsmap <aidsmapnews@nam.org.uk>

Psychologists to review stance on gays

The American Psychological Association is embarking on the first review of its 10-year-old policy on counselling gays and lesbians, a step that gay-rights activists hope will end with a denunciation of any attempt by therapists to change sexual orientation.

Such efforts - often called reparative therapy or conversion therapy – are considered futile and harmful by many gay-rights activists. Conservative groups defend the right to offer such treatment, and say people with their viewpoint have been excluded from the review panel.

A six-member task force set up by the APA has its first meeting beginning next Tuesday.

Already, scores of conservative religious leaders and counsellors, representing such groups as the Southern Baptist Convention and Focus on the Family, have written a joint letter to the APA, expressing concern that the task force's proposals would not properly accommodate gays and lesbians whose religious beliefs condemn gay sex.

"We believe that psychologists should assist clients to develop lives that they value, even if that means they decline to identify as homosexual," said the letter, which requested a meeting between APA leaders and some of the signatories.

APA spokeswoman Rhea Farberman said a decision on when and how to reply to the letter had not yet been made.

The current APA policy, adopted in 1997, opposes any counselling that treats homosexuality as a mental illness, but does not explicitly denounce reparative therapy. The APA has decided to review the policy at a time when gay-rights groups are increasingly critical of such treatment and groups that support it.

Conservatives contend that the review's outcome is preordained because the task force is dominated by gay-rights supporters.

"We're concerned," said Carrie Gordon Earll of Focus on the Family. "The APA does not have a good track record of listening to other views."

Joseph Nicolosi, a leading proponent of reparative therapy, predicted the task force would propose a ban of the practice - and he vowed to resist such a move. Nicolosi, who was rejected as a task force nominee, is president of the National Association for Research and Therapy of Homosexuality.

Clinton Anderson, director of the APA's Lesbian, Gay and Bisexual Concerns Office, insisted the panel would base its findings on scientific research, not ideology. He defended the decision to reject certain conservative applicants to the task force.

"We cannot take into account what are fundamentally negative religious perceptions of homosexuality - they don't fit into our world view," Anderson said.

One of the counsellors denied a seat on the task force was Warren Throckmorton, a psychology professor at Grove City College near Pittsburgh. Though Throckmorton doesn't advocate a specific form of reparative therapy, he argues that psychologists should respect gay clients' religious beliefs in cases where the faith teaches that homosexual behaviour is wrong.

"We work with clients to pursue their chosen values," he said. "If they are core, unwavering commitments to their religious belief, therapists should not try to persuade them differently under the guise of science."

However, one of the task force members, New York City psychiatrist Jack Drescher, said the conservatives don't acknowledge the harm that might be caused when a gay patient - even voluntarily - undergoes therapy to suppress or change sexual orientation.

"They want a rubber stamp of approval for a form of therapy that's questionable in its efficacy and they don't want to deal with the issue of harmful side effects," said Drescher, who is editor of the Journal of Gay and Lesbian Psychotherapy.

As the APA planned the policy review, it received input from gay-rights groups, including Parents, Families and Friends of Lesbians and Gays.

PFLAG's executive director, Jody Huckaby, said reparative therapy had been particularly harmful for young gays whose parents insisted on trying to change their sexual orientation. His group contends these efforts can cause depression and suicidal behaviour.

Current APA policy stipulates that no therapy should occur without "informed consent" of a gay or lesbian client. Jason Cianciotto of the National Gay and Lesbian Task Force said he hoped the APA would declare that no young person could ever be deemed to have given informed consent, and thus no reparative therapy would be approved for minors.

The largest ministry that does counsel gays to change their sexual orientation is Exodus International. Its president, Alan Chambers - who says prayer and therapy enabled him to move away from homosexuality - is among those apprehensive of the APA review.

"I had hoped for more diversity on that panel," Chambers said. "I see a lot of people who represent the other side - who don't believe that people like me have a right to self-determination."

The task force may submit a preliminary report to the APA's directors in December. Anderson said a final report might be completed by next March. *MSM-Asia, 11/7/07*

Iran’s sodomy law: reading between the lines

International Gay and Lesbian Human Rights Commission
*By Hossein Alizadeh and Grace Poore**

(Note: This reflection is meant to take the discussion on Iran beyond the anniversary of the execution of the two young men in 2005 - facts on which the charges against them were based are inconclusive to this day - and to address the Iranian government’s strategy of using criminal law to annihilate sexual rights.) July 20, 2007

Sodomy laws make it a crime to engage in non- procreative sex. Crimes against nature, deviant sexual conduct, and homosexual conduct are among the many terms used within criminal codes around the world. Frequently, in the context of arrests and imprisonment, an actual act of sodomy has not been committed. Rather, the law is used to target those whose sexuality is believed to defy social norms and preferences for heterosexual relationships and to justify state action in removing the “offenders” from the community.

At the same time, within the structure of many penal codes, if not in the minds of the general public, sodomy laws are grouped together with rape, sexual assault, incest and sexual abuse of children thereby conflating crimes of sexual violence with acts of non- reproductive sex. People in both groups are lumped together as social deviants. They must be cast out, punished and, in the case of some countries like Iran, executed.

In Iran, a disturbing pattern of joining rape and sodomy charges has emerged, leaving LGBT, women’s and sexual rights defenders somewhat immobilized in terms of a response. It is difficult enough to challenge a government that cloaks its criminal process and manipulates public opinion around sexuality. But, add to that the quandary of how to respond to cases of public execution of young men on combined charges of sodomy and rape. If LGBT rights groups assume they are gay and mount a campaign to stop the targeting of gay men, they risk relying on unofficial information, putting others in the country at risk, and being insensitive to the fact that perhaps a rape was committed. If women’s rights groups remain silent, they risk tacitly agreeing that execution for charges of rape is acceptable and ignore the targeting of same-sex sexuality. Also, if we question the accused men’s innocence, we run the risk of capitulating to the Iranian government’s campaign of framing charges to carry out homophobic assassinations. If we assume their innocence and defend them unquestioningly, we play into the cultural bias against victims of rape who are routinely disbelieved.

Iranian authorities seem satisfied to publicly flaunt its laws allowing for undue punishment of lesbians and gay men. Just a week ago the Spokesperson for the Iranian Judiciary announced that in the next few days, 20 criminals will be hanged in Tehran on a variety of charges, including rape and sodomy (ISNA News Agency, July 10, 2007). This echoes the situation in July 19, 2005 where two teenage boys, Mahmoud Asgari and Ayaz Marhoni, were hanged in public for their alleged involvement in sodomy and rape. Both teenagers were juveniles at the time of the offense, and one was believed to have been a juvenile at the time of his execution.

