

Sexualities, Sexual Behaviours and Sexual Health

Consultation Meeting Of Representatives From
Governmental Organisations Working On HIV/AIDS
Prevention Issues From The Central Asian Republics

24th - 26th March, 1997, Almaty, Kazakstan

Report



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Title	Sexualities, Sexual Behaviours and Sexual Health Developing Strategies for Prevention and Control of HIV/AIDS in the Central Asian Republics
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The consultation meeting was organised to explore issues of male sexual behaviours and sexual health with a specific focus on males who have sex with males and their needs in the Central Asian Republics.

Representatives from governmental agencies working in the field of HIV/AIDS prevention and care in the Central Asian Republics participated in a series of working groups to share, dialogue, discuss and evaluate the personal, psycho-social, medical, political and religious impact of HIV/AIDS and the education, prevention, and support services available within their countries/communities for males who have sex with males, with particular attention being paid to the development of community-based AIDS service organisations in these countries.

Participants discussed the impact upon the management and control of STDs/HIV in relation to male to male sexual behaviours, the socio-cultural frameworks within the Central Asian Republics of males who have sex with males, the changing socio-economic-political structures since independence, and the growing influence of Islam within some of the Republics.

They also discussed the suitability and applicability of current HIV/AIDS education and prevention programmes and services and their relevance to the sexual and social health needs of males who have sex with males and explored the development of appropriate services through governmental support of community based organisations towards implementing and delivering such services.

Issues explored included psycho-social dynamics of male to male sex, good practice, provision of appropriate HIV/AIDS education and prevention, behaviours leading to possible HIV/STD transmission, empowering behavioural communities to develop community-based AIDS service organisations and provision of appropriate sexual health services.

Identifying gaps and shortcomings in current service provision, exchanging visions of ideal standards and religious values, and exploring appropriate methodologies for service delivery, the participants developed a series of recommendations on good practice, appropriate education and prevention. These recommendations will guide government and non-governmental agencies in developing policies and practices in these areas.

**Sexualities, Sexual Behaviours
and Sexual Health**

A Consultation Meeting Of Representatives From Governmental Organisations Working On HIV/AIDS Prevention Issues From The Central Asian Republics, Almaty, Kazakstan, 24th - 26th March 1997, was organised by the Naz Foundation with local technical assistance provided by UNAIDS Inter-Country Programme. The Consultation Meeting was sponsored by the Mercury Phoenix Trust and the Know How Fund of the Foreign and Commonwealth Office, British Government.

Organisers

Mr. Shivananda Khan of the Naz Foundation and Mr. Ali Firat of the Berlin Society of Turkish Health Professionals formed the organising team for the consultation. The Working Group Facilitators were Ms. Ludmillla Mamedova and Mr. Ulfat Mekhtiyev of the Azerbaijan AIDS Association 'ILHAS'. Opening presentations were made by Mr. Erkin Durmbetov, Deputy Health Minister of Kazakstan, Mr. Herbert Behrstock, Resident UN Coordinator, Chairperson of the UN Theme Group on AIDS, Ms. Ludmillla Mamedova and Mr. Khan.

Participants

21 participants from Kazakstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan took part. They were invited in their capacity of working in governmental HIV/AIDS agencies providing education, prevention and/or support and care.

Process

The number of people affected by HIV and AIDS is increasing in the Central Asian Republics. While these countries are deemed low-prevalence, it is an opportune time to explore risk issues and behaviours and develop appropriate strategies towards ensuring effective programmes of intervention that deal with a range of risk behaviours. The meeting focused on the growing recognition that male to male sexual behaviours in these countries play a significant role in any possible epidemic, and needs to be appropriately addressed. Clearly recognising that in developing such strategies, community-based organisations dealing with males who have sex with males would be more effective than any governmental approach, methodologies would need to be developed to ensure such developments. This was demonstrated by the work in Kyrgyzstan, and the recent discovery of several males who have sex with males who are HIV positive in Karagande, Kazakstan.

Recognising that the political, social, cultural and religious frameworks of these countries create specific issues in developing appropriate education, prevention and support services, the aim of the meeting was to bring together representatives from governmental AIDS service organisations working in the Central Asian Republics in a consultative process. During the process, Muslim religious values and beliefs, Soviet influences, psycho-social and cultural frameworks, economic issues, and personal male to male sexual behaviours that could lead to HIV transmission, medical practices, and human rights, were identified and explored. Participants looked at a range of strategies to halt the spread of HIV within their countries and communities, developing a series of guidelines and recommendations for implementation.

