NAZ FOUNDATION INTERNATIONAL
promoting sexual health in south asia

Bharosa
an STD/HIV/AIDS and sexual health society

Mithrudu
an HIV/AIDS and sexual health agency

helping others to help themselves

an NFI partners consultation meeting

FINAL REPORT

7th - 10th December 2000
Hyderabad, India

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Helping Others To Help Themselves
a Naz Foundation International Partners Consultation Meeting
7th - 10th December 2000
Hyderabad, India

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Shivananda Khan
Naz Foundation International

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

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

Over the last four years, Naz Foundation International has been providing technical, financial and institutional support primarily to kothi-based networks of MSM in a range of cities in South Asia. The intention of such assistance is to empower these local networks to develop their own independent peer-led sexual health services.

These services and projects are working among MSM, primarily kothis and their partners, providing a range of services such as education and prevention, syndromic management of STIs, social support and community building, drop-ins, and empowerment programmes such as literacy class, income generation and such like.

Framework of the Partner Projects
Goal
To address the lack of appropriate provisions of HIV/AIDS and sexual health services to meet the specific needs of marginalised and low income males who have sex with males through the development of appropriate outreach, prevention and treatment support services in ....

Objective
To develop and provide an appropriate and accessible sexual health promotion services and products and their use promoted amongst marginalised males who have sex with other males and who may be at risk from STI/HIV in....

Following on from the successful regional consultation meeting on male reproductive and sexual health and HIV/AIDS in South Asia for MSM held in Calcutta between 4th - 7th March 1999, this meeting was held to consolidate the achievements of the previous meeting, as well as to firmly establish the network of MSM sexual health agencies that Naz Foundation International supports and provides assistance to.

While the previous meeting explored issues and needs from which a series of recommendations were made, this meeting looked at skills building and information sharing between organisations, as well as building the network. Six new partner agencies developed during the intervening period were also participating.

This meeting was funded by the Royal Netherlands Embassy, New Delhi and Naz Foundation International.

The Partners' Network
Praajak Development Society, Calcutta
Pratyay, Calcutta
Maitraya, Calcutta
Bharosa, Lucknow
Naz India MSM Project, New Delhi
DART, New Delhi
Sahodaran, Chennai
Visak-Sahodaran, Visak
Shramaa, Cochin
Mithrudu, Hyderabad
Jagruthi-Gelaya, Bangalore
Gelaya, Mysore
Sneghedhan, Pondicherry
Bandhu Social Welfare Society, Bangladesh (Chittagong, Dhaka and Sylhet)
Vision MSM Project, Pakistan

EXECUTIVE SUMMARY

Following on from the discussions held in Calcutta, India between 4th - 7th March 1999 in the regional consultation meeting for MSM sexual health projects, this consultation meeting provided a resource rich environment on skills building and information sharing for the emergent network of those MSM agencies which Naz Foundation International has assisted in development and service delivery.

The meeting was organised by Mithrudu (Hyderabad), Bharosa (Lucknow) and Naz Foundation International. 122 participants were brought together from the NFI partner agencies network, and included observers from USAID (Washington, USA, New Delhi, India and Dhaka, Bangladesh), DFID India, FHI India and Indonesia, PSI Pakistan and Myanmar, and NIH, USA. Presentations were also made by Lalitha Kumaramangalam of Prakriti-Sahodaran, Rajesh Jha of EPOS India, Carol Jenkins of NIH USA, reflecting network concerns and future network projects on micro-credit schemes, behavioural surveillance, women partners of MSM, and a new form of lubricant which will be promoted through Mithrudu.

While the conference language was English, translations were provided through individual project support for Bangla, Hindi, Kannada, Tamil and Telegu.

All workshop and discussion group facilitators were drawn from the network itself, based on the principle of maximising use of internal resources.

Objectives

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 practice 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 provide skills building workshops in a number of areas of service delivery and so enhance the capacity of individual projects.
4. to explore human rights concerns regarding males who have sex with males and develop appropriate mechanism to address these concerns.
5. to look at training needs specifically addressing issues concerning sexual health needs for males who have sex with males and the development of appropriate sexual health services.

Workshops and Discussions

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

Workshops

* fieldwork methodologies
* community mobilising strategies
* social marketing of condoms
* developing BCC materials
* living with HIV/AIDS - care and support
* counselling
* female partners of MSM
* monitoring and evaluation
* writing a project proposal

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

Discussion Groups

* building networks/sharing resources
* kothis, gay men and other MSM - gender and/or sexual identities
* gay rights or sexual health rights - advocacy and human rights
* 6th International Conference on AIDS in Asia and the Pacific
* masculinities, sexualities and MSM HIV/AIDS interventions - a research need
* religion and MSM

Specialised presentations were also given during the morning plenaries by experts drawn from the NFI

technical advisory network. These were:

* MSM and Issues of concern - female partners of MSM
  Lalitha Kumaramangalam, Executive Director, Prakriti-Sahodaran
* Developing a micro-credit scheme for the NFI partners network - a project under development
  Rajesh Jha, Vice-President, EPOS India
* Behavioural Surveillance in Bangladesh - An MSM focus
  the Bandhu Social Welfare Society intervention in Dhaka City making a difference
  Dr. Carol Jenkins, NIH USA
* A new water-based lubricant -insertion-based technology
  Seema Pharmaceuticals, Mumbai

Conference Recommendations

1. Regular partner consultation meetings should be held every two years in different cities in South Asia. This networking process should also include support for localised networking meetings at state and national levels.
2. NFI to facilitate sharing and exchange of information and skills and develop an MSM trainers and consultancy network across the region.
3. NFI to pursue development of linked web pages for the internet for the partners network.
4. Increased support for advocacy for repeal for Section 377, and development of appropriate resources for local human rights initiatives and support.
5. NFI training manuals and other resources translated/developed in vernacular languages. They should include:
   * field services manual
   * community building strategies manual
   * social marketing
   * designing BCC materials
   * care and support
   * counselling
   * monitoring and evaluation
   * developing project proposals
   * financial management
   * management and administrative systems
6. More capacity-building training programmes developed for the projects on:
   psycho-sexual issues
   counselling
   care and support
   monitoring and evaluation
   financial management
7. Protocols and guidelines developed for the network on:
   * telephone counselling
   * counselling on
     - HIV/AIDS and testing
     - sexualities and genders
     - marriage and children
     - psycho-sexual issues
     - religious beliefs and MSM
8. Standardised monitoring and evaluation system with clear Process and Outcome indicators for use by all the partner projects, both in manual and computerised format.
9. Support BCC resource development in all the vernacular languages.
10. Sustained capacity-building programme for all the partner projects bringing in other expertise and technical skills.
11. Access to water-based lubricant sachets urgently developed and distributed.
12. research issues clarified and research programmes developed utilising the network
    - religious issues and MSM
    - STI/HIV prevalence among MSM
    - MSM behavioural prevalence in South Asia
    - definitive anal STI treatment protocols and algorithm
    - masculinities, sexualities, genders and MSM in South Asia
13. MSM reference library developed accessible to network.
14. Increased financial support for MSM sexual health projects advocated from NACO and other donors.

15. Develop working relationships with gay organisations towards advocacy and technical support.
16. Extend the network beyond South Asia to include South-East Asian initiatives.
17. Obtain funding to support sponsorship for each project in the partners network to send one representative to the 6th ICAAP Melbourne Conference in October 2001 and develop a shared booth space at the conference for the network partners to display their individual resources

Outcomes

* Information and skills shared between the different projects
* Increased networking amongst existent and new projects
* South Asia MSM AIDS Network (SAMAN) strengthened
* A commitment to share resources and advocate on each other's behalf
* A strengthened commitment towards a high quality standard of service delivery
* Skills building achieved on specific work-related issues
* Further training and capacity building needs identified
* Increased donor support for current individual projects, projects to be developed, and for the network
* A commitment to hold such meetings every two years, depending upon donor support

Concluding Statement

This was the first Naz Foundation International Partners Network Meeting following the Calcutta Conference on male reproductive and sexual health consultation meeting in March 1999.

The Partners Meeting brought together old friends and newly developed projects, providing a safe space to discuss issues of concern, share information, skills and knowledge, and highlight training, resources and knowledge needs.

With over 17 projects represented, a range of technical experts from the NFI's technical advisory network, donors and supportive guests, the range of issues covered were substantive.

Participants believed that "this conference continued from the historic moment that Calcutta represented, where the kothi voiced was heard loud and clear"...that "the conference was empowering moment for me.. we are not alone"... and ".. together we have strength..."

The conference also highlighted the range of work that is being requested of Naz Foundation International to support individual projects as well as developing the network and its information sharing capacities, resources and products.

Once again access to water-based lubricant was urgently highlighted, and the Conference urged NFI to develop such a product that was cheap, easily available and user friendly. While a new product was displayed at the meeting, an anal insertion lubricant based on suppository technology, conference participants wanted a range of options. As no water-based lubricant sachet was available in South Asia, NFI was strongly urged to advocate on this need.

Similarly, NFI was also urged to develop a range of training manuals, protocols, resource booklets and guidelines for the network projects, which have been highlighted in the recommendations.

At the same time, conference participants believed that such networking meetings made a significant contribution to the individual project's capacity, as well as providing an opportunity for exchange, community building and mobilising across the whole region.