Iran’s penal code considers sexual intercourse between members of the same sex to be a crime punishable by death for men and by lashings for women (Islamic Penal Code of Iran, Article 108-134). Any man found guilty of having penetrative sex with another male should be killed, whether the sex is consensual or not. It does not matter whether the other party is a minor or an adult (Islamic Penal Code of Iran, Article 108).

By contrast, the second book of the forth chapter of the Islamic Penal Code, which covers all forms of sexual crimes, remains silent on the subject of rape between a married couple. And, raping a minor is a crime only if the sex act is conducted outside religiously sanctioned relationships. Therefore, an adult man who forces sex on a nine-year-old girl is not considered to have committed a crime if the victim’s father agrees that the rapist can marry his daughter.

The law also requires all claims of sex crimes to be accompanied by at least four adult male witnesses. In cases where those who bring claims of sex crimes to court fail to provide what the court considers to be adequate evidence, they are punished. (Islamic Penal Code of Iran, Section five, Book Two, second chapter, articles 139-164). In total, laws that govern adult rape and child sexual abuse make it nearly impossible for many victims to come forward, let alone demand justice.

Given the legal ambiguity of Iran’s penal code on rape and child sexual abuse, and considering the fact that in most publicized cases, the alleged perpetrators of rape and/or child abuse are also found guilty of sodomy, it is not possible to determine whether the convicted people are truly guilty of sexual offenses, or are being penalized for being homosexuals. Furthermore, in the case of Iran (and also other countries like Malaysia), it is difficult to know whether those accused of sodomy are really gay or being framed by the government as gay. Not surprisingly, in recent cases documented by IGLHRC, Iranian authorities have made no effort to publicly present the required four male witnesses needed for conviction - thus lending to our suspicions that their current practice really is to rid society of lesbians and gay men and promote fear. But, of course, we will never really know.

Take the instance of Ali-Akbar Saidi Sirjani, the well-known Iranian author, who was arrested and killed in 1994 by the Iranian authorities. He was charged for a variety of what were called, “morality crimes,” including homosexuality. His case is an example of how the Iranian authorities used the sodomy law to discredit and frame one of their outspoken political opponents.

Executing people is inhumane and illegal under human rights law. Rape and child sexual abuse are reprehensible and heinous crimes. IGLHRC does not believe that condemning one is antithetical to condemning the other. Both are part of a larger pattern of oppression.

A women’s rights activist from Iran who uses the pseudonym, Azzadeh (which means freedom) observes: “All kinds of people are being executed. All kinds of people are being jailed. We have people from the women’s movement, university students movement, public transportation workers movement, teachers movement - all working for civil rights, and one after the other they are being arrested. Passports are taken, activists can’t leave the country. This is like a place where a bomb is coming down and people are running around, trying so hard not to be damaged in order to survive.”

It is an important time for all of us to band together, confront the nuances and ambiguities, and find the way to speak out against these atrocities. As human rights defenders it is our mandate. As human beings we have no choice.

*Hossein Alizadeh is IGLHRC’s communications coordinator and a gay Iranian man. Grace Poore is IGLHRC’s research and policy associate for Asia and the Pacific Islands and a Malaysian feminist advocate.

The International Gay and Lesbian Human Rights Commission (IGLHRC) is a leading human rights organization solely devoted to improving the rights of people around the world who are targeted for imprisonment, abuse or death because of their sexuality, gender identity or HIV/AIDS status. IGLHRC addresses human rights violations by partnering with and supporting activists in countries around the world, monitoring and documenting human rights abuses, engaging offending governments, and educating international human rights officials. A non-profit, non-governmental organization, IGLHRC is based in New York, with offices in San Francisco, Johannesburg, and Buenos Aires. Visit http://www.iglhrc.org for more information.

Don’t ask, don’t tell, Iranian style

Why did Ahmadinejad claim Iran has no homosexuals? It has to do with a quilt.
By Sandip Roy

At Columbia University Mahmoud Ahmadinejad established himself as the Great Denier - of nuclear weapons, the Holocaust and homosexuals. “In Iran, we don’t have homosexuals like in your country,” he told the audience. “In Iran we do not have this phenomenon. I don’t know who’s told you that we have it.”

Perhaps it was the ghosts of Ayaz Marhoni and Mahmoud Asgari.

On July 19, 2005, Marhoni and Asgari, both teenagers, were hanged publicly for homosexual sex in the Iranian city of Mashad. That was the year Ahmadinejad became president. Maybe what he meant to say is that in Iran we have no more homosexuals.

The loud, skeptical laughter from the audience showed that while some might still believe that Iran is pursuing nuclear weapons for peaceful purposes, no one bought his homosexual-free zone.

But the problem lay in the question. Ahmadinejad was asked why his country denies women and homosexuals rights. If the questioner had asked the Iranian president about homosexual acts instead of a class of people known as “homosexuals,” maybe Ahmadinejad would have conceded the existence of such a “phenomenon.”

Iran is not alone in refusing to acknowledge homosexuals. From Uganda to India, many countries, especially ones with colonial histories, try to disown this Western import. (Cricket, Marxism, washing machines, are apparently OK despite their Western roots.)

This thing of darkness, Ahmadinejad seemed to say, I do not accept as mine.

The West always wants to label, classify, order. In the East, to label, classify, order, reveal or name can invite conflict. In 1944, in one of the first obscenity cases in India, famous Urdu writer Ismat Chughtai was hauled before the court for a short story about lesbianism called “The Quilt.” It was clear to any reader what was going on under the quilt when a noblewoman and her favorite maid pulled it over themselves at night. “Begam Jan’s quilt was once more swaying in the dark like an elephant ... The elephant was making sounds as if it was trying to squat. The sound of someone smacking his lips as if savoring a delicious sauce.”

But the court absolved Ismat Chughtai because she never named the act that happened under the quilt. She never took the quilt off. Safely hidden under it, Begum Jan could do whatever she wanted.

Five decades later, Indian-Canadian filmmaker Deepa Mehta pulled the covers off lesbian sex in the film “Fire,” where two Delhi housewives are shown not only making love but also wondering what name to call themselves. Theaters were ransacked, screenings disrupted, questions were raised in Parliament. And not just by homophobic religious fundamentalists. “There is a danger that many of those exposed to this controversy will learn to view all such signs of affection through the prism of homosexuality. As a consequence many will feel inhibited in expressing physical fondness for other women for fear of being permanently branded as lesbians,” worried Madhu Kishwar, the editor of one of India’s most famous feminist magazines, Manushi.