The consultative process involved a working group framework led by trained facilitators, who through a questioning process, created discussion, dialogue, sharing, information exchange, and debate to address the issues confronting males who have sex with males in the Central Asian Republics and develop methodologies to address their sexual and social health needs.

Scope And Purpose

1. To bring together representatives from National AIDS Programmes and sexual health services within the Central Asian Republics towards developing models of good practice for promoting sexual health amongst males who have sex with males.
2. To enable discussions and the sharing of skills, knowledge and information towards ensuring that STI/HIV/AIDS can be effectively managed and that a potential epidemic is prevented amongst males who have sex with other males.
3. To explore culturally appropriate frameworks of HIV education, prevention and care within these countries, particularly in terms of sexual health, taking into account issues of sensitivity, denial and shame and the political, social and religious concerns that sexual behaviour issues generate within these countries.
4. To promote the development of appropriate community-based strategies for prevention and control of STI/HIV amongst males who have sex with other males

1. Participants clearly stated that for effective STI/HIV prevention programmes, all risky sexual behaviours must be appropriately addressed. These should be seen in terms of the socio-cultural dynamics of the Central Asian republics with their Muslim and cultural past, the experience of the Soviet period, and the growing experience of economic dislocations for many of their citizens as the Republics experience rapid change from a planned economy to the free-market.
2. Recognising that male to male sexual behaviours exist in all the Central Asian Republics at unknown levels, and that unprotected anal sexual behaviour was most risky in terms of HIV transmission, participants discussed the socio-cultural contexts in which these behaviours exist. Exploring issues of identities, sexualities and labelling it was understood that while it may be possible to use the terms homosexual or gay men for some males who have sex with males, clearly this did not apply to all such males. Identifying individuals and service programmes by such labels would mean that significant numbers of males who have sex with males would remain unidentified and inaccessible.
3. The term males was used because it included those young boys and adolescents who also have sex with other males.
4. It was understood that both the penetrated and the penetrator (what participants called “active” and “passive” partners) were at risk in any sexual encounter between males, that their sexual behaviours and desires may not be central to their personal identity that their sexual networks may not have a social or community focus, and that their actual sexual practice may not be unitary but could be somewhat polymorphous, that is the penetrator may also be penetrated. In this context we could talk about behaviourally bisexual males.
5. Further it was understood that socio-cultural dynamics in Central Asia and a growing influence of Islam, may well indicate that significant numbers of males who have sex with males, whether penetrated or penetrator may also be married, creating conditions for a substantial impact upon female sexual health.
6. Issues of stigma and shame were discussed where the penetrated carried the most shame and seen as ‘feminised’, whilst the penetrator could still be seen as masculine. It was most likely that those were regularly penetrated, as their sexual preference could possibly have an identifiable sexual identity, whilst their penetrating partners may see themselves as ‘heterosexual’.
7. In this discussion, it was understood that in the context of the Central Asian Republics, personal identities were not focused on sexual behaviour and choice as such, but rather on family, clan, marital status, children, economic class, religion and nationality. This was demonstrated clearly in the terminology of local languages which have multiple words for different positions in an extended family, whilst in English there are single terms such as cousin, mother-in-law, and so on.
8. It was recognised that whilst the Soviet period had a significant influence upon the Islamic heritage of the Republics, in terms of what is stated publicly and what is done privately carries the same socio-cultural frameworks of Muslim social constructions. The Soviet experience of social control with the Muslim injunctions against public avowal of difference from the acceptable community standards leads to cultures that have substantial denial and invisibility of male to male sexual behaviours. The lack of any community organising based upon sexualities and sexual behaviours, and the public stigma and shame that configure male to male sexual behaviours, create great difficulties in addressing their sexual and social health needs.
9. Issues of appropriate terminology were also discussed and the relative merits of the use of the terms such as homosexual, active, passive, gay men, males who have sex with males, including the issue of risky behaviours versus risky groups. Participants agreed that strategies should focus on risky behaviours, and in the context of sexual health promotion, the term males who have sex with males was the most appropriate.