For Naz Foundation International, this was both a challenging and a confirming conference, bringing together all is current partners to develop and advise NFI on its work, both current and future, and participants hoped that donors would recognise the needs expressed at the conference, and in this report, and support NFI and individual projects towards fulfilling those identified and expressed needs.

Naz Foundation International and its partners would like to thank the Royal Netherlands Embassy in New Delhi for its faith, commitment and support to enable this Conference to take place.

INTRODUCTION

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

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Sneghedhan, Pondicherry
Bandhu Social Welfare Society, Bangladesh (Chittagong, Dhaka and Sylhet)
Vision MSM Project, Pakistan

In March 1999, a South Asia regional meeting of MSM sexual health projects was held in Calcutta, India. Organised by Naz Foundation International, Sahodaran (Chennai) and Praajak (Calcutta), it brought together some 85 representatives from a range of MSM projects across the South Asia region. Most of these projects had been developed by Naz Foundation International as independent agencies.

From these discussions and with the growing number of partner agencies, it was decided that NFI would co-host a regional partners consultation meeting and training workshop to link with World AIDS Week in December 2000. This Consultation Meeting would be co-hosted by Bharosa and Mithrudu.

SCOPE AND PURPOSE OF THE MEETING

The Conference will bring together representatives from all the Naz Foundation International partner agencies working in the field of males who have sex with males and sexual health issues, as well as provide access to a number of technical experts on the issues of concern. A number of one day workshops will be held during the meeting to provide capacity and skills building so as to enhance the individual projects service capacity. Representatives from NACO and a range of donor agencies will also be invited.

OBJECTIVES OF THE MEETING

1. to discuss and develop appropriate strategies to address the sexual health needs of males who have sex with males and their sexual partners in 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 identification.
3. to provide skills building workshops in a number of areas of service delivery and so enhance the capacity of individual projects.
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METHODOLOGY

Workshops and discussions groups

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Workshops

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  Seema Pharmaceuticals, Mumbai

WORKSHOPS

Each one day workshop was repeated with a different group of people. The notes below reflect a combined summary of the discussions.

1. Field work methodologies

Facilitator: Shale Ahmed, Executive Director, Bandhu Social Welfare Society, Dhaka, Bangladesh
Reporters: Ali Firat, Director, Naz Germany, Berlin, Germany
Shaleen Rakesh, MSM Programme Coordinator, Naz Foundation India Trust, New Delhi, India

This workshop explored possible approaches to outreach and prevention in public environments among kothis, panthis, sex workers and clients.

Questions: What are the goals and objectives of fieldwork?
What are the most effective methodologies to achieve these goals?

Primary goals defined as:
1. to promote safer sex and condom use
2. reduce risks for STI/HIV transmission amongst MSM and their partners

Questions: How is the project defining MSM in the context of fieldwork?
How would the project reach them?

Strategy: to use existent networks at these sites towards building a sense of community

Purpose: to utilise peer pressure to change behaviours and sustain that change

Questions: Does giving only condoms and leaflets change behaviour?
What does change behaviour and sustain that change without further input?

Methodologies:
- community building and mobilising
- providing education and awareness
- promoting condom use for:
  - safer sex
  - cleanliness
- building MSM networks and networking of networks
- referrals to appropriate services
- field counselling on:
  - condom use and safer sex
  - eroticising non-penetrative sex
  - STDs and HIV/AIDS
  - pre-test counselling
  - psychosexual counselling
  - personal issues
- promoting behaviour change:
  - sexual
  - social
  - partner reduction

Primary importance:
- befriending and socialising
- developing friendship and support
- building self-esteem

Outreach Activities then consist of:
* accessing individuals across the whole site, not only kothis, panthis, and male sex workers and their clients, but also the local shops, stall, other individuals at a site
* forming friendships across the site
* providing information, advice and appropriate BCC resources
* providing emotional and practical support wherever possible and as such needs arise
* identifying issues and problems that affect individuals and networks across a site
* referring individuals to specific Centre-base services
* monitoring sexual practices and choices at a site
* providing data to the Centre
* being there ......

Field work is a key part of a broader strategy that incorporates the provision of safe spaces for group meetings and clinical support for treatment of STDs, as well as general health questions. Appropriate information resources would be necessary that is both entertaining and factual, as well as meaningful to MSM and relevant to their behavioural choices.

In the field MSM are identified through:
* eye contact
* direct contact
* actual behaviours

Approaches to field work:
* using appropriate individuals as "site buddies" who already use the site and are well known to others at that site... a regular user
* building peer support mechanisms within specific sites and across sites
* utilising already existent friendship AND sexual networks

Advantages of this approach:
* issues are known
* personal experience
* existent rapport within site
* existent levels of trust
* existent degree of confidentiality

Disadvantages:
* possible police harassment of site buddies and field workers
* problems with local thugs and violence
* possible breaking of confidentiality outside a network
* jealousy
* soliciting for sex

It was suggested that these issues would need to be addressed through local advocacy, training and empowerment towards personal behaviour change.

Recommended that Field Teams be developed for each site consisting of:
1. Field Officer
   providing primary skills and information
2. Site Buddies
   providing localised knowledge, networking and support
3. Volunteers and Friends
   providing additional knowledge and support

Qualities and skills of field workers:
* should be MSM themselves
* good communication skills with beneficiaries
* good knowledge of MSM issues and sociocultural contexts
* good knowledge of HIV/STDs
* ability to enable people to feel at ease and comfortable
* ability to develop friendship with a range of MSM with differing identities and behavioural choices
* ability to speak openly on MSM sex without shame
* good working knowledge of the male and female body
* knowledge of psychosexual issues and counselling
* a proven commitment to the issues

Qualities of site buddies
Site Buddies must always come from the site/framework in which they have considerable knowledge. This knowledge should include:
* differing MSM using the site
* local traders, assistants, transport workers, etc.
* sexual activities at the site and areas of risk
* condom usage
* personal friendships

2. Community building and mobilising

Facilitator: Sunil Menon, Project Coordinator, Sahodaran, Chennai, India
Reporters: G. Prashant Kumar, Administrator, Mithrudu, Hyderabad, India
Dev Anand, Programme Coordinator, Jagruthi-Gelaya, Bangalore, India

What is community? How do we build a community when none exists? How do we mobilising these communities around risk reduction? What do we need to do?

The workshop explored frameworks of MSM networks, identities and sexualities as they exist in the field, as well as what promotes sustainable behaviour change.

It was recognised that education and condom promotion was insufficient to build sustainable behaviour change in the socio-cultural context of South Asia where so much sexual behaviour is based on gender identification, and where certain sexual roles are highly stigmatised. Poverty, low self-esteem, gendered sexual identities, shame, and cultural-social pressures, create a dynamic that makes it difficult to enable sustainable behaviour change to be developed and maintained.

Question: What makes an MSM community?

This lead to the questions: What is an MSM?
Who is MSM?
And who within the diversity of MSM can be empowered towards developing a community?

Does an MSM community exist? To some extent the answer is yes, but this tends to be focused as localised networks that may cut across each other. Primarily these networks are made up of kothis or gay-identified men.

Recognising the strengths of community affiliations as they already exist, this requires ensuring that kothis and their partners 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. Mobilising networks, encouraging network development, and networking of networks is feasible under current social realities and should be used as first entry points into networks.

Characteristics of a community:

* 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

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.

It is recognised kothis are stigmatised as feminised and penetrated males. 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. However, it should be noted that for many kothis, this gender play and practice is locational, and does not carry over into other situations and locations, i.e. in the home, with one’s wife, or at work, and so on.

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.), and marriage and children, making shared behaviour characteristic a basis for community building becomes a major initiative and a challenge to the social basis.

In terms of community building and development, kothis represent the most effective opportunity form changing behaviour practices. 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.

A safe space where people can meet, socialise, discuss personal issues, receive appropriate and needful services and act as a focal point for an emergent community is an essential element in the process of community-building. A drop-in centre providing a range of services is a necessary component for any such programme.

The field work would promote the drop-in centre and its activities as a part of its programme. While field work promotes friendship building and provides on-site emotional and practical support, this is insufficient on its own. Community building and mobilising requires an empowered sensibility from an individual as well as group standpoint.

Building community ownership
a. Drop-in service
A safe, non-sexual environment providing entertainment (such as TV, games, etc.) as well as access to individual psychosexual counselling, instruction on condom use, and information and advice on STIs/HIV/AIDS, as well as a safe space to meet each other.
b. Socialising meetings
A variety of social groups developed meeting specific sexual/social needs. These groups act as a space within which personal friendships and community-building can be developed, experiences shared, and common purposes evolve. It develops as a community bonding process.
c. Sexual health education classes
Providing information and education on sexual health issues
d. Personal skills development
A range of educational classes should be offered including literacy, social skills, life skills, health seeking knowledge, vocational skills, income generation skills, and so on.

Such Centre-based activities address:
i. personal and emotional needs including
sexual abuse and violence
personal hygiene
friendship
identity and desire
emotional support
empowerment
personal skills development
personal health issues
support and care for those living with HIV/AIDS
ii. social needs
education
employment
economic development
human rights
family, marriage and children
vocational skills
socialising spaces
iii. sexual health needs
access to quality condoms
access to appropriately packaged water-based lubricant
appropriate STI treatment
psychosexual counselling
HIV/AIDS counselling
knowledge
empowerment
negotiating kills
female partners and wives of MSM

These activities lead towards
* the overcoming of fear and shame
* building a shared sense of common purpose and self
* developing confidentiality and trust
* working together towards common goals and purposes
* building self-esteem and self-worth
* providing mutual support and comfort

In others words - a community.

