

male reproductive and sexual health and hiv/aids in south asia

a south asian consultation meeting for
males who have sex with males

4th - 7th March, 1999, Calcutta, India

Meeting Report

 NAZ FOUNDATION

S a male sexual health project
Sahodaran

 PRAAJAK
NEW ALIPORE
DEVELOPMENT SOCIETY

meeting co-organised by Naz Foundation International, Prakriti - Sahodaran, and Praajak Welfare Society

sponsored by UNAIDS, Family Health International and Global Health Council

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some of the participants on the final evening

This meeting was unique in providing a safe space for discussion of topics that must be brought out, if we are stop the needless deaths of those marginalised by society as a whole. It was also unique in bringing community -based initiatives to the same table as the highest levels of policy makers and international organisations.

comment from a participant

AIDS in has become a issue of serious concern in the South Asia region. India alone has an estimated 4-5 million people living with HIV, with major implications for economic development, poverty alleviation and health care services.

The AIDS epidemic in the region has been defined as “heterosexual”. However, socio-cultural constructions of male sexual behaviours in South Asia do not fit into heterosexual or homosexual identity frameworks. Research conducted by Naz Foundation International and others indicate that levels of male to male sex, whether based on desire or on semen discharge are much higher than assumed. Patterns of STD and HIV transmission must therefore take into account such behaviours if effective strategies to promote sexual health are to be achieved.

The debate regarding the development of appropriate strategies for STD/HIV prevention programmes amongst males who have sex with males in the South Asia region is a recent one. Little technical expertise has developed, whilst several of those who are trying to develop responses approach it from a gay identified framework.

Naz Foundation International believes that such a “gay” approach is very limited and excludes the vast majority of male to male sexual behaviours. A more culture-specific and eclectic approach must be developed. At the same time NGOs, governments and donors must be persuaded that the issue of male to male sexual behaviours in the context of developing effective sexual health promotion programmes, and to control the HIV/AIDS epidemic, must be taken into account, and appropriate services developed.

To effect this discussion, a South Asia Regional Consultation Meeting for males who have sex with males sexual health projects was organised in Calcutta, India, between 4th - 7th March, 1999.

It was funded by Family Health International - Asia, UNAIDS, Global Health Council, and the Office for International and Refugee Health (USA Government).



speaker on MSM youth

Executive Summary

In order to discuss these issues and develop a range of recommendations for action that deal with the range of male to male sexual behaviours and the consequent risks for STI/HIV transmission amongst both males and females a special consultation meeting was organised in Calcutta, India by Naz Foundation International (based in the UK), Praajak Development Society (Calcutta), and Prakriti-Sahodaran (Chennai). All these agencies work in the field of sexual health promotion amongst males who have sex with males, and are managed by MSM themselves.

84 participants were brought together from a range of South Asian beneficiary led sexual health projects working with males who have sex with males, as well as interested donors, and observers from a number of South East Asia countries involved in similar issues. The majority of the participants had never been to such a meeting, whilst many of them had no access to English, or very poor English. Translations were provided by colleagues. Languages being spoken were Hindi, Urdu, Bangla, Tamil, Singalese, Malayalam, Kannada, Marathi, and English.

Objectives ■

The objectives of the meeting included:

1. to discuss and develop appropriate programmes and strategies to address the sexual health needs of males who have sex with males and their sexual partners in the region.
2. to encourage the development of information sharing mechanisms and develop models of good practices in providing local culturally appropriate sexual health promotion strategies amongst males who have sex with males and their sexual partners of whatever gender.
3. to develop strategies for ensuring appropriate research is conducted regarding risk and needs assessments amongst males who have sex with males to inform sexual health promotion service development, other NGOs, governments and donors.
4. to develop mechanisms to advocate for the funding and support of locally based beneficiary led sexual health services working with males who have sex with males.
5. to explore human rights concerns regarding males who have sex with males and develop appropriate mechanism to address these concerns
6. to look at training needs specifically addressing issues concerning sexual health needs for males who have sex with males and the development of appropriate sexual health services.
7. to establish a regional network of sexual health projects working with males who have sex with males.

Participating countries ■

Participating countries were Bangladesh, India, Pakistan and Sri Lanka. Observer countries were China, Indonesia, Malaysia, Thailand and Vietnam. Donor representation and guests included Family Health International, UNAIDS, NACO, USAID, and the Office of International and Refugee Health (USA) and Ryan White Fund (USA).

Discussions ■

Over the three days of the Meeting, participants, in working groups and discussion groups, explored a range of issues and needs that reflected their concerns. These included:

- South Asian psychosexual identities and male genders
- socio-cultural-religious contexts of male to male sex
- marriage and families
- wives and other female sexual partners of MSM
- legal and human rights issues
- MSM living with AIDS
- discrimination and stigmatisation
- male sex workers
- community development and mobilising
- modifying risky behaviours
- IEC materials, condom promotion and lubrication
- STI treatment and anal STIs

- economic issues and poverty
- funding
- advocacy
- strategies for sexual health promotion

Recommendations ■

Recommendations reflected these concerns and the need for immediacy of action. The Meeting stressed the need for personal empowerment, community development and personal/agency actions. "What can we do" was a statement that was reinforced throughout the Meeting.

Recommendations included

- developing a pro-active South Asia regional network of MSM sexual health projects
- establishing a nodal agency to act as an advocacy and resource/training/information centre for MSM sexual health projects in the region
- skills development and capacity building for current MSM sexual health projects
- developing new MSM sexual health projects throughout the South Asia region, through training, capacity building and resource allocation
- developing appropriate sexual health responses to the needs of female partners of males who have sex with males, in particular wives
- advocacy amongst government institutions, legislators, and donors
- training/sensitising of institutions regarding MSM issues and sexual health needs
- epidemiological studies of anal STIs amongst both males and females
- training of doctors on anal STIs
- access to appropriate condoms and lubricants
- effective sex education, both formal and informal, for youth
- repealing of legislation and ordinances that impede sexual health education

The Consultation Meeting produced a range of actions for MSM sexual health agencies, other sexual health agencies, government institutions, and donors. As one participant stated, "it was a historic moment... for the first time my voice was being heard."

Outcomes achieved ■

1. Regional Network of MSM sexual health projects in South Asia established
2. Models of good practice for developing appropriate sexual health promotion services for males who have sex with males developed
3. Training and capacity building needs identified
4. Appropriate strategies for sexual health promotion amongst males who have sex with males identified and elaborated
5. Research models working with MSM developed
6. Advocacy programme promoted
7. A report published of the proceedings with recommendations for action
8. Institutional support from UNAIDS and NACO developed including
 - i. UNAIDS support for developing an MSM TRG in India affiliated to NACO with representatives of each of the MSM sexual health projects in India
 - ii. NACO investigating with a range of projects the issue of anal STIs amongst males and females
 - iii. donor support for epidemiological studies on anal STIs
 - iv. increased advocacy by donors of MSM and sexual health issues
9. Naz Foundation International and Pakistan representatives to organise a national meeting in Pakistan under Male Reproductive Health for MSM in 1999

Introduction

In the socio-cultural frameworks of South Asia, the issue of male to male sexual behaviours and their impact upon the reproductive and sexual health of both males and females has profound implications for any effective control and management of STIs and HIV infections. Because of cultural, religious and social reasons, these behaviours are to a great extent invisible, often difficult to access, as well as not framed within heterosexual and/or homosexual dichotomised constructions. Male sexual behaviours in South Asia appear to be much more polymorphous than the simplified reductionisms of heterosexual/homosexual identities would indicate, whilst anal sex between males and females and between males and males is much more common than has been assumed.

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

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

The invisibility of much of male sexual behaviours is further exacerbated by the claim that transmission of HIV in South Asia is based on “heterosexual” intercourse, i.e. vaginal sex, which allows government, non-government, international, and donor agencies, to ignore the possibilities of wide-spread anal transmission. Whilst it is recognised that substantial levels of STI/HIV infections in South Asia are caused by vaginal sex, it also needs to be clearly and openly recognised that with the public and social denial of anal sex behaviours between males and between males and females in the region, its significant role in STI/HIV transmission is grossly underplayed, if not denied completely. Such focusing on vaginal sex as the only route of sexual transmission often ends up victimising females (particularly female sex workers) as the source of infection and disease, whilst it also often denies the male role in STI/HIV transmission. At the same time such a process by invisibilising the role that anal sex plays in transmitting STIs/HIV ensures that significant levels of sexually active males sees such a sexual behaviour as a safer option. “They have never said that unprotected anal sex can be dangerous, so I have always thought of it as a safer option,” as has been reported to a range of MSM agencies.

Current research into constructions of male to male sexual behaviours in South Asia indicate that they do not fit the patterns of heterosexual/homosexual behaviours so common in HIV literature. Even the term “men who have sex with men” can be problematic. Rather the discussion (in an HIV/AIDS context) should be looking at male sexualities, male genders and male to male sexual behaviours. Identities of the majority of South Asian males do not centralise themselves around sexual orientation. To attempt to do so for all male sexual behaviours creates further invisibility of male to male sexual behaviour patterns. Many males who have anal sex with other males also have vaginal and anal sex with females. Many males who have sex with males are married. Early sexual encounters by many males are often with another male.

A major consequence of a heterosexual/homosexual labelling of the AIDS epidemic has meant that if there is any discussion on sexual transmission, males

who have sex with males become subsumed within a category of “gay” or “homosexual”. This further marginalises and invisibilises the behaviour. Of course there are gay-identified males in South Asia. But they are overwhelmingly outnumbered by non-gay identified males who have sex with males, whether such males define themselves as *kothi/durani*, or *panthi/giriya*, *double-deckers/do-parathas*^{*}, or just have sex with other males for *maasti* or semen discharge.

The consequences of unrecognised epidemiological patterns of STI/HIV transmission, whether through denial or invisibility, regarding the management and control of the epidemic should be clearly understood. The impact upon the epidemiological, social and economic frameworks need not be overstated where these have been discussed in other forums over the last 10 years. Clearly at the family level, such behaviours, should they lead to STI/HIV infections, have a devastating impact upon its economic welfare. At the social level, the economic impact upon the country is also clearly recognised.

* these terms are used within South Asian male to male sex networks. Whilst there may be variations in different areas of the region, the sensing remains the same.

Kothis/duranis can be seen as a gender as well as a sexual term and is a self-identifying label used by many males who present exaggerated effeminacy as a means to attract the sexual attention of other males who they define as panthis/giriyas, i.e. real men who will penetrate them. Do-parathas/double-deckers are the terms kothis use to label those who will be penetrated and sexually penetrate. There is a whole kothi language to give different labels to men/young boys, the range of sexual attributes and behaviours, and relationships between males.

Deep Purkyastha of Praajak Development Society, Calcutta



Scope and purpose

The Consultation Meeting was held to bring together representatives from a range of beneficiary-led sexual health projects working with males who have sex with males from the South Asia region. In a consultative process, participants were to discuss ways forward to improve access to HIV/AIDS and sexual health services appropriate to their needs, to develop frameworks of collaboration, and to develop a series of recommendations for action for themselves, other NGOs, government institutions and donor agencies. Further, it was also to ensure that culture specific issues around male genders and sexualities, sexual behaviours, sexual health, and STIs/HIV/AIDS were appropriately addressed and developed.

Lalitha Kumaramangalam of Sahodaran, Chennai



1. ■ to discuss and develop appropriate strategies to address the sexual health needs of males who have sex with males and their sexual partners in the region
2. ■ to encourage the development of information sharing mechanisms and develop models of good practices in providing local culturally appropriate sexual health promotion strategies amongst males who have sex with males and their sexual partners of whatever gender
3. ■ to develop strategies for ensuring appropriate research is conducted regarding risk and needs assessments amongst males who have sex with males to inform sexual health promotion service development, other NGOs, governments and donors
4. ■ to develop mechanisms for advocating for and increase of funding and support of locally based, beneficiary led sexual health services working with males who have sex with males
5. ■ to explore human rights concerns regarding males who have sex with males and develop appropriate mechanism to address these concerns
6. ■ to look at training needs specifically addressing issues concerning sexual health needs for males who have sex with males and the development of appropriate sexual health services
7. ■ to establish a regional network of sexual health projects working with males who have sex with males
8. ■ to establish collaborative links with other agencies and institutions working in the field of HIV/AIDS prevention and care



1. Working Groups ■

Participants were separated into 7 Working Groups, each group be led by a Facilitator drawn from the participants, but with specific experience and knowledge. Working Group participants stayed within their Working Groups for all three days. The process was one of group discussion, a sharing of personal experiences, and consensus building.

Day One: Setting The Context

Issues analysis

Working groups explored: socio-cultural frameworks, male gender constructions, sexual behaviours, sexualities, nature of identities, homosexualities, male sexual behaviours, denial and invisibility, internal dynamics of South Asian cultures, and religion. This was a process of identification of issues.

Day Two: Developing The Agenda

Needs analysis

Working groups explored: resources, education, social support, access to STI appropriate treatment, appropriate HIV services, developing identities, empowerment, appropriate access, living with HIV/AIDS, family support, social spaces. This was a process of expressing needs towards STI/HIV prevention

Day Three: The Way Forward

Strategies and Recommendations

Working groups explored: developing communities need; ownership of agendas; sexual health products and services; human rights; appropriate strategies for education and awareness; HIV prevention; emotional and practical support programmes within our own communities for people living with HIV/AIDS; ways of stimulating government and non-government agencies to develop appropriate and accessible programmes. This was a process of developing recommendations and action plans.

A training day for the Working Group Facilitators was held prior to the Meeting.

2. Discussion Groups ■

There were also a range of Discussion Groups on each of the first two days of the Meeting. The Discussion groups were led by a facilitator drawn from the participants with relevant experience. Participants were able to select the discussion groups they wished to join. The Discussion Groups focused on the following issues:

Day One

1. kothis, panthis, religion and sexualities
2. MSM and women's sexual health
3. MSM and STI/HIV services: testing, counselling and support
4. male genders and sexual identities
5. risk and needs assessments amongst MSM
6. MSM, government policies and human rights

Day Two

7. MSM and community mobilisation/empowerment
8. MSM, marriage, family and children
9. MSM and living with AIDS
10. strategies for intervention amongst MSM
11. male sex workers

Participants explored these issues and developed recommendations for action.

84 participants were brought together from a range of South Asian beneficiary led sexual health projects working with males who have sex with males, as well as interested donors, and observers from a number of South East Asia countries involved in similar issues. The majority of the participants had never been to such a meeting, whilst many of them had no access to English, or very poor English. Translations were provided by colleagues. Languages being spoken were Hindi, Urdu, Bangla, Tamil, Singalese, Malayalam, Kannada, Marathi, and English.

Participating countries were Bangladesh, India, Pakistan and Sri Lanka. Observer countries were China, Indonesia, Malaysia, Thailand and Vietnam. Donor representation and guests included Family Health International, UNAIDS India, National AIDS Control Organisation, India, USAID, Office of International and Refugee Health (USA,) and The Ryan White Fund (USA).

Special guests were Ms Shailaja Chandra, Project Director of the National AIDS Control Organisation in India, and Gordon Alexander, Country Representative of UNAIDS in India.

A representative of INP+ was also present, and gave a presentation on the needs of people living with HIV/AIDS, as well as facilitated a discussion on this issue. Also present was Carol Jenkins of CARE-Bangladesh who gave a presentation on anal STD prevalence in Bangladesh, as well as facilitated a discussion on STI treatment and care, including anal STDs.

Hisham bin Hussein of the Malaysian AIDS Council represented the 5th ICAAP meeting to be held in Kuala Lumpur in October 1999, and urged participants to attend the meeting.

Other guests included, Clifton Cortez of USAID, Philippe Girault of FHI/IMPACT, Cambodia, Dr Joe O'Neil of the Ryan White Fund, USA, and Dr. Gregory Pappas of the US Government Office for International and Refugee Health, all of whom made brief presentations on their perspectives of male to male sexual behaviours and sexual health.

We are grateful to all the donors, speakers, facilitators, and participants, who came together in a spirit of mutual support and trust to achieve what one participant called "a historic moment" , whilst another stated, "at last my voice was heard".

... a partnership with the right folks, a truly successful meeting. I say this since it was able to accommodate the voices and points of view of the MSM groups as well as have political/scientific support from brand-name organisations such as UNAIDS, Care, US Government, NACO. Interacting with my working group was a learning experience, and more than just increasing awareness. I think the meeting as a whole impelled us towards actions as well. If one output can be just that increased level of commitment, I think your goal is met.
comment from a participant

1. Issues

setting the ontent ■

Participants discussed the context of their lives and those of the constituents of the sexual health projects they work for. What shapes and construct their lives? What impedes or can encourage safer sex behaviours amongst them? What are the issues that affect them?

1.1 ■ *man or male?*

Participants discussed the context of men who have sex with men, but felt that the term “men” should be replaced by the word “male”. This was because there were many adolescent boys involved in male to male sex and therefore could not be termed “men”. Similarly *public kothis* are not perceived as men, either by their sexual partners, or by themselves. It should also be noted that *public kothis* are also not seen as women (or pretend women) either.

1.2 ■ *language*

There is a semi-secret language that has developed across South Asia historically, with local variations, that are a part of the *kothi* identity, and is used amongst *kothis* as a form of recognition as well as a means of mutual communication that “outsiders” do not access.

1.2.1 The term *kothi* (or there local equivalents such as *durani*) is a self-identifying label for an effeminate (often exaggerated) male who has sex with other males, usually as the penetrated partner. Within this are the *public kothis* who visit a range of sites to pick up *panthis/giriyas* for sex. The latter terms are given to “real men” by the *kothis* themselves. It is a label for the male penetrator. Secret (*gupti/gopon*) *kothis* are those who pretend to be “real men” but are penetrated in male to male sex. (But it should be noted that *kothi* to *kothi* penetrative sex does occur, and sometime a *panthi* will also be penetrated. These behaviours are kept even more secret)

1.2.2 Further to this there is a whole *kothi* discourse on sex, behaviour, sexual anatomy, and relationships, which is used as a part of conversation. Accessing this language becomes important in understanding sexual behaviours and identities.

1.3 ■ *behaviour versus identities*

Participants explored the South Asian socio-cultural contexts of male sexual behaviours in the context of male to male sex. Using personal experiences, participants expressed many differing frameworks of male to male sex. For those with *kothi* identities, accessing males was considered very easy, irrespective of the location. These males, known to the *kothis* as *panthis/giriyas*, could be from any occupation, class, or income. The *kothis* use exaggerated effeminacy to draw the attention of these males, who do not see the *kothis* as males - nor as females - but sexualise them to be penetrated, orally or anally.

1.3.1 the term men who have sex with men was also seen as problematic even with the above amendment of using the term males. The term MSM has been used to identify a collective, and is even developing as an identity, i.e. “I am man who has sex with other men”. Participants believed that for many males who have sex with males, no sexual orientation, or even male to male desire is involved, but rather the sex act is one of semen discharge. The term male to male sex seemed to be more appropriate to describe what is happening.

1.3.2 However this does not mean that there aren't males who sexually and emotionally desire other males. But in the context of HIV/AIDS prevention we should be exploring the whole range of what one participant termed *alternate male sexualities*, and what another participant defined as differing *male genders*.

1.3.3 Whilst acknowledging the existence of gay-identified men in South Asia, most participants felt that such men represent a minority, usually English speaking and middle class. Considerable tensions were evident between a gay-identified framework of male to male sex, and those with *kothi* frameworks.

1.3.4 Participants believed that for many males who penetrate other males, it was the actual act of semen discharge that was central. South Asia self identities are shared social constructs based on occupation, class, caste, religion and marital status, not on sexual object choice, desire, or orientation.

1.3.5 To attempt to contextualise all male to male sex as “gay” or “homosexual” was to invisibilise (if not marginalise) other constructions of male to male sexual behaviours.

1.4 ■ **penetration as an identity**

A part of the *kothi* is constructed on concepts of penetration, orally or anally. *Kothis* perform as *kothis* to attract other males for sexually purposes, as well as seeking “a real man” as a “husband”.

1.4.1 *Kothis* do not see themselves as women, nor are they perceived as women. They are not imitating women, but recognise the gender hegemony of masculine/feminine. By exaggerated femininity they offer themselves as sexual objects to the “real men”.

1.4.2 In the context of South Asia, sexual acts are not seen as mutual, egalitarian, and equitable, but rather one of penetration - the penetrated or penetrator. This leads to the supposition that part of the *kothi* identity reflects the act of being penetrated. Much of the *kothi* language reflects the desire for, and pleasure of, penetration, as well as the size, shape, strength, and sexual prowess of the “real man’s” penis.

1.4.3 Since anal/oral receptivity is so much a part of the *kothi* identity, this can have a major influence in how HIV/AIDS prevention strategies develop amongst them and their sexual partners. Unless methods are clearly worked through that understand these dynamics, prevention, in terms of changing sexual behaviours towards safer sex, will fail.

1.5 ■ **male genders or male sexualities**

For *kothis*, attracting other males for sex is a public performance. That is the exaggerated feminised actions, the body language, and the conversational style, are all mechanisms to draw the sexual attention of the other “real man”. Not only does the *kothi* signify himself as a sexual object to be penetrated, he also sexualises the “real man” as a potential sexual partner. For the *kothi*, all “real men” are possible sexual partners.