The protection of the quilt was gone. The act of naming is dangerous.

The act of showing is even more so. The soon-to-be-released film version of the bestselling novel “The Kite Runner” is causing a ruckus in Afghanistan for showing the rape of a young boy. The family of the 12-year-old boy actor wants the scene cut. “This is against Afghan culture,” the boy’s father told the Associated Press.

Yet if there is one country whose culture is imbued with boy-love, it’s Afghanistan. Nineteenth-century British explorer Richard Burton wrote in his accounts of travels through the region about “lads almost in women’s attire with kohl’d eyes and rouged cheeks.” “The cities of Afghanistan and Sindh are thoroughly saturated with Persian vice,” wrote Burton, in a blow to both Iran and Afghanistan.

A famous Pathan marching song goes, “There is a boy, across the river with a bottom like a peach. But alas, I can’t swim.” The Taliban even had an injunction against their fighters taking boys without facial hair into their private quarters.

But when an act is shown on film, it moves from private quarters to the public sphere. It gets a name. It gets an identity. It gets a marker on the Kinsey scale. And you cannot avert your eyes from it. It becomes real.

”The people of Afghanistan do not understand that it’s only acting or playing a role in a film,” the boy’s father told the Associated Press. “They think it has actually happened.”

And it has. It has happened thousands of times, hundreds of thousands of times. But now it’s been dragged into the light, pinned down like a butterfly on an entomologist’s table, available to dissect, label, name and even post on YouTube.

There are men having homosexual sex in Iran. Ahmadinejad knows that. His questioner knows that. The questioner tried to shame the Iranian president. The Iranian president retreated into blind denial. The real failure of the interrogation at Columbia University was in not being able to find a way to talk about that obvious truth without completely stripping off the quilt.

Once we figure out how to do that, we might even be able to discuss nukes.

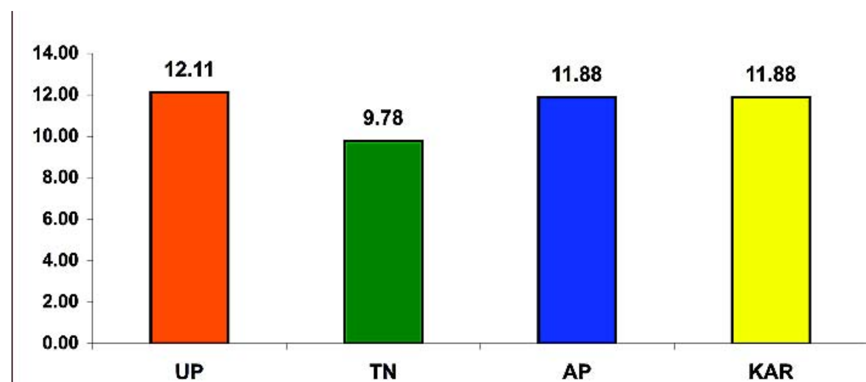
A version of this story was originally published by New America Media.

http://www.salon.com/opinion/feature/2007/09/26/iran_gays/
Sept. 26, 2007

In an NFI study in 2006 across 36 districts in 4 Indian states, some 7,200 self-identified 'MSM' were interviewed in a situational assessement, where the majority were *kothi*-identified.

This graph represents the average number of anal penetrating partners these 'MSM' had in the previous month of the study.

AP - Andhra Pradesh
KAR - Karnataka
TN - Tamil Nadu
UP - Uttar Pradesh



Washing penis soon after sex increases risk of HIV among uncircumcised men, study says

Washing the penis minutes after sex might increase the risk of HIV infection among uncircumcised men, according to a study funded by NIH's National Institute of Allergy and Infectious Diseases and presented on July 25 at the 4th IAS Conference on HIV Pathogenesis, Treatment and Prevention in Sydney, Australia, the *New York Times* reports. According to the *Times*, the washing analysis was the secondary part of a study undertaken to determine the effectiveness of male circumcision as an HIV prevention method.

For the study, Fredrick Makumbi of the Makerere University Institute of Public Health and colleagues examined 2,552 uncircumcised, HIV-negative men ages 15 to 29 in the Rakai district of Uganda. Eighty-three percent of the participants said they washed their penises with all sex partners, the *Times* reports. The researchers asked the men when and how they washed their penises — including if they washed with or without cloths - after sex at the beginning of the study and at six, 12 and 24 months after the study began. According to Ronald Gray, a study co-author and professor of population and family planning at Johns Hopkins Bloomberg School of Public Health, the researchers did not ask details about how the washing was conducted or if soap was used because of an oversight. Some soaps used in Africa are more irritating than soaps used in other places, according to the *Times*.

The researchers found that men who washed within three minutes after sex had a 2.3% risk of HIV infection, compared with a 0.4% risk among men who delayed washing for 10 minutes or more. Makumbi and other AIDS experts said they do not know why washing might increase vulnerability to HIV, but they offered some explanations. One is that delaying washing and prolonging exposure to vaginal secretions might reduce viral infectivity. Another explanation is that the acidity of vaginal secretions might impair the ability of HIV to survive on the penis, the *Times* reports. In addition, the use of water, which has a neutral pH, might prolong viral survival and possible infectivity, according to the *Times*. HIV likely needs to be in a fluid to cross the mucosa and infect cells, Gray said, adding that if HIV-infected fluid dries, its infectivity could decrease. Adding water, therefore, could resuspend HIV and increase its infectivity, the *Times* reports.

One message from the study is that "there ought to be a little time left for postcoital cuddling before you go and wash," Gray said, adding, "Don't just finish and jump out of bed." Merle Sande - an infectious disease expert at the University of Washington-Seattle and president of the Academic Alliance Foundation, a group that trains health workers to treat HIV/AIDS and other infectious diseases in Uganda - said the study's findings are counterintuitive and "show why you have to do the studies, because until you do them, you just don't know." He added, "There is still so much we don't understand about the complex factors that influence HIV transmission in the genital tract, but this important study will help" (Altman, *New York Times*, 8/21).