Strategies For Intervention

1. Participants agreed that there were only two possible strategies for STI/HIV prevention and control. These were defined as:
 - a. Don't do it
 - b. Do it safely
2. Adopting the "don't do it" strategy requires increased measures of social control and the use of deterrent frameworks which would include punishment. This strategy would require:
 - a. media campaigns promoting fear, intolerance and a moral message
 - b. rigid enforcement of the legal codes with an increase in policing, and surveillance of behaviour
 - c. use of employment practice in regard to dismissal and shaming
 - d. increased moral injunctions in educational institutions
 - e. increased enforcement of parental controls
 - f. increased use of testing of suspected individuals
 - g. increased use of imprisonment and other forms of punishment
 - h. possible use of shar'ia laws which include the death sentence
3. Such a deterrent strategy would sustain and increase stigmatisation which could lead to increased harassment, victimisation and violence, and abuse of human rights.
4. The question "does it work?" was asked. Could such a strategy reduce the risks of STI/HIV transmission amongst males who have sex with males? Can the use of fear and punishment control sexual behaviours?

Participants agreed that such a strategy would have an extremely limited affect only. Male to male sexual behaviours would be driven even further underground, making it more difficult to access in terms of sexual health issues. STI/HIV transmission would increase as a result.
5. Further it was recognised that there were substantial differences between what individuals said they did in public and what they did in private. Issues around sexual behaviours within closed systems such as prisons, the military, and other all male institutions could not be adequately addressed. Male to male sexual behaviours were not confined to clearly identified groups who could be targeted, but rather should be seen as part of the sexual repertoire of a significant number of males throughout the socio-economic frameworks of any of the Central Asian Republics. Such males could just as easily be a politician, a businessman, a soldier, a teacher, a student, an unemployed male, a hotel worker, a truck driver, as much as a self-identified homosexual or gay man.
6. The participants clearly rejected the deterrent "don't do it" strategy as unworkable in the long run, and a return to the social control frameworks of the Soviet era.
7. Participants strongly felt that the only workable and appropriate strategy for the prevention and control of STI/HIV amongst males who have sex with males was that of promoting a "do it safely" message.
8. Promoting safer sex behaviours amongst males who have sex with males means educating and encouraging such males to change sexual practice towards safer sex methods including an increased use of condoms, and to ensure that appropriate and accessible sexual health services were readily available for them.
9. Participants discussed what would need to be done for these to be achieved. This included:
 - a. provide frameworks of social support for such males to maintain this behaviour change
 - b. increase accessibility to appropriate condoms and lubricants
 - c. promote peer pressure and support for safer sex practices
 - d. de-stigmatise male to male sex and make it easier for such males to access sexual health services
 - e. promote community development for peer education and support
 - f. appropriate educational materials focusing on male to male sexual behaviours

- g. appropriate media campaigns to educate the general public
 - h. appropriate research and risk assessments conducted towards designing effective programmes
 - i. community-based organisational development, where beneficiaries act as agents of change
 - j. establishment of self-help groups encouraged
 - k. training for a range of public and private institutions on issues concerning males who have sex with males
 - l. accessible and appropriate sexual health centres which would provide anonymous counselling, testing and support
 - m. STI services taking into account anal sex and providing appropriate anonymous testing
 - n. National AIDS Programmes incorporating appropriate strategies for males who have sex with males
 - o. legislative changes to ensure increased access to appropriate sexual health services
 - p. sexual health education programmes that incorporate issues reflecting the needs of males who have sex with males for schools, colleges, universities, military, police, etc.
- 10.** Participants then went on to explore organisational definitions, purposes and differences of:
- a. governmental agencies
 - b. non-governmental agencies
 - c. community-based AIDS service organisations
 - d. gay organisations
- 11.** It was felt that AIDS service organisations and gay organisations have different priorities, whilst there were possible cross-overs in agendas. Also it was recognised that whilst homosexuals and gay men are males who have sex with males, not all males who have sex with males are self-identified as homosexuals or gay men.
- 12.** In the context of the provision of appropriate sexual health services it would be necessary to develop different organisations to address differing needs, both sexual health and social. Developing community-based male sexual health strategies focusing on males who have sex with males could be a possible umbrella term for a wide variety of strategies addressing differing groups, networks and individuals.
- 13.** Discussions then focused on whether government agencies or community-based agencies would be the most appropriate towards delivering appropriate sexual health programmes for males who have sex with males by exploring what the capabilities of each would be for such service delivery.
- 14.** Participants felt that community-based organisations would be more effective than government agencies in :
- a. providing peer education, prevention and support
 - b. accessing communities, networks and male to male sexual behaviours
 - c. developing trust and anonymity
 - d. mobilising communities
 - e. community development
 - f. local involvement and ownership of issues
 - g. flexibility
 - h. easy accessibility
 - i. reduce red tape and bureaucracy
 - j. provide grass-roots activism and involvement
 - k. involve beneficiaries as agents of change
- 15.** Differences between education and prevention were clearly identified, and participants agreed that whilst education can provide knowledge and information this does not necessarily change behaviours.