3. Social marketing of condoms

Facilitator: Indrani Mirajkar, Independent Consultant, New Delhi, India
Reporters: Lok Prakash, Shivlok Enterprises, New Delhi, India
G. Prashant Kumar, Administrator, Mithrudu, Hyderabad, India

This workshop explored approaches to empowering MSM to purchase their own condoms from field staff or from public outlets, and to sustain such a practice.

Objective
to persuade increasing numbers of MSM to
a. purchase their own condoms on a regular basis
b. to make condom use a normative behaviour
c. to promote safer sex

Why?
a. free condoms - costings prohibitive
b. misuse of free condoms
c. more likely to personally use condoms if self-purchased

Condom use issues: reproductive sex
recreational sex

Question: Whose life will the condom save?
a. both partners involved in the penetration
b. other sex partners
c. lovers
d. sex friends
e. clients and sex workers
c. wives, children
d. families - economic issues

Question: What are the barriers for condom use?
* accessing condoms in the right place and right time
* shame of purchasing
* reaction of shop-keepers
* public spaces
* masculinity attitudes
* incorrect use
* condom price
* belief in reduction of pleasure
* condoms as family planning
* belief that condoms are not suitable for anal sex
* lack of a habit for condom use
* condom use stigmatised as disease prevention

Question: Can these barriers be overcome?
* accessing condoms on site
* establishing MSM distribution network
* education of shop-keepers to promote condom sales
* promote condoms as pleasure and not for family planning

* eroticise condom use
* destigmatise condoms
* increase condom habit
* masculinise condom use
* find new ways of promoting condom use - not focusing on disease prevention i.e. genital/anal hygiene
* reduce cost of condoms
* market condoms with lubricant sachets
* more direct education on condom use
* more openness in discussions on sex
* addressing sexual myths directly through psychosexual counselling and education
* peer pressure on regular condom use

Selling an idea: condom use
The following issues were also explored:
* protection from disease
* potential for stigmatisation
* protect your family - stronger sense of family than individual
* increase your pleasure?
* sex lasts longer
* keeps penis and rectum clean

Different processes were explored including:
* one-on-one education towards change
* role modelling behaviour change
* community mobilising
* generating desire for using condom through cultural frameworks, i.e. cleanliness, or as a form of masculinity

Sustainability of behaviour change towards regular condom use was explored through
* sustained peer and community-based pressure
* ensuring regular access to condoms
* sufficient availability of condoms
* ensuring affordability
* ensuring quality
* locational availability
* teaching preparedness

Note: condoms should be readily available when needed.

Issues of water-based lubricant were also explored in terms of packaging, accessability, price, and user friendliness. Participants urgently expressed the need for readily available, appropriately packaged, and cheap water-based lubricant.

Question: Why social marketing?
Following an explanation of what social marketing means, participants looked at how such a programme would be implemented.

Condom Distribution:	1st phase	increase condom awareness
	2nd phase	increase condom usage through initial free distribution
	3rd phase	build condom use habit
	4th phase	initiate subsidised sales
	5th phase	persuade to purchase directly

4. Developing education materials

Facilitator: Subodh Rathod, Chairperson, Naz Foundation International, London, UK
Reporters: William Christy, Chairperson, Mithrudu, Hyderabad, India
Lok Prakash, Shivlok Enterprises, New Delhi, India

What do you need to ensure when you are designing a new information booklet, leaflet, or poster for MSM and HIV/AIDS?

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

* how appropriate is the framework of education resources for the target group?
* what language are these education resources in?
* what terminology and images are being used? Are they appropriate for the target group?
* what methodology is being used?
* is it appropriate to the cultural frameworks and context of delivery for the target behaviour/group?
* who controls the agenda for the development of these education resources?
* who produces the information and resources?
* who receives the information?
* who delivers the information?
* how is this information delivered?
* can we differentiate between culturally sensitive and culturally appropriate resources?
* do services exist to cater for expressed and felt needs that such information may generate?
* who staffs these services?
* what do they deliver?
* how do they deliver services?
* how are appropriate are they?
* what skills do they have and are they appropriate?
* what messages are being delivered?
  - don't do it?
  - do it safely?
* what is the objective of these resources?
  - 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 can effective resources be developed.

Objective?: sensitise general public
educate general public
targeting MSM behaviours
targeting MSM networks
increase awareness
build self-esteem

How?: leaflets for distribution
newspaper/magazine adverts
street theatre
word of mouth
posters
internet
wall graffiti
public transport slogans

Note:

* keep in mind who will be seeing/reading these images/messages
* social class/caste/religion/locality
* Needs to be appropriate for local area/region
* should have a visual impact
* creating imagery which are culturally simple and specific in appropriate language and terminology

What are we trying to say?
* practice safer sex
* promote condom use
* promote non-penetrative sex
* other messages?
* moral message?
  - "don't do it" or "do it safely"

Framework of development
* developing a budget
* anticipate number of beneficiaries
* development plan
* field test

In terms of MSM, there a broad range of differing frameworks of MSM identities and behaviours. Messages need to be appropriate for each of these differing frameworks, i.e. kothis, panthis, gay men, other MSM.

One suggestion was the possibility of developing the use of kothi language.

Also the need to explore alternative mediums, rituals, and frameworks, such as the utilisation of the Shiv Shaktis in Andhra Pradesh, photography exhibitions, dance, street theatre, mime and other performing arts.

It should be remembered that passing on information does not equal to a change in behaviours. Messages must be followed through with one on one and group support.

Also development of education materials must involve those for whom the message is being targeted at.

Messages should be
* short,
* clear
* meaningful
* understandable
* within context
* appropriate
* make sense
* cost-effective

5. Living with HIV/AIDS - care and support

Facilitators: Rajiv Dua, Independent Consultant, Mumbai, India
KK Abraham, INP+, Mumbai, India
Reporters: Dr. Rajender, Trustee, Mithrudu, Hyderabad, India
Dev Anand, Programme Coordinator, Jagruthi-Gelaya, Bangalore, India

What do you need to ensure that those living with HIV/AIDS can obtain the appropriate care and support in a resource poor environment?

Participants were briefed on
* HIV infection and its consequences
  - physical
  - emotional
  - family
  - community
  - financial
* symptoms
* AIDS
* death and dying

Question: Are there specific issues around living with HIV/AIDS and MSM?
Which MSM?
Kothis? Panthis? Gay men? Other non-identified MSM?

Issues for kothis, gay men and other self-identified MSM
* sexual behaviour and choices
* impact of MSM transmission of HIV
* double jeopardy: HIV infected and MSM
  anal transmission/penile transmission
  sociological consequences

Question: What is needed?
* appropriate counselling
  - personal
  - partner
  - family
* support mechanisms
  - personal
  - family
  - social
* confidentiality of both HIV status and MSM behaviours/identities
* access to treatment
* addressing poverty and basic care issues
* addressing stigmatisation
  - MSM
  - HIV status
* appropriate training for
  - those MSM living with HIV/AIDS
  - medical profession on both MSM and HIV
  - family

Objectives
* Developing a pathway to appropriate care and support
* Understanding the importance of care and support
* linkages of care, support and prevention of HIV transmission
* organisational and individual levels of support and care

Obstacles to care and support
Note: Significant levels of MSM are poor, and lack access to basic needs
  - shelter
  - food
  - water
  - medicine for opportunistic infections

* lack of proper voluntary testing facilities
* lack of appropriate counselling facilities
* lack of facilities for STI management for MSM in particular anal STIs
* lack of networking
* invisibility of the issues
* very little information on appropriate care and support for MSM
* lack of appropriate home-based care systems

Need to address:
* stigmatisation: - of MSM behaviours
  - of kothis
  - of living with HIV/AIDS
* pathways to infection
* developing positive attitudes towards people living with HIV/AIDS
* developing positive attitudes by those living with HIV/AIDS
* self-esteem around sexual identities/behaviours
* acknowledgement of differences between HIV/AIDS and other diseases
* stigmatisation by media and medical profession
* discrimination

Need:
* to promote condoms, safer sex and safer blood programmes
* monogamous relationships
* behaviour change
* partner notification
* appropriate BCC materials
* MSM friendly counselling
* voluntary testing and counselling
* confidentiality
* access to treatment
* poverty alleviation
* medication for opportunistic infections
* voluntary testing sites
* appropriate information in appropriate formats
* challenge “quack cures” and promotion of “false cures”

NOTE: A basic booklet in simple vernacular languages should be produced by Naz Foundation International for each of the partner projects.

6. Counselling

Facilitator: Tahir Khilji, Director, Visions, Lahore, Pakistan
Reporters: Dev Anand, Programme Coordinator, Jagruthi-Gelaya, Bangalore, India
Shaleen Rakesh, Programme Coordinator, Naz Foundation India Trust, New Delhi, India

What are the essential components to appropriate counselling in terms of
a. psychosexual concerns
b. STIs/HIV/AIDS

Issues to address
* What is counselling?
* What are appropriate methodologies for South Asian MSM?
* What is the differences between Optional or Directive counselling?
* What is the difference between Counselling and Advice/support?
* What skills are necessary?