Kaisernetwork.org, 21/8/07

Empowering men who have sex with men to fight AIDS

By Kevin Frost and Dr. Chris Beyrer

In 85 countries of the world, it is illegal for men to have sex with other men. Male-male sexual relationships are stigmatized, driving men to hide their activities from friends, family members and health workers, according to a recent report by the International Lesbian and Gay Association. Because these men are forced to live part of their lives underground, they often lack access to basic services, and, as a result, are at increased risk of HIV/AIDS.

Men who have sex with men, or "MSM," is a term that applies to those who identify as "gay," but it also includes many MSM throughout the world whose gender and sexual identities defy Western categorization. For instance, in India there are at least three designations: "Kothis" are effeminate MSM who may nonetheless be married to women and have families; "panthis" are masculine men who have sex with kothis; and "hijras," who are often castrated, are considered to be a third gender altogether.

While these groups often do not identify as a cohesive community, they share a vulnerability to HIV/AIDS. Men who have sex with men are among the most vulnerable populations to HIV transmission worldwide, and yet they continue to be one of the most underserved. Today, fewer than one in 20 MSM has access to basic HIV education, prevention services or care. Many will die of AIDS simply because appropriate programs to support them do not exist.

The numbers tell the story. Studies in Uruguay and Ukraine have shown prevalence of HIV infection among MSM to be between 20 and 30 percent; in Kenya, the number is a staggering 38 percent. These statistics are comparable to the parts of sub-Saharan Africa with the highest rates of HIV infection. Around the world, these epidemics threaten to take an even greater toll unless something is done.

We have learned many lessons in the fight against AIDS in the West, where the gay community was among the first to be severely affected by the disease. Responding to the epidemic in the early 1980s, grassroots gay organizations arose to combat homophobia and fight for increased funding for AIDS research and social services.

Just as grassroots organizations led the fight against AIDS in the West, they are vitally needed in the developing world. Grassroots organizations work because they understand the obstacles facing the communities they serve. They know who to reach, how to reach them, and what to say to move this issue to the forefront. Today's challenge is how to learn from our past successes to support burgeoning grassroots movements in Asia, Africa, Latin America and Eastern Europe.

In response to this global challenge, amfAR, The Foundation for AIDS Research, is launching a new initiative this week that will provide seed grants to grassroots organizations doing innovative work with MSM groups on the ground in the developing world.

These grants will be designed to fight stigma and discrimination, provide AIDS education, fund prevention efforts, treatment and care and generate visibility and resources for these groups. For too long, squeamish and homophobic governments have failed to provide even the basic tools for MSM to protect themselves from HIV. We must have the courage to stand side by side with the grassroots organizations on the front lines of this epidemic delivering services and demanding greater action from governments and the global institutions charged with protecting vulnerable populations from HIV.

Collectively, we have learned many lessons over the last quarter century in the fight against AIDS. One of these lessons is that, in any culture, the people who can make the biggest difference are those who have personal experience on the front lines of the epidemic. To effectively fight the AIDS epidemic among MSM, we need to enable community-based groups to design and implement their own programs. The AIDS activist movement owes its success to its grassroots heritage and its ability to empower the disenfranchised. As we move forward, let us remember the lessons of our earlier success.

msm-Asia, 3/8/07

Size estimations

(extract from a document produced by NFI, August 2007)

National or other representative samples of males throughout the world usually find between 5 and 20 percent have had sex with another male some time in their lives, although in certain countries proportions were higher. However, the proportion of males who report recent male-to-male sex within the past year or past 6 months is always considerably lower, ranging from 2 to 10 percent, or approximately half. Certainly, the manner in which these surveys are conducted and the degree of stigma associated with male-to-male sex varies region by region and can be expected to influence survey results, most likely towards under-reporting. Men who report being exclusively interested in male-to-male sex rarely exceed 5 percent in any population. A recent review attempting to examine surveys from around the world suggested that lifetime prevalence of male-to-male sex was 3-5 percent for East Asia and 6-12 percent for South and Southeast Asia.[1] This same study also estimated that the prevalence of male-to-male sex during the past year was approximately half of the lifetime figures but that the prevalence of unprotected sex was around 40-60 percent in East and Southeast Asia but 70 to 90 percent in South Asia.[2]

Current studies and formulae that are being used to develop size estimations in regard to MSM at risk in various states in India are also problematic, and the experience of NFI and its local partner projects have found that they their level of reach to at-risk MSM populations, often have a higher number than the prevalent questimates being offered by so-called experts. While it is understandable that funding agencies and programme designers need some framework to understand the size of the issue and problem, often these MSM "estimates" are framed within implicit homophobia and denial. Socio-cultural dynamics of sexual practices are not taken into account, how MSM are defined and how risk is defined provide convenient barriers to fully understand what is actually going. All we can really say with any honesty is that there are significant levels of high risk male-to-male sex going on involving a significant level of the sexually active male population, and that this is usually higher than most people believe. The individual state reports below try to calculate actual numbers as indicated by these differing formulae, but NFI disclaims and responsibility for their accuracy.

Based on the calculations of Cáceres (see above paragraph) of 6%-12% range, this gives an approximate number of MSM in the South Asian countries where almost half of this would have experienced male-to-male sex in the previous 6 months, we are suggesting a figure of some 6% of sexually active males have been involved in at risk male-male sex in the previous month. (Fig. 1)

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Figure 1

Country	Total population	Total males 15+	6% of male population 15+ years	10% of male population 15+ years
Bangladesh	141,822,000 (2006 estimate)	45,369,092	2,722,145	4,536,910
India	1,065,070,607 (2004 estimate)	375,671,529	22,540,292	37,567,153
Nepal	28,287,429 (2006 estimate)	9,193,414	551,605	919,341
Pakistan	165,803,560 (2006 estimate)	51,470,363	3,088,222	5,147,036

Sources:
Bangladesh: www.discoverybangladesh.com (accessed 16/5/07);
India: www.iloveindia.com/population-of-india (accessed 16/5/07);
Nepal: www.google.co.in/search?hl=en&q=Nepal+population (accessed 16/5/07);
Pakistan: www.en.wikipedia.org/wiki/Pakistan (accessed 16/5/07)

There are of course many other estimates, some much lower, some m uch higher. Ashok Row Kavi of The Humsafar Trust in Mumbai, India, a leading expert on MSM and HIV issues, had at one time estimated that there are perhaps some 50 million MSM in the country based on the Kinsey framework, while the Indian government estimate of MSM at risk hovers around 2.5 million.