1.5.1 Participants discussed the dynamics of this performance, and its implications in terms of STD/HIV prevention. A further explanation evolved which saw the *kothi* identity as a male gender rather than a sexual identity.

1.5.2 It was considered shameful for two *kothis* to have sex with each other. They deemed it “lesbian sex” or “incest” (i.e. two sisters having sex). However there was an acknowledgement that *kothis* do have sex with each other, and will even penetrate each other. However this behaviour will be kept secret from other *kothis*. This means that it must not be assumed that *kothis* do not act as penetrators themselves.

1.5.3 At the same time there was an acknowledgement that there are those who mutually sexually penetrate each other, secretly or otherwise, or those supposed “real men” who will also be penetrated. Gay identities were supposed to reflect this, although *kothis* were believed to be scornful of gay identities and claimed that gay men were really *gupti kothis*.

1.5.4 Sexual and/or male gender identities, do not frame clear divisions of actual sexual behaviours as the language intimates.

1. Issues

1.6 ■ **social contexts of male sexual behaviours**

Participants believed from personal experience that male to male sexual behaviours in South Asia, and anal sex between males and between males and females, were very common. A range of explanations were given for this which included gender segregation, female virginity prior to marriage, economic costs of marriage and accessing female sex workers, male migration to urban areas, and women being more socially policed. This means that males were often much more easily available for sexual discharge.

1.7 ■ **sex seen as play**

What gives this further support and sanction is that male to male sex is not seen as serious act, but rather as play - if it is seen as sex as at all. Real sex is vaginal sex. Everything else is not sex. Such definitions and understanding have a serious implication for terms used in IEC materials and education.

1.8 ■ **non-kothis**

The sexual partners of *kothis* are not themselves self-identified as *panthis*. Nor do the many males involved in casual male to male sex occurring in all male settings, hostels, guest houses, tea-shops, etc., label themselves based on what they do sexually and whom they do it with. Nor are the countless sexual acts between males in a variety of settings considered as sexual acts. "My body is hot- it just needs discharge", as one participant stated about one of his sexual partners.

1.8.1 Any effective sexual health promotion programme amongst males who have sex with males will need to take into account the wide variety and localities of male to male sex encounters. These can include all male institutions such as orphanages, boarding schools, prisons, the military, and so on. But also in neighbourhood settings of cramped housing, mess rooms, hostels, shared beds. Amongst truck drivers and assistants, rikshaw drivers, taxi drivers, tea-shops, restaurants, guest houses, hotels, anywhere there are males who can access each other.

1.8.2 The *kothi* sexual dynamic is just one male to male sexual framework, the most visible and the most readily accessible.

1.8.3 *Kothis* of course access many of these other males across these settings so that potentially, they can reach into these dynamics more readily than any other.

1.9 ■ **community?**

There is no community of *kothis*, or even of males who have sex with males. It is a great mistake to think so and speak of "the community" or "a community". Such loose terms invisible and marginalise many frameworks of male to male sex. There isn't even a "gay community. At best there are friendship networks, or sexual networks usually site specific, and often there is very little, or no interactions between them.

1.10 ■ **social support for male to male sex behaviours**

Participants believed that the socio-cultural frameworks of South Asian countries actually provide tacit support (if not encourage) male to male sex. For example, most guest houses and hotels will not allow residents to take a female into their rooms, but will have no qualms with two males sharing a bed. Bed sharing amongst males is very common. South Asia has a homosocial and homoaffectionalist culture, allowing close physical encounters between males to occur without comment, even with sanction.

1.11 ■ **multiple partners**

A significant issue arose in terms of STI/HIV prevention arose in that many *kothis* have high numbers of penetrative sexual encounters. It is not unusual for some *kothis* to have between five to ten penetrative encounters on a single night (if not

more), usually without condoms. Multiple partners could even be seen as a “normative” sexual behaviour amongst many *kothis*.

1.12 ■ **methodology of penetration**

Participants agreed that the method of actual sexual penetration was conducive for increasing the risks of transmission of STIs/HIV. The act of anal penetration is often quite violent, and without appropriate lubrication. Saliva is used at the best of times. In such anal penetration, penile thrusts are usually very rapid which often leads to anal tearing, fissures, and bleeding. At the same time for oral sex, the penetrating partner usually holds the head of the penetrated against his crotch and thrusts his penis into the mouth of the penetrated, refusing to take his penis out, prior to ejaculation. The means that oral sex is usually of the “deep throat” variety.

1.12.1 In both cases the time frame from initial penetration to ejaculation can be a matter of just a few minutes. There is often no time to put a condom on the penetrator. As participants stated, the penetrator is usually in a state of high sexual tension and urgency, and the time taken to use a condom and its almost masturbatory effect creates to rapid discharge.

1.13 ■ **use of condoms**

All participants stated that condom usage generally was very low. Several of the projects did report an increase in condom usage by utilising the *kothis* as condom promoters, but these systems required a great deal of support.

1.13.1 For many of the sexual partners of *kothis*, planning for sex is not a part of their thinking, since so much of their male to male sexual activity is immediate and opportunistic.. They would not carry a condom as part of sexual preparation.

1.13.2 Carrying condoms can also have serious implications in regard to their marital status, family environment, and so on.

1.13.3 Many males who have sex with males would not (or could not) go to a local condom distribution point, like a pharmacy, or a paan shop, and purchase a condom. They would feel to ashamed to ask.

1.13.4 At the same time, condoms appropriate for anal sex (i.e. thicker condoms) were not available.

1.14 ■ **use of lubricants**

As mentioned above, the act of penetration can be violent, and, at the least, “rough”, creating anal bleeding. Participants reported that many *kothis* and male sex workers (primarily *kothi*-identified) have piles, which also increases the risks of bleeding. In South Asia there is no access to water-based lubricants except for KY jelly, which is inadequately packaged, and too expensive for most males who have sex with males.

1.14.1 If any lubricant is used in public sex environment, it usually is saliva, whilst in private spaces, it could also include oil-based products such as vaseline, ghee, or massage oils.

1.15 ■ **public environments**

Whilst most male to male sex will occur in private spaces such as personal rooms, guest houses, hotels, restaurants, etc., a great deal of sex also occurs in public spaces such as parks, toilets, cinema halls, railway/bus stations, construction sites, dark alleyways, back streets, and so on. The fear of discovery adds to the tensions and urgency of the sex act, increasing its rapidity and need to ejaculate quickly. This also leads to “roughness” in the act of penetration, and reduces the capacity for condom use.

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1.16 ■ **adolescent males**

Historically, South Asia has seen young adolescent males as sexual objects for older males. Not a man, nor a woman, but perhaps a “male gender” as sexual object. Many participants reported very early sexual encounters, where ages for first sexual contact varied between 8 years and 12 years. Pakistani participants reported on easy access to young boys at a range of tea-shops and restaurants in Peshawar, whilst other participants spoke of sexual encounters in the family between young boys and their uncles, cousins, brother-in laws, etc.

1.16.1 Such behaviours also involve street children, male children in orphanages, boarding schools, domestic servants, etc.

1.16.2 Some of these young males may develop a *kothi* identity, whilst others will not but will continue to have sex with other males as they grow older.

1.17 ■ **sexual violence**

Many of the participants reported significant levels of sexual violence and rape of males by other males. The abusers were not only adult males. Many male youths also rape younger males, and/or sexual abuse them.

1.18 ■ **stigmatisation of the “penetrated” male**

There are a range of abusive terms for *kothis*, such as *gandu*, or *khusra*, that reflect the stigmatisation of the sexually penetrated male. Such stigmatisation is often a “masculine” performance, usually done in groups of “masculine” males. This stigmatisation may lead to acts of harassment, abuse, violence, and even of rape, which can be conducted by local police as well as thugs, or even at times, members of a local community.

1.18.1 There is also the social stigmatisation of a male not performing his “manly” duties, obligations and performance, such as marriage and production of children.

1.18.2 Sex itself is stigmatised so there is very little public discussion on sex. Sex is seen as shameful, and discussions on sex are seen as “dirty”, and “childlike”. This can produce a level of social “blindness” to exist which can allow a significant level of male to male sex to occur without creating social tensions through its “invisibility”.

1.19 ■ **denial and invisibility**

This silence on sex leads to a denial of sex taking place, particularly male to male sex. Such a silence creates its invisibility. Participants felt that the statement “everyone knows it goes on, but no one admits it goes on” describes the situation quite appropriately.

1.19.1 With the increasing political tensions in South Asia regarding Western interference and power, expression of male to male sex is also often taken as a sign of Western corruption and importation. This leads to poorly designed sexual health promotion, if any exists at all. As an example, in the National AIDS Programmes of all the South Asian countries, no mention is made of anal STIs.

1.20 ■ **self-esteem**

With such stigmatisation, denial, and possible violence, and with the patriarchal structures and cultural-social-religious demands placed upon males, *kothis*, and other penetrated males often have a very low self esteem. This can be reflected in their own self - pejorative attitudes, high levels of depression, and sometimes the levels of risk that they are willing to take, both in terms of infection, as well as in terms of personal violence.

1.20.1 There is currently no statistical evidence of suicide as an issue, but this does not mean that it is not. Participants reported significant levels of suicidal depression amongst their constituents.

1.21 ■ **privacy**

There are 1.4 billion people in the South Asia region, more than China but with less territory. There is a lack of privacy for most males, where family size and structure (i.e. extended families, joint families), as well as income levels, dictate over-crowding, shared rooms, and often shared beds.

1.21.1 In an anecdotal report from one of the participants, a *kothi* would take his *panthi* to his room where his wife was sleeping with her children on the one bed. The *kothi* would do sex with the *panthi* under the bed.

1.21.2 Lack of privacy has serious implications for the practice of safer sex for many males.

1.22 ■ **male sex workers**

With such huge population levels, significant levels of poor education and literacy, lack of employment opportunities, under-employment, poor salary levels, massive migration from rural areas, overcrowded urban areas, and with the demands placed upon males to be income generators for their families, the pressure upon young males, youth and young adults to earn is enormous. Such pressures lead many young *kothis* to sell sex as a means of earning an income for their families, or at the least increasing their income level.

1.22.1 The vast majority of male sex workers are usually *kothi* identified (both as a self-identity, and as a performance to attract customers).

1.22.2 Usually such male sex workers are from low income groups, and their clients are also drawn from low income, working class groups as well. These sex workers tend to operate in certain public environments such as parks.

1.22.3 However, participants noted that there were also middle class male sex workers who catered for the educated, middle class males as well. These sex workers could act as both penetrated and penetrator.

1.22.4 There were also significant levels of “massage boys” either operating freelance or through massage parlours, who also offered sex as part of their massage.

1.22.5 There is also the dynamic of “gift sex”, where a gift, such as shirt, lungi, jeans, jewellery, and even at times a meal, is exchanged for sex. The males involved in such activities tend to operate opportunistically rather than as sex workers. Such sex usually involved street males, males living in slums, low income males in a wide variety of occupations, but can also involve students, taxi/rikshaw drivers, and so on.

1.22.6 Further to this are guest house, restaurant, and hotel staff who can at times supplement their income through sex with customers. But it should also be recognised that they may have sex with males as part of discharge or desire too.

1.23 ■ **marriage and family**

In South Asia, marriage is socially compulsory for the vast majority of males. Family, religious, and neighbourhood pressures ensure that marriage will take place. Most marriages are arranged through the parents.

1.23.1 There is almost no choice in this situation. With no welfare system and independence, the family represents physical and economic security. Families provide social support during times of unemployment, sickness, and old age.

1.23.2 A further dynamic is the social compulsion for children, particularly for sons. This means that procreative sex becomes compulsory.

1.23.3 The vast majority of males will be married or are going to get married,

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irrespective of whether they are *kothi* or not. This cultural situation also carries a range of implications for sexual health promotion work amongst males who have sex with males.

1.23.4 Further, the sexual partners of *kothis* and other penetrated males, may well be married too.

1.23.5 Sex with one's wife is often seen as "duty" and to produce children, rather than a source of sexual satisfaction and pleasure.

1.23.6 To be unmarried often carries a heavy social stigma.

1.24 ■ **relationships to parents**

Culturally and socially, children are raised to be obedient to their parents wishes. This is reflected in following the parents' wishes for their son or daughter to get married and produce sons.

1.24.1 A further implication of this is that of respect for someone who is older. For many young males, saying no to an older male is a sign of disrespect. This has implications for sexual activity between older and younger males.

1.25 ■ **space as a determinant of risky practices**

The lack of privacy in the home and the use of public environments as a place for sex creates conditions for risky sexual practices. The sex act become a process of rapid thrusts to ejaculation, there are difficulties around condom and lubricant use, and everything must be hurried in case participants are discovered.

1.26 ■ **lack of research**

Male to male sexual behaviours have been, to a large extent, ignored as a possible vector in STI/HIV transmission in South Asia. Where it has been acknowledged, the construction has usually been around the terms "gay" or "homosexual". Participants believed that this was totally inadequate response to what they believed to be a ubiquitous and common behaviour pattern across South Asia.

1.26.1 Who is having sex with whom? Why? Where? When? Levels of STIs (particularly anal STIs)? HIV transmission between males? Issues around desire, discharge, patterns, social frameworks?

1.26.1 Research, not only in terms of epidemiology, but also behavioural, sociological, ethnographic, and historical, is inadequate at best, and too often totally lacking.

1.27 ■ **economic issues**

Sexual behaviours, risky practices, and changing behaviours, are to a great extent, not only to do with personal choices and social-cultural frameworks, but also to do with economic issues. In situations of high levels of multiple partners, where condom and lubricant use can be relatively expensive, where private STD clinics can be costly, and HIV testing can be out of reach for many people, day to day living is circumscribed by a daily pittance. A man earning 50 Indian rupees a day (less than £1 sterling), who has a wife and family to sustain, who has to try to send his children to school, deal with sickness and ill health, purchase food, buy clothes, rent a room, pay the doctor's bills, get clean water, mend his shelter, and so on, will not think about safer sex as a priority.

1.28 ■ **living with AIDS**

This too has implications in terms of living with HIV/AIDS, where the personal, family, social and community environments can place unbearable burdens upon the person and his family. When water, food and medicine can be adulterated. When the price of everything is increasing, and when income is scarce. Male sex workers infected with STIs or with HIV may not feel able to stop selling sex because of their infections. The quantity of condoms and lubricants required to sus-

tain their income may be just too much in terms of costs, when their priority is food and family. Stigmatisation is doubled, not only in terms of behaviour and/or identity, but also with one's HIV status.

1.29 ■ **religion**

Religion in South Asia is not so much a personal choice, but reflects being born into the religion of the family. Further, socio-cultural frameworks of religious belief and practice in the sub-continent also reflect a public performance of religion. The visit to the temple, mosque, church. To be seen to be observing one's religion is also to be practising it. Religion thus can also be seen as performance.

1.29.1 Not to have a religious belief is seen as an aberration, and at times, even a sickness. Personal and family lives, the neighbourhood and community obligations, family duty and honour, are all entwined with religious belief, custom and practice., whether it is the namaz, the puja, or the prayer.

1.29.2 Participants felt a dual attitude toward their religious beliefs, whether it was Hinduism, Islam or Christianity. Whilst many participants obtained some comfort from their religious beliefs, customs and practices, at the same time they felt shame and guilt regarding what they believed their religions stated about male to male sex.

1.29.3 Participants expressed a desire to know more about their religions and what they really stated about male to male sex, so they could share this with their projects' constituents, as part of building self-esteem and reducing shame.

1.30 ■ **police, legal restrictions, and human rights**

In all South Asian countries, male to male sex is seen as "against the order of nature" and is legislated against through the retention of the old laws from British colonial times. However, there have been extremely few prosecutions using this law, known in India as Section 377 of the Indian Penal Code.

1.30.1 But there are many times when local police will use this law, and others in regard to public indecency and also on obscenity, as a means to threaten males who have sex with males in public spaces, to blackmail them for money, sex, or both. There are also occasions when these police will victimise, harass and beat these males. Participants reported occasions when police have arrested *kothis* (both sex workers and those who are not), taken them to the local jail, and raped them there, or beaten them. Incidents of rape using a stick were reported. Money was taken from them.

1.30.2 At the same time male rape is not a recognisable offence.

1.30.3 There are several laws and regulations which can make it problematic for distributing condoms and provide education for males who have sex with males.

1.30.4 Also police have been known to harass and victimise field workers from the range of sexual health projects working with males who have sex with males.

1.30.5 Such violence and harassment is not only restricted to the local police. For male sex workers many clients are violent and refuse to pay, or local thugs will beat the *kothis*, or rape them. Who can they report these incidents too?

1.30.6 Human rights. What rights? South Asian countries have signed up to various international protocols and laws on human rights, and still they have abusive environments for street children, women, prisoners, low caste people, people of minority religions, tribal peoples, participants asked how can *kothis* (or even lesbians and gay men) ask for special privileges?

1.30.7 However, participants believed that unless such issues were appropriately and adequately addressed, sexual health promotion campaigns will not be suc-

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cessful. It was accepted that these issues should be addressed as human rights concerns.

1.31 ■

accessibility and availability of condoms and lubricants

Many males feel very uncomfortable (if not ashamed) to purchase condoms at a local shop. At the same time condoms have historically been promoted as a family planning device. And currently condoms have been promoted as a device against disease. There have been adverts for the promotion of condoms as a sensual device, but these have been exclusively for male-female sexual encounters.

1.31.1 There are no appropriate condoms for anal sex available in South Asia. Nor is there any appropriately packaged water-based lubricant available either.

1.31.2 Condom prices were also of concern, as was distribution and access.

1.31.3 Participants discussed a range of issues reflecting concerns about quality, availability, price, methods of distribution, changing attitudes, and empowering use.

1.31.4 A serious concern was the lack of knowledge on how to use a condom properly. From the range of sexual health projects present, most participants believed that the majority of their constituents did not have the skills to use a condom properly before their education programmes.

1.31.5 Condoms for oral sex were also not available, and participants believed that this needs to be adequately addressed if they were to be able to modify risky practices. This requires flavoured condoms to be in the market. However, a concern was also expressed that these flavoured condoms should also be suitable for anal sex, since one of the techniques being promoted in the field is to encourage the penetrated partner to put the condom orally on his penetrating partner before the act of anal penetration, to reduce condom resistance.

1.31.6 There was also a discussion regarding water-based lubricant, where concern was expressed that even if such sachets were available, looking at the quantity of sex that many *kothis* (particularly male sex workers) have in a single night, they would also need to carry some cleaning mechanism to wipe the surplus lubricant from their hands and anuses.

1.31.7 Disposable of the used condom and lubricant product and packaging was also an issue of concern, since so much sex was happening in public environments, that disposal problems were self-evident.

1.32 ■

education materials

Participants pointed out that there were no appropriate education materials for males who have sex with males, other than those produced by Naz Foundation International and a few other agencies. There were no appropriate materials on STIs, especially anal STIs, none on condom and lubricant use, none on male to male sexual behaviours, and male to male risky practices including anal sex.

1.32.1 Several participants pointed out that many males practice significant levels of non-penetrative sex, such as thigh sex. If mutual masturbation and thigh sex could be promoted as heavily as condom use, this also might reduce the levels of risky practices. At the same time it was suggested that perhaps oral sex should be promoted as less risky activity than anal sex.

1.32.2 This would require more explicit and visual materials, avoiding the word sex, and use the language of the *kothis* themselves, and descriptions of actual sex acts. Language and imagery should be descriptive.

1.33 ■ sex education

Participants stated that psycho-sexual issues were a significant component of the counselling and clinical services of their sexual health projects. The majority of the questions asked reflected the normality (or not) of an individual's penile shape, size, erection, and discharge, self-knowledge of the body, lack of knowledge of the partner's - both male and female, fears about premature ejaculation, loss of erectile "power", and so on. These questions showed a gross misunderstanding of male and female bodies, the sexual organs and their functioning, and the range of sexual behaviours body pleasures and sensations. Knowledge was often limited to a range of myths gained from friends. Generally males in South Asia have very limited (if any at all) of sex, the body, and sexual functioning.

1.34 ■ confidentiality

It was pointed out to participants that no person who was living with HIV/AIDS and who was also MSM was present at the Consultation Meeting, even though the organisers personally knew of several. The reason for their non-attendance was because of the fear of disclosure of their HIV status amongst fellow *kothis*. This led to a discussion regarding confidentiality, and the *kothi* propensity to gossip about each other.

1.34.1 This was clearly an issue of concern as it was recognised that confidentiality about sexual practice, identity and STI/HIV status was not as secure as it should be, and there were great fears of disclosure. A great deal more work will need to be done within each sexual health project as well as among each project's constituents.

1.35 ■ access to STD treatment

Participants expressed concerns that the majority of *kothis* (and many other males who have sex with males) cannot access current STD treatment because of their shame, or because of the attitudes of the clinicians, or because such services were either not available, or easily available.

1.35.1 Where such services are accessed, talking about anal sex and anal STIs was extremely problematic because of their stigmatisation, and often the clinician (where the approach is syndromic) will not ask questions about anal sex, or where often the clinician lacks knowledge of anal STIs. And where doctors do provide anal STD treatment, they are often stigmatised by their colleagues.