- 16.** What was needed to change sexual behaviour towards safer sex practices was:
- information and knowledge
 - desire to change
 - appropriate skills, i.e. condom use
 - availability of appropriate condoms and lubricants
 - continuous support to maintain behaviour change
- 17.** The responsibility of Government was discussed and included the following:
- ensuring the health and safety of all its citizens
 - providing appropriate education for all citizens
 - ensuring legal support and due process
 - addressing human rights concerns and abuses
 - ensuring access to appropriate services that address the sexual health needs of all its citizens
 - provide appropriate sexual health education which included the full range of sexual behaviours and sexualities
 - effective monitoring and surveillance programmes that do not abuse human rights provide social welfare
 - ensure that sufficient appropriate sexual products such as condoms and lubricants are easily and cheaply available and are of high quality and safety standards
 - invest in the development of community-based AIDS service organisations as active partners with Government
- 18.** The responsibilities of community-based organisations were delineated as well. These included:
- provide appropriate sexual health services to their constituents
 - involve beneficiaries as agents of change
 - provide community development and empowerment programmes
 - provide accessible counselling and support services
 - be accessible
 - provide advocacy support
 - provide access to behaviour groups through its networks
 - ensure financial and management responsibility
 - be accountable to its constituents
 - challenge human rights abuses
 - ensure programme effectiveness
- 19.** Participants recognised that community based agencies are not competing with or supplanting government services but rather work with such services to provide a complimentary framework towards ensuring that all people have access to an appropriate service to meet their needs.
- 20.** Both government and community-based AIDS service organisations need to work together to save lives. This requires a “shared responsibilities and shared rights” framework.

1. Participants discussed the differences between education and prevention and came to the following conclusions:
2. Education gives information, increases knowledge and teaches. It provides a theoretical framework and depends upon teaching skills and access to accurate and appropriate information whilst increases awareness of issues and facts.
3. Prevention on the other hand was seen as putting into practice what had been learnt. It involves promoting safer sex behaviours and practices, promotes methodologies of such practices and develops empowering strategies to enable people to put into practice what has been learnt.
4. For this to operate effectively amongst males who have sex with males, it would be necessary to ensure that there is:
 - a. easy availability and access to appropriate condoms and lubricants
 - b. readily available appropriate educational materials including how to use condoms
 - c. peer support for behaviour modification and a solidarity of practice
 - d. social support frameworks to promote group solidarity which may require community
 - e. community development, including economic development and empowerment
5. The term access was also discussed and, in terms of sexual health products and services, defined as involving quality, quantity, choice, price, availability and location.
6. Participants then explored the methodologies of service delivery by community-based AIDS service organisations and government agencies for males who have sex with males.
7. **Community-based AIDS service organisations**
 1. Identify, recruit and train peer leaders within the sexual networks to become peer educators and support behaviour modification.
 2. Produce and distribute appropriate sexual health educational materials for males who have sex with males, taking into account literacy, terminology, imagery, social frameworks, age and behaviours.
 3. Provide training and sensitisation programmes on male to male sexual behaviours and sexual health for different government and non-government institutions
 4. Provide accessible and anonymous sexual health counselling and support.
 5. Act as an advocate.
 6. Develop a range of social support groups and community development programmes.
 7. Conduct appropriate needs and risk assessment studies amongst males who have sex with males, using this information to develop appropriate strategies of intervention and promotion of sexual health amongst them.
 8. Develop an effective referral service, networking with a range of high quality and appropriate sexual health clinics and services.
 9. Provide an anonymous telephone advice and information service.
 10. Work with the media towards public education.
 11. Provide safe and secure drop-in facilities.
 12. Distribute appropriate condoms and lubricants through processes which include social marketing as well as free distribution.
 13. Educate constituents on condom usage.
 14. Promote safer sex behaviours among its constituents through outreach work and peer education.
 15. Provide social and educational public events to raise awareness of the issues and to generate income.
 16. Recruit and train staff and volunteers from the male to male sexual networks so as to ensure that beneficiaries are empowered to act as agents of change.
 17. Establish sexual health discussion groups so as to promote peer support for behaviour modification towards safer sex practices.
 18. Provide appropriate and accessible accommodation to house equipment, staff and facilities.
 19. Work closely with STD services and other AIDS service organisations towards addressing the needs of males who have sex with males and to improve quality standards.