Calculations depend on quality of research and a broad range of factors, but for example, the National AIDS Control Programme in India uses the formula below:

Figure 2

District/Town	Number of males	Male population above 15 years (approximately 67% of the total population - 2001 Census)	65% of these males deemed to be sexually active	5% of this population deemed having anal sex in previous year	20% of this population deemed as having 5 or more partners in previous month - to be reached by programme

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Size estimations

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But we cannot assume that the assumptions and figures realistically reflect those MSM most at risk, since the derived percentages may not reflect the reality of male-male sexual behaviours and risk, as can be seen from many of the situational assessments that NFI has conducted in several cities across South Asia. What about the partners of these males? For NFI, the size estimations used to formulate policy and funding decisions appear suspiciously under-estimates.

A similar problem exists where in India, some State AIDS Control Societies believe that the size estimation of those MSM most vulnerable who need to be reached is developed through a different formula, i.e. total number of new MSM reached multiplied by 8 (an average number of different male sex partners in the previous month). But using this formula would mean that the estimated numbers of MSM that should be reached by an MSM HIV project is based on their productivity and effectiveness (i.e. how effective their outreach activity is).

There would also be issues of concern regarding the derived numbers using this formula, primarily how many newly identified MSM are reached by the project will be dependent on a variety of factors, chief among these being:

- How long has the intervention being going on
- Number of outreach workers being employed
- Quality of outreach
- Frequency of outreach, time and location

All this has an impact on the number of newly identified MSM, which will vary from month to month. NFI believes it is somewhat dubious to try to identify the number of MSM that needs to be met by any given intervention using this particular approach.

A final question needs to be raised in trying to determine size estimations of MSM at risk, and that involves a deeper understanding of male-to-male sexual dynamics and networking in South Asia. All the evidence indicates that a very high proportion of MSM are highly sexually active with multiple partners along with low condom use, irrespective of whether these MSM are involved in commercial sex or not. Further gender performance, invisibility and denial also impacts on being able to determine size estimations. All this numbering depends on who MSM are being defined. The question is who are MSM?

Tops and bottoms

by John Corvino

(Yes, this column is about exactly what you think, so readers squeamish about such topics should find another page.)

Years ago I lived next door to a young born-again Christian rock singer (I know - it sounds like the premise for a sitcom). While Jason strongly disapproved of my being gay, he was also fascinated by it, and he constantly asked me questions.

One day I revealed to him that I had never had anal sex. His face brightened. “That’s awesome!” he shouted.

“Why, pray tell, is it awesome?” I asked.

“Because maybe you’ll try it, and then realize you don’t like it, and then you won’t be gay.”

For Jason, being gay meant liking anal sex. He found it strange that the equivalence had never occurred to me. For me, being gay means that I like guys. It means that I *like guys* - I have crushes on them, I fall in love with them (one in particular), I want to “get physical” with them. It doesn’t specify how I should do this.

I suppose the mistake is understandable. Most people would find it odd for a heterosexual not to desire penile-vaginal intercourse. It’s “standard.” For some gay men, anal sex is functionally similar—it’s what they might call “the real thing.”

But that’s not true for all of us. A guy who’s into other guys but prefers oral sex or mutual masturbation or frottage (look it up) is still gay. Sorry Jason.

If such confusion were limited to callow born-again Christian rock singers, I could ignore it. But the assumption that we all want anal sex is shared by many gays. Here’s a familiar conversation from my single days:

Interested Guy: “Are you a top or a bottom?”
Me: “No.”
Interested Guy: “What do you mean, ‘No’?”
Me: “I mean I’m neither a top nor a bottom.”
Somewhat Less Interested Guy: “That means you’re a bottom.”

What - so “bottom” is the default setting now? As the saying goes: “If he says he’s a top, he’s versatile. If he says he’s versatile, he’s a bottom. If he says he’s a bottom, he’s honest.”

So why not just say that men who don’t identify with either category are “versatile”? The answer is simple: because it ain’t so. As one similarly oriented friend put it, “Versatile? Hell no. I’m a total bore.”

Besides, this suggestion just feeds the myth that every gay male organizes his sexual identity around anal sex. The point is that some of us don’t - which doesn’t mean that we’re naive or inhibited. (Quite the contrary: those who “think outside the box” may be quite sexually skilled.)

The myth that other kinds of sex aren’t “real” reflects heterosexual practice. A lot of straight people insist that oral sex doesn’t “count” as sex - it’s just foreplay. I used to think that this was merely a rationalization for clinging to the title of “virgin” or denying having sex with White House interns. I’ve since realized that, in many people’s minds, “real” sex requires a man sticking his penis into some orifice below the waist. No wonder some people have such a hard time conceptualizing lesbianism.

Another way of putting my point, borrowing from a longstanding academic controversy, is to say that people are “essentialists” about the top/bottom dichotomy: if you’re a gay man, you are “naturally” one or the other, and your job upon coming out is to figure out which. (It’s a job some people undertake with great relish; I, by contrast, keep calling in sick.)

I’m not denying that these categories can be useful for those to whom they actually apply. They can be a handy way of communicating and identifying preferences - for example, in personals ads (“Hot and hung power-bottom seeks friendship, maybe more”). Nor am I denying that people ought to explore new territory, provided that they take the usual sensible precautions. I’m simply denying that certain territory is a required checkpoint.

A related myth concerns associated personality traits: tops are supposed to be manly, assertive, and dominant, whereas bottoms are supposed to be effeminate, passive, submissive. I’ve interviewed a lot of gay guys over the years, and I’ve done more direct - shall we say - "research.” I’m here to tell you: not true.

It’s funny to watch people’s expectations shattered on this point. Once at a bar I overheard a guy expressing disappointment that the object of his interest was, like him, a top. “But that can’t be!” he exclaimed. “He wears too much hair product to be a top!”

Personally, I would imagine that tops especially need hair product. It keeps their bangs [hair fringe] out of their eyes. But as I’ve said, I’m no expert.

John Corvino is a writer, speaker, and philosophy professor at Wayne State University in Detroit. His column “The Gay Moralist” appears bi-weekly at 365gay.com.

Purple Sky Network: Despite improved co-ordination and better data for advocacy, HIV interventions for men having sex with men in the Greater Mekong Subregion still far from sufficient

By Jan W de Lind van Wijngaarden, UNESCO Bangkok, for MSM-Asia
31st August 2007

Bangkok, 30 August 2007 - Around 75 community representatives, policymakers, experts and researchers from Myanmar, Thailand, Lao PDR, Cambodia, Vietnam and 2 Southern Chinese provinces have come together for the "Greater Mekong Region Purple Sky Network meeting" at Narai Hotel, Bangkok on 30-31 August 2007 to assess progress in improved coverage and coordination of HIV and sexual health responses for Men who have Sex with Men in the Greater Mekong Subregion. The meeting is hosted by Purple Sky Network (PSN) Secretariat, which is hosted by TREAT Asia in Bangkok.