1.35.2 This means that very few males who have sex with males are approaching STD clinics for treatment. What they usually do is either use self-medication through purchasing antibiotics from pharmacy (where sometimes they are prescribed the wrong medicine, or the wrong dose), or using a known and friendly doctor, or visiting street quacks.

1.35.3 At the same time, whilst the range of MSM sexual health projects are attempting to develop their own clinical services which have proved to be very successful, these are limited because of the lack of funding and support.

1.35.4 Issues of clinical fees and medical treatment, especially for the poorer constituents were also a major concern.

1.36 ■ HIV testing

None of the sexual health projects were offering HIV testing. However participants believed that this should be explored for their constituent as an option where there may be demand for such a services.

1.36.1 Concerns were expressed about the quality of pre-test and post-test counselling, confidentiality, and support for people living with AIDS, and the capacity for the projects to provide this currently.

1.36.2 However various participants believed that knowledge of HIV status could

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act as a means to reduce risky practices. But in South Asia, HIV testing as a voluntary process requiring informed consent, education and knowledge is very low and so informed consent could be problematic.

1.36.3 To develop such a services would require a major investment in skills development, training and resources.

1.37 ■ **counselling**

Participants believed that counselling ,as a skill and a practice, is greatly lacking in South Asia generally, as well as within their own projects as well. What the projects provide is a space to talk and listen, and to offer general advice and support. Is this adequate?

1.37.1 Another issue is the general South Asian custom of obedience to the respected person, such as the elder or the professional. There isn't a cultural practice of pro-actively asking questions. Patients too often ask to be told what to do , rather than listen to a range of possible choices and make their own decisions.

1.37.2 The majority of the constituents of these MSM sexual health projects are from low to middle income groups, and are often poor, and semi-literate. Approaches to counselling should reflect the realities and socio-cultural frameworks existent in South Asia. Is anything available as a model? What appropriate training is available? Who will conduct the training?

1.38 ■ **skills development**

Participants recognised that each of the projects present went through an extensive training and technical support programme as part of their development. All the CBOs present started from a zero base, i.e. they were nn-existent before the process was initiated. There were serious skills gap around basic administration, sexual health promotion strategies, monitoring and evaluation, finance, budgeting and management.

1.38.1 Participants recognised that without such an investment, both technical and financial, there would not be any sexual health projects.

1.38.2 However, appropriate trainers and technical support was often not available except in very limited situations, and apart from that given by one or two agencies. It was stressed that participants wanted such training and support to be given by those who were MSM themselves, and understood the dynamics of MSM behaviours in South Asia thoroughly.

1.38.3 It was believed that this was centrally important in the development of new MSM CBOs promoting sexual health amongst their constituents.

1.39 ■ **female partners of MSM**

Participants clearly recognised that the needs of female partners of MSM, whether wives, girlfriend, female sex workers, had to be taken into account in developing their sexual health promotion strategies.

1.39.1 Infection, re-infection, treatment for female partners, counselling, marital issues, and family issues, were all significant components in any effective sexual health promotion strategies.

1.39.2 How this was to be achieved was still uncertain. Effective working models need to be developed. Ethical values and personal responsibility need to be promoted. For example, a husband who is MSM and is infected with an STI through sexual contact with another male, will need to inform his wife. How? And how will the wife access treatment? What will be the personal, family and social consequences?

1.40 ■ **old age**

Participants expressed concerns about being a *kothi* and growing old. As attractiveness is one of the factors for drawing attention of other males, would the older *kothi* be willing to increase his risky behaviours towards increasing opportunities for sex?

1.40.1 And what if the *kothi* is unmarried, or widowed, or divorced? What support systems exist for an aged MSM, of whatever identity or gender? What if the male has been thrown out of his home because of his behaviour/identity? What if he is living alone as an old man?

1.41 ■ **hijras**

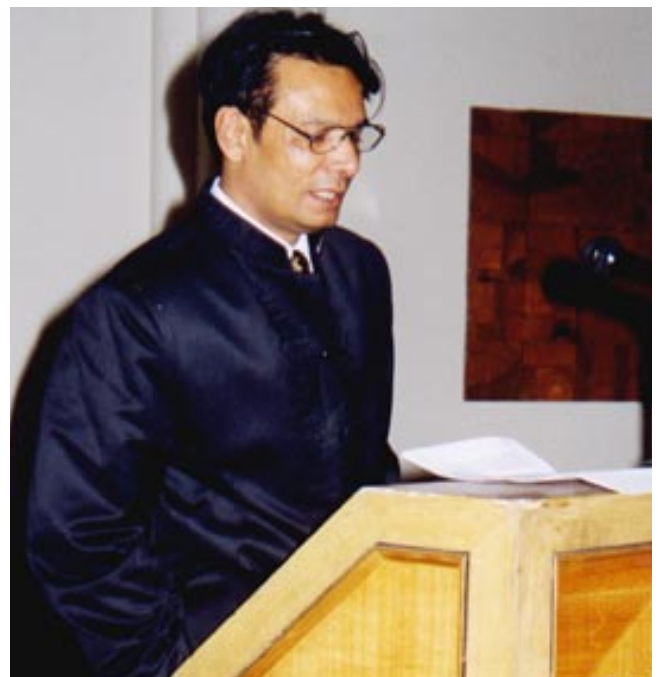
Participants felt that *hijras*, whilst biologically males, those who are castrated could not be defined as MSM. Rather they should be seen as another gender requiring different sexual health promotion strategies and projects appropriate to their specific needs. Considerable tensions were expressed by the *kothis* present at the Meeting and *hijras*, reflecting social prejudices and attitudes, as well as the publicness of the *hijras*.

1.41.1 However, participants recognised that many of the sexual partners of *hijras* could easily also be partners of *kothis*. In this recognition, some process of linking with *hijra* communities and developing frameworks around shared agendas and common purposes need to be evolved and worked out.

1.41.2 Further to this, participants also recognised that many *kothis* would also cross-dress on occasions, and that many *hijras* are not castrated and perhaps *hijras* could be seen as the end of a spectrum of male masculinities along which *kothis* also were presented. The line between *hijra* and *kothi* may not be clearly defined, and may easily blur at times.

1.41.3 This requires developing work on sexual health promotion with *hijras*, and mechanisms will need to be developed to achieve this. Whilst *hijras* have a stronger community identification and structure than *kothis*, this does not preclude developing mutually beneficial sexual health programmes, if the appropriate methodologies are worked out.

Shivananda Khan of Naz Foundation International, UK



2. Needs

developing the agenda ■

Using the WHO definition of sexual health as a basis for discussion, participants identified a series of needs that should be effectively and appropriately addressed if any sexual health programme for males who have sex with males is to be effective in reducing the levels of risk for STD/HIV transmission amongst these males and their sexual partners.

WHO definition of sexual health ■

the integration of physical, emotional, intellectual and social aspects of sexuality in a way that positively enriches and promotes personality, communication and love

Participants believed that the only effective strategy for promoting sexual health amongst males who have sex with males and their partners is to ensure that beneficiary-led appropriate sexual health and social support services are available and accessible, which respect confidentiality and anonymity and build upon their trust and respect, and that anal sex issues are adequately addressed by all reproductive and sexual health agencies.

2.1 ■

community building

Participants believed that community-building amongst *kothis* and other males who have sex with males is an urgent and central necessity for not only effective promotion of safer sex, but also for the long term maintenance of behaviour change. With no cure of vaccine, safer sex needs to be seen as a life-long commitment

2.1.1 The only way to achieve this shift to safer sex behaviours and maintain that change is to make it a collective and community norm. In other words, we need to see safer sex, better and regular STI treatment, support and care for those living with HIV/AIDS, not on an individual basis per se, but as a social and community concern. Where no such community exists, then one needs to be developed.

2.1.2 There is no MSM community, or even a *kothi* community. Whilst there may well be small scale friendship networks, these are often site specific and limited. Friendships amongst the marginalised, stigmatised and under-privileged.

2.1.3 A range of strategies for community building needs to be developed and implement. This requires an understanding of what forms a community. In terms of *kothis* and possibly other males who have sex with males the dimensions of an emergent community would be that of:

- i. shared behaviours and identities
- ii. common concerns and needs
- iii. affiliation to a shared consensus
- iv. shared services

2.1.4 There will be a need to emphasise self-esteem, empowerment, and choice in these strategies.

2.1.5 Participants identified five frameworks for changing behaviours:
knowledge
desire to change
the will to change
skills
the power to change

2.1.6 It was believed that all these components will need to be addressed adequately and appropriately for any effective sexual health promotion strategy.

2.2 ■

stigmatisation

As part of any community building and development, the stigmatisation of male to male sex, in particular anal sex and of *kothis*, will need to be addressed and reduced, not only by agencies working with MSM, but also donors, other NGOs, government institutions, legal and judicial institutions.

2.2.1 This will require developing a range of sensitising materials and training programmes, the media acting responsibly, legislation, actions with the police, and so on. Strategies and methods will need to be developed for this to be achieved.

2.3 ■ **visibilising male to male sexual behaviours**

So much of male to male sex is invisible and denied. Several participants believed that in order to be effective sexual health strategies will need to visibilise such behaviours. However it was recognised that such an approach could possibly carry a heavy burden of increased stigmatisation with all its social and legal threats. This whole issue will need to be explored most carefully.

2.4 ■ **kothis as a risk core group**

Participants believed that *kothis* are a key risk core group because of their high sexual activity and numbers of partners across a broad spectrum of males. Sexual health strategies must take such networks and groups into account. Participants also recognised that, because of *kothi* sexual dynamics and constructions, they could be seen as key educators and informants in any sexual health strategy. To achieve this would require extensive recruitment, training, and support.

2.4.1 However, identifying *kothis* as a risk core group also carries with it the possibility of increased stigmatisation and violence against them. Methods of conducting sexual health programmes will need to be sensitive to this, and find appropriate avenues to achieve positive outcomes.

2.4.2 Nor should HIV be equated with males who have sex with males. One approach could be working publicly under the term of male sexual health so that the actual promotion work amongst males who have sex with males is not so visible.

2.5 ■ **changing kothi behaviours**

Because so many *kothis* base their gender/sexual identity on concepts of penetration, participants felt that there may well be a need to explore developing different types of identities based on different dynamics. This could be through presenting alternate models of sexual identities, different ways of expressing male to male desire, forming partnerships, encouraging stable sexual friendships, and so on. This will require a deep understanding of psychosexual/social constructions of a *kothi* gender/identity.

2.6 ■ **other male to male sexual dynamics**

It was clearly recognised that the *kothi* dynamic is just one framework of male to male sex. Other dynamics exist, such as those based on semen discharge, friendship, gay-identified males, adolescents, and all male institutions. This means that there is a need to develop a multi-strand approach to male to male sex, not only dealing with those with specific gender/sexual identities, but also in regard to anal sex as a risky practice.

2.7 ■ **education materials**

This means that a broad range of educational materials, that accurately and explicitly informs and educates, targeting these differing framework is an urgent necessity. Materials that teach not only about STD/HIV/AIDS, but also about safer sex practices, alternates to anal sex, and proper condom usage.

2.7.1 Male to male sexual behaviours, and unprotected anal sex as a risky practice, needs to be a part of any STD/HIV prevention literature too reach the maximum number of males in a wide variety of settings.

2.7.2 At the same time differing approaches to education will need to be used, particularly those aimed at non-literate groups and networks. A wide variety of methods for such education, such as street theatre, puppetry, and/or dance, need to be explored.

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2.7.3 Further condom use should be eroticised so as to encourage a more comfortable and “sexy” approach to their use.

2.7.4 Whilst to a large extent, education materials have often used a fear approach (i.e. AIDS kills!), participants believed this approach has a low level of long term sustainability. Other approaches to safer sex and condom use needs to be developed.

2.7.5 At the same time, participants acknowledge that too often it is “outsiders” who have designed education materials with a lack of understanding of the psychosocial dynamics of the differing male to male sexual frameworks. This leads to a perception of some unitary framework - “gay” or “homosexual” Male to male sex patterns are too diverse for such a unitary approach. There needs to be a proper understanding of these frameworks.

2.7.6 Questions need to be asked in terms of language, terminology, appropriateness, imagery, the producers and disseminators of the materials, and so on.

2.8 ■ **accessing information**

At the same time such education materials need to be easily accessible in appropriate ways that do not stigmatise those who access these materials.

2.8.1 Participants also identified anonymous access to information as need, perhaps through telephone helplines as one possible strategy.

2.9 ■ **sexual health promotion products**

There is a need for appropriate condoms, both for anal and oral sex, to be easily available at affordable prices for the poor and low income groups. This means thicker condoms as well as flavoured condoms. Participants believed that flavoured thicker condoms are also needed. With this there is a need for easily accessible water-based lubricants in appropriate packaging.

2.9.1 Increasing access will not be enough to ensure that such needs are being met. Condom use education also needs to be effective, and techniques for persuasion, negotiating, and encouraging their use will need to be taught.

2.9.2 Different strategies for distribution of condoms and lubricant will need to be developed and implemented. These strategies may well include on-site social marketing, perhaps a component of free distribution, one-to-one sales, using other on-site personnel such as tea-boys, and so on. Taking condoms to the person may way well be more effective.

2.10 ■ **condom messages**

Most messages around condom use reflect a negative approach, i.e. “using condoms protects against disease”. Other more pro-active approaches need to be explored, i.e. condoms as a pleasurable event. There is a need to see condom use and safer sex not only as an approach against STIs/HIV, but as a part of recreational sex and enjoyable in themselves.

2.11 ■ **sex education**

With knowledge of the body and its sexual functioning so low, with so many holding incorrect beliefs and myths surrounding the body and sex, and with sexual performance carrying its own risks of tissue damage and thus increasing exposure to infections, there is an urgent need for appropriate and effective sex education. With this there is also a need for proper guidance around sexual practices. Such guidance should not be equated with morality. Moral teachings tend to hide behaviours, not stop them. This requires a recognition that sexual behaviours themselves needs to be destigmatised .

2.11.1 Sex is not only for procreation. It is a source of recreation and pleasure. This needs to be acknowledge centrally in all sexual health programmes.

2.11.2 It should also be noted that such education should also involve a “how to” approach as much as just the presentation of facts. For example, participants pointed out that many males who have sex with males have limited knowledge on how to penetrate without causing undue pain and damage, how to do oral sex without causing damage, or how to masturbate without causing friction burns. Such forms of “how to” education could reduce levels of risky practices, as well as increase pleasure in a wide variety of reduced risk sexual activities.

2.11.3 A sex manual - such as the Kama Sutra - for males who have sex with males was seen as a need which would act as an educational tool to reduce risks during sex acts.

2.11.4 It was recognised that government and several other institutions would not be able to deliver on these needs for a range of religious and political reasons. Where such a service delivery cannot be achieved because of these reasons, then community based agencies should be empowered to do so.

2.12 ■ **psychosexual issues**

Because of the lack of knowledge of the body and sexual practices, many psychosexual problems arise for males who have sex with males. These need to be urgently addressed.

2.13 ■ **counselling**

Participants were not able to identify any appropriate counsellors in their localities and available for their projects. What was available tended to be of the psychiatric variety which still tends to state that male to male sex was a “sickness”. There is an urgent need to develop appropriate and culturally specific frameworks of counselling. This may require training and skills development of specific individuals within these sexual health projects to provide such counselling.

2.13.1 Such counselling needs to address psychosexual issues and concerns of many MSM. Because of the lack of body knowledge and knowledge and understanding of sexual functioning, emotional responses, and sexual practices, where so many myths have been taken on board, a significant number of *kothis* and other males who have sex with males are burdened with fears, misunderstandings, concerns and confusions.

2.14 ■ **rural areas**

Participants expressed a range of concerns regarding male to male sexual behaviours in rural areas, how such individuals/networks can be accessed and sexual health services provided. It was recognised that a significant number of males in urban areas who are involved in male to male sex are migrant workers and who regularly return to their wives and families in their villages. Strategies will need to be developed in order to provide supportive services for them.

2.15 ■ **family**

Family is central to a South Asian person’s life. The family provides social security, welfare, and support. The vast majority of MSM keep their behaviours/identities secret from their families. Participants expressed a range of fears that, should their families find out about themselves, they are liable to be rejected and isolated. Strategies need to be developed to look at needs arising from this. Such needs could well be family counselling, housing, employment, financial support, and an alternative family/support structure.

2.15.1 This raises a series of questions around different types of families and legal recognition for such alternate families. Questions arose regarding legitimisation of same-sex marriages, adoption, and other family structures.

2.16 ■ **self-esteem**

Being sexually penetrated and/or developing a *kothi* identity carries significant social stigmatisation. This often leads to low self-esteem of many males who

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have sex with males. Caught between desire and practice and the socio-cultural attitudes prevalent in South Asia regarding patriarchal values and concepts of “manliness”, the *kothi* and/or other males being penetrated find themselves in a constant inner battle. This often leads to serial depressions and challenges, which can lead to even more exaggerated behaviours.

2.16.1 It is essential that any programme promoting sexual behaviour change must address the issue of building self-esteem amongst their constituents. A range of strategies need to be developed to address this.

2.16.2 This will require not only specific sexual health projects working together on this issue, but also would require the cooperation of other NGOs, government institutions, medical profession, and the media.

2.17 ■ **empowerment**

Self-esteem and empowerment are closely allied. These mutually related issues arise from increased knowledge, skills, support, and personal power, to enable males who have sex with males to make positive decisions in terms of their health seeking behaviours. Strategies and methods need to be developed for this to occur. Such strategies reflect personal ownership and decision-making.

2.18 ■ **social support and welfare**

Developing sexual health promotion programmes is not only about educating people about STIs and HIV/AIDS it is about providing an environment in which males who have sex with males will desire to change to safer sex behaviours, and which supports the maintenance of such a change. It needs to be an environment where personal change is supported by a community and where personal empowerment is sustained.

2.18.1 This means that (in line with the WHO statement on sexual health) any sexual health strategy for males who have sex with males will need to develop responses to the personal, social, emotional, psychological, economic, as well as the physical health needs of such males.

2.18.2 It was recognised by participants that education alone does not change behaviour. Behaviour change on such a scale requires social and community support. And where there is no community, one needs to be developed as a first phase.

2.18.3 Social and welfare needs need to be explored and appropriate programmes be developed to sustain the well-being of males who have sex with males.

2.18.4 What is a required will be developing a positive environment in which males who have sex with males can sustain a caring attitude for themselves, for their partners and families, and for the larger community.

2.19 ■ **collective responsibility**

This will mean developing a social environment amongst males who have sex with males, where a sense of collective response to STIs/HIV/AIDS prevention can be built.

2.20 ■ **friendship building**

For these needs to be effectively addressed, it will be necessary to facilitate a process of friendship building amongst males who have sex with males in non-sexual environments. Encouraging a mutuality of concerns and needs will be essential, and processes will need to be developed that enable such friendship building to occur.

2.21 ■ **safer social spaces**

This friendship and community building will require the development of safe socialising spaces, where MSM can meet in acceptance and support, and where

the fear of harassment and violence does not exist, in order to facilitate the sharing of problems and issues and the development of consensus. Such a space will be where learning can take place, where they can have fun also, and where males who have sex with males can learn to work together for their own betterment. There will also be a need to create specific and differing spaces for the differing male to male sex networks and for differing genders/identities.

2.22 ■ **development of MSM community-based agencies**

All these needs can only be effectively addressed if community-based agencies, developed by males who have sex with males themselves, are available to facilitate the processes.

2.22.1 This requires that sexual networks in specific localities need to be accessed, individuals from these networks need to be trained, support be given (both financial and technical), where MSM sexual health agencies are developed and provided with the funding to service these needs.

2.22.2 Participants recognised that in the context of the differing male to male sex networks, there were perhaps three distinct - and differing networks - that could be utilised for the development of such agencies to provide services for their own individual constituents. These three networks reflect the differing identity structures and socio-cultural frameworks in which they are embedded in. These three networks are a) the *kothi* networks, b) the gay-identified networks, and c) the *hijra* networks. Whilst these three networks are not necessarily incompatible, the dynamics are different, and thus they would require different organisations and services

2.22.3 Further the participants recognised that the Consultation Meeting was primarily focusing on the *kothi* dynamics of male to male sex.

2.23 ■ **marriage**

Marriage is a fact of South Asian life, where choice is very limited. For many males who have sex with males, and in particular *kothis*, marriage creates its own specific issues and concerns. These reflect the risks that extra-marital sexual encounters bring to the wife and children in terms of STIs and HIV/AIDS and the stigmatisation that visibility of such behaviours bring to the family.

2.23.1 Personal responsibility needs to be encouraged amongst *kothis* and other males who have sex with males in terms of their sexual behaviours and the risks that are taken. Marital counselling will be necessary to deal with all the family issues that arise in terms of discovery and/or infection. Services will need to be developed that specifically address the issues of an infected wife. How to enable the wife to access treatment and care if her infection was passed to her by her husband who was infected by sexual contact with another male?

2.23.2 What services will be needed if, upon discovery - the husband is thrown out of his home? What support would be required? What counselling should be available?