What is needed
* Pre-Test/Post- Test counselling
* Psycho-sexual counselling
* Counselling on Risk reduction
* Counselling on sexualities, masculinities and MSM
* Counselling on religion, family, marriage and children

It is necessary to develop “grass-roots” methodologies of counselling on all these issues, appropriate to the needs of MSM.

Framework of counselling
* develop a friendly and support environment
* non-judgemental
* complimentary attitude and speech
* show concern through eye contact, body language, position
* share experiences and knowledge content
* avoid physical barriers (such as a desk)
* regular feedback
* focusing on client’s issues
* provide options if possible
* avoid personal involvement

Skills
* good at rapport building
* empathic

* a good listener
* good knowledge of the issues
* able to provide advice and information
* able to summarise and recap the issues
* able to prioritise issues
* must be non-judgemental
* voice modulation

Other areas
* confidentiality must be assured. A verbal assurance should be given
* counsellor should maintain records of clients and follow up
* differences between open-ended and closed questions
* power dynamics
* information vs advice
* counsellors''s power
* ownership
* ethical issues
* providing incomplete information

The use of role play can be a very effective methodology in dealing with issues such as police harassment at cruising sites, and initiation of counselling sessions.

Recommendations
* more specific skills-building workshops on counselling for partner projects
* NFI to develop an MSM training manual
* source and reference materials and information made available
* networking to share experiences
* protocols and guidelines developed
* developing frameworks for telephone counselling
* explore relevant issues and needs for MSM in small towns and villages

7. Female partners of MSM
Facilitator: Hanif Khan, Sahodaran, Chennai, India
Reporters: Lok Prakash, Shivlok Enterprises, New Delhi, India
William Christy, Chair, Mithrudu, Hyderabad, India

Many MSM (kothis, panthis and others) will be married, get married, and/or have sex with other women. Ensuring that our beneficiaries do not infection their female partners, no become re-infected, requires developing appropriate sexual health services.

* family and marriage context in South Asia
* panthis, masculinity and sex with females
* what concerns regarding cross infection?
* male to male to female to male transmission risks
* partner notification? Why not?
* how can this be addressed
* treatment issues regarding STIs infection for female partners
* HIV infection of female partners
* wives and children
* support mechanisms and methodologies

The workshop was participant orientated based on sharing experiences and ideas. It focused on married MSM.

Question: Why get married?
* traditional and social structures in South Asia demand marriage, usually arranged by family
* continuing the family line
* support, companion and security for old age
* to avoid loneliness
* sons have to get married so that their sisters can get married

MSM activities outside marriage
* usually married MSM avoid emotional encounters with other men, keeping the sexual encounter physical
* if there is an emotional involvement can create difficulties in marriage
* requires demarcation of love

Some issues
* wife will get more disturbed if she knows that her husband is having sex with women
* wife will also suffer guilt and blame herself as she may think she is not satisfying her husband
* even non-kothis fear getting married
* majority of participants believe that kothis should not inform their wives

If the wife comes to know
* shame
* perhaps lead to broken marriage and divorce
* may have disastrous results with family and community
* possible traumatised children
* may have to try and give up MSM activities to save children

Participants believed that “no woman wants to share her husband”, and that they will keep quiet about this because of the social security that marriage provides. Divorced women are always considered to be of “loose” character.

Participants believed that if the MSM is STI/HIV infected then
* tell the truth
* if this is not considered possible then they should always use a condom, stating that he enjoys using a condom because it takes a longer time to do sex

Protecting female partners
* practising safer sex always
* spend quality time with wife and children
* balance MSM activity with family life
* reduce level of MSM activity

Other trauma of married MSM
* dual life style
* keeping secret
* potential of threats and blackmail
* constant fear of wife and children finding out
* conditioning of family members to cope with phone calls, messages, and meetings
* can’t invite MSM friends home
* can’t do sex with other male in personal home
* difficulty in satisfying wife after having sex with other male
* need to fantasise

Is it necessary to tell your female partner that you are MSM? This will be a personal decision, but ensure support systems are available.

Recommendations
* projects should have a well developed support strategy for
  - married MSM
  - female partners of MSM
* female doctors for female partners
* condom negotiation skills for males and females
* learn more about female partners
* families should not force kothis to marry
* sensitise people in general about MSM
* promote communication skills of married MSM to counsel their female partners
* training of field workers to positively communicate to family, friends and society

Other actions
* give wife a lot of love and respect and time
* balance your roles
* act diplomatically
* ensure that she is treated if you have disease
* non-vaginal sex should be experimented with (with permission)
* don't let her feel bad
* adopt a child if you don't have your own child
* proper maintenance should be provided

Participants believed that there was no proper and adequate solution.

8. Monitoring and evaluation

Facilitator: Deep Purkayastha, Programmes Coordinator, Praajak Development Society, Calcutta, India
Reporters: Ali Firat, Director, Naz Germany, Berlin, Germany
G. Prashant Kumar, Administrator, Mithrudu, Hyderabad, India

It is essential that a project/programme measure the impact that its services are making in terms of its outcomes, including changes in safer sex behaviours, and rates of infection. What should be measured and how?

Question: What is monitoring? Why monitor?
* measures what you do
* provides a means to determine
  Output: what you do
* also can be called indicators
  measures a project's progress in terms of achieving its stated Outputs
* it is a quantitative measurement

Question: How do you monitor?
* documentation (measurement) of all project's activities
* requires appropriate measuring instruments for monitoring activities
* these can be monitoring forms, telephone log books, reports, expenditure statements
* anything that can be quantified
* also comments, issues arising, concerns as stated by beneficiaries - feedback processes

Measurable Indicators
* numbers of males accessing information on sexual health, services and resources
* condom distribution
* numbers referred to and accessing to STD treatment
* numbers accessing HIV counselling and testing
* numbers accessing appropriate support and counselling
* number of BCC resources distributed
* range and number of sexual health discussion groups, and numbers attending

Measurement in the field
* numbers accessed
* type and range of sexual activities
* condom usage
* harassment an violence - towards developing advocacy work
* range and number of training programmes and numbers attending
* safer sex practices
* reported STI levels
* referrals
* issues and concerns
* number of partners
* changes in sexual practices
* resources distributed
* advice and counselling
* other activities

Measurement in the Centre
* numbers accessing centre
* numbers utilising centre services
  - drop-in
  - social groups
  - special education groups
* telephone logs
* meetings, workshops, training programmes
* advice and counselling
* condom resources stock book
* expenditures
* other activities

Measurement in the Clinic
* numbers attending clinic
* STIs, type and treatment
* other issues and concerns
* testing
* counselling
* return visits
* stock books
* other issues

All of these can be realistically monitored through appropriate methodologies.

Monitoring data can be computerised and analysed for changes as the Project progresses. These changes can then be evaluated to determine the Outcomes of the Project.

Will also need to evaluate the validity of the data from the reports. This can be achieved through unannounced inspections, field visits, financial reviews, etc.

Monitoring has to be systematic and standardised, while monitoring costs should be included in the budget.

There could also be a mid-term review of monitoring indicators.

Question: What is evaluation? Why evaluate?
* determines effectiveness of programme
* determines it stated Outputs and Outcomes are being achieved
* determines if goal and purpose are being met
* provides a cost-benefit analysis
  - is it cost-effective?
  - is it sustainable?

Question: How do you evaluate?
In terms of MSM sexual health projects, the stated Goal is to reduce the risks of STI/HIV transmission among its beneficiaries, while the Purpose is usually to provide a range of services to promote and sustain safer sex behaviours, and self-esteem as a process to achieve this.

Monitoring processes should measure sexual practices at a range of sites, as well as any changes in these practices
* on-going sexual behaviour surveys
* measurement of changes in sexual practices on a site and time basis
* changes in beliefs, attitudes, knowledge and self-perception

Various methods are available towards developing effective evaluation procedures
* establishing targets
* feed-back systems available to service users and providers
* documentation processes at STD services and other sexual health services
* comparative studies between city programmes
* on-going analysis between input and output
* on-going service reviews through focus groups and interviews

* time-based reviews and studies within certain environments
* participatory systems for on-going evaluation
* comparisons between identified outputs and achieved outputs leading to the Purpose and Goal

Single group time series analysis
A single group time series includes a group (cohort) of individuals, who are subject to assessment both before and during and/or after an intervention in order to establish what impact the intervention has had.

Cross-sectional time series analysis
Same as the Single group time series, but involves sequential samples over time with different groups.

Over specific periods of time comparative analysis can be conducted with initiatory baseline studies, as well as on-going evaluation. Such indicators will be able to show not only changes in behaviours, but their long term impact upon the affected communities.

The process used for monitoring and evaluation will be based on participation of service deliveries and service users, with a comparison study between the stated outputs and activities and the achieved outputs and activities. From such a comparison it is possible to indicate achievements towards the stated Purpose of the Project and whether this will lead to the Goal of the Project.

Initial indicators must be clearly identified at the beginning of the Project, and measurement must be continuous and logical, if effective evaluation can be conducted.