Epidemiology update

Dr Frits van Griensven of the Centres for Disease Control (CDC)/ Thailand Ministry of Public Health, provided an overview of the epidemiology of HIV and sexually transmitted infections in the greart Mekong sub- region (GMS). Since the last meeting in 2005, new data has emerged from China, showing a rise in HIV prevalence in MSM in Beijing from a bit over 2% to 5.8%. There is also new data on HIV prevalence in other Chinese cities like Shiang Hai and Shengzen. Furthermore, an HIV prevalence survey is currently being conducted by CDC, Burnet and the Lao Ministry of Health in Vientiane in Lao PDR; data are expected within a few months time - this will be the first time any HIV prevalence data will be available for this country. In Thailand, a third round of HIV prevalence research has just been completed; although the data has not yet been officially announced, Dr Griensven indicated that HIV prevalence is 'not going down yet' from the 2005 figure of 28.3% prevalence in Bangkok. In Cambodia and Vietnam, prevalence among MSM is hovering between 5-10% in the main cities. In Myanmar, MSM will be included in HIV surveillance in 2008; there is only anecdotal data, suggesting an HIV prevalence among MSM hovering around 30%.

Coverage

Dr Frits showed that men who have sex with men in major cities in the region contribute around 30% of the total number of HIV positive people in these countries, and he asked the question whether this significant role of male to male sex in national epidemics was reflected in budget allocation for HIV prevention programs for MSM, and in coverage of interventions.

Later, Rapeepun Chommaroen of Rainbow Sky Association of Thailand, representing the Thailand MSM Network, reported that only 20% of MSM in Thailand are currently covered by comprehensive prevention, care and support programs; Habibur Rahman of Population Services International in Myanmar, representing the Myanmar MSM Network reported coverage of 30%. Coverage in Lao PDR, Vietnam and China is also still low - especially when compared to the relative importance of HIV in male-to-male sex in these countries. This data was confirmed by recent research findings of Constella's Group, a presentation of which was shared with MSM Asia two days ago.

New information on 'what works'

Philippe Girault of Family Health International's regional office presented an evaluation of the Sex Alert! media campaign for MSM in Chiang Mai and Bangkok, which was implemented for 6 months in 2006. The evaluation shows that the campaign managed to reach up to 95% of MSM community there, and that there was a significant correlation between exposure level to the campaign and condom use with certain types of partners and with HIV testing uptake. It was shown how a combination of different communication channels can increase coverage and reach of such campaigns dramatically. Although the campaign was costly, when calculated as a 'cost per person reached' figure this approach may be an appealing alternative or additional option to outreach or group events.

Coordination and collaboration at the country level

After this, groups from different countries presented updates of what is happening in their country in terms of MSM intervention work. In all countries, national level 'MSM working groups' have been established, and a mapping of ongoing interventions and intervention types has been completed. Collaboration and coordination between different partners at the country level has improved a lot in the past two years as a direct result of the establishment of these country level working groups - which was, together with improved advocacy based on evidence, one of the key objective of the subregional Purple Sky Network.

Main challenges mentioned by nearly all countries was a lack of funding and technical support for scaling up successful interventions, how to reach out to 'hidden' MSM, how to improve the availability of water-based lubricants, how to reduce societal stigma and discrimination against MSM, which prevents them from accessing health care services. Furthermore, there is still a low uptake of testing and counselling services, because only few of the counselling and testing centres are friendly and appropriate for MSM.

TREAT Asia was congratulated by USAID, CDC and FHI for nurturing the Secretariat over the past two years. A spokesperson for USAID indicated that it will continue to support the Purple Sky Network's activities over the next years.

Purple Sky Network sets ambitious targets for scaling up HIV work with MSM

During the second day of the Purple Sky Network meeting in Bangkok, the focus was on reviewing and renewing the Two Year Vision for 2008-2009. Ambitious targets were set by the country delegations of Thailand, Cambodia, Myanmar, Lao PDR, Vietnam and the two Chinese provinces of Yunnan and Guangxi.

Myanmar's priorities were to increase the number of MSM reached by peer educators to 100,000 (out of a total of 267,000 - as estimated in the National Strategic Plan); the number of sites for VCT for MSM should be expanded to 20 (from 11 now); two self-help groups for MSM with HIV will be established in addition to the one that already exists; 25% of MSM that need antiretroviral treatment will be covered by the end of 2008. Myanmar also plans for a national MSM advocacy meeting next year, and for a process of capacity building. In terms of research MSM will be included in surveillance activities starting in 2008, and qualitative research on male to male sexuality is planned for in January 2008.

Cambodia's priorities included raising access to services for MSM to 80% for STI services, and 50% for voluntary counselling and testing. It is planned to reach 90% of MSM with prevention services by the end of 2009. Cambodia also plans to include MSM in its surveillance activities. Cambodia will also include MSM in the next

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Purple Sky Network meeting

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process for fund application for the Global Fund; in the area of capacity building a focus should be on management and monitoring and evaluation training, since many new organizations have been established in recent years working with MSM.

China's two southern provinces of Yunnan and Guangxi listed the following priorities for the next two years: strengthening linkages between community based organisations and government services (VCT and STI). Also, self-help groups for HIV positive MSM will be established, and in order to reduce stigma and discrimination of this group the Chinese plan to link these groups up with existing networks and help them facilitate resources. MSM will also be incorporated in provincial surveillance; it was noted by the Chinese group that no data from their provinces was presented in the epidemiology overview yesterday, and they would like to address this lack of data. Furthermore, coordination between donors, international NGOs, community based groups and the government is called for. Also, training and sensitizing of male sexual healthcare providers is needed. Finally, the Chinese delegation will evaluate the effectiveness of current HIV programmes and projects with MSM to determine which strategies are worthwhile to scale up.