20. Work closely with governmental institutions and agencies towards implementing national AIDS control strategies and towards ensuring that legal and regulatory impediments to sexual health service delivery for males who have sex with males are amended appropriately or removed.

8. Government agencies

1. Financially invest in community-based AIDS service organisations, as well as improving the quality and accessibility of its own sexual health services.
2. Develop, provide and distribute sexual health information which include appropriate and accurate inform on all sexual behaviours.
3. Procure, provide and distribute condoms and lubricant to ensure easy accessibility at affordable prices.
4. Address human rights concerns by implementing and acting on the range of policy documents, guidelines, and recommendations produced by UN agencies as they affect the sexual health of males who have sex with males.
5. Amend any law, regulation or policy which impedes appropriate access to sexual health services by males who have sex with males.
6. Promote and encourage the development of community based organisations through financial support, technical assistance and capacity building, networking and enable them to access media and government ministries where appropriate.
7. Collaborate with community-based organisations towards developing and implementing national AIDS strategies.
8. Collaborate with community-based agencies to enable them to access closed male systems, such as the military and prisons towards increasing awareness of safer sex issues.
9. Localise and decentralise sexual health service delivery and decision making.
10. National AIDS Programmes to regularly monitor and evaluate ministerial action plans and their implementation, and make appropriate recommendations for change if necessary.
11. Implement an effective and anonymous surveillance programme which is accessible and free.
12. Develop a National AIDS Advisory Committee to advise the National AIDS Programme Coordinator which should include representatives of community-based organisations as partners.
13. Clearly recognise and accept grass-roots experience and activism.
14. Regularly review the National AIDS Programme for effectiveness.
15. Upgrade the technical expertise and knowledge of government officials.

9. Participants also explored designing and implementing a community-based project to address the sexual health needs of:

- a. homosexual and gay-identified men
- b. male sex workers and males who have sex with males

and were asked to address the following questions:

- a. What is the overall goal?
- b. What is the purpose of this Project?
- c. Who is the target/behaviour?
- d. What would the outputs be?
- e. How will the Project be implemented?
- f. Who will implement?
- g. What would the work consist of?
- h. How will the work be done?
- i. Who will do the work?
- j. Where will they get their skills?
- k. How will the success of the Project be measured?

1. Participants explored male sexual behaviours and STI/HIV transmission and their impact upon both male and female sexual health, with a specific focus on males who have sex with males in the socio-cultural context of the Central Asian Republics.
2. This led to an understanding that it was extremely important for National AIDS Programmes and Government to recognise and acknowledge that male to male sexual behaviours do exist in the countries of Central Asia, and that in addressing sexual health issues in these countries it was essential that Government take responsibility for ensuring appropriate education, prevention and care programmes are available to address the needs of males who have sex with males.
3. Recognising the socio-political issues that this may involve, it was suggested that any strategies and programmes developed to address the sexual health needs of males who have sex with males could fall under the general rubric of “male sexual health programmes”.
4. Participants also believed that without such an acknowledgement and appropriate action taken, no effective strategic response to the control and management of STI/HIV/AIDS could be developed.
5. It was recognised that different cultures may well have different frameworks of sexual identities and that the terminology of heterosexual, homosexual or bisexual may not be appropriate to address all the issues of male to male sex in the Central Asian countries. It may therefore important to separate sexual behaviour from sexual identity. That is not so much who a person is but what they do. In this context, it is risk behaviours that should be targeted, not “risk groups”.
6. In societies where frameworks of shame predominant, where public (and even private) discussions of sex are often taboo, and where there may be a growing influence of Islam, such behaviours will be substantially hidden and difficult to access.
7. These behaviours should not be stigmatised as part of a Western “invasion” or capitalism, nor blamed upon the Soviet experience. There is considerable historical evidence to indicate that male to male sexual practices substantially existed in the Central Asian Republics prior to both the Soviet and Western experiences.
8. Using a deterrent strategy to prevent male to male sexual behaviour was discussed, but participants felt that while this may work for some, for others it would only drive these behaviours further underground. Use of punishment and deterrence were felt to be only a partial solution and would not eradicate such behaviours. Participants felt that what was needed was the development of a more pragmatic approach towards STI/HIV/AIDS education and prevention for males who have sex with males.
9. Participants also discussed mandatory testing of those defined as “high risk groups”, but believed, as has been shown in countless studies, that mandatory testing cannot be justified medically, socially or economically and is an abuse of human rights. The issues of control and management of STI/HIV infections must be addressed through education and awareness programmes, as well as through appropriate prevention strategies clearly targeted at risky behaviours.
10. It was recognised that there is a significant difference between public statements and private practice in the context of male to male sexual behaviours, because stigma, illegality, denial and invisibility exist so strongly. This means that identifying those males who have sex with males will be particularly difficult unless programmes can gain the active cooperation and support of those from these sexual networks who may act as peer educators amongst them.