Issues of concern
* data is valid, accurate and true
* supervision of staff
* lack of staff and training
* negative effects of local harassment by police and thugs
* lack of adequate data collection
* inadequate reports written and figures collected
* lack of commitment by Project to measure and evaluate

Recommendations
* Monitoring needs to be systematic and standardised
* NFI should promote uniform standards of monitoring for MSM projects in South Asia, using as a basis the processes already developed
* evaluate Bandhu Social Welfare Society's computerisation of the monitoring process and if found to be effective share this with all partner projects
* ensure that monitoring and evaluation costs are embedded in the project budget
* develop protocols and guidelines for monitoring and evaluation
* such data must be fed-back to beneficiaries
* Donors should utilise MSM projects to evaluate other MSM projects
* seasonal effects on activities need to be taken into account
* Technical Advisory Group should be established involving MSM from the networks to conduct evaluations
* more training conducted on monitoring and evaluation
* NFI should develop a module/package for use by all its partners

9. Writing a proposal

Facilitator: Arif Jafar, Director, Bharosa, Lucknow, India
Reporters: William Christy, Chair, Mithrudu, Hyderabad, India
Anindya Hajra, Pratyay, Calcutta, India

Donors require a funding proposal before you get and money to deliver a service. What does such a proposal contain? What is its structure? How long should it be? What language and words should you use?

Participants were asked to respond to a series of questions as pre-requisite to developing a project proposal.

* Why write a proposal?

* Why should a donor give you money?
* What value for money can you offer?
* How can you persuade them to give you money?
* How do you determine
  a. what you will do
  b. how you will do it
  c. what will you achieve
  d. how will you prove this
  e. is this what the donor wants
  f. is it cost effective
  g. does it change behaviour and reduce risks
  h. is this change sustainable

Following a discussion on these questions, the Facilitator explored with the participants the framework for developing a project proposal.

Proposal Guidelines
It was noted that different donors may well have different proposal structures and require differing information. Each section was discussed and examples were shared from the partner projects.

1. *Project Summary*
   Brief outline of the proposed project
   less than one page

   should also contain:
   a. purpose of project - one sentence
   b. inputs
   c. any partner organisations involved
   d. length of time of the application
      usually between 3 to 5 years - need to check with donor
   e. anticipated start date

This is summary document which helps a donor whether to study the proposal further.

2. *Project Purpose*

   Recognise a funders priority areas - the Purpose must fit into this.

   Outputs
   Number of outputs of the project, that is what will the project do to achieve its goals.

   Outcomes
   Number of outcomes, that is what will be achieved by the end of the project..

3. *Cost summary*

4. *Background of the project*
   What are the issues of concern and why was the proposal developed.

5. *Technical Appraisal*
   - detail the problem being addressed and fully justify the approach selected to achieve the outputs/ outcomes
   - degree of local ownership
   - choice of personnel should be justified with CVs for the main personnel attached

   In other words:
   - what is the problem
   - how will it be tackled
   - who will tackle it
   - what is their experience
   - what is different about your agency compared to others

Or: why should the donor fund you?

6. *Social Appraisal*
   What is the social framework in which the project takes place?

7. *Institutional Appraisal*
   Describe the implementing agency and their particular ability to implement the project. You will need to give its history and achievements.

8. *Project Implementation*
   How will the project be implemented?

   Develop a time table and work plan.

9. *Risks and Assumptions*
   What risk are being taken by the implementing agency regard this project?

   What assumptions are being taken by the implementing agency in regard to this project?

10. *Monitoring, evaluation and reporting arrangements*
    How will you monitor the work being done?
    What are the measureable indicators that you will use?
    What measures will you take ?
    How will you evaluate the success of the project?

11. *Sustainability*
    How cost-effective is the project compared to others?
    What will you do to sustain the project after funding is over?

Project Logical Framework
Following discussions on the outline above, a Project Logical Framework was explained, utilising a DFID structure, i.e.
Goal
Purpose
Outputs
Activities

With verifiable indicators, means of verification, and assumptions being made, recognising that the more assumptions being made for the project, the more likely the project would not succeed.

It was explained that a Project Logical Framework creates a matrix which can be utilised as a tool to evaluate components of a project as well as the Projects Outputs and Outcomes over a period of time.

A Naz Foundation International explanatory document which discussed these issues was distributed.

Examples of Project Logical Frameworks from a range of Naz partner agencies were also examined.

Developing a Project Budget
A brief outline of budget structures, developing costings, and formatting was also presented.

a. annual budget over the period of funding for the project
b. Sections
   i. Project management
      staffing costs, i.e. Director and office staff
      salaries should be at local rates
      check on inflation allowed by donors on annual basis
   ii. Revenue costs
      these are the different costs for the office, i.e. rent, phone, stationary, etc.
   iii. Programme costs
      includes: programme staff

materials for programme
actual programmes and their costs
monitoring and evaluation
training

iv. Capital costs: one of equipment purchases
v. Technical Assistance: consultants etc.
vi. Costs summary

NOTE: check with donors; they have limits to what they will agree to.

The total number of pages for the whole proposal should be kept to a minimum. It was suggested that this should not be more than 12 - 16.

Other information and supporting documents should be attached as annexes to the main proposal.

Recommendation
Participants requested that Naz Foundation International develop a manual for writing project proposals, project logical frameworks, and budgets in the vernacular languages.

DISCUSSION GROUPS

1. Building networks/sharing resources

Facilitator: Tahir Khilji, Vision, Lahore, Pakistan
Reporter: William Christy, Chair, Mithrudu, Hyderabad, India

This discussion focused on building the Saman network, and how we can share the resources within the network. It will explored networking with other networks that are developing in the region.

This is a discussion towards enabling the development of a network of kothi and other MSM sexual health projects which have been assisted by Naz Foundation International.

Provisional name: SAMAN
South Asian MSM AIDS Network

Question: What is a network?
- What is its purpose?
- What can it achieve?
- What can the SAMAN network achieve?

Support: NFI Liaison Office in Lucknow

Other networks? Networking with networks?

The network can achieve
* shared resources to reduce costs
* sharing of information
* shared technical support
* advocacy
* strength in numbers
* expertise shared
* expedite networking of networks
* local strengthening
* provide resource persons for emergent MSM sexual health projects
* provide capacity building
* advocate on behalf of each other
* facilitate and own research
* produce a range of resources
* purchasing in bulk for network distribution

Such a network would require funding in its own right to conduct workshops, seminars, meetings, and such like.

2. Kothis, gay men and other MSM: gender and sexual identities

Facilitators: Anindya Hajra, Pratyay, Calcutta, India
Shaleen Rakesh, MSM Programme Coordinator, Naz Foundation India Trust, New Delhi, India
Reporter: Agniva Lahiri, Pratyay, Calcutta, India

There is a growing debate regarding the issues of differing identities in South Asia, particularly around gay vs kothi. This discussion explores differing types of identities, whether they are gender or sexuality based. It will also look at how differing frameworks of MSM operate in South Asia.

Discussion document
Kothis, gays and (other) MSM

In the July 2000 edition of Trikone (Vol. 15, No.3), an article by Owais Khan was published: A Rose By Any Other Name...? Gay vs MSM.

A key implication in this article was that the word gay and the phrase men who have sex with men were too often been seen as interchangeable, synonymous and equivalent by those working in the field of sexual

health. This is having the effect of invisibilising the lesbian and gay struggle in India, or as is quoted "a well thought out game plan not to let autonomous gay identities become visible...."

This is a very distressing reading of the issue, particularly for those who are involved in fighting AIDS among those many men/males who do not identify as gay, but who have sex with other men.

In a country of one billion people, with some 520 million males (it is estimated that in India there are 50 million more males than females - who are they having sex with?) where over 5 million people are reported to be living with HIV/AIDS, and where this number is rapidly increasing, this confusion between identity politics and HIV/AIDS concerns is distressing. Distressing because what we surely should be talking about is how we can all work and support each other in saving lives, not what labels we give ourselves, or impose upon others.

So what is this word gay that we bandy about so readily as a means of self-identity and expression? What does it mean? Is it a noun, an adjective or a verb? In South Asia I have heard the term used in all these ways. I am gay, I am a gay, I do gay sex (or homosex). What does is meant when a person says "I am gay". And in South Asia who says I am gay? The truckdriver who may have sex with his male helper? The farmer in the villager who has sex with a young man, the rickshaw driver who has sex with a hijra? The slum dweller when he has sex with a kothi? What about male sex workers? What about male prisoners, jawans, males in hostel, lodgings, street males, labourers. Or is it the middle-class urbanite with access to the English language press, Trikone, email and the internet? Ask ourselves this. How many people in South Asia speak and read English? How many people in South Asia can be defined as the middle or upper classes? How many people live in cities. How many people live below the poverty line? How many people are literate, even in their own language?

If I understand gay history correctly, the word gay arose as a means of developing a sense of positive identity as a loci for the self, where a core sense of self was constructed around sexual desire and longing. We were no longer faggots, queens, fairies, perverts, homosexuals. We were gay. Here the concept involved a masculinising process. We were men who loved other men a framework of same gender/same sex relationships.

In other words I am gay because as a man I desire other men because they are men with specific attributes that I like, i.e. handsome, intelligent, good personality and so on. And in the context of the evolution of sexual identities and encounters from Western constructions, gay relationships reflected heterosexual (another Western constructed term) frameworks of relationships. That is these relationships were companionate, egalitarian and mutual.

The word gay came into general use in the mid-fifties and sixties, particularly after the Stonewall riots in New York. The word homosexual was invented in the 19th century as term that particularised behaviour into an identity. Likewise the word heterosexual was also invented in the late 19th century, much later than its oppositional term, and only was it in the 1920s that it took on the meanings that we attribute to it. Likewise identity politics arose in the States and has become a global feature since then, a globalising culture that sweeps indigenous identities and constructions of sexuality and gender before it.