The Lao PDR group mentioned that the Government has already determined that a 'supportive environment' for MSM/MSW and transgenders will be fostered, so that they can identify their own needs. Goals already included in the National Strategic Plan for 2006-10 is that 70% of male sex workers in selected locations use condoms; 80% of 'ladyboys', as the presenter referred to them, should use condoms in selected locations. Finally, the NSP calls for better evidence on the HIV epidemic among MSM and transgenders. For the next two years, six priorities were identified by the Lao delegation. First, to organize a national meeting with MSM, partly to break the silence about MSM in Lao society; this idea appears to have been partly influenced by the positive experiences in Myanmar, Cambodia and Thailand with similar meetings. The second priority is to build the capacity of community based groups currently working on HIV prevention among MSM, in programme management, technical and advocacy skills. Third, qualitative research is called for in areas outside Vientiane (where UNESCO recently conducted a study, which is in the process of being approved); 'hot spots' should be identified in other cities and areas. Fourth, an increased number of MSM should have access to prevention and VCT/STI services by the end of the period. On the services side, clinicians and other health care providers should be trained and sensitized on providing care to MSM. Sixth, behavioural and HIV surveillance among MSM should be set up, including not only Vientiane but other cities in the country.

The Thai delegation presented their new five-year MSM strategic plan, which includes ten strategies.

The Vietnamese delegation set itself the following targets: to develop a strategy on MSM and HIV, to have a national targeted communication strategy, also to include MSM in Vietnam's next Global Fund application. In terms of HIV services, the Vietnamese plan to double the number of MSM who have access to peer education, antiretroviral treatment (ART), voluntaret counselling and testing (VCT), and sexually transmitted infections (STI) care by 2010. They also call for increased participation of MSM living with HIV/AIDS, including them in the MSM National Technical Working group. The Vietnamese delegation also hopes to establish a Vietnamese non-governent community based organisation specifically working on MSM issues by 2010.

The group discussing priorities for the regional Purple Sky Network secretariat listed six priorities: first, to intensify partnerships with other regional entities, including the recently established Asia-Pacific Coalition on Male Sexual Health (APCOM), the Asia Pacific Network of people living with HIV/AIDS (APN+), the Technical Support Facility and others. Secondly, the PSN Secretariat should advocate and coordinate regional level resource mobilization activities, including the recent possibility of submission of regional proposals to the Global Fund, and a mapping of donors' interests and priorities and funding cycles. Third, PSN Secretariat, based on the current assessment of capacity building needs by API, should help facilitate the provision of technical assistance (by other organizations) to countries that need it. Fourth, the regional group discussed the issue of possible independence of the PSN Network from TREAT Asia – although TREAT's role and performance in mentoring and nurturing the secretariat over the past year has been excellent, it is important to study the desirability and feasibility of having PSN as a truly independent organization in a number of years time. Fifth, information provision in the six main languages of the GMS should be promoted in order to improve intercountry communication; this may include a regional website and a regular newsletter in the 6 languages of the region (which UNESCO has promised to support over the next 2 years, using UNAIDS/UBW funds). Lastly, the principle of greater involvement of people living with HIV/AIDS in planning should be revisited and possibly given greater importance than has been the case in the past two years.

A new MSM network arises

The Pacific MSM Network meets for the first time

A four day networking meeting was held in Apia, Samoa between 28th-31st August 2007, bringing together representatives from seven of the twenty two island nations and territories making up the Pacific Islands.

Organised by the Samoa AIDS foundation (SAF) under the aegis of UNAIDS and with support from the New Zealand AIDS Foundation (NZAF), it brought together representatives from the SAF, the Samoa Fa'afa Fini Association, the Tonga Fa'aka Leiti Association, the Equal Grounds Pacific of Fiji, representatives from PNG, the Wan Smol Bag Theatre of Vanuatu, and the emerging fa'afa Fini network of the Cook Islands.

Day one was devoted to country reports, based on certain predetermined criteria:

- legislation concerning MSM
- history of same sex/MSM in the country
- access to services/availability of services
- organisations that work with MSM and other stakeholders

Out of the island nations, only in American Samoa and Vanuatu is same-sex behaviour legal.

Aditya Bondyopadhyay, APCOM Secretariat coordinator also gave a presentation of the background and development of the Asia Pacific Coalition on Male Sexual Health, explaining its constitution, the Interim Governing Board, and a briefing on future activities that APCOM proposes to undertake.

The first half of day two was focused on discussions on the legal and legislative situation of MSM in the Pacific region. Matautia Phineas, a lawyer, made a detailed presentation and possible ways forward to address illegality.

Following lunch, Silipa Take of NZAF gave a presentation on the sociocultural situation faced by Pacific Islander MSM and how these situations are addressed in a counselling setting.

Finally, a draft constitution for the Pacific MSM Network was presented by Carlos Perera of Equal Ground, Fiji and Ken Moala of Samoa AIDS Foundation.

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The 2007 Ramon Magsaysay Award for Emergent Leadership Citation for Chung To

Ramon Magsaysay Award Presentation Ceremonies
31 August 2007, Manila, Philippines

In China today, a transformation of dazzling speed and complexity is reshaping society and calling forth new leaders. Chung To and Chen Guangcheng are two of these. Each one in his own way, and on his own initiative, has stepped forward to address an urgent contemporary need. Where others have been slow to act, they have acted.

Chung To was born in Hong Kong but migrated with his family to the United States when he was fifteen. He attended Columbia University, earned a master's degree at Harvard, and then plunged into a career in banking. In 1995, success led him back to Hong Kong as a senior bank executive.

By this time, Chung To was already sensitized to the AIDS crisis through the death of a favourite teacher and of many friends. In Hong Kong, he was alarmed to find the male homosexual community largely ignorant of the threat. Gay men accounted for a third of the city's HIV/AIDS cases, yet unprotected sex was commonplace.

Chung To! reacted by creating the Chi Heng Foundation (CHF) in 1998, to arm gay men with a means of protecting themselves. Beginning in Hong Kong but later expanding into the mainland, he enlisted the help of pimps and brothel owners and hundreds of volunteers to distribute condoms and safe-sex kits in gay bars and clubs. He set up a help line with frank, factual information about HIV/AIDS and offered workshops and personal counselling, legal advice, and links to doctors. And he exploited the rising popularity of the Internet to reach the millions of gay Chinese men who use it. By 2006, Chung To had established CHF branches in ten Chinese cities. Taking note, the United Nations named his direct, management-savvy approach one of its "best practice" models for China.