2.23.3 These issues are extremely sensitive and add an ethical dimension to the discussion. What stand should MSM sexual health projects take in regard to married MSM and Partner notification?

2.24 ■ **women's sexual health**

At the least, women's sexual health concerns have an intimate relationship with the sexual health concerns of males who have sex with males. Not only because of marriage, but also because many sexual partners of *kothis* (who may or may not be married) will also be married, and/or have sex with other female partners. Infection and re-infection are considerable issues for maintaining sexual health.

2.24.1 Obviously no agency should operate on blaming who is infecting whom,

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but rather needs to provide a sensitive, accepting, and caring environment for all participants involved in the infection routes.

2.24.2 However, participants believed that it may not be possible for MSM specific sexual health projects to also provide a sexual health service for women, as this might destroy the integrity of the primary service itself. Methodologies will need to be explored and developed that enable the wives and other female sexual partners of males who have sex with males to access appropriate sexual health services.

2.25 ■ **male on male rape and sexual violence**

There are significant levels of male on male rape, sexual abuse and violence. Such violence is not only by local thugs, but can also involve local police, security services, institutional staff, military personnel and others.

2.25.1 Institutions such as prisons, orphanages, boarding schools, juvenile homes, and other all male environments themselves can breed significant levels of sexual abuse and violence.

2.25.2 There are also significant levels of male child sex abuse in families and neighbourhoods. Most of the abused have no one to talk with, no one to share their experiences, and no one to go to who can address the abuse.

2.25.3 As it stands male on male rape is not recognised as an offence in the same manner as male on female rape. Further, extremely few males will actually report such a case because of the shame involved.

2.25.4 These issues need to be effectively addressed in ways that are sensitive and supportive. Appropriate counselling methods needs to be developed. Support systems need to be developed. And ,at the least ,legal changes are required.

2.26 ■ **confidentiality**

There are two main concerns in regard to confidentiality. The first is in regard to behaviour and gender/sexual identity. The second is around STI/HIV/AIDS status. It was clearly recognised that confidentiality is not only to do with medical personnel and other professionals, but is also a personal matter. That is, *kothis* and other MSM also need to address the issue of confidentiality as ardently as they request other agencies/personnel to do so.

2.26.1 Currently *kothis* and other MSM who are HIV+ are afraid to disclose their HIV status to their *kothi* friends/networks because of a justifiable fear of disclosure, whilst similarly, anecdotal reports indicate that in reverse, HIV+ males, who are *kothi* identified and other MSM, find it difficult to disclose their sexual behaviours and/or gender/sexual identity to HIV+ groups because of fear of stigmatisation.

2.26.2 There is a need to develop mechanisms to collaborate with HIV+ support groups and organisations, learning from them as much as teaching them about the issues. Mechanisms need to be developed in such a mutual process of support and learning.

2.26.3 MSM agencies, whether sexual health or otherwise, will need to educate their own constituents on the issue of confidentiality.

2.26.4 This will also have an impact in terms of partner notification in regard to STI/HIV infections, and methods need to be developed to deal with this, particularly in regard to wives of MSM, which do not create more tensions and difficulties for the concerned families and individuals, not only for the sake of the partner involved, but also in terms of avoiding re-infections.

2.26.5 These issues also raise certain ethical concerns, and protocols need to be developed by each of the MSM sexual health agencies to address them. It also reinforces the necessity to make the issue of personal responsibility a cornerstone for an education and support service.

2.27 ■ **STI treatment**

There is an urgent need to provide appropriate, accessible, and sensitive STI treatment services for *kothis* and other males who have sex with males. This requires the development of appropriate training and sensitising of current STI services around male to male sex and anal sex issues, with the recognition that male to female anal sex also exists. It requires the development of appropriate syndromic management tools appropriate to anal STIs, and the destigmatising of anal sex amongst the medical profession.

2.27.1 Several participants expressed reservations in regard to non-MSM STI treatment services. To address this concern will require support for MSM sexual health agencies to provide their own clinical treatment programmes. In this way *kothis* and other MSM can be sure of a sympathetic and supportive environment.

2.27.2 However, participants also recognised that there are several dynamics of male to male sex which would not access such a service. Other approaches for treatment should also be explored for non-*kothi* anal sex encounters, where a combination of method could be developed. These could include mobile clinics directly accessing males in wide variety of locations, male sexual health centres at fixed locations, or even taking the clinician to public sex environments.

2.27.3 At the least, it was suggested that perhaps specialist STI services be developed and promoted which would include anal STI issues of concern.

2.27.4 Specialist training needs have to be addressed to increase the skills capacity of the medical profession in regard to anal STIs and related issues.

2.27.5 Another possible approach, once effective syndromic management techniques have been developed that include anal STIs, could be to train sexual health projects field workers to also provide a syndromic management service.

2.27.6 Another area of concern was the need to access low cost testing kits for STIs, such as gonorrhoea, chlamydia, and other STIs, wherever available, and provide the MSM sexual health project clinics with these kits at a subsidised rate.

2.27.7 There is also a need to provide medical treatment for STIs at subsidised rates for certain sections of the project's constituents, who find poverty a barrier to appropriate treatment.

2.27.8 At the same time, treatment for anal fissures and bleeding, piles, and other symptoms will need to be appropriately addressed.

2.28 ■ **HIV testing**

This was a controversial issue. In the context of a socio-economic environment where there are no vaccines or cures available, where there is a lack of confidentiality, where support systems are minimal, where there is a high degree of poverty, and where access to general medicine, clean water, good food and shelter, can be extremely problematic, is offering HIV testing worth the investment.

2.28.1 The countervailing argument was that knowledge of HIV status can act as part of a strategy for developing sexual responsibility and promote safer sex behaviours. It was also pointed out that many people have asked for HIV testing, but appropriate services were just not available. The axiom "knowledge brings power brings change" was a key element in this.

2.28.2 It was finally agreed that an effective voluntary HIV testing services was a

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specific need that should be made available, focusing on *kothis* and other males who have sex with males who asked for them. This would require the development of adequate safeguards for confidentiality, appropriate pre-test and post-test counselling services, as well as adequate and appropriate support services for those who were HIV positive. In particular, MSM sexual health projects should be supported in developing these service requirements.

2.28.3 This led to the question of costs, and participants identified the need to access low cost HIV testing kits for their projects to reduce overall budgetary constraints. Support should be provided for this.

2.29 ■ **living with HIV/AIDS**

The provision of HIV testing brings with it the need to ensure that adequate and appropriate support services are in place for those males who have sex with males who are positive or living with AIDS. These support services relate to emotional, physical, family, medical, psychological, economic, and social needs. Building a community response to STIs/HIV/AIDS amongst *kothis* and others involved in male to male sex needs to be a part of that strategy.

2.29.1 MSM sexual health projects will also need to collaborate and work closely with HIV+ groups, organisations and networks, accessing their skills, knowledge and support. Such links will also need to be established with those agencies working on advocacy and human rights concerns in terms of people living with HIV/AIDS.

2.30 ■ **general health**

Several participants noted that many constituents of their sexual health projects come from low income groups, where the general health conditions may be quite poor. Inadequate nutrition, poor living conditions, and high stress, can lead to a range of medical conditions that require treatment, but which these constituents may not be able to afford to access.

2.30.1 Many of their constituents have also stated that because they are *kothis*, they cannot access appropriate treatment and care programmes.

2.30.2 Participants therefore suggested that provision of health care for *kothis* is an urgent need. Several projects are experimenting in expanding their STD clinical service to include other medical conditions. *Kothis* feel comfortable in accessing this because of the environment in which the service is available.

2.30.3 However, this need identifies a broader need which affects all health care service providers. That is, the general attitude of the medical profession and ancillary staff, whether it be in a clinic setting or hospital. Stigmatising attitudes, prejudice, harassment, and denial of services are issues of great concern, and can be considered human rights abuse, whether the person is a *kothi*, *hijra*, and/or HIV+. These concerns will need to be addressed as part of an overall government strategy in responding to the HIV epidemic.

2.31 ■ **drop-ins**

Accessing accurate and appropriate information, counselling, support, and treatment is an urgent need for *kothis* and other MSM. Appropriate spaces need to be developed where these individuals can utilise as and when they need to. Casual walk-in spaces which provide a supportive environment for individuals to ask questions and be assured of appropriate answers without stigmatisation was identified as a clear need for *kothis* and other males who have sex with males.

2.31.1 Drop-in spaces, as a part of any MSM sexual health services, which can provide a comfortable environment to attend, also can act as a part of a community building strategy.

2.32 ■ ownership of the issues

For overall development of effective sexual health strategies amongst *kothis* and other males who have sex with males, there is a need to “own the issue”. Personal, collective, and community ownership can act as a process of empowerment, and encourage personal responsibility as well as increase health seeking behaviours.

2.32.1 However to develop such ownership will require all the processes for effective community building and development mentioned above.

2.33 ■ alternate sexual behaviours

Significant levels of non-penetrative sex already exists between males, and it was accepted by participants that there is a need to encourage more non-penetrative sexual activity. Such non-penetrative activities include mutual masturbation and thigh sex. At the least, oral sex needs to be encouraged as an alternate to, and less risky behaviour than, anal sex. Developing such shifts in behaviour will need to be clearly thought through and techniques and mechanisms for supporting such a change need to be developed.

2.33.1 To be effective the strategy that needs to be employed by MSM sexual health projects is one of “harm reduction”, a pragmatic approach which recognises the realities of male to male sexual behaviours in South Asia.

2.34 ■ male sex workers

Participants recognised that for many *kothis* and other and males, poverty, low education and vocational skills, and other pressures, place them in a difficult position in regard to selling sex. Options for income generation are minimal, and so encourages sex work, both as a primary source of income or as an income supplement. For many, the socio-economic conditions keeps the price of sex acts low, which encourages an increase in the number of clients, placing them, and their clients, at an increased risk.

2.34.1 There needs to be specific programmes targeting male sex workers and their clients (including wives and other female partners), which create conditions where the level of sex work can be reduced, if not halted. These programmes need to look at providing not only STI/HIV prevention services, but also explore the provision of vocational and literacy training, and increased employment opportunities.

2.35 ■ risk and needs assessments

There is a tremendous lack of knowledge and understanding regarding the socio-cultural dynamics of male to male sex, as much as the levels of risk, behaviours, safer sex activities, levels of STIs and HIV. Participants expressed an urgent need for the development of appropriate risks and needs assessments amongst males who have sex with males, assessments that also explore the sociological frameworks of male to male sex. It is this combination of qualitative and quantitative data that would provide appropriate guidelines for service development. Such assessments should not only be about counting the number of specific sex acts, numbers of condoms used, and so on, but should reflect the reasons, conditions, desires, and frameworks in which male to male sex takes place.

2.36 ■ research and documentation

Participants recognised a considerable lack of research documentation in four main areas. These are:

i. historical

For both psychological and social reasons, historical research in the South Asia region on male to male sex was seen as urgent, not only to indicate its continuity, but also to place in a cultural context.

ii. contemporary

Patterns of male to male sex, constructions of masculinities, male genders and sexual behaviours, life histories, the meanings and contexts given to sex behav-

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ious, the plurality of desires, and so on, need also to be researched and documentation developed.

iii. Epidemiology

There is very little and documentation regarding epidemiological patterns of STI and/or HIV infection amongst males who have sex with males, specifically in terms of anal transmission of STIs and HIV.

iv. human rights abuses

Human rights abuses can reflect issues around sexual behaviours, and/or gender/sexual identities, or issues around HIV/AIDS status. There is a need to have more research and documentation on these issues in South Asia

2.36.1 This research and documentation would be invaluable in developing appropriate responses to some of the expressed and felt needs of *kothis* and other males who have sex with males, such as self-esteem, empowerment, accessing funding, advocacy work, and so on.

2.37 ■ **outreach programmes**

If there is to be an effective national strategy on the management and control of HIV/AIDS, then there is an urgent need to expand the number of current MSM sexual health projects that exist in the South Asia region. In a population of some 1.4 billion people, there were only some 10 such sexual health projects focused on males who have sex with males, and are managed and operated by the beneficiaries themselves. Seven of them were present at the meeting.

2.37.1 Outreach here means taking knowledge, skills, resources, and other services, to the particular constituents of each project, in this case to the differing male to male sex networks. Such programmes would need to also act in concert towards community building and development.

2.37.2 Participants stressed that such outreach programmes should be developed by the beneficiaries themselves. Sexual health projects need to be owned and managed by and for, their constituents. In this case, males who have sex with males, accessible by such programmes would be those with identifiable characteristics and a part of an emerging community/group/network. These males would be *kothis*, *hijras*, or gay-identified males. Thus potential partners within these networks need to be accessed, skills training provided for them, and support given to enable them to develop and implement their own sexual health agencies.

2.37.3 The rationale for such an approach was the need to ensure trust, acceptance, confidentiality, mutuality of need and concerns, a collective response. At the same time, such a strategy enables community building and ownership of the issues.

2.37.4 This would need a major commitment from government institutions and donors to enable such a development. It would also need access to appropriate trainers, skill development programmes, and other resources.

2.37.5 At the same time, participants recognised that for many other males who have sex with males, such a strategy would not be appropriate since their male to male sexual behaviours are sporadic, semen discharge based, and opportunistic.

2.37.6 In this situation, male to male sexual behaviours (and in particular, anal sex) need to be a part of the agendas of all agencies providing STI/HIV prevention and care services. This would include agencies working with street children, and occupational groups such as truck drivers or taxi drivers, factory worker, and so on. Anal sex behaviours as a risky practice will need to be a part of their activities, not only anal sex between males, but also that between males and females.

2.37.7 Anal sex issues would also need to be a part of any women's reproductive and sexual health programme, not only in terms of what husbands and other male partners may be doing with other males, but also what may be occurring between male and female.

2.38 ■ *sensitisation*

Making visible the issues of anal sex, both between males and between males and females, as well as those regarding *kothis*, *hijras*, gay identified men, and other males who have sex with males, would need a great deal of work in sensitising, not only institutions who provide specific services, but also government, the legal and judicial profession, the media, medical services, education authorities, employers, trade unions, and the general society at large. Sensitisation is a need towards ensuring destigmatisation of behaviours and identities, and encouraging access to both specialist and mainstream services. It will reduce harassment and violence, create an empathic environment, and enable the marginalised and stigmatised to gain social acceptance. Such social acceptance would act as a support for increasing the health seeking behaviours of males who have sex with males.

2.39 ■ *training and skills development*

All the participants involved in specific male to male sexual health projects at the Meeting recognised that without access to appropriate training and skills development (apart from funding), then they would not have existed.

2.39.1 There is a need for more appropriate trainers to be available and accessible, trainers who are themselves MSM and understand or come from the same behavioural/identity frameworks as the trainees.

2.39.2 There is a lack of appropriate training manuals, programmes for skills development, capacity building, and project development, with specific regard to specialist services for *kothis* and other males who have sex with males.

2.39.3 Such training needs for MSM include:

- development of risk and needs assessments
- designing and implementing an MSM sexual health project
- budgeting and financial management
- organisational structures
- management
- outreach and prevention
- condom and safer sex promotion
- social marketing
- monitoring and evaluation

in other words from a zero base line of no project existing to one where there is a fully functioning, appropriate and effective sexual health programme managed by MSM for MSM.

2.40 ■ *government institutions and national AIDS programmes*

For effective development of appropriate strategies to promote sexual health amongst *kothis*, *hijras*, gay-identified men, and other males who have sex with males, government, its institutions, and National AIDS Programmes in all the countries of South Asia, need to be sensitised to the needs of males who have sex with males in relation to their specific objectives of health for all its citizens, and for the management and control of the STI/HIV/AIDS.

2.40.1 National AIDS Programmes need to take on board all the issues and needs identified in this report, and others as yet to be identified, and provide a supportive environment for these issues and needs to be appropriately and adequately addressed.

2.40.2 They need to access these male to male sex networks, and encourage community building and development through financial and technical support.

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2.40.3 They need to ensure that their national AIDS control strategies incorporate all these issues and responses to them, as well as utilise members of these differing male to male sex networks, groups, sexual health agencies, as technical experts in the planning and development processes.

2.40.4 National AIDS Programmes need to ensure that appropriate condoms and their adequate supply are available; that medical services should have the skills and sensitivity to deal with anal sex issues and males who have sex with males; that appropriate protocols are developed and in place for these issues; that human rights abuses are addressed and appropriate measures taken against individuals and institutions that abuse these rights.

2.41 ■

NGOs and other institutions

Non-government organisations and other public and private institutions need to be sensitised on the issues, needs and concerns of male who have sex with males, whether they are *kothi*, *hijra*, gay-identified, or other males who have sex with males.

2.41.1 Training programmes need to be developed for these agencies and institutions to achieve this. These agencies need to provide sensitive and appropriate services for all within their catchment area irrespective of gender/sexual identity or behaviour.

2.41.2 It is the responsibility of these NGOs, CBOS, ASO, civil society agencies, and other institutions, to demand and access such training programmes, and donors should be aware whether the operational and management components of these agencies and institutions have taken these concerns on board. Funding of these agencies should be conditional on working on these issues.

2.41.3 At the same time it is the responsibility of the National AIDS Programmes and donors to make such programmes available, while it is the responsibility of MSM agencies to design, develop and provide such training.

2.42 ■

donors and resourcing

Funding is a priority concern and an urgent need. National and international funding for MSM sexual health projects is minimal, if existent at all. Sexual health needs of MSM are not seen as a priority, or a necessity. This has arisen partly because of the prejudice and homophobic attitudes of some donors and their staff, partly because of the concept that sexual health is a reproductive issue and therefore a woman's concern, and partly because of the assumption that HIV/AIDS is a "heterosexual problem" in South Asia and that MSM is a marginal activity limited to upper-middle class gay-identified men. There is the concept of gender in a gender polarised construction, without the recognition that gender also involves males, and that there are several differing male genders in South Asia (as there are probably several female genders too).

2.42.1 Donors need to be educated on the issues of male to male sex in South Asia, both as an issue in itself, and as an issue affecting women and their reproductive and sexual health. Further it needs to be recognised that unless male sexual health is addressed in terms of all forms of male sexual behaviours, then no effective overall sexual health strategy can be developed. Beyond this of course is the fact that males are the main income generators in South Asian societies, and their ill-health and/or death will have a devastating impact on the economic viability of the their families.

2.42.2 At the same time, donors who are sensitive and understanding of the issues will need to ensure that their local staff are trained on these issues. Too many times local MSM networks have been denied access by local staff because of their attitudes, behaviours, and prejudices.

2.42.3 Such training will need to encompass the differing genders/sexual identi-

ties that exist in South Asia, not only “gay” or “homosexual”, or even just “sexuality” (whatever that means).

2.42.4 However, funding should not be on a short-term basis, or project based only, but needs to look at capacity building, core costs, management costs, technical equipment, development costs, and so on. Donor parsimony creates poor projects and service delivery that cannot achieve its objectives.

2.43 ■ **police and the law**

Police harassment and violence (both physical and sexual) needs to be addressed to increase the safety of males who have sex with males, as well as project staff who are working them.

2.43.1 This needs training and sensitisation of all police staff, and not only the command structures that exist. Most of the harassment and abuse is by local constables, which the upper levels of the hierarchy may not be aware of it.

2.43.2 Deterrents to such behaviour may need to be in place. Process for complaints need to be developed, without stigmatising of the complainant.

2.43.3 Further, there are various laws (such as Section 377 of the Indian Penal Code and its equivalents in the other countries of South Asia), regulations, and ordinances which hinder or directly impede the development of sexual health services for males who have sex with males. These will all need to be reviewed and repealed or amended wherever necessary.

2.44 ■ **liaison with local police**

With this in mind, participants believed it was necessary for MSM sexual health projects to liaise and work with local police, perhaps using advocates whom the police may be more likely to listen too (i.e. State and National AIDS Programmes, lawyers).

2.44.1 Such a liaison programme will need to explain to the police the necessity for the work, persuade a reduction in local harassment and violence, and even provide training programmes for the police on sexual health issues as well as government concerns on the epidemic.

2.45 ■ **human rights abuses**

The need to address human rights abuses of *kothis*, *hijras*, gay-identified men and other males who have sex with males was clearly identified as need. Such abuse inhibits accessing sexual health services, creates an environment of fear, and increases the likelihood of risky sexual practices. It also encourages blackmail and sexual violence.

2.45.1 Appropriate methods of addressing such human rights abuses need to be developed, such a documentation, accessing human rights organisations, challenging such abuses, and ensuring that legal address is possible.

2.45.2 This will require the training of human rights organisations in regard to the issues of sexual health of males who have sex with males, and of seeing this in a broader social context.

2.45.3 Participants believed that human rights abuse of those involved in male to male sex need to be seen as a part of a general human rights framework.

2.45.4 This also mean the need to develop links with those advocating on behalf of lesbians and gay men in the region, since there will be some common needs and issues.

2.46 ■ **advocacy**

At the same time, there needs to be specific programmes of advocacy regarding

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sexual health issues and other concerns of males who have sex with males, not only for *kothis*, *hijras* and gay-identified men, but also for all other males who have consensual sex with other males. Local, national and regional strategies will need to evolve for this.