The terms gay, homosexual, heterosexual have a history. They are social constructions that arise from a specific context and sociocultural frameworks and a past. To claim some universality of identity across different cultures and histories is a claim of arrogance. Perhaps we can call it the Coco-Cola of sexual and gender politics.

So let me ask readers of Trikone this. In what ways do sexual relationships exist in South Asia, whether between males or males and females. In what context is marriage framed. Are primary sexual relationships egalitarian and companionate? Have they ever been for the majority of people. Are marriages freely chosen? Is there gender equality and individuality? And if there is, for whom? And what does this say about the way sexualities are constructed in the sociocultural frameworks of South Asia?

What does the word "man" mean to most biological males in South Asia? In what context is it used? What defines manhood, manliness and masculinity? So what does it mean when a kothi-identified male say's "I am looking for a 'real' man as a husband".

What does it mean when a husband says he "does duty to his wife" rather than saying he has sex with his wife. What significance does this have on sociocultural constructions of sex, male to male sex, male to

female sex?

The word male used in the phrase male to male signifies something else than just transgenerational sex (or paedophilia), particularly in the context of the risks of HIV infection through anal sex. It signifies that there are specific cultural differences in our understanding of the word 'sex', and the word 'man'. Do all kothis see themselves as men? Do hijras see themselves as men? Do young *unmarried* males from "lower class" groups, whether rural and urban, define themselves culturally as "men"? Do panthis see kothis as men? Here the differences between biological definitions and cultural interpretations must be understood, if we are going to make any headway of empowering reducing behavioural risks.

In South Asia the sociocultural frameworks are supremely gendered, and often sexual relationships are framed by gender roles, power relationships, poverty, class, caste, tradition and custom, hierarchies of one sort of another. Here for many men/males we have gender identities, nor sexual identities.

The phrase males who have sex with males, or men who have sex with men is not about identities and desires, it is about recognising that there are many frameworks within which men/males have sex with men/ males, many different self-identities, many different contexts of behaviour. Some will call themselves gay, some will say they are kothi, some will say they are do-paratha, dubli or double decker. But almost none will call themselves panthi. This is a kothi term for their manly partners.

Of course kothis get married. What 'man' in South Asia is not under intense pressure to marry. And how many are in a social and economic context in which they can refuse their family's pressure.

So what does this say if a kothi can get an erection and penetrate his wife? Does this stop himself identifying as a kothi? This is an indigenous term, not an imported word. *Ulti*, the language of kothis and hijras across South Asia. I have heard similar phrases and concepts spoken in Sylhet, Bangladesh to Hyderabad, India, to Karachi, Pakistan.

I am not saying this is either good, bad or indifferent. It is the reality.

HIV/AIDS is a scourge whose primary victims are the poor, the disenfranchised, the marginalised. HIV is not transmitted by an identity. There is no such thing as a heterosexual transmission or a homosexual transmission. It is primarily transmitted by unprotected anal or vaginal sex. Anal sex is not an exclusive behaviour of gay-identified men. There are other identities which involve anal sex as a core behaviour, and there are a significant proportion of males who are involved in anal sex behaviours who have no specific sexual identities. In fact whereas the Indian government speaks of heterosexual/homosexual transmission of HIV, they speak of a ratio of 80%/0.5%. Is this really valid? How many men/males who have anal sex with other men/ males will tell a doctor that they have had anal sex with another man/male? No, of course they do not. They will usually state they had sex with a woman. The only way an agency can tell that the transmission is through "homosexual behaviour" from a positive result is if the male says that he has been anally penetrated, or is a homosexual, or is gay. And of course the issue of anal sex between men and women is not addressed.

The article is in reality a discussion around essentialism vs constructionism as frameworks for sexual behaviours and identities. But I wonder, if those working in the field of HIV/AIDS and 'MSM' should only work with gay-identified men because they do not accept the concept that non-gay-identified can also have sex with other men. And then where does this lead us to? Is sexual behaviour only equivalent to gender desires? Or specifically equivalent to a sexual identity?

Looking from this perspective in terms of social constructionist theories, what we have in South Asia are cultures in which so many men are behaviourally heterosexual and/or behaviourally homosexual. I see South Asian countries as emergent heterosexual societies, along with emergent gay constructions/communities. There many others with differing identities that have a longer history in the region than does gay politics. All these frameworks are equally valid. In the meantime, HIV/AIDS is about the reality of where people are right now, what they do with their own bodies, what the identify with, how they perceive themselves, and also how they perceive what they do.

In Western cultures so much work has been done in exploring queerness as a framework for the presence or absence of sexual identities, their fluidity and often amorphousness, a space with no boundaries. A tremendous amount of work has been done on the sociocultural constructions of gender, sexualities, masculinities and femininities. And yet this article appears to be ahistorical and ignores all this pioneering

work. Is South Asia somehow so different from all the other cultures in the world so that it is outside these processes?

It is not gay vs MSM. It is gay men and MSM. And in South Asia I would have to say gay men, kothis and a variety of MSM. In the amazing diversity of male sexual frameworks (and perhaps female as well), localised terminologies, identities and sensibilities become lost in the globalising of the term gay, a term that specifically arose from an Anglo-Saxon history and context.

A unnecessary conflict has developed where there is no need, one that is really phantasmagoric. There is no dispute. Maybe you are working within a context of emerging gay identities and gay rights, which can (but sometimes does not) include HIV/AIDS issues. Or maybe you are working in the field of saving lives from the scourge of AIDS amongst those most at risk and articulate issues in terms of sexual rights. Sometimes you are doing both.

In terms of actual risk, unprotected anal sex is the most risky sexual encounter. So some people may have differing priorities. Is this a problem? And if so, why?

In the context of AIDS, developing effective and sustainable prevention initiatives, one should not impose your own personal concepts of what people should call themselves, or what identity they should have. You start with where people are at, not where you think they should be, helping to create safe spaces where they can explore their sense of self as an empowerment process of change towards less risky behaviours.

South Asia has an incredible diversity of identities, desires, and frameworks of expression. It can truly be called a queer space. Hijras, transvestites, transgendered, gay-identified men, kothis/dangas, panthis/giriyas, double-deckers/do-parathas/dubli, men/males who have sex with other men/males, in all its variety of terminologies, behavioural choices, desires and constructions. Are we truly saying that we should reduce this diversity into the singular construction of a gay identity, a term that does not readily translate into the multiplicity of languages and dialects that reflect the diversity of South Asia itself?

And are we also saying that control of AIDS in South Asia does not matter, that people who do not identify with a gay sensibility do not matter? Behaviour and identity are not always congruent as any good social anthropologist should know.

Of course the emergent gay movement in South Asia is extremely important for those who do identify as gay, and also for those who are exploring their own emergent sexual sense of self and gayness and are looking for a positive affirming identity that makes sense to them. Then to say gay is appropriate and right. But at the same time to denigrate or deny other frameworks of identities and choices is not.

Let us stop seeing a debate that pits those who work for gay rights and those who work in preventing HIV/AIDS among men who have sex with men against each other. Let us work together whatever our own frameworks and priorities, and recognise that in a region of over one billion people there is space for everyone to work out their destinies.
Shivananda Khan

Discussion points

* labels and identities different from Western gay frameworks
* MSM behaviours more gendered
* differing identities developing under the MSM umbrella
* are labels necessary to define a person?
  - some participants believe it is so as part of sensing of self
  - others did not think so because it should be about what people do and not labels
* definitions and understanding labels
  - who is a kothi?
  - “passive” kothi - a stereotype or a reality?
  - sexual roles or feminine behaviour?

Participants believed this was a complex discussion and not enough time or understanding to fully come to grips with the issues involved. They believed it was an important discussion though because of its impact on HIV/AIDS/STI prevention strategies.

Further labels do not always define sexual behaviours. Some kothis also penetrate males, and many kothis are married with children.

Identities, labels, sexual roles, and choices are complex human phenomena. Human sexualities and behaviours are dynamic and fluid, and often choice of label reflects social frameworks and networks, a socialising process, rather than actual behavioural/role choice.

3. Gay rights?/sexual rights?: advocacy and human rights

Facilitators: Deep Purkayastha, Praajak, Calcutta, India (also reporter)
Aditya Bondapadhya, New Delhi, India

For MSM sexual health projects, what is the best strategy regarding advocacy and human rights. Should we get involved in the lesbian and gay struggle as the best approach. Should we be advocating on behalf of sexual health rights?

Discussion notes
Section 377 of the Indian Penal Code says:
"Of Unnatural offences: Whoever voluntary has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment of either description for a term which may extend to ten years and shall be liable to fine.
Explanation:
"Penetration is sufficient to constitute carnal intercourse to the offence described in this Section."

As a development professional working with an NGO which has been working with MSM among other marginalised male populations, I would like to say that removal of section 377 is not a non-issue for us or for that matter with NGO's with similar mandates. It cannot be.

NGO's, with their organisational memories and shared experiences, feel in their guts that a challenge to 377 on the basis of sexual rights can be very risky, especially in the social environment which has become conservative. If you have read the innumerable surveys done about the attitudes of the youth today, you will see my point.

NGO's, like ours, would like to challenge 377 in court on the basis of the threat it poses to human life, to every Indian's right to health-related information and to appropriate health services.