In 2001, an encounter with AIDS victims (sic) in Henan Province led Chung To in a different direction. In Henan, the AIDS epidemic was caused not by sexual contact but by the egregiously careless practices of blood buyer! s. Here, he saw villages where half of the adults had either died of AIDS or were HIV positive. "I have never seen so much hardship and suffering concentrated in one small village," he says. He was especially moved by the plight of children orphaned by AIDS. Their grim lives and futures stirred him to launch the AIDS Orphans Project in 2002. He left his job at the bank to devote himself full-time to China's AIDS crisis. "I figured that the world could do with one less banker," he says. "But these children, they cannot wait."

Pondering how to help the children, Chung To concluded that education was the key. In its target areas, his AIDS Orphans Project provides every child who has an AIDS-infected parent with school fees and expenses through university or vocational school. To avoid reinforcing the AIDS stigma and its social isolation, Chung To spurns orphanages and foster homes and insists that AIDS-impacted children attend normal village schools and live with relatives. His foundation also provides the children self-affirming counselling through art and writing therapy, summer camps, and home visits by CHF volunteers-including Chung To himself. Chung To's orphans project began with 127 students in a single village. Today, four thousand children of AIDS in five provinces are benefiting.

Chung To with Douglas Sanders at the 2006 Montreal Gay Games

Chung To works cooperatively with the Chinese authorities and has found allies in international NGOs and foundations. Still, raising funds is a constant concern. CHF has a "six-step fund-raising strategy" and Chung To himself has also recently returned to the business world-another strategy for sustainability. As CHF's chairperson, he hopes to multiply the foundation's impact with a new "business model." What began as a "family run" enterprise, he says, will become "a multi-branch franchise."

In electing Chung To to receive the 2007 Ramon Magsaysay Award for Emergent Leadership, the board of trustees recognizes his proactive and compassionate response to AIDS in China and to the needs of its most vulne! rable victims.

http://www.rmaf.org.ph/Awardees/Citation/CitationToChu.htm
AIDS_Asia egroup, 1/9/07
(Editor's Note: Chung To was on the Steering Committee of Risks and Responsibilities: Male Sexual Health and HIV in Asia and the Pacific International Consultation Meeting, held in New Delhi in September 2006)

The Pacific MSM Network

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Day three consisted of a workshop on transformation leadership, followed by a break-out sessions on developing a work plan for the Network.

Day four was a half day detailed discussion of the draft constitution, where suggested changes were incorporated into the final draft leading to the constitution being formally adopted.

This was followed to nominate the Pacific representative onto the Interim Board of APCOM.

Joey Mataele, founding president of the Tonga Fa'aka Leite Association was nominated. It was also decided that an alternate to Joey would be Carlos Perera of Equal Ground, Fiji in case Joey not be available at some point to attend to the duties of the Interim Governing Board member.

UNAIDS has offered US$50,000 towards supporting this new regional network.

Aditya Bondyopadhyay of APCOM has prepared a detailed report of the situation of MSM in the Pacific as reflected by the participants at this meeting which is available from apcom@msmasia.org on request.

The development of this new regional network is also joined by another outcome from the New Delhi Risks and Responsibilities (RR) meeting in September 2006, where a sub-regional configuration called Developed Asia, consisting of Japan, Hong Kong Special Administrative Region, Macau Special Administrative Region, Singapore, South Korea and Taiwan was formed to address the concerns of MSM in these economically developed countries and states. Members of this working group at RR have continued to keep in contact with each and are exploring ways to formalise this network. It is represented on the APCOM Interim Governing Board by Masao Kashiwazaki of OCCUR, Japan.

Kathmandu Declaration 2007

We are the sexual and gender minority people of Nepal. We are human beings. We are fearless in the defense of our fundamental rights to life, dignity, and equality.
We will not be ignored
We recognize Nepal as our country, Nepal must recognize us.
We will not be stopped
We will not be stopped until our rights are recognized. We will not cease in our efforts until these rights are embodied in the laws, policies, actions and attitudes of government, institutions and society that affect our lives.
We will not allow our rights to be denied.
We condemn and challenge the stigma and discrimination that excludes us. We condemn economic, physical, mental and sexual violence against us.
We will not wait.
We will not wait for politicians to conduct business as usual.
We will not be denied.
We will not be denied these demands. Our principles are unshakeable. Our solidarity is unbreakable.

WE COMMIT OURSELVES TO:

- Respect each other and join together as a community speaking with a single voice to lead a campaign for our constitutional, legal, political, economic and social rights
- Mobilize our grassroots communities, our political leaders, our journalists, our human rights activists, our families and all sectors of society to ensure our inclusion, representation and full participation in the upcoming Constituent Assembly elections and the building of a New Nepal
- Select and support independent candidates to stand in the forthcoming elections

WE DEMAND THAT OUR GOVERNMENT AND POLITICAL PARTIES:

- Acknowledge the gravity of exclusion, violence and discrimination towards sexual and gender minorities by state and society;
- Commit to a constitution that ensures full protections and equal rights for every Nepali including ensuring the basic human rights, freedom, employment security and equal opportunity for sexual and gender minorities;
- Urgently change law and policy that excludes third gender from citizenship and exercising voting rights
- Adopt policies in political manifestos that ensure the needs of sexual and gender minorities
- Bring to account all perpetrators, whether they be security forces or civilian, of violence or intimidation (including arbitrary arrest) towards sexual and gender minorities.
- Amend or repeal any provisions of the criminal code that discriminate against sexual and gender minorities

WE DEMAND THAT THE INTERNATIONAL HUMAN RIGHTS COMMUNITY AND GOVERNMENTS:

- Hold government and politicians to the commitments made in International Conventions to which Nepal is a signatory and monitor the implementation of these
- Support and encourage the drafting of a new Constitution that meets the highest standards of human rights including those relating to sexual and gender minorities

WE DEMAND THAT CIVIL SOCIETY AND OTHER HUMAN RIGHTS ACTIVISTS:

Join with us to ensure that New Nepal is a fully inclusive society in which all people have full and equal rights and are protected from unfair discrimination on any basis such as race, gender, ethnicity, caste, health condition, disability, motherhood, profession, sexual orientation or gender identity.

Agreed this 11th day of September 2007 by the participants of the National Seminar "Towards a more tolerant and inclusive society" including representatives from:
Blue Diamond Society
Mitini Nepal (Kathmandu)
CruiseAIDS (Kathmandu)
Parichaya Samaj (Lalitpur)
Naulo Bihini (Pokhara)
Western Star (Nepalgunj)
Mono Supporting Maple Group (Bhairahawa)
Sunaulo Bihani Samaj(Janakpur)
Human welfare Society(Itahari)