2.47 ■ **media**

Media plays a strong role in developing social attitudes generally. It has been involved in breaching confidentiality, victimising males who have sex with males, and creating fear and tensions.

2.47.1 At the same time the media in all its forms, can play a strong constructive role in educating and ameliorating the social stigmas and conditions for males who have sex with males.

2.47.2 Methods of working directly with the media need to be developed which does not sensationalise the issues, break confidentiality, or increase the risks and dangers for males who have sex with males.

2.47.3 This will need the development of sensitisation and training programmes for media personnel, to increase the levels of understanding by them of the issues involved.

2.47.4 The media needs to be treated as a potential ally in preventing STI/HIV/AIDS amongst males who have sex with males and in gaining social acceptance of them, rather than always be seen as the enemy.

2.48 ■ **networking**

Participants believed that MSM sexual health projects need to network in several ways. These ways include:

- i. with each other as a means of sharing information, advocating on each others behalf, supporting each other, teaching each other, as well as providing solidarity and an extended community, locally, nationally and regionally.
- ii. with agencies in countries outside the region working on similarly issues, i.e. Asian countries, European and North American countries
- iii. other agencies working in the field of sexual health promotion
- iv. other networks may also need to be developed

2.48.1 However, to facilitate such networking requires technical and financial support, such as email, internet, developing a web-site, and so on.

2.49 ■ **allies**

There are many individuals, groups, organisations and agencies, who may not themselves be either MSM, or involved in MSM issues, but are understanding and accepting of MSM and their issues of concern. MSM sexual health projects and advocates will need to recruit allies such as these towards gaining the skills and support they need, as well as to advocate on their behalf.

Calcutta was in many ways a very learning and intensely emotional experience for me. I met so many great people in one place that I may not have been able to come across in any other situation.
comment from a participant

- the way forward** ■ Actions and recommendations were developed by the participants covering a range of issues and needs. These recommendations deal with specific issues, strategies, required actions, and relate to all key stake holders in responding to the sexual health needs of males who have sex with males in South Asia.
- 3.1** ■ **Self-help organisations as a model of MSM sexual health agencies**
In a population of 1.4 billion people there are an extremely few beneficiary led sexual health service agencies for males who have sex with males. By the very size of the population and the frameworks of male to male sex in South Asia, the numbers involved must involve millions.
- 3.1.1** ■ **self help**
Self-help approaches are seen as the most effective amongst those with specific gender/sexual identities, and amongst emergent male to male sexual networks and/or communities. Here self-help means beneficiary-led services, that is, males who have sex with males helping and providing services for other males who have sex with males. Many more of these agencies must be developed across South Asia. Every significant urban area should have at least one such agency, if not more.
- 3.1.2** ■ **funding**
Adequate and appropriate long-term funding must be made available to develop and sustain these initiatives. Such funding should include core costs as well as project costs, and sustainability issues must be thoroughly explored in the context of service delivery needs to ensure programme continuity. Funding should be provided for technical equipment, capacity-building and community development.
- 3.1.3** ■ **kothis as sexual health promoters**
Within the range of differing male to male sex frameworks, *kothis* often provide a significant link between the various sexual players. *Kothis* should be seen as potential lead personnel as sexual health promoters amongst the different networks. Appropriate *kothis* should be identified, recruited, trained, and helped to form their own service agencies, where all the staff in an agency reflect the dynamics of their constituents.
- 3.1.4** ■ **access to capacity building**
As there are a lack of appropriate self-help agencies currently, it will be necessary to develop more of them. Acknowledging the lack of technical skills in developing such organisations, whether it be around infrastructure, service design and delivery, programme implementation, project management, financial accountability, appropriate outreach strategies, monitoring and evaluation, resource design and development, needs assessments, or producing budgets and accounts, such agencies/individuals/networks/groups must be provided with access to these skills through training and capacity building from appropriate trainers and consultants who are MSM themselves. Funding must be available for this.
- 3.1.5** ■ **technical skills development**
A range of training modules and resources have already been developed that specifically deal with male to male sexual behaviours and sexual health issues in South Asia. These training modules explore project development, peer education and outreach, monitoring, and a range of other issues. Emergent projects should be aided in accessing these training manuals, and assistance should be provided to develop other training manuals appropriate to meet the needs of these emergent agencies, as well as those already developed.
- 3.1.6** ■ **risk and needs assessments**
In developing appropriate strategies to promote sexual health amongst specific groups/networks of MSM, funders will often demand a risk and needs assessment. Too often such risk and needs assessment are conducted by those with no understanding or appreciation of the issues involved. Emergent MSM sexual health agencies should be provided with the training and adequate funding to develop

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their own risk and needs assessments. Peer- led assessments will often have more validity in terms of data collection than otherwise. However the question arises of how many risk and needs assessments are necessary, when the patterns of male to male sex in South Asia are already clearly identified. Must each locality have its own risk and needs assessment? This can be seen as an enormous waste of resources and time, when more urgent needs are at hand.

3.1.7 ■ **model sexual health agencies**

There are a few sexual health projects developed by MSM and working with *kothis* and their sexual partners already existent in Bangladesh and India. They share common parameters of service delivery, indicating replicability and effectiveness. Such agencies include Bandhu Social Welfare Society in Dhaka, Bangladesh, Praajak Development Society in Calcutta, Sahodaran in Chennai (Madras), and Bharosa Project in Lucknow, these latter in India. The common components include:

- i. outreach education and support programmes, using *kothi* field teams which use friendship building as a community development strategy at specific sites
- ii. safer sex promotion and condom distribution
- iii. safe socialising spaces and drop-ins
- iv. community building and development initiatives
- v. access to appropriate STI treatment
- vi. a peer management and staff structure
- vii. a range of appropriate IEC materials
- viii. telephone helplines
- ix. provision of psychosexual counselling
- x. development of vocational and literacy programmes
- xi. networking and advocacy

These agencies are also exploring establishing small scale savings and loan clubs, employment agencies, emergency housing and a range of other welfare support systems.

These systems are a mutually supportive matrix of service provision, and have been shown to be successful in achieving appropriate outputs that reflect the issues and needs already identified in this report.

It is therefore recommended that this model of agency development and service provision should be used as a framework for other similar agencies to be developed across South Asia.

The skills and experiences already available in the above mentioned agencies should be accessed towards enabling the development of these new MSM sexual health agencies.

It should be noted that all these agencies operate under the project title of either "Male Sexual/Reproductive Health" or Male HIV/AIDS Prevention Project". This discreteness was found to be necessary in assuaging local sentiments.

3.1.8 ■ **community building and development**

A central component of the sexual health strategy being promoted by the above agencies is community building and development towards collective responsibility. All MSM sexual health agencies should be encouraged, supported, and funded to initiate and develop such a strategy, with the elements identified above.

3.1.9 ■ **sex education and psychosexual counselling**

Appropriate books, leaflets, training manuals, workshops, and other resources, must be developed to meet the sexual health of needs of males who have sex with males. They will need to be explicit, use local terminology and address increasing the knowledge, understanding, and skills around the male and female bodies, sex (including functioning of sexual organs,, sexual behaviours, and sexual

desires), sex practices, safer sex, and other relevant issues. They should also address the most common questions that *kothis* and other males who have sex with males ask. This will enable the agencies to provide accurate and non-judgmental answers to the issues that their constituents raise.

3.1.10 ■ **STD treatment services**

Whilst the current MSM sexual health projects mentioned above already provide a limited STD syndromic management services, a range of difficulties have been experienced. These include locating appropriate STD doctors, either those who are MSM themselves, or are sympathetic to the issues and are non-judgmental. Further, the lack of knowledge that doctors have around oral and anal STD's, and in terms of MSM, is clearly evident.

It is therefore recommended that MSM sexual health agencies, in collaboration with donors, other sexual health services, and government, ensure that:

- i. appropriate training is provided to medical students, maybe through accessing international expertise on these issues
- ii. sensitisation and capacity-building programmes is provided to all doctors and clinicians providing STD services
- iii. training of pharmacists to provide syndromic management as well as sensitise them to the issues of male to male sex and anal and oral STIs
- iv. training for MSM field workers on STI syndromic management for the provision of on-site treatment and counselling

Current and new MSM sexual health agencies should be encouraged to provide their own clinics which can access cheap testing facilities and reduced costs for treatment regimes through funding support, access to technical training, and appropriate equipment and medical needs. These agencies should be encouraged to provide subsidised rates for treatment with the principle of "no charge - no responsibility".

Further, with appropriate training and capacity building, networks of STD services should be developed as referral points. Anonymity and confidentiality need to be a part of this service, and can be achieved through appropriate numbered referral cards given by field workers and/or agency drop-ins.

Other framework of providing access to appropriate STD services should be evaluated and implemented. One such example could be a mobile clinic (particularly useful in rural areas and small towns).

3.1.11 ■ **HIV testing**

MSM sexual health agencies should explore this issue thoroughly before they consider providing HIV testing facilities. If they do, they must provide this service under anonymous and confidential conditions, following international protocols. To provide such a services, training must given be to provide and manage such a service and these agencies must provide appropriate pre-test and post-counseling. Funding also should be give to sustain this service. Access to cheap rapid testing kits should be facilitated by donors and National AIDS Programmes.

3.1.12 ■ **HIV/AIDS support services**

In regard to MSM living with HIV/AIDS, agencies must develop a range of social and welfare support services in line with their needs. Project must collaborate with and access the knowledge and skills of already existent HIV+ groups and organisations in developing these services.

3.1.13 ■ **condom and lubricant promotion**

Promotion of condom and lubricant use are key components for and MSM sexual health agency. However several key issues must be addressed.

MSM sexual health projects must promote condom use pro-actively. Whilst it is recognised that initially building a habit of using condoms may require free distri-

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bution, projects should move as rapidly as possible to social marketing principles, based on the idea that free access may not encourage actual and continuous usage.

Projects should recognise the actual quantity of need and ensure that there are enough condoms available for their constituents and their partners. Simple calculations can provide relative numbers. For example, if a Project has built up a constituency of some 10,000 MSM in its catchment area, and each MSM needs approximately 3 condoms per week, then this will produce a figure of 30,000 condoms distributed each week, bringing a 6 month total of 720,000 condoms. At this level of condom distribution, costs may be prohibitive for free distribution, which generates another reason for social marketing to reduce project costs.

In order to gain access to such levels of condoms, Project should insist on an adequate budget line for condom procurement. They should also work closely with the National AIDS Programmes/State AIDS Cell/Family Planning Centre to obtain higher levels of condoms.

It is recognised that government condoms may have a poor reputation. Each Project must recognise that they are involved in marketing condom use, and should use marketing techniques to shift this level of condoms.

Potential strategies that Projects could utilise would be obtaining unbranded condoms from suppliers, and/or negotiating with other Projects for bulk purchasing. Other methods for large scale purchasing should be explored and developed.

Condoms must be readily and easily available. Different approaches should be explored. These could include:

- i. on-site distribution directly to constituents
- ii. drop-in and clinic distribution
- iii. utilisation of site personnel, such as tea boys, or food stall staff as distributors

Distribution of condoms must also include education and demonstration for their proper use. This could be in the form of visual materials in small leaflets which explicitly show how to use a condom. Or it could be with an actual demonstration on a penile model carried for such purpose by the field worker. However, this may have implications in terms of police harassment, and it will be necessary to take steps to deal with this.

Projects should also be promoting appropriate lubrication for anal sex. Constituents need to be educated about proper lubrication, and if water-based lubrication is not available, then the use of saliva will need to be promoted.

Whilst accessing condoms appropriate for anal sex, or flavoured condoms, or even water-based lubricant sachets, may be difficult or too expensive for MSM sexual health projects to procure, discussions must take place with donors, National AIDS Programmes, and other stakeholders, about the Projects accessing these products at an affordable rate for their constituents. These products are seen as essential components for any sexual health promotion amongst males who have sex with males.

3.1.14 ■

promotion of alternate sexual practices

Concurrently, with condom and lubrication promotion, Projects should also promote other forms of sexual pleasure, such as mutual masturbation, thigh sex, and oral sex.

It is recognised that oral sex carries its own risks for STI/HIV infection, but it has been generally accepted that these risks are significantly lower than that for anal sex. With a paradigm of risk reduction, and where condom usage is low, or where appropriate condoms and lubricants are not available, risk reduction must be

seen as an appropriate strategy.

However, with the promotion of oral sex as a behaviour change, Projects will need to ensure that constituents are aware of the risks involved, issues around oral hygiene, and other related matters.

Further, in discussing hygiene issues, and recognising the data on circumcision and HIV, Projects will need to promote genital hygiene as a co-issue with condom usage.

3.1.15 ■ ***IEC materials***

Projects must have adequate supplies of appropriate education materials that relate to all the issues around STIs/HIV/AIDS for males who have sex with males. They must be accessible in terms of language, imagery, and terminology, simple to understand, easy to carry without being recognised, and accessible in a variety of settings. They must provide clear, accurate, and non-judgmental advice and information.

A diverse range of such education resources should be developed and distributed dealing with specific issues. Trying to crowd a whole range of issues into one leaflet creates confusion and makes the document too lengthy and boring to read. Projects should recognise that these materials are for their constituents, not for their donors or themselves.

3.1.16 ■ ***street theatre***

Alternative forms of providing education and information should be explored and developed, particularly for non-literate constituents and their sexual partners. Such methods could include different forms of street theatre, or puppetry, or dance, and Projects which could hold performances at specific sites such as parks, street corners, outside cinema halls, and so on.

The intention is to have a broad range of processes for the sharing of information and skills that will protect lives. Such processes need to work closely with Project field teams and counsellors operating at different sites in terms of community building, so that the differing approaches work together to mutually support each other.

3.1.17 ■ ***marriage, children, and families***

Without a radical change in South Asian cultures, marriage, children, and families will always be one of the central concerns of males who have sex with males.

Ethical concerns regarding personal responsibility, partner notification, possible infection of the wife, infected children, and economic issues brought on by illness and/or death, all bring concerns that MSM sexual health projects must also address in regard to the wives of MSM.

This means that specific approaches must be developed that enable the wives of STD and/or HIV infected MSM to access appropriate services. These will include

- i. working directly with women's reproductive and sexual health agencies
- ii. developing links with STD clinics offering services to women
- iii. working with MSM husbands regarding partner notification and treatment

Such services will require great sensitivity and skills on the part of Project staff and other agencies. Education of MSM husbands is central to this. Training programmes must be developed in terms of capacity building in this area.

3.1.18 ■ ***income generation***

Project sustainability beyond its donor funded life is a urgent priority. A range of possible options for Projects to develop income strategies to support the various services being offered should be explored and developed. Such schemes can include:

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- i. utilising the variety of skills of the Project's constituents in offering the general public a range of educational and vocational classes for fees
- ii. social marketing of condoms and lubricant
- iii. sliding scale fees for accessing STD clinic and treatment, as well as HIV testing
- iv. cultural events offered to the fee-paying public
- v. training programmes offered on a fee basis
- vi. handicrafts that are made by a Project's constituents being sold
- vii. other vocational skills, such a tailoring, or marketing goods purchased in one area of the country and sold in another area at a mark-up
- viii. collaboration with other MSM agencies throughout the region in a range of marketing ventures.

3.1.19 ■ **male health centres**

Projects, in cooperation with donors, should explore, and if possible develop, the concept of Male Health Centres which would offer treatment, counselling and support on a range of issues, not only STIs/HIV. They would also work in collaboration with drop-in centres, and would deal with all male sexual behaviours. They could also work closely with female health centres, particularly in regard to wives and other female partners of males who have sex with males.

3.1.20 ■ **networking**

This consultation meeting brought together, for the first time, a range of MSM sexual health projects in the South Asia region. For many participants it was the first opportunity for project staff to meet each other, compare services and delivery methods, share information and skills, and exchange ideas. It should be noted that many participants did not have access to English, so significant levels of translation were being conducted during the Meeting.

Projects should be financially supported to network locally, nationally, regionally and internationally. At a primary level, MSM sexual projects must network with each other, accessing each other's skills, knowledge, and capacity.

To facilitate this, a network of such Projects should be developed and a nodal agency established to coordinate the network. Regular regional meetings must be held to continue and expand the networking.

At a secondary level, such networking should expand beyond the South Asia region into other areas where there maybe similar projects.

At the tertiary level, networks should be establish with other individuals, AIDS services organisations, and institutions who are sympathetic and supportive of the issues of male to male sex and sexual health concerns.

Funders should look at ways of providing financial and technical support to establish and develop these networks through the provision of equipment and training, i.e. access to computers so that the internet becomes available, developing a web-site, a newsletter and so on.

Regular network meetings should be held both nationally and regionally, and support for this meetings must be provided by Government and donors. Participants recommended that there should be an annual national meeting for MSM sexual health projects, and a bi-annual regional meeting for the same. These meetings should be facilitated by the network itself, and/or an appropriate nodal agency.

It is recommended that since Naz Foundation International is developing a Regional Centre for Male Reproductive and Sexual Health in India to provide technical assistance and promote MSM sexual health agencies, that it be given this task to facilitate this networking.

3.1.21 ■ **advocacy**

Male to male sex and its sexual health implications is a major issue of concern but it has not been seen as such by many NGOs, government agencies, or donors. There are several areas of advocacy in regard to males who have sex with males that must be addressed. These are:

- i. Advocacy at the local, state and national levels on behalf of a Project's constituents in terms of service needs, their delivery, and access to such services, for example, police harassment, legal issues, appropriate STD treatment, condoms, people living with HIV/AIDS, and so
- ii. MSM sexual health projects should advocate on the behalf of all males who have sex with males and their sexual health and social needs in the South Asia region
- iii. Advocacy on an international level
- iv. Collaboration with other advocacy agencies, and lesbian and gay rights organisations

Such advocacy must address the human rights concerned already identified in this report, as well as other as they arise. This could be facilitated through the development of the network of such MSM sexual health Projects.

3.1.22 ■ **research**

One of the significant issues affecting government and donors has been the lack of data on the issues of male to male sex in South Asia, and the consequent issues around anal transmission of STI and/or HIV. This lack of data has been a stumbling block in the provision of resources to develop appropriate sexual health programmes for males who have sex with males.

All MSM sexual health projects should ensure that their data collection and monitoring is adequate and effective in providing information on these issues.

They should advocate for donors to provide funding for appropriate research that not only looks at epidemiological information, but should also explore issues around the social constructions of masculinities and sexual behaviours, the meanings and content that males give to their sexual practices, the issues of culture and religion in terms of male to male sex, and the historical contexts of male to male sexual behaviours.

Such research provides a context in which effective strategies can be developed to promote sexual health, behaviour change, safer sex, and other health seeking behaviours for males who have sex with males.

3.1.23 ■ **government**

MSM sexual health projects should cooperate and collaborate with National AIDS Programmes and their government affiliates to ensure a strategic approach to the issues of sexual health amongst males who have sex with males and their sexual partners. This should be seen as a common goal towards achieving the targets of NAPs, and as serving all the citizens in any country of the region. This must be seen as a mutual obligation.

3.1.24 ■ **NGOs and other institutions**

Similarly, MSM sexual health projects should work with other NGOs and institutions working in the fields of reproductive and sexual health, advocacy, human rights, and all related issues. It is only through working together that the AIDS epidemic in the region can be halted.

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3.2 ■ **The Role of National AIDS Programmes and Government**

National AIDS Programmes and governments must accept and acknowledge the existence of significant levels of male to male sexual behaviours in their countries and take responsibility for ensuring appropriate education, prevention and support programmes are available and accessible to address the sexual health needs of males who have sex with males.

3.2.1 ■ ***investment***

These programmes should play a lead role in encouraging, investing and enabling the development of peer-led community-based AIDS service organisations by investing in, and empowering them, to deliver appropriate HIV prevention and sexual health services for males who have sex with males,

3.2.2 ■ ***gaining trust***

In order for this to occur, government and other agencies will need to ensure that they can gain the trust and confidence of males who have sex with males, and the sexual health Projects that serve them by ensuring their confidentiality, safety, security and anonymity.

3.2.3 ■ ***commitment***

This requires a political and social commitment by Government and National AIDS Programmes to support peer-led initiatives developing STD/HIV/AIDS education and prevention services, where the beneficiaries of change act as the agents of change

3.2.4 ■ ***provision of support***

Such an investment in the development of appropriate sexual health services for males who have sex with males would be in the form of:

- i. provision of long term financial support
- ii. provision of, or unhindered access to, technical assistance
- iii. unfettered access to capacity-building training
- iv. addressing legal and regulatory constraints which may hinder the development of such peer-led community-based agencies
- v. accessing the knowledge and skills of MSM sexual health projects

3.2.5 ■ ***other frameworks of MSM***

Recognising that not all males who have sex with males will be accessible to these MSM sexual health services, whether provided by government or community-based agencies, National AIDS Programmes will need to develop appropriate frameworks for a national programme on sexual health education amongst the general public that takes into account the sexual behaviours of males who have sex with males, as well as ensure that other sexual health agencies incorporate the issues of anal sex as a risky practice, whether between males or between males and females.

3.2.6 ■ ***training programmes***

National AIDS Programmes should provide training and awareness programmes to government and non-government agencies providing sexual health services on the social and sexual health needs of males who have sex with males in order to address the lack of knowledge and understanding. Such programmes must provide unbiased information, sensitisation, as well as destigmatise the issue.