Another thing. 377 is just not about homosexual acts. It is also about heterosexual acts which do not fit the description of peno-vaginal intercourse. This is not just a "gay" issue. It is about personal choices and our right to choose irrespective of our sexual preferences. This is an issue about sexuality without prefixes. It is about our freedom to choose. We have to build broad coalitions if we think of abrogating 377. Broad coalitions are not built on narrow platforms.

The health issue is as much a human rights issue. We feel it is a more immediate human rights issue.

There is no question of not supporting a campaign to repeal 377 even if it is based on the sexual orientation angle.

What I tried to say was that if our ultimate aim is to see that 377 is abrogated then I feel it makes no sense to risk a deadlock or what is more likely, an adverse verdict. (Remember "Balance Barabar" of The Population Council and the accompanying harassment of health workers just doing their job?) We would rather base it on grounds we are certain to carry through.

Talking about sexual orientation is surely going to involve what is natural and what is unnatural. Since such a term is used in the section itself. This is an area where you can never prove anything either way. This is also an area where discourses about sexuality should not be located at all. Arguments and counter-arguments can tickle the brain cells of all our pundits, but it is not going to save lives.

I would like to mention the Nimmalpadu Bauxite mining case in Andhra Pradesh, 1997 to illustrate the point I am trying to make. Nimmalpadu is a village under schedule 5 i.e. a tribal village where no non-tribal is allowed to acquire land from tribals. One company belonging to the Birla group did acquire land in this area for bauxite mining.

NGO's working in that area immediately protested. They pointed out the extent of environmental damage it would create in the area with adverse consequences for the local people. When they went to court however, they did not fight their case on the basis of the fact that 30 species of turtle or 21 species of fish would be driven to extinction.

This is because they were aware of the fact that such an assessment is difficult to prove in a court of law however true it may be. They however could prevent an ecological disaster if they fought the Birlas on less fashionable grounds, on the fact that the bauxite mining company had acquired land in contravention of the law. This way, they knew they would win this case.

They did. And this has become a classic example of advocacy for NGO's across this country. They saved the land without saying they were saving the land, because if they did, they would have lost.

I wanted to exactly say this. I will still say this, not because NGO's want to opt out of this fight but because we want to win it.

I do not know how this assumption was made that we do not want to join other groups in fighting 377.

When I talked of a broader platform I meant that it would be easier for NGO's working with MSM issues to garner support of a wide cross-section of NGO's working in the area of sexual health if the health angle is highlighted. Many NGO's may be reluctant to be seen on the same platform as gay groups. And we must realise this that we will not go far without others joining up.

There is also the additional risk that 377 becomes a gay issue (this is the narrow platform I am talking about) , which I repeat it is not. It is a sexuality issue for all, irrespective of their sexual orientations. We need to keep it that way if we are to succeed.

While it is imperative that homophobic attitudes are also confronted head on, and there are no two opinions on that, it is also important that a strategy which has the highest probability of success is chosen. If it means we take two steps backward now so that we can actually leap forward in the near future, so be it.

The stakes as we all know are very high. Human lives, Indian lives, many of them males who have sex with males. Can we afford to be careless?
Deep Purkayastha

I think the intrinsic link between human rights and health issues will become much more obvious if we remember to talk about "health" in the broadest possible manner. Health = Physical health + Mental health (or well-being). Human rights to my mind have the single most important function of ensuring a person's overall well-being. Whether it's getting treated in an STD clinic without being sneered at or whether it's willing my property to my partner after my death without my family claiming it all . . . human rights are supposed to ensure these things.

Therefore roughly speaking human rights = health. And Section 377 can easily be seen to be linked to either side of the equation. So I really don't see the problem in it being tackled on either front. The issue that troubles me is what would be the best strategy ? Deeps argument seems quite solid when it comes to arguing in a court of law. I like it because it is akin to fighting on horses rather than elephants Wars are not necessarily won on the basis of strength. Guile plays a role too.

But what about outside the court of law? Will the removal of Section 377 on health grounds remove social prejudice too? To some extent maybe. But largely homosexuality will not stop being a dirty word and the risk to health will remain. Isn't it that larger social forums are the place where human rights of sexual minorities need to be talked about in greater measure ?

And there is a "but" here too I believe in things circular, and feel that decisions taken in court are in many ways influenced by the larger social understanding of a subject, that is, by things being talked about outside the court. So it would only be a matter of time before the courts will have to entertain the issue of the human rights of sexual minorities.
Pawan

Discussion points

- what are gay rights and sexual health rights
- both should be seen as parallel rights
- mobilise people on the basis of sexual health rights and then move on to gay rights
- look at the issues from a larger human rights perspective
- the Right to Life
- the Right to Equality
- advocacy and campaign to repeal Section 377

4. 6th International Conference on AIDS in Asia and the Pacific, Melbourne, Australia. 2001

Facilitator: Sunil Menon, Sunil Menon, Project Coordinator, Sahodaran, Chennai, India
Reporter: Aziz Haque, Project Coordinator, Bandhu Social Welfare Society, Dhaka, Bangladesh

The 6th ICAAP will be held in 2001 in Melbourne, Australia. How should we, as a network of MSM sexual health projects in South Asia, get involved and ensure that sufficient representation is made?

This discussion focused on the need to use the 6th ICAAP to ensure adequate representation from the SAMAN network is present at the conference, and that the issues that the different MSM sexual health agencies address should be highlighted at the meeting.

Suggestions

- a shared/common booth where all partners can exhibit their resources
- a shared banner
- sponsorships for one representative from each organisation in the network
- MSM/Kothis to have their own space, panel, sessions, etc.
- human rights of kothis (and not only LGBT) to be addressed
- discussions on female partners of MSM/kothis and children of MSMs/kothis
- attention given to religious and cultural aspects of MSM/kothis
- sexualities, masculinities and gendered identification of MSM
- SAMAN network and AP Rainbow can organise separate meetings/workshops/skills building for MSMs/kothis
- Share experiences and BCC resources with AP Rainbow members
- appropriate knowledge around STIs problems for MSMs/kothis
- anal STIs

5. **Masculinities, sexualities and MSM HIV/AIDS interventions: a research need**

Facilitator: Carol Jenkins, Senior Scientist, National Institutes of Health, Washington DC, USA
Reporter: David Northcott, Trustee, Naz Foundation International, London, UK

Social anthropological research is an essential component for a successful HIV//AIDS intervention. Such research produces a range of necessary information regarding designing a project and building sustainability. What should we be doing in this arena? Who can we work with. Can we trust the scientists?

Discussion notes

- Why do we need research?
- Who controls the research agenda?
- Who does the research?
- Where do we get the skills?
- Who owns the research?
- What happens afterwards?
- Where do we get the funds?

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?

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.

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.

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.

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, there specific meanings, and how they can determine desire and sexual behaviours.

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.

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

* prison populations
* military personnel
* overseas and migrant workers
* rural male populations
* males in educational establishments
* occupational groups, i.e. truckdrivers
* male sex workers in a variety of settings
* males in refugee camps
* male domestic servants
* male street children
* male factory workers
* male child sex abuse
* male on male rape
* early male sexual activities
* male suicides

Other areas could be

* STI/HIV prevalence among MSM
* anal STI prevalence
* prevalence of MSM behaviours
* female partners of MSM

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

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

Discussion points

* distinguishing between sex and gender/identity and practice
  sex - biological
  gender - social
* need to research the whole gamut of male gender roles to understand the issues of sex and sexualities in the context of HIV/AIDS interventions of MSM populations
* research into one's sexuality - sexual preference
* decades of research in the US has shown that the upbringing of a child cannot influence the sexuality of a child
* in certain cultures, the sex derivatives from the "norm" are seen as "normal" or "non-deviant", hence there is no need to explain the casuality of one's sexuality or sexual preference
* kothi's identity - how does it influence their behaviour such that they be vulnerable to HIV/STIs
* sexual practice is formative influence of sexuality and sexual preference
* fear - the need to research this new arena could lead to stereotyping in connection to HIV/AIDS
* exploitation by individuals/groups who are not from the community (ies)
* distrust of any form of research
* Why do we need research?
  - making visible the invisible
  - empowerment
* community should be involved in initiating the research process
* requirement of training of members of the community/networks to do the research themselves
* has to be owned and operated by the people of the community/networks
* need to ask what are the questions which have real value towards the research in question
* questions about the ethics of the research
* the ethics as a process of empowerment of the community/networks

6. Hinduism, Islam and MSM

Facilitators: Tahir Khilji, Vision, Lahore, Pakistan
Deep Purkayastha, Praajak, Calcutta, India
Reporter: Agniva Lahiri, Pratyay, Calcutta, India

In South Asia, religion is a central focus in our lives. And MSM very often find that their religion and their behaviour and desire appears to be in conflict. What can we say to those whom we work with when they want to know about religion and themselves?

This discussion was very difficult with a wide variety of viewpoints, beliefs, attitudes and knowledge.

Discussion issues

* what do we believe?
* is there any mention of MSMs in the scriptural texts?
* are punishments mentioned?
* what is really said, and is this different to what people believe is said?
* what happens after death?
* why has God made me like this?
* what about acceptance/rejection in our religions?
* very little knowledge of the texts in relation to MSM
* Islam focus is on duties and obedience
  - Sufi traditions most tolerant, where several Sufis of historical important had male to male relationships, such as Madholal Hussain, Sarmad, Amir Khusro
* God has made us as we are
* specific punishment in Quran: admonish and leave them
* Hinduism is a broad and eclectic system of beliefs, traditions and customs, including
  - Bhadirath
  - Ayyappa
  - Shiv Shakti
  - and a range of others relating to God as beloved, mother, father, etc.
* every religion teaches us tolerance, compassion, non-judgemental, non-violence
* need for more specific research into what specifically every religion says about MSM
* documentation
* distribute this documentation amongst the MSM projects
* develop guidelines around counselling for MSM and their religions

CONFERENCE RECOMMENDATIONS

1. Regular partner consultation meetings should be held every two years in different cities in South Asia. This networking process should also include support for localised networking meetings at state and national levels.
2. NFI to facilitate sharing and exchange of information and skills and develop an MSM trainers and consultancy network across the region.
3. NFI to pursue development of linked web pages for the internet for the partners network.
4. Increased support for advocacy for repeal for Section 377, and development of appropriate resources for local human rights initiatives and support.
5. NFI training manuals and other resources translated/developed in vernacular languages. They should include:
   * field services manual
   * community building strategies manual
   * social marketing
   * designing BCC materials
   * care and support
   * counselling
   * monitoring and evaluation
   * developing project proposals
   * financial management
   * management and administrative systems
6. More capacity-building training programmes developed for the projects on:
   - psycho-sexual issues
   - counselling
   - care and support
   - monitoring and evaluation
   - financial management
7. Protocols and guidelines developed for the network on:
   * telephone counselling
   * counselling on
     - HIV/AIDS and testing
     - sexualities and genders
     - marriage and children
     - psycho-sexual issues
     - religious beliefs and MSM
8. Standardised monitoring and evaluation system with clear Process and Outcome indicators for use by all the partner projects, both in manual and computerised format.
9. Support BCC resource development in all the vernacular languages.
10. Sustained capacity-building programme for all the partner projects bringing in other expertise and technical skills.
11. Access to water-based lubricant sachets urgently developed and distributed.
12. research issues clarified and research programmes developed utilising the network
    - religious issues and MSM
    - STI/HIV prevalence among MSM
    - MSM behavioural prevalence in South Asia
    - definitive anal STI treatment protocols and algorithm
    - masculinities, sexualities, genders and MSM in South Asia
13. MSM reference library developed accessible to network.
14. Increased financial support for MSM sexual health projects advocated from NACO and other donors
15. Develop working relationships with gay organisations towards advocacy and technical support.
16. Extend the network beyond South Asia to include South-East Asian initiatives.
17. Obtain funding to support sponsorship for each project in the partners network to send one representative to the 6th ICAAP Melbourne Conference in October 2001 and develop a shared booth space at the conference for the network partners to display their individual resources

OUTCOMES

* Information and skills shared between the different projects
* Increased networking amongst existent and new projects
* South Asia MSM AIDS Network (SAMAN) strengthened
* A commitment to share resources and advocate on each other's behalf
* A strengthened commitment towards a high quality standard of service delivery
* Skills building achieved on specific work-related issues
* Further training and capacity building needs identified
* Increased donor support for current individual projects, projects to be developed, and for the network
* A commitment to hold such meetings every two years, depending upon donor support

CONCLUDING STATEMENT

This was the first Naz Foundation International Partners Network Meeting following the Calcutta Conference on male reproductive and sexual health consultation meeting in March 1999.

The Partners Meeting brought together old friends and newly developed projects, providing a safe space to discuss issues of concern, share information, skills and knowledge, and highlight training, resources and knowledge needs.

With over 17 projects represented, a range of technical experts from the NFI's technical advisory network, donors and supportive guests, the range of issues covered were substantive.

Participants believed that "this conference continued from the historic moment that Calcutta represented, where the kothi voiced was heard loud and clear"...that "the conference was empowering moment for me.. we are not alone"... and ".. together we have strength..."

The conference also highlighted the range of work that is being requested of Naz Foundation International to support individual projects as well as developing the network and its information sharing capacities, resources and products.

Once again access to water-based lubricant was urgently highlighted, and the Conference urged NFI to develop such a product that was cheap, easily available and user friendly. While a new product was displayed at the meeting, an anal insertion lubricant based on suppository technology, conference participants wanted a range of options. As no water-based lubricant sachet was available in South Asia, NFI was strongly urged to advocate on this need.

Similarly, NFI was also urged to develop a range of training manuals, protocols, resource booklets and guidelines for the network projects, which have been highlighted in the recommendations.

At the same time, conference participants believed that such networking meetings made a significant contribution to the individual project's capacity, as well as providing an opportunity for exchange, community building and mobilising across the whole region.

For Naz Foundation International, this was both a challenging and a confirming conference, bringing together all is current partners to develop and advise NFI on its work, both current and future, and participants hoped that donors would recognise the needs expressed at the conference, and in this report, and support NFI and individual projects towards fulfilling those identified and expressed needs.

Naz Foundation International and its partners would like to thank the Royal Netherlands Embassy in New Delhi for its faith, commitment and support to enable this Conference to take place.

ANNEXE ONE

CULTURAL PERFORMANCES

Thursday, 7th December:	Subodh Rathhod, Wise Thoughts, UK
Friday, 8th December:	Rikh Basu, Praajak Development Society, Calcutta, India
Saturday, 9th December:	Arun Choudhary and Mithrudu, Hyderabad, India
Sunday, 10th December:	Anisul Islam Hero and Bandhu Social Welfare Society, Dhaka, Bangladesh Shiv Shaktis, Hyderabad, India

CONSULTATION MEETING TIME TABLE

Thursday, 7th December 2000

Registration

Welcome address	William Christy, Chair, Mithrudu, Hyderabad
	Arif Jafar, Executive Director, Bharosa, Lucknow
	Shivananda Khan Executive Director, Naz Foundation International

DAY ONE
Friday, 8th December 2000

9.30am Opening and Welcome

Chair: Shale Ahmed
Executive Director, Bandhu Social Welfare Society, Dhaka

Key Note Address: Lalitha Kumaramangalam
Executive Director. Prakriti- Sahodaran

Shivananda Khan
Executive Director, Naz Foundation International

10.30am Workshops

1.1 Fieldwork methodologies for kothis and their partners
1.2 Community building and mobilising
1.3 Social marketing of condoms
1.4 Developing education materials
1.5 Living with HIV/AIDS - care and support
1.6 Counselling MSM

1. 00pm LUNCH

2.30pm Workshops (continued)

4.30pm break

5.00pm Plenary Session: Feedback from the day

Chair: Shaleen Rakesh
Programme Coordinator, Naz Foundation India Trust MSM Programme

6.00pm Discussion Groups

1.1 building the network, sharing the resources
1.2 kothis, gay men and other MSM: gender and sexual identities
1.3 gay rights and/or sexual health rights?

DAY TWO
Saturday, 9th December 2000

9.30am	Plenary Session Chair: Sunil Menon, Project Coordinator, Sahodaran, Chennai Discussions from Day One Speaker: Rajesh Jhan Vice-President, EPOS India
l0.45am	Workshops 2.1 Female partners of MSM 2.2 Monitoring and evaluation 2.3 Writing a proposal 2.4 Fieldwork methodologies 2.5 Community building and mobilising 2.6 Social marketing of condoms
1.00pm	LUNCH
2.30pm	Workshops (continued)
4.30pm	break
5.00pm	Plenary Session: Feedback from the day Chair: Dev Anand, Programme Coordinator, Jagruthi-Gelaya
6.00pm	Discussion Groups 2.1 6th International Conference on AIDS in Asia and the Pacific, Melbourne, Australia 2.2 Research on masculinities, sexualities and HIV/AIDS interventions among MSM 2.3 Hinduism, Islam and MSM

DAY THREE
Sunday, 10th December, 2000

9.30am	Plenary Session	
	Chair:	Deep Purkayastha, Project Coordinator, Praajak Welfare Society Discussions from Day Two
	Speaker:	Dr. Carol Jenkins Senior Scientist, NIH, USA
l0.45am	Workshops	
	3.1	Developing education materials
	3.2	Living with HIV/AIDS - care and support
	3.3	Counselling MSM
	3.4	Female partners of MSM
	3.5	Monitoring and evaluation
	3.6	Writing a proposal
1.00pm	Lunch	
2.30pm	Workshops (continued)	
4.30pm	break	
5.00pm	Final Plenary	
	Co-chairs:	Arif Jafar, Bharosa William Christy, Mithrudu
	Feedback of recommendations to Plenary Feedback from Delegates	
	Closing speeches:	Shivananda Khan Executive Director, Naz Foundation International
	CLOSING CEREMONY	

FACILITATORS

Shale Ahmed, Bandhu Social Welfare Society
Sunil Menon, Sahodaran
Indrani Mirajkar, independent consultant
Subodh Rathod, Wise Thoughts
Tahir Khilji, Vision
Rajiv Dua, independent consultant
Hanif Khan, Sahodaran
Deep Purkayastha, Praajak Development Society
Arif Jafar, Bharosa
K.K. Abraham, INP+

SPEAKERS

Lalitha Kumaramangalam, Executive Director, Prakriti-Sahodaran, Chennai, India
Rajesh Jha, Vice-President, EPOS India, New Delhi, India
Dr. Carol Jenkins, Senior Scientist, National Institutes of Health, Washington DC, USA

CONFERENCE VOLUNTEER STAFF FROM MITHRUDU

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T. Avinash Kumar
G. Christopher Jaya Kumar
Jawar Mohammed
Gopi Nath
A. Shyam Rao
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