3.2.7 ■ ***addressing legal issues***

Where laws, regulations, policies, and practices hinder males who have sex with males to access sexual health services, or discriminate against them through intimidation, fear, harassment, violence, denial or the risk of imprisonment, then these should be amended or repealed to empower such males to access appropriate services. This will require working with the police, judiciary, politicians, and the range of other government institutions.

- 3.2.8 ■ *technical resource group***
A Technical Resource Group made up of all the MSM sexual health project leaders and other technical experts must be formed to provide a National AIDS Programme with the knowledge, information and expertise of sexual health concerns of males who have sex with males. There should be regular meetings of this TRG with National AIDS Programme officials.
- 3.2.9 ■ *national educational strategies***
National AIDS Programmes should also develop national educational strategies to educate the general population against discriminatory attitudes towards STI/HIV/AIDS and sexual behaviours as well as to de-stigmatise male to male sexual behaviours through the use of the mass media. Such sexual health programmes that include male to male sexual behaviours should also involve schools, colleges and universities, families, business, occupational groups, the military and prisons.
- 3.2.10 ■ *access to appropriate condoms***
National AIDS Programmes must ensure that appropriate condoms, suitable for anal sex, and lubricants, are readily available, affordable, and accessible to males who have sex with males, ensuring good quality, affordable prices and adequate distribution in a variety of locations
- 3.2.11 ■ *collaboration on human rights***
There should be effective collaboration between National AIDS Programmes, MSM sexual health agencies, and international agencies such as UNAIDS, UNICEF, UNHCR and others, towards implementation of agreed policies, recommendations and guidelines, locally adapted to address concerns of human rights abuse, service development for males who have sex with males, accessibility to these services and to reduce discrimination.
- 3.2.12 ■ *sex education***
Sex education programmes aimed at youth, both formal and informal, must be developed, under whatever name, by National AIDS Programmes and educational institutions, in order to reduce the risks of STI/HIV infections amongst young people. Such education programmes must include male to male sex behaviours and anal sex issues.
- 3.3 ■ *Government and private STD services***
Both public and private STD services, family planning centres, and other reproductive and sexual health agencies, must be provided with training and sensitisation, as well as provide training and sensitisation to their own medical and ancillary staff around male to male genders/sexualities and sexual behaviours, as well on anal STIs and their syndromic management. Anal sex issues must deal with both male to male and male to female behaviours.
- 3.3.1 ■ *government and donor support***
This will require support from government and donors. Appropriate services delivery, accessibility, prejudice and human rights must be addressed, and protocols developed and implement that confront these issues.
- 3.3.2 ■ *collaboration with MSM sexual health projects***
Collaboration and cooperation must be sought with MSM sexual health projects so that appropriate referral systems that allow confidentiality and anonymity to be maintained, can be developed.
- 3.3.3 ■ *treatment programmes***
All treatment programmes must be non-judgmental, and must offer correct advice and information on condom promotion and safer sex behaviours.

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3.4 ■ **Private and Public Institutions**

Private and public institutions must take on board issues around male to male genders/sexualities and sexual behaviours as well as related concerns around STIs/HIV/AIDS, perhaps with government support. These institutions include the corporate sector, the media, trade unions, schools, colleges, universities, chambers of commerce, legislators, the civil services, military, the prison service, and so on. This will require extensive training and sensitisation programmes.

3.4.1 ■ ***recognition of male to male sex***

Many of these institutions must recognise anal sex behaviours amongst males do occur, and that such behaviours require a sympathetic approach in regard to anal transmission of STIs/HIV. They must develop the expertise and skills to respond to the sexual health and social needs of males who have sex with males.

3.5 ■ **Non-Government Organisations**

Non-government organisations and community-based agencies, whether they are working in the context of reproductive and sexual health, street children, education, rural development slum improvement, and so on, must also take on board these issues, and enable them to become a part of their sensitisation programmes towards destigmatising the issues, address human rights concerns, and provide appropriate and accurate information to address these issues. Collaboration and cooperation should be sought with MSM sexual health projects, where shared concerns, agendas and issues can be developed, and mutual support can be encouraged. Male to male sex, genders/sexualities and issues around STIs/HIV/AIDS prevention that arise from them must not be seen as somehow only being the concern of MSM sexual health projects. It is a general social issue as well, and needs to be a part of all appropriate agencies' agendas. At the same time, those NGOs working on family planning, reproductive and sexual health, all male institutions and so on, must ensure that issues of anal sex behaviours and their potential STD/HIV consequences be adequately addressed in their programmes.

3.6 ■ **Donors**

Donors, whether local, national, or international, must take on board the issues of male to male sexual behaviours and their implications for male **and** female reproductive and sexual health. Anal transmission of STIs/HIV must be recognised as a concern affecting both males and females.

3.6.1 ■ ***donor investment***

Donors must be willing to invest and support MSM sexual health initiatives that are MSM led. Such funding support should not only be focused on projects, but should also include core costs, capacity-building, sustainability, resource development, equipment, and other related issues. Often there are no service agencies available in a given locality. This requires urgent investment in developing local community-based MSM sexual health agencies also.

3.6.2 ■ ***increase in investment***

There must be a significant increase of funding available for such developments by donors. Funding must be on a long term basis with adequate support for monitoring, impact assessments and technical assistance.

3.6.3 ■ ***donor support for other initiatives***

Donors should also support initiatives around MSM sexual health centre, the training of medical professionals on the issues, the range of research needs, as well as to support the networking of such agencies, as identified above.

3.7 ■ Other Recommendations

3.7.1 ■ *regional resource, information and training centre*

Participants recommended that a nodal agency should be developed for the South Asia region which would act as a resource, information and training centre for focusing on sexual health issues of males who have sex with males. Donors should explore various funding options in conjunction with Naz Foundation International, for this development. Such an agency would provide technical assistance, training programmes, facilitate regular networking meetings, and act as a distribution agent for sexual health products such as condoms, lubricants, testing kits, and so on. Such a centre would also act as an advocacy agent for these sexual health projects in regard to governments, donors, and national/regional institutions.

3.7.2 ■ *training of trainers*

In line with this development, such a Centre would provide a range of appropriate training manuals and as well as capacity-development courses for MSM sexual health project staff at all levels, including training of trainers courses to localise skills and technical expertise. At the least, a range of training of trainers courses for the development and management of MSM sexual health projects must be implemented to expand the capacity of services currently available, as well as develop new ones.

3.7.3 ■ *MSM donor agency*

Donors have their own priorities, and often there is a competition for funding from a range of NGOs where there is limited financial resources. Participants recommended that international donors should consider facilitating the development of a specific donor agency for South Asian MSM sexual health projects and programmes. Fund-raising initiatives should also be considered for such a donor agency to increase the level of funding available for MSM sexual health issues.

3.7.4 ■ *newsletter*

A specific newsletter should be developed as a networking initiative amongst the MSM sexual health agencies. Naz Foundation International was asked to explore whether its newsletter, *Naz Ki Pukaar*, could take on this role. Funding would need to be secured for this.

3.7.5 ■ *women's sexual health*

The Consultation Meeting highlighted the issues of female partners of males who have sex with males, and anal sex issues for women. Specific programmes must be developed by government institutions, NGOs, as well as MSM sexual health projects to ensure that these issues are adequately and appropriately addressed, and that female sexual partners of males who have sex with males have access to appropriate sexual health services

3.7.6 ■ *male rape and sexual violence*

The issue of male on male rape and sexual violence must be addressed through appropriate legislation, counselling and support of those abused. This can be effectively done within collaborative frameworks between government, MSM sexual health projects, and other concerned organisations. This will mean looking at the context of sexual violence in all male institutions, such as prisons, military establishments, boarding schools and so on. However great care must be taken not to confuse this issue with consensual male to male sexual activities in such environments. At the same time, such institutions must be made aware of the issues of sexual health risks in such environments, and appropriate resources, information and education must be made available to reduce the levels of risks for STD/HIV transmission. Such an initiative is based on the concept that all citizens of the countries of South Asia have the right to have unhindered access to information and resources that protect their health.

3. Recommendations

3.7.7 ■ **Naz Foundation International Briefing Papers**

Meeting participants finally recommended that two technical papers that Naz Foundation International submitted as a part of the Meeting Briefing Papers should be seen as key technical documents for the development of MSM sexual health projects. It was asked that National AIDS Programmes, donors, NGOs, and international agencies involved HIV/AIDS issues in the region, should adopt these key documents as part of their strategies for MSM sexual health.

The two key briefing papers were:

- i. Actions for Life: looking at sexual health services for males who have sex with males
- ii. Community Mobilisation

These documents are attached as annexes to this report

Sunil Menon of Sahodaran, Chennai



1. ■ ***South Asia Regional Network of MSM Sexual Health Agencies***
 Following discussions with the agencies and donors present, and in line with Naz Foundation International establishing a South Asia Regional Centre for Male Reproductive and Sexual Health in India working with the sexual health concerns of males who have sex with males, it was agreed that support for this new network will be provided by the Centre, in terms of resources, facilitation, and advocacy. In the meantime the Regional Network of MSM Sexual Health Agencies was formed with the participating agencies being those present at the Meeting.

2. ■ ***Network newsletter***
 These discussions also reflected a need for a newsletter of the network. Participants explored the idea of developing Naz Ki Pukaar as a possible regional MSM newsletter, as it already exists as a forum to discuss MSM issues in the region. Naz Foundation International agreed to explore this issue with donors and its own Board of Trustees. An option also exists to create a new newsletter which the aforementioned Centre would develop and disseminate.

3. ■ ***Models of good practice***
 Participants from the range of MSM sexual health agencies shared ideas and the frameworks of their work. From these discussions a replicable model of good practice arose which reflected the work of the agencies. This model is based upon working to develop a community and then mobilise this community for collective action of promotion of safer sex behaviours amongst MSM and includes:
 - * developing field teams working in specific areas of a given locality and developing friendship networks
 - * developing a drop-in centre
 - * developing a range of vocational and skills building class
 - * providing a savings and loan club
 - * providing an STD service (this may be expanded to include HIV testing)
 - * providing psychosexual counselling as well as pre-test/post-test counselling
 - * developing employment and housing information services
 - * providing a helpline
 - * social marketing of condoms and lubricants
 and a range of others. Participants believed that the two briefing papers, "Actions for Life", and "Community Mobilising" encapsulated this model.

4. ■ ***Training and capacity building needs identified***
 Participants recognised the need for increased capacity building, and training programmes for emergent and/or new MSM sexual health projects. These training needs included:
 - * developing MSM-led risk and needs assessments
 - * developing outreach programmes for MSM
 - * project management
 - * financial management
 - * social marketing
 - * savings and loan clubs
 - * managing a sexual health centre
 - * safer sex promotion
 - * STIs/HIV/AIDS
 - * psychosexual counselling
 - * monitoring and evaluation
 - * impact assessments and baseline studies
 - * education materials and resource development
 - * writing project proposals and funding raising
 - * advocacy and human rights
 Participants requested free access to all the Naz Foundation International MSM training manuals as well as its MSM IEC materials in the differing South Asian languages.

5. ■ ***Appropriate strategies for sexual health promotion***
The discussion identified a range of strategies for sexual health promotion amongst males who have sex with males. These included:
- * recruitment of kothis as field workers and site friends
 - * friendship building amongst kothis, male sex workers, and their sexual partners as a community building strategy
 - * explicit education resource materials
 - * on-site social marketing of condoms and lubricants
 - * affordable access to appropriate condoms and lubricants
 - * anonymous referrals to appropriate STD clinics and HIV testing sites
 - * socialising frameworks in safe spaces
 - * development of social welfare services
 - * access to appropriate psychosexual counselling
6. ■ ***Research models working with MSM developed***
A fundamental principle adopted by the participants for developing research amongst MSM was the necessity for MSM involvement in design, implementation, analysis, and ownership of the research. This framework was whether the research was epidemiological, anthropological, or sociological. Participants felt that too often they have been used to collect information, and then used in ways that lead to increased stigmatisation and harassment, or they have not been informed as to what use the data has been put to. Unless MSM were involved directly in the research, participants agreed not to participate in further research. Protocols have to be developed to take into account these issues.
7. ■ ***Advocacy programme promoted***
Participants requested all the donors and guests present, as well as agency leaders and Naz Foundation International to actively promote the issues of sexual health for males who have sex, as well as addressing the human rights concerns that arise from them. This was agreed by all concerned.
8. ■ ***Consultation Meeting report circulated***
This report will be circulated, not only to the participants, donors, and guests at the Meeting, but also to all interested parties internationally.
9. ■ ***Institutional support***
UNAIDS India and the Indian National AIDS Control Organisation have agreed to the following:
- i. UNAIDS support for developing an MSM TRG in India affiliated to NACO with representatives of each of the MSM sexual health projects in India on board
 - ii. NACO investigating with a range of projects the issue of anal STIs amongst males and females
 - iii. donor support for epidemiological studies on anal STIs
 - iv. increased advocacy by donors of MSM and sexual health issues
10. ■ ***Regional development***
Naz Foundation International and Pakistan representatives to organise a national meeting in Pakistan under Male Reproductive Health for MSM in 1999,
- Further plans for subsequent meetings, both for networking and capacity building, will now be developed, as the network seeks donor support for its activities.

This was the first South Asia regional consultation meeting on the sexual health needs of males who have sex with males, bringing together a range of MSM sexual health projects that were community-based and beneficiary led.

Intensive discussions, sometimes controversial, sometimes argumentative, but always within a framework of cooperation and collaboration, participants believed that “a historic moment” had been achieved.

However, it was clear that whilst effective recommendations for actions had been developed, it should not stop there. Implementation of these recommendations must be assured.

It was agreed that all the MSM sexual health projects present at the meeting would work together with allies and friends to ensure that this was achieved through advocacy with donors, government institutions, and other agencies.

As one participant stated, “it is not only up to donors and government - we must play our role”.

Following this it was suggested that the next regional meeting should focus on developing skills and capacity building, and this request will be forwarded to donors.

If the South Asia region has any hope in halting the spread of HIV/AIDS in the future, it not only has to include strategies for working directly with males who have sex with males in an inclusive framework of mutual support and action, but it must also ensure that the energy, vitality, skills, and knowledge of males who have sex with males, whatever their gender/sexual identity is, are recognised, accepted, and incorporated into these strategies.

Rikh Basu of Praajak Development Society, Calcutta



A series of presentations were made each day by invited speakers. These were:

- Day One: Clifton Cortex, USAID
Philippe Girault, FHI/IMPACT, Cambodia
Gordon Alexander, India Country Representative, UNAIDS
- Day Two: Divya Sagar, Bharosa Project - MSM Youth Group
Sivananda Sharma, INP+ - Living with AIDS
Lalitha Kumaramangalam, Prakriti-Sahodaran - MSM and women
Dr. Joe O'Neil, Ryan White Fund, USA
- Day Three: Carol Jenkins, CARE-Bangladesh - Anal sex and STDs
Dr. Gregory Pappas, Office for International and Refugee Health, USA
Ms. Shailaja Chandra, Project Director, National AIDS Control Organisation, India

cultural performances ■

Each evening cultural performances were presented.

- Day One: Subodh Rathod, Wise Thoughts, UK
- Day Two: Rikh Basu, Praajak Development Society, Calcutta, India
- Day Three: Anisul Islam Hiru, Azizul Haque and Shahidul Islam Babu, Bandhu Social Welfare Society, Dhaka, Bangladesh

meeting timetable ■

Thursday, 4th March, 1999**Registration**

Welcome address: Deep Purkayastha
Project Director, Praajak Development Society
Lalitha Kumaramanglam
Executive Director, Sahodaran
Shivananda Khan
Executive Director, Naz Foundation International

Day One ■

Friday, 5th March, 1999**Setting The Context**

9.30am	10.30am	<p>Opening Session and Welcome Chair: Lalitha Kumaramanglam Prakriti - Sahodaran, Chennai</p> <p>Speakers Clifton Cortex, USAID Philippe Girault, FHI/IMPACT, Cambodia Gordon Alexander, India Country Representative, UNAIDS</p> <p>Theme of the day Lalitha Kumaramanglam</p>
10.30am	1.15pm	<p>Working Groups <i>setting the context</i></p>
1.15pm	2.30pm	LUNCH
2.30pm	4.30pm	<p>Working Groups <i>setting the context</i></p>
4.30pm	5.00pm	BREAK
5.00pm	6.00pm	<p>Plenary Session Chair: Shale Ahmed, Executive Director, Bandhu Social Welfare Society, Dhaka, Report back from Working Groups</p>
6.00pm	8.00pm	<p>Discussion Groups</p> <ol style="list-style-type: none"> 1.1 kothis, panthis, religion and sexualities 1.2 MSM and women's sexual health 1.3 MSM and STI/HIV services: testing, counselling and support 1.4 male genders and sexual identities 1.5 risk and needs assessments amongst MSM 1.6 MSM, government policies and human rights

Day Two ■

Saturday, 6th March, 1999 Developing The Agenda

9.30am	10.45am	<p>Plenary Session Chair: Deep Purkayastha Project Coordinator, Praahak Development Society, Calcutta</p> <p>Report back from Day One Discussion Groups Discussions</p> <p>Speakers Divya Sagar, Bharosa Project - Youth as MSM Sivananda Sarma, INP+ - Living with HIV/AIDS Lalitha Kumaramangalam, Prakriti-Sahodaran - Women and MSM Dr. Joe O'Neil, Ryan White Fund, USA</p> <p>Theme of the day Deep Purkayastha</p>
10.45am	1 .00pm	<p>Working Groups <i>developing the agenda</i></p>
1.00pm	2.30pm	LUNCH
2.30pm	4.30pm	<p>Working Groups <i>developing the agenda</i></p>
4.30pm	5.00pm	BREAK
5.00pm	6.00pm	<p>Plenary Session Chair: Dalip Daswani Report back from Working Groups</p>
6.00pm	8.00pm	<p>Discussion Groups</p> <ul style="list-style-type: none"> 2.1 MSM community mobilisation/empowerment strategies 2.2 MSM, marriage, family and children 2.3 MSM and living with HIV/AIDS 2.4 strategies for intervention amongst MSM 2.5 male sex workers and sexual health

Day Three ■ Sunday, 7th March, 1999
The Way Forward

9.30am	10.45am	<p>Plenary Session Arif Jafar Project Coordinator, Bharosa Project, Lucknow Report back from Day Two Discussion Groups Discussions</p> <p>Speakers Carol Jenkins, Care Bangladesh, Dhaka Dr. Gregory Pappas, Office of International and Refugee Health, US Government Ms Shailaja Chandra, Project Director, NACO</p> <p>Theme of the day Arif Jafar</p>
10.45am	1.00pm	<p>Working Groups <i>the way forward</i></p>
1.00pm	2.30pm	LUNCH
2.30pm	4.30pm	<p>Working Groups <i>the way forward</i></p>
4.30pm	5.00pm	BREAK
5.00pm	7.00pm	<p>Final Plenary Chair: Sunil Menon, Project Coordinator, Sahodaran, Chennai Feedback of recommendations to Plenary Feedback from Delegates on Consultation Meeting</p> <p>Closing speech Shivananda Khan. Naz Foundation International</p> <p>CLOSING CEREMONY Lalitha Kumaramangalam Deep Purkayastha</p>

ANNEXE 1

organising group ■	<p>Lalitha Kumaramangalm Prakriti - Sahodaran, Chennai</p> <p>Deep Purkayastha Praajak Development Society. Calcutta</p> <p>Shivananda Khan Naz Foundation, UK</p>																										
venue ■	The Park hotel, Calcutta, India																										
meeting date ■	4th - 7th March 1999																										
participant localities ■	<p>South Asia</p> <table border="0"> <tr><td>Bangladesh</td><td>9</td></tr> <tr><td>India</td><td>37</td></tr> <tr><td>Pakistan</td><td>2</td></tr> <tr><td>Sri Lanka</td><td>6</td></tr> </table> <p>South-East Asia Observers</p> <table border="0"> <tr><td>People's Republic of China</td><td>1</td></tr> <tr><td>Indonesia</td><td>1</td></tr> <tr><td>Malaysia</td><td>1</td></tr> <tr><td>Thailand</td><td>1</td></tr> <tr><td>Vietnam</td><td>1</td></tr> </table> <table border="0"> <tr><td>Resources Persons</td><td>6</td></tr> <tr><td>Guests</td><td>7</td></tr> <tr><td>Meeting staff</td><td>6</td></tr> <tr><td>Organising Group</td><td>3</td></tr> </table> <p>It should be noted that several invitees from Pakistan could not get their visas on time, whilst others felt to intimidated to attend such a meeting. Similarly, whilst several Nepalese delegates had been identified, they felt to exposed to attend the meeting.</p>	Bangladesh	9	India	37	Pakistan	2	Sri Lanka	6	People's Republic of China	1	Indonesia	1	Malaysia	1	Thailand	1	Vietnam	1	Resources Persons	6	Guests	7	Meeting staff	6	Organising Group	3
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Organising Group	3																										
speakers ■	<p>Gordon Alexander <i>Country Representative, India, UNAIDS</i></p> <p>Ms Shailaja Chandra <i>Project Director, NACO, India</i></p> <p>Clifton Cortez <i>USAID, USA</i></p> <p>Philippe Girault <i>Family Health International/Impact, Cambodia</i></p> <p>Carol Jenkins <i>CARE - Bangladesh</i></p> <p>Shivananda Khan <i>Naz Foundation International, UK</i></p> <p>Lalitha Kumaramangalam <i>Prakriti - Sahodaran, India</i></p> <p>Dr. Joe O'Neil <i>Ryan White Fund, USA</i></p> <p>Dr. Gregory Pappas <i>Office of International and Refugee Health, USA</i></p> <p>Divya Sagar <i>Bharosa Project, India</i></p> <p>Sivananda Sharma <i>INP+, India</i></p>																										

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Dalip Daswani
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 Arif Jafar
 Sunil Menon
 Deep Purkayastha
 Subodh Rathod
 Al Qamar Sangha

Discussion Groups

5th March, 1999

kothis, panthis, religion and sexualities

Deep Purkayastha

MSM, marriage, family and children

Shivendra Gurha

MSM and STD/HIV services

Carol Jenkins

male genders and sexual identities

Sunil Menon

risk and needs assessments amongst MSM

Arif Jafar

MSM, government policies, and human rights

Hisham bin Hussein

6th March, 1999

MSM and community mobilising/empowerment

Deep Purkayastha

MSM and women's sexual health

Lalitha Kumaramangalam

MSM and living with AIDS

Sivananda Sharma

strategies for intervention promoting sexual health

Arif Jafar

male sex workers and sexual health

Sunil Menon

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meeting documentation ■

- 1. Pre-Meeting Documentation**
 - i. Sexuality and sexual health in South Asia
Shivananda Khan
 - ii. Culture, sexualities and identities
Shivananda Khan
 - iii. Indian homosexualities
Jeremey Seabrook
 - iv. Not so gay life in Karachi - a native view
Badruddin Khan
 - v. The big crisis: avoiding marriage in India
P. Parivaraj
 - vi. Issues of concern: male to male sex
Shivananda Khan
 - vii. Sexual health workshops in Bangladesh and India for males who have sex with males
Shivananda Khan
- 2. Meeting Documentation**
 - i. Sexual Health
a WHO definiton
 - ii. Observations on male to male sex in Bangladesh
Shivananda Khan
 - iii. Under the blanket - bisexualities and AIDS in India
Shivananda Khan
 - iv. Through a window darkly - males selling sex to other males in India and Bangladesh
Shivananda Khan
 - v. Conversations on the frontline
Jeremey Seabrook
 - vi. Varieties of homosexuality in Bangladesh
Carol Jenkins
 - vii. A dialogue between two believers
Maarten Schild
 - viii. The politics of penetration
Shivananda Khan
 - ix. Indian law and the homosexual
Shrikant Bhat
 - x. Actions for life:looking at sexual health services for males who have sex with males
Shivananda Khan
 - xi. Community mobilising?
Shivananda Khan
 - xii. Recommended reading list from Naz Foundation International

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Actions for Life - looking at developing sexual health services for males who have sex with males

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Introduction

The challenge of HIV/AIDS confronts all countries and communities globally, and whilst the countries of Africa are confronted with increasing numbers that are dying from AIDS, the countries of South Asia (as well as other Asian countries) stand before the abyss of an uncontrollable epidemic. It is clear that Government, non-government, and community-based agencies, as well as many other institutions, must work together to face this challenge if there is to be any hope of effective strategies to control and manage HIV transmission so as to reduce the levels and rates of infection and thus AIDS.

There is no vaccine for HIV, and whilst there are a range of medical treatments available to prolong life and reduce the impact of HIV related illnesses, treatment costs are prohibitive, particularly so for developing countries.

At this juncture, as we approach the end of the 20th century and enter into a new millennium, it seems that the only real hope is to ensure that the countries of South Asia and beyond, develop an effective STD/HIV prevention strategy that addresses **all** risky behaviours and practices. No country can afford to ignore or deny what occurs within it, whether it is a particular risky sexual practice or a stigmatised identity that is deemed to be immoral, illegal, or supposedly against its culture. Such denial and stigmatisation creates ideal conditions for an increasingly rapid spread of HIV infections across the country.

Over the last few years, Naz Foundation International has conducted a series of sexual health risk and needs assessment amongst males who have sex with males in South Asia as part of a process of providing technical assistance to local sexual networks to develop their own sexual health service provision. In this work, issues that were explored included sex behaviours amongst males who have sex with males (including anal sex between males and also between males and females), their sexual health seeking behaviours, access to condoms and lubricants, socio-cultural constructions of sexual behaviours, sexual and gender identities, and appropriate (if any) sexual health service availability. Much of this work had to be done under a general framework of male sexual health, invisibilised and hidden, since male to male sex was clearly stigmatised and those involved victimised whenever such individuals and behaviours became part of the public arena.

It should be clearly recognised that because of denial, invisibility, stigmatisation and illegality (often under both religious and civil laws and codes), males who have sex with males already face considerable risks of harassment, violence, and perhaps imprisonment, if not death. HIV/AIDS creates another framework for further victimisation. It is therefore perceived to be incumbent upon all National AIDS Programmes and AIDS service organisations to explicitly work towards preventing stigmatisation and victimisation of males who have sex with males, as much as towards preventing STD/HIV infections amongst them as one of the central issues of concern. It would only be through such an approach that HIV/AIDS/STD prevention services can be increasingly more effective and more accessible by males who have sex with males.

It needs to be clearly recognised that whilst many in authority, both religious and secular, government and non-government, would prefer to promote sexual abstinence before marriage and faithfulness within marriage, that those who are involved in male to male sex should stop their behaviour, there will always be those for whom these are essentially public acts of obedience, whilst in private other more secretive behaviours often come into play.

The corollary to this is to fully accept that the only effective and appropriate HIV/

AIDS education and prevention strategy to ensure that the spread of STDS and HIV/AIDS was controlled would be to also promote safer sex behaviours amongst males who have sex with males. Such promotion to be successful would also need to ensure that appropriate and accessible sexual health services are available which also respect their confidentiality and anonymity and build upon their trust and respect.

This will require a clear understanding of the difference between religious values and beliefs, stated public opinions, socio-cultural values, and actual practice.

Such a pragmatic approach (despite all the issues that this might raise within the socio-cultural contexts of South Asian countries, and the other countries of Asia) would necessarily include a respect for human rights which would require governments, and other institutions and agencies, to develop cooperative, trustful, and working partnerships with representatives and peer leaders from male to male sexual networks, ensuring safety, security and confidentiality. It is only through such partnerships that males who have sex with males can be accessed and provided with appropriate information, advice, counselling, support towards behaviour change, and STD/HIV prevention and treatment services.

It also needs to be recognised that not all males who have sex with males are gay-identified, homosexual, or whatever label we may wish to give them. Patterns of male to male sex are complex, dynamic and fluid. There are many reasons as to why males have sex with males, and not all of them are to do with identity or desire.

At the same time it is also understood that not all males who have sex with males will access services provided by generic sexual health agencies for a range of reasons, no matter how sympathetic or understanding they may be. It is Naz Foundation International's contention that it would be more appropriate and effective if the beneficiaries of services were also the agents of change. This means that it would be necessary to support the development of peer-led community-based AIDS service organisations working with males who have sex with males.

This is about saving lives. Silence is not golden! It is about being honest and open and accepting. If we are truly involved in preventing the spread of HIV and AIDS in our countries, then it is time to look again, time to be truthful, time accept that people will do what they do irrespective of our own morality, judgements or beliefs.

Based on these concepts, understandings and principles the following recommendations have arisen from the work of Naz Foundation International.

1. ■ **Behavioural, epidemiological, and anthropological research**

If we are going to develop strategies for changing risky sexual practices towards safer practices, and in the context of there being a vaccine or cure against AIDS, maintaining such safer practices over a lifetime, then we need to understand actual sexual practices. But understanding sexual behaviour does not arise from what individuals actually do, or many times they do within a given period. It arises from placing such behaviours within a given socio-cultural context. What influences such behaviours. Why do people do what they do?

1.1 Their is a need for qualitative information on socio-sexual histories and behaviours amongst males who have sex with males, the impact of locality, economics, religion, and so on, on these behaviours. Such understanding within its socio-cultural context would enable effective strategies of persuasion to develop and evolve. This is an urgent priority.

1.2 This requires appropriate behavioural and anthropological research methodologies that include the subjects of such research both as subjects and as observers. Such inclusion will facilitate access as well as ensure that those being

studied are involved in managing the study and what happens to the results following such a study. For this to be achieved, academics and research institutions will need to develop different approaches to such research and understanding. Such research would of urgent necessity be action-based, leading to clear outputs towards reducing the spread of STDs/HIV/AIDS.

1.3 Such research should recognise the wide diversity of sexualities, male genders, identities, and sexual behaviours of the “target population”, which would include those whose primary sexual behaviours would be male to male, as well as those whose male to male sexual behaviours are intermittent, secondary and discharge based.

1.4 If individuals, male sexual networks, social groups, and “communities” involved in male to male sexual behaviours are to be empowered towards an increase in their health seeking behaviours, then more effective research needs to be done to identify as to who, how and why various sexual identities and genders are constructed, their specific meanings, and how they can determine desire and sexual behaviours.

1.5 Research should look at frameworks of support for males who have sex with males towards encouraging them to practice safer sex as a normative behaviour, levels of knowledge, understanding and acceptance by medical staff and social service agencies regarding males who have sex with males and their sexual practices, and what would work in promoting sexual health in the differing sexual frameworks and networks of males who have sex with males. For such research to be effective would require males who have sex with males to conduct such research themselves.

1.6 Areas of research amongst males who have sex with males should also include:

- 1.6.1 prison populations
- 1.6.2 military personnel
- 1.6.3 overseas and migrant workers
- 1.6.4 rural male populations
- 1.6.5 males in educational establishments
- 1.6.6 occupational groups
- 1.6.7 male sex workers in a variety of settings
- 1.6.8 males in refugee camps
- 1.6.9 male domestic servants
- 1.6.10 male street children
- 1.6.11 male factory workers
- 1.6.12 male child sex abuse
- 1.6.13 male rape
- 1.6.14 early male sexual activities
- 1.6.15 male suicides

1.7 In conducting any such research amongst males who have sex with males, several significant questions must always be asked by researchers:

- a. who is going to conduct the research
- b. how is it going to be conducted
- c. how is information going to be collected and by whom
- d. what questions are going to be asked, how are they asked, and in what language
- e. what terminology will be used
- f. how will the information be analysed and who will do the analysis and in what way will it be used
- g. how will the data be used in developing appropriate STD/HIV prevention and sexual health services
- h. who will develop such services and who will work in them

2. ■ Risk and needs assessments

What is the STD/HIV/AIDS situation in a given locality? What are the socio-cultural factors that can impede safer sex practices? What are the levels of STDs/HIV in a given area? Who is involved in risky practices?

2.1 Before strategies for change can be implemented, there is an urgent need to develop appropriate risk and needs assessments amongst males who have sex with males within different sexual networks, and amongst those expressing differing sexualities, identities, genders and behavioural frameworks. Such information is a pre-requisite for ensuring local participation and involvement in programme design and implementation. With local involvement in both management and conducting these risk and needs assessments, there is often a greater likelihood of ensuring the validity of data, an appropriate analysis of the data, and adequate protocols on confidentiality.

2.2 It is therefore important to ensure that adequate and sufficient funding is made available for these risk and needs assessments to be conducted.

2.3 At the same time such research must assure respondents that any data collected will not be used against them, that their confidentiality and anonymity will be respected, and that the information will only be used to develop appropriate strategies for the prevention of STD/HIV/AIDS amongst them with their support and assistance.

3. ■ Developing community-based AIDS service agencies

To be fully effective, prevention strategies must incorporate the means to stop the spread of HIV infection through whatever behaviour. However many of these issues are taboo, and to publicly discuss them creates issues of shame, fear, anger and hostility which will lead to resistance and denial.

Who has seen any public debate in the countries of South Asia about anal sex? In fact Naz Foundation International has substantial anecdotal information on changes of behaviour from vaginal sex to anal sex because there has been no debate on anal sex. These males have assumed that such a silence indicates no risk!

At the same it is recognised that in the South Asian context, providing prevention services that address anal sex as well as male to male sex behaviours can be extremely problematic in an environment of shame, stigma and violence. Who can you trust?

It is also recognised that non-government community-based agencies are often more effective in accessing stigmatised groups and behaviours and empowering behaviour change.

3.1 Community based agencies developed by males who have sex with males themselves need to be supported so they can provide such HIV prevention programmes without undue harassment or hindrance and within the rubric of "harm reduction" and "male sexual health". Individuals, networks and groups who are involved in differing frameworks of male to male sexual behaviours should be empowered to address these issues for themselves and develop their own sexual health service agencies.

3.2 Acknowledging the lack of technical skills in developing such community-based sexual health promotion agencies addressing male to male sexual behaviours, whether it be infrastructure, developing service delivery and implementation, project management, financial accountability, appropriate outreach strategies, monitoring and evaluation, resource design and development, needs assessments, or producing budgets and accounts, such emergent agencies should also be provided with technical assistance to access these skills through training and capacity building from appropriate consultants.

3.3 At the same time, all agencies providing family planning, HIV/AIDS prevention, STD treatment, and/or sexual health services, should also be providing services regarding anal sex behaviours, whether between males or between males and females. Anal sex is not a restricted behaviour to a few stigmatised individuals.

3.4 Further appropriate agencies need to be developed that work with prisons populations, juvenile homes, young offenders institutions, orphanages, the military, police, and migrant workers, around STD/HIV/AIDS and issues involving male to male sex.

3.5 National AIDS Control Programmes and State AIDS Cells should be directly involved with such community based agencies developed by males who have sex with males in ensuring effective distribution of appropriate sexual health products and educational resources (such as condoms, lubricants and literature) targeting male to male sexual behaviours. This will mean resourcing such agencies to provide such appropriate products and resources.

3.6 Different distribution strategies will need to be explored and developed by these community-based agencies, such as social marketing, free distribution as well as distribution in a wide variety of private and public locations. These differing strategies should be supported by Government and other non-government agencies.

3.7 Appropriate peer -led education initiatives should be actively encouraged and supported. Safe spaces will need to be developed where individuals and groups can gain access to confidential information as well as discuss issues around sexualities and sexual health within appropriate contexts.

3.8 Psycho-social support programmes will need to be a part of any ongoing sexual health programme for males who have sex with males. These could include telephone lines (“hotlines”) providing free and anonymous advice and information, social support groups, counselling, sexual health discussion groups, and other services deemed appropriate and needful by males who have sex with males themselves.

3.9 In terms of risky sexual practices, and because of the nature of the *kothi*¹ identity being based upon feminisation as a means to attract males and anal penetration where there are high levels of multiple partners and multiple acts of penetration, *kothis* represent an identified socio-identity network and an emerging community which is at particularly vulnerable and at risk of STD/HIV infections.

As a part of the sexual activities, *kothis* access many other males with differing identities and differing sexual behaviour frameworks.

Kothi networks should be supported through appropriate empowerment processes towards enabling them to develop their own sexual health promotion services amongst several sectors of males who have sex with males. For this to occur they would need institutional and government support because *kothis* represent publicly stigmatised behaviours and identities.

3.10 This would require effective relationships with local police to be developed in regard to the levels of harassment and blackmail that many *kothis* face in public spaces. Such working relationships with police would also be necessary to ensure that outreach and field workers from any agency themselves would not be harassed by either police or local people.

3.11 Other male to male sexual communities which would not access services provided by the *kothi* networks will also need to be developed. Such service development could be organised by the other emergent male to male sexual com-

munity, perhaps those who are gay-identified, with appropriate support and assistance.

3.12 Attitudes of doctors and other medical staff towards such stigmatised males and identities should be addressed through sensitisation programmes and appropriate regulations.

3.13 Issues of human rights abuse, freedom to receive information that will protect lives, advocacy for the right to services, will need to be effectively addressed.

3.14 Because so much male to male anal sex takes place outside “cruising” sites and external to *kothi/panthi* dynamics, other NGOs developing sexual health services will need to promote safer sex behaviours that include anal sex in their programmes of education and prevention. These would include rikshaw drivers, female sex workers, truck drivers, educational establishments, factory workers, overseas workers, prison populations, et al.

3.15 Government institutions and services will also have to address these issues through the provision of appropriate training and sensitisation.

3.16 Because of the religious, cultural, political and social issues that such intervention work may raise, it will be important to recognise that different, and possibly non-public, strategies may need to be developed for such interventions.

3.17 There should be regular consultation between such community-based AIDS service agencies and National AIDS Control Programme and its local affiliates to ensure that issues, needs and service development for males who have sex with males are always reflected in any National AIDS programmes and strategies.

3.18 Networking enables the sharing of appropriate skills, educational materials, knowledge and information which can enhance the capacity of an AIDS service agency. This should be actively encouraged and supported by Government through the provision of any necessary technical assistance so that these agencies addressing the needs of males who have sex with males can access and actively participate in local, regional, national and international forums dealing with similar issues of concern.

3.19 In order for such service development and sustained effectiveness, such community-based AIDS service organisations would need to be provided with long term funding which would include core costs as well as project costs and sustainability issues must be thoroughly explored with such AIDS service organisation to ensure programme continuity.

3.20 It is also important that all agencies providing HIV/AIDS education, prevention and support should be effectively monitored for the quality and appropriateness of their services and their accessibility in regard to males who have sex with males. Quality of service delivery in relation to male to male behaviours should be assured where public (and private) funding is being used, whether these services are being provided by males who have sex with males themselves, or by other agencies.

3.21 In order to ensure that these agencies can deliver a high quality of service, it is essential that appropriate skills training be offered to the policy makers of these agencies, their management boards, staff, and volunteers, on the sexual health needs of males who have sex with males. Such skills training should include issues on understanding the contexts of such behaviours, destigmatising, developing appropriate outreach programmes, community involvement, designing education and intervention strategies, needs assessments, project management, monitoring and evaluation, and educational resource development.

3.22 This will require a multi-sectoral approach including the provision of good quality sex education, easy access to appropriate and cheap sexual health products and information, accessible STD services that are appropriate to the needs of differing males who have sex with males, appropriate counselling and support, and development of support structures for those males who have sex with males living with HIV/AIDS.

4. ■ Education for prevention

Changing behaviour requires desire, will, skill and power. It also requires appropriate knowledge. In South Asian countries, sexual knowledge, accurate information about STDs and its treatment, correct understanding of HIV and AIDS is sorely lacking. There is an urgent need to address the high levels of incorrect beliefs about sex, sexual functioning, the male and female body, and all aspects of sexual behaviours. These beliefs are damaging and impede any effective development of STD/HIV prevention.

4.1 The lack of appropriate and accurate sex education should be urgently addressed and would require government action in order to provide an effective sex education programme which should be made available for both the formal and informal education sectors. Such education should be aimed at children, youth and parents, be available in educational establishments, hostels, male institutions, informal sectors, factories, et al.

4.2 Appropriate peer-led education initiatives should also be encouraged and supported and individuals and families should be able to access non-judgemental premarital counselling on all reproductive and sexual health issues.

4.3 Society as a whole should be mobilised in creating appropriate awareness of HIV/AIDS. It is essential for the whole community to work together to ensure that education and prevention strategies are effectively implemented to prevent the spread of HIV.

4.4 These education and prevention strategies could utilise a wide number of formats including posters, electronic and print media, leaflets, videos, audio-cassettes, cinema, theatre and so on, and involve political and religious leaders, doctors, veds and hakims, business and union leaders. But it is essential that they deal with all risky practices.

4.5 This will mean that all religious, political, medical, social, community, media, and business leaders be offered awareness and sensitisation programmes on HIV/AIDS and related issues in order to incorporate them into community education.

4.6 There is a need for specifically targeted resources to be developed that are aimed at differing social, economic and behavioural groups, including medical staff, family planning clinics, religious teachers, educational staff, factory workers, hotel staff, and so on.

4.7 This would also mean educating and updating all health and social care workers skills with regard to prevention, care, management, counselling and related issues on HIV/AIDS, including issues on anal sex and males who have sex with males.

4.8 At the same time there is an urgent need for a broad range of educational resources, reflecting the sexual practices of all males including those who have sex with other males, and these should be made available in appropriate format and distributed as widely as possible.

4.9 Males who have sex with males community-based agencies should be empowered to develop and deliver their own sexual health education resources appropriate to their needs that are explicit and direct.

4.10 Resources will also need to be developed that cater for those who are not literate, who are visually impaired and other marginalised and physically impaired groups. For example, in one city, a young male of 16 years, with a below normal mental age was being regularly sexually accessed for anal sex by other young males in his neighbourhood.

4.11 Further to this there should be educational campaigns that de-stigmatised the public discussion of sexual behaviours through multi-media efforts that involve government, non-government and business institutions and agencies. Unless we are willing to confront the issue of AIDS head-on, we can never hope to stop its spread.

4.12 When developing appropriate education resources, the following questions should always be asked:

- a. how appropriate is the framework of education?
- b. what language is it in?
- c. what words and images are used
- d. is it appropriate to the cultural frameworks and context of delivery?
- e. who controls the agenda
- f. who produces the information?
- g. who receives the information?
- h. who delivers the information?
- i. how is this information delivered?
- j. can we differentiate between culturally sensitive and culturally appropriate?
- k. do services exist to cater for expressed needs that such information may generate?
- l. who staffs these services
- m. what do they deliver?
how do they deliver services?
- n. how are appropriate are they?
- o. what skills do they have?
- p. what messages are being delivered?
don't do it
do it safely
- q. what is the objective?
to inform?
to change behaviour?
to reduce the rate of HIV transmission?
to halt the spread of HIV?
to increase reproductive health of women?
of men?
how will this be achieved?

It is only when these questions can answered satisfactorily should resources be developed.

5. ■ Sexual Health Products

There is no point providing knowledge to change behaviours towards safer sex practices unless the tools to achieve this are not also being provided.

5.1 Condom promotion is usually left to family planning clinics (which are primarily visited by women), some ad-hoc local government poster campaigns (which of course necessitates literacy), STD clinics (if you attend them), and a range of HIV agencies, either through free access or through social marketing principles.

5.2 There needs to be a more vigorous approach to condom promotion through on-going multi-media campaigns and by all sexual health services and HIV/AIDS agencies.

5.3 Such campaigns should address accessibility. Many young people, and

especially kothis will not go to a local shop, pharmacy, or some other outlet for condoms. Often many males do not think about condoms until a sex act is about to be done, and there are no condoms available at site. Taking condoms home is problematic with joint and extended families, and with lack of privacy and space.

5.4 Condoms should be available where they are needed. At the point where sex is being done, wherever that may be. Personal distribution networks should be explored and developed. Tea shops could be used. Food sellers in parks. On buses, trains, in toilets, wherever males congregate.

5.5 The nature of anal sex requires appropriate stronger condoms that are suitable. Less easily damaged, such condoms should be cheap and easily accessible, and should be made available to the general male public.

5.6 At the same time an urgently needed requirement for the promotion of safer sex is the easy and cheap availability of a suitable water-based lubricant in appropriate packaging that allows for a low market price and is easy to carry and use. Issues of distribution, availability and easy accessibility need to be addressed. Price and distribution would need to reflect accessibility for the poorest and the sexually active at locations where sexual activities take place.

5.7 As mentioned earlier, there is some evidence from anecdotal reports that there are some men who are practising anal sex (either with a female or a male) because they believe it will protect them from STDs/HIV. The reason for this is because they have heard no discussion about the risks of infection through anal sex. It is an urgent necessity to ensure that future campaigns on condom promotion also address condom usage for anal sex.

5.8 Based on experience in a range of workshops for males who have sex with males in South Asia, Naz Foundation International found that over 70 per cent of the participants did not know how to use a condom safely and correctly. Considerable education needs to be done on the correct use of condoms.

6. ■ **STD Services**

6.1 All STD medical staff should be trained in the issues surrounding anal sex behaviours, whether between males or between males and females, in regard to symptoms, treatment and counselling. Further abuse and harassment at such services by staff must be stopped. All staff should be sensitised to the needs of males who have sex with males, particularly those with stigmatised behaviours and identities. Confidentiality and anonymity must be available in accessing such services.

7. ■ **Women And Sexual Health**

The vast majority of males who have sex with males will be married or going to get married. The socio-cultural context of South Asia almost demands marriage of all males on reaching whatever appropriate age the parents of these males decide on. This means that the sexual behaviours of many males, whether they have sex with other males, or have sex with females outside of marriage, place their wives at considerable risk.

7.1 There is an urgent need to address issues of gender, empowerment of females, anal sex behaviours, and male sexual behaviours in any strategy for reducing STD/HIV rates, if women's sexual health is to greatly improved.

7.2 Appropriate strategies should be developed that address the sexual health issues of wives and other women that arise from the sexual behaviours of males who have sex with males, without a loss of confidentiality and trust.

7.3 Women's sexual health programmes should also address the issues of anal sex between males and females and also confront the issues of male to male sexual where they impact upon women's sexual health.

8. ■ Psycho-sexual counselling

8.1 Trained personnel providing psycho-sexual counselling should be available, perhaps through the establishment of Male Sexual Health Centres, which can offer non-judgmental, appropriate and accurate advice, information and support to males who have sex with males.

9. ■ The Role of National AIDS Programmes

9.1 National AIDS Programmes (NAPs) should be playing a lead role in encouraging, and enabling the development of peer-led community-based AIDS service organisations by investing in, and empowering them, to deliver appropriate STD/HIV prevention and sexual health services for males who have sex with males.

9.2 Such an investment should be in the form of:

9.2.1 provision of long term financial support

9.2.2 provision of, or unhindered access to, technical assistance and financial support

9.2.3 access to appropriate capacity-building training

9.2.4 addressing legal and regulatory constraints which may hinder the development of such peer-led community-based agencies

9.3 In order for this to occur, NAPs, State agencies, and other agencies will need to ensure that they can gain the trust and confidence of males who have sex with males by ensuring confidentiality, safety, security, anonymity and support for developing their own sexual health services.

9.4 Recognising that not all males who have sex with males will be accessible to generic sexual health services, whether provided by government or community-based agencies, nor to peer-led services, NAPs will also need to develop appropriate frameworks for a national programme on sexual health education amongst the general public that takes into account the sexual behaviours of males who have sex with males, as well as anal sex.

9.5 NAPs should provide training and awareness programmes to government and non-government agencies providing sexual health services on the social and sexual health needs of males who have sex with males in order to address the lack of knowledge and understanding. Such programmes should provide unbiased information and sensitisation, as well as destigmatise the issue.

9.6 Where laws, regulations and policies hinder males who have sex with males to access sexual health services and health information, or discriminate against them through intimidation, fear, harassment, violence, denial, or the risk of imprisonment, then these should be amended or repealed to empower such males to access appropriate services. This should include the:

9.6.1 Repeal of the specific section in the Penal Code on “carnal intercourse” as a step towards increasing the confidence of males who have sex with males to access legal, judicial and sexual health services.

9.6.2 Training of police and the judiciary on issues regarding males who have sex with males and related sexual health concerns.

9.6.3 Development and/or support of advocacy programmes for males who have sex with males to ensure the human rights of individuals are being respected, and that those who are harassed or violently abused can seek legal redress.

9.7 NAPs should include in any advisory and/or technical committee appropriate representatives from non-governmental agencies and community-based agencies delivering sexual health services specifically working with males who have sex with males.

9.8 NAPs should also develop national education strategies for the general

population against discriminatory attitudes towards HIV/AIDS and sexual behaviours as well as to de-stigmatise male to male sexual behaviours through the use of mass-media and educational forums.

9.9 All sexual health programmes should include relevant and appropriate information on male to male sexual behaviours and anal sex issues, and should also involve schools, colleges and universities, families, business, the military and prisons.

9.10 NAPs and associated agencies need to ensure that appropriate condoms suitable for anal sex and suitably packaged water-based lubricants are readily available and accessible to males who have sex with males, ensuring good quality, affordable prices and adequate distribution in a variety of locations. Such distribution should also include appropriate educational materials in the correct usage of such products.

9.11 NAPs should also ensure that all STD treatment service staff, private or government, as well as all sexual health services provided by government and non-government agencies receive appropriate training on ALL frameworks of sexual behaviours which must include anal sex as a practice, both between males and between males and females, towards improving the quality, accessibility, and delivery of these services to all sections of society.

9.12 Such training should also include the sensitising of health staff regarding the needs of individuals and families in regard to possible infections through anal sex, and that the quality of service delivery regarding this issue should be regularly investigated to ensure that all individuals can access sympathetic and high quality services.

9.13 There should be effective collaboration between the National AIDS Programmes, community-based agencies, and international agencies such as UNAIDS, UNDP, UNICEF, UNHCR and others, towards implementation of agreed policies, recommendations and guidelines, locally adapted, to address concerns of human rights abuse and service development for males who have sex with males, accessibility to these services, and to reduce discrimination.

Naz Foundation International believes that if these recommendations become a part of all government and non-government response to HIV/AIDS then effective preventive bridges can be built across the AIDS abyss that confronts the South Asia region and elsewhere. We cannot wait till there is an appropriate vaccine and/or cure for AIDS. People are becoming infected every day. And in the process more and more people will die because we are unable or unwilling to confront the challenge of AIDS. It is time to "break the silence" and speak out, to do and to act.

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1. Kothi

In the South Asian context of male to male sex the term kothi is used both as a sexual and gender identity. Primarily it signifies a male who is effeminate and sexual penetrated by other males. The term is part of what is known as kothi language, a secret language used by kothis and not understood by the general public.

This doesn't mean that kothis do not penetrate other males, but to do so is considered shameful by themselves.

Kothis are very sexual active and will often have several partners in one night. Research amongst them indicates low condom usage, and extremely high risks regarding STD/HIV infection.

Kothis call their penetrating partners, panthis or giriya (meaning a real man), and these panthis (who do not label themselves as such) can be accessed through desire for sex with male or through discharge needs.

Kothis socialise with each other in specific public sites and environments, and can recognise each other in social spaces through language, both verbal and physical.

The actual terminology may vary across South Asia, but the kothi language appears to spread across the whole sub-continent with few variations.

Another gender group are hijras who are males who cross-dress and are supposed to be castrated for a range of religious-cultural reasons. But not all hijras are castrated. Hijras are not kothis, but some kothis may eventually become hijras.

Neither kothis or hijras should be confused with gay - identified men, or as transvestites or transsexuals. It is not an issue of "wanting to be a woman" for kothis, but using effeminacy to attract males in a society which is highly gender segregated, and based upon gender hierarchy.

Community Mobilisation

1. ■ **Purpose**
To reduce the risks of STD/HIV infections amongst males who have sex with males.
2. ■ **Goal**
To enable males who have sex with males to practice safer sex as a normative behaviour, increase use of appropriate STD treatment services and reduce levels of STDs.
3. ■ **Belief**
It is understood that safer sex practices amongst males who have sex with males can only be encouraged and maintained over the “long haul” if such practices become a normative behaviour amongst males who have sex with males. To achieve this goal, it therefore requires such safer sex practices to be adopted as a community behaviour, which requires the whole community to be involved in promoting and adopting such practices. However, this presupposes that an MSM community exists as a cohesive force. This is not a valid assumption in South Asia, where no such community (ies) exist.

There is therefore an urgent need to understand the psycho-social-sexual constructions of male to male sexual behaviours, their frameworks within South Asian cultures, and their particular socio-sexual dynamics. From such an understanding appropriate strategies can be developed towards utilising shared characteristics as a form of “psychological community” as a means of mobilising shared actions.
4. ■ **Behavioural Summary**
In South Asia, the vast majority of males who have sex with males fall within a range of behavioural dynamics. These are:
 - a. kothis
males who feminise their behaviours (usually in specific situations/context) and who state that they prefer to be sexually penetrated anally or orally
note: for a kothi to take on the role of penetrator is seen as shameful and where this occurs is kept secret
most male sex workers are self-defined as kothis, but not all kothis are sex workers
 - b. panthis
a term given to males who sexually penetrate kothis by kothis themselves
the vast majority of “panthis” do not label themselves as such
 - c. do-parathas
those who practice sexual behaviour mutuality
another term given to such males by kothis, where such males are not respected as such by either kothis or panthis
 - d. others who may practice male to male sex as
 - i. a regular part of their sexual repertoire
 - ii. non-access to females
 - iii. all male institutions
 - iv. “hotness”
 - v. opportunistic discharge
 - vi. desire
 - vii. curiosity
 Most of these males are considered gopon/gupti or secret
 - e. gay identified males
in the main small, English speaking, educated male networks

Whilst kothis may participate in a number of overlapping social/friendship networks, these tend to be small and site-based, rather than within frameworks of “community”.

Panthis and others as such are involved in different social networks that are to do with non-sexual friendship networks, ruralised frameworks, employment affiliation and so on. These tend to be neighbourhood based.

In other words, for males who have sex with males in South Asia, communities based around sexual behaviour and/or sexual identity as a primary focus does not exist.

To attempt to use the model of community mobilisation as a methodology towards empowerment and development of safer sex as a normative behaviour within an imagined community requires the construction and development of a community. This means defining what community means, and how affiliations to a community are developed, nurtured and explored.

What sort of community is needed then? On what basis is this imagined community emerging? Can such a community develop? What do people share in such a community?

In the male to male sexual environments in South Asia as has been pointed out before, the only emergent groupings that sexual health projects targeting male to male sexual behaviours can currently work with in developing such a community are the kothis. However, kothis do not form a community.

In South Asia, kothis are usually within small social/friendship personal networks, based upon sites and sexualised localities. Networks can overlap, with members within one network, also belonging to another network (s).

Kothis are stigmatised as feminised and penetrated males. They are perceived as not-women and not-men. In many ways the kothi is gendered as not-woman/not-man. Such characteristics enable kothis to recognise themselves as a “gender” apart, and to also recognise each other with shared characteristics of desire, behaviour and sexuality.

Since the primary community frameworks and social identities within South Asia revolve around family (the joint and extended family system), rural origins, i.e. shared village experiences, locational (where you live), work affiliations (truck-driver, rikshaw driver, student, etc.), marriage and children, making shared behaviour characteristic a basis for community building becomes a major initiative and a challenge to the social basis.

Kothis are the most vulnerable in terms of male to male sex. Multiple penetrations in a day, multiple partners, extremely low condom usage by their penetrating partners, low levels of knowledge, extremely low access to STD treatment services, high levels of anal bleeding, and no lubricant use (apart from saliva - perhaps). Apart from these, the majority of khotis, like their penetrating partners, will choose to marry and have children due to social necessity.

In terms of community development, khotis represent the most effective opportunity. Their sexual choices enable them to access panthis from different socio-occupational communities, as well as a cross-section of society. They are already, for the most, embedded within behavioural and identity social frameworks, and their shared characteristics can be the basis for community building.

For the penetrating male, the most obvious route towards behaviour change would be to work through occupational and neighbourhood strategies. This means to ensure that those NGOs working with community/occupational based methodologies to promote safe sex must include anal sex within their discussions, whether they be working with truck drivers, rikshaw drivers, adolescents, schools, colleges, slums, low income groups, or whatever.

5. ■ Process

What makes a community?

Recognising the strengths of community affiliations as they exist, this requires ensuring that khotis as a behavioural group/network are specifically targeted to draw them into an emergent community where affiliation is based upon behavioural and emotional characteristics as well as on personal friendships

In this sense Naz Foundation promotes its partner agencies to work with kothi networks, expanding these networks, and networking amongst networks towards encouraging an emergent community.

Recognising social, cultural and religious realities in South Asia, enabling community development amongst khotis may be seen as very problematic and unobtainable in the foreseeable future. However, mobilising networks, encouraging network development, and networking of networks is feasible under current social realities and is being used first entry points into networks.

Our partner agencies working on sexual health promotion amongst males who have sex with males are developing a series of mechanisms to enable such mobilising of networks and towards building an emergent community amongst khotis with all the characteristics of a community, which are:

- affiliation to a shared consensus
- solidarity as a “community”
- mutual support mechanisms
- social support services
- shared ideologies and social characters
- socialising frameworks
- mutual concerns
- shared needs
- shared rituals

These agencies thus manage a Kothi sexual health promotion project (under the term male reproductive and sexual health programme as a screening device in conservative societies). However, the sexual partners of khotis and male sex workers are also being drawn into these service framework through contacts established by khotis and through collaboration with other sexual health promotion agencies and services.

Our partner agencies who specifically work with male to male sex ensure that all Board members, staff and volunteers are drawn from localised kothi social networks.

In this situation, community is not defined by some geographical space or locality, but rather as a sensibility, a psychological realm of shared concerns, sexual behaviours, needs, histories and desires.

6. ■ Development

The following briefly outline the components being used towards developing a sense of community affiliation, of mobilising networks, and networking of networks creating frameworks in which condom usage and STD treatment can be promoted as normative behaviours.

6.1 Outreach/Networking

Using field workers drawn from these kothi networks to be site specific -based developing friendships in that specific site that can be extended beyond the sites through shared characteristics, socialising, support and enabling access to service provision.

Using site-based key informants (although the term informant is problematic, and we would rather use the term “site-buddies”) who can provide supportive frameworks to the field worker with their knowledge and insight into specific sites and

provide continuity within a site when the field worker is not present.

6.2 Socialising meetings

A range of of-site social groups developed, each facilitated by a Field Worker, drawing upon his own personal, social and field work networks. These groups can act as a space within which personal friendships and bonding can be developed, experiences shared, and common purposes evolve.

6.3 Personal skills development

A range of educational classes offered including literacy, social skills, life skills, health seeking knowledge, vocational skills, income generation skills, and so on.

6.4 Employment and accommodation networks

Using kothi networks to identify employment opportunities and vacant accommodation, as well as emergency housing.

6.5 Savings and Loans Club

Using the Grammen Bank model, encouraging small scale savings and loans amongst the kothi networks.

6.6 Advocacy

Police and maastan harassment are common factors amongst khotis who use public environments as social spaces, for sexual encounters and to sell sex. By developing legal aid services, challenging human rights abuses, and providing counselling and support, a framework of service use and access can be developed which can be seen as a "community service", encouraging affiliation to an "emergent sexual community".

6.7 STD treatment services

Extremely problematic in main stream services because of the stigmatisation of behaviours, khotis have extremely few choices to access appropriate treatment services, particularly around anal sex behaviours. Kothi services providing such appropriate STD treatment services, either as syndromic management, or through direct testing, ensures that khotis will be treated sympathetically, with respect and consideration, and access correct information and treatment.

6.8 Condoms and lubricants

Many khotis feel very ashamed to access condoms in regular outlets (particularly if they are young and unmarried), nor do they access family planning clinics. Further South Asia does not have appropriate condoms for anal sex, nor any appropriately and cheaply packaged lubricant. Provision of condoms and lubricants in ways that are affordable and easily accessible through site distribution can increase condom usage.

6.9 Needs assessments

Regular surveys of service users, site surveys, and focus group discussions, ensures that assessments are conducted regularly as to how needs are being defined by the khotis. These needs can be felt needs, expressed needs and/or projected needs. These discussions and surveys built up consensus on shared needs, which can also be used towards building a sense of community. Such needs do not necessarily directly relate to STD/HIV/AIDS. However addressing such needs can build a sensing of shared concerns which can be developed as a community sensibility.

Such needs can be:

6.9.1 Social needs

- education
- employment
- economic development
- human rights
- family, marriage and children

vocational skills
socialising spaces

6.9.2 Personal and emotional needs

sexual abuse and violence
counselling
personal hygiene
friendship
identity and desire
emotional support
empowerment
personal skills development
personal health issues

6.9.3 Sexual health needs

appropriate condoms
appropriate lubricant
sexual spaces and privacy
access to appropriate treatment
psychosexual issues
counselling
knowledge
empowerment
negotiating skills

6.10 Responding to needs

It is essential that the service provision should build upon these needs and find appropriate ways to ensure that these needs are being adequately and appropriately addressed.

Thus, for example:

- 6.10.1 a health service that can look at non-sexual issues and provide appropriate treatment and care, i.e. chest infections, TB, and other potential illnesses
- 6.10.2 an employment agency/network
- 6.10.3 vocational skills development including reading and writing
- 6.10.4 an emergency housing network
- 6.10.5 address poverty issues, such as subsidised medicine and treatment, and access to low interest credit and small savings
- 6.10.6 socialising spaces that allow non-sexual friendships to be developed amongst khotis and non-kothi identified MSM
- 6.10.7 access to legal aid
- 6.10.8 addressing discriminatory laws and regulations
- 6.10.9 addressing police and maastan harassment
- 6.10.10 a sexual health service that is appropriate and sympathetic and easily accessible
- 6.10.11 a non-judgmental service provision irrespective of class, economic group, work affiliation, sexual behaviour/desire and feminisation
- 6.10.12 development of socialising rituals for community bonding, such as dance, music, prayer, songs, food rituals, etc.

The frameworks of all these actions is to create a psychological community that transcends family, locality, origin (where rural or urban), class, economic group, work affiliation. It is a psychological community with shared concerns and needs. It is utilising networks to network and build a community (ies).

7. ■ Summary

- 7.1 In South Asia there is no community amongst males who have sex with males, and those who practice male to male sex
- 7.2 Khotis, however, do have a shared sense of identity and behaviour
- 7.3 Khotis are self-defined males who feminise their behaviour and are sexu

- ally penetrated.
- 7.4 There is a proviso to this, in that this is a performed and public identity. Khotis may penetrate other males, and/or have sex with other khotis, but this is perceived by khotis to be bad. Hence such behaviour is kept secret from other khotis.
 - 7.5 However kothi should not only be seen as a sexual identity, but also as a gender term in the South Asian culture
 - 7.6 Khotis are mainly within social/sexual networks, which are spread around in a range of public sites.
 - 7.7 These sites are used for socialising as well as for sex with panthis
 - 7.8 To enable a development of a sense of community identity is to use these networks towards creating a psychological community.
 - 7.9 Using socialising and community development process, such a community sensibility can be evoked
 - 7.10 In evoking this community, sexual health promotion can be configured towards community normalisation.