11. Because of this stigmatisation and illegality, many males who have sex with males will not access what sexual health services exist because of fear and a lack of confidentiality.
12. There is a lack of data on actual sexual behaviours and their diversity within Central Asian societies. Too much reliance is placed upon ignorance and assumptions based upon Muslim/Soviet ideals. This creates difficulties in developing appropriate strategies for the prevention of HIV infection.
13. There is also a lack of appropriate sexual health education and STI/HIV/AIDS information and knowledge amongst the general public and through such ignorance, prejudice, fear and harassment of those seen as “risk groups” will increase, making it more difficult for males who have sex with males to access sexual health services. Sexual health education should be developed addressing all forms of sexual behaviours, sexualities and identities towards de-stigmatising any particular behaviour or group and should include both formal and informal methodologies.
14. It was also understood that in any education and prevention strategy, it should be recognised that people exist in many different social spaces, including homes, schools, colleges, working environments, and on the streets. They also exist in different living environments, rural or urban, and in different economic groups. It would be important to address all these social spaces with appropriate education.
15. Further, appropriate strategies for education and prevention would need to be developed that deal with the short, medium and long term issues for maintaining safer sex practices.
16. A lack of appropriate condoms and lubricants suitable for anal sex and a lack of available appropriate educational materials concerned with the sexual health needs of males who have sex with males were seen as urgent issues that need to be addressed.
17. With rapid economic changes in the Central Asian Republics leading to increasing migration from rural areas to towns and cities, cross-border migrations, high unemployment, and poverty, many young people with a need to support their families and themselves, are easy prey to victimisation and abuse through employment and/or sexual exploitation. In other situations both parents may be working, and children have to fend for themselves during the working day with a lack of proper attention and supervision.
18. Poverty, social inequality and lack of empowerment lead to poor general health and access to medical and social care may be very difficult. Poverty may also generate behaviours that lead many young males to increased risky behaviours, such as “commercial sex work”, lack of sexual hygiene, low nutrition and diet, which all affect sexual health.
19. Effective awareness and sensitisation training programmes for government and non-government institutions need to be implemented to address the lack of knowledge and understanding that surrounds male to male sexual behaviours in Central Asian countries.
20. Because STI/HIV/AIDS is often only seen as a medical issue, the psychological and social dimensions are ignored leaving individuals being treated as a medical condition and not as human beings. Developing prevention strategies that ignore the psycho-social-behavioural frameworks would increase the sense of marginalisation and isolation for many males who have sex with males, where there is a need for self-help and mutual support towards encouraging solidarity in safer sex practices.
21. Government institutions at national, regional and local level, often develop policies and strategies around HIV/AIDS education, prevention and care without consulting those most likely to be affected. Government agencies are often isolated from people who practice risk sexual behaviours and therefore cannot truly represent their interests or develop appropriate strategies for education, prevention and support .

22. It was also recognised that many government agencies and personnel involved in sexual health issues do not have the necessary knowledge, understanding or skills to address the sexual health concerns of males who have sex with males. They would need to access capacity building and technical expertise in this area.
23. It was believed that this may mean that certain laws, regulations and policies that affect males who have sex with males will need to be amended so as to increase their accessibility to sexual health services without fear of discovery, stigmatisation, harassment and possible arrest.
24. How to access males who have sex with males without generating fear and ensuring confidentiality and anonymity, was seen as a crucial issue. Lack of recognition, denial and invisibility means very little accurate information exists upon which appropriate programmes for education and prevention could be developed. Risk and needs assessments need to be done as a priority. This would require identifying appropriate individuals amongst males who have sex with males to conduct such research. Participants believed that it would be more appropriate to encourage the development of community-based AIDS service organisations serving the specific needs of males who have sex with males, and perhaps managed by themselves as a self-help organisation.
25. However, an added difficulty was the lack of non-government community-based organisations in the Central Asian Republics addressing such issues. Participants believed that it would require the support and encouragement of Government towards enabling the development of such agencies before services could be effectively delivered. It was also accepted that only through such agencies could effective methodologies be developed in a long term strategic response towards prevention of STI/HIV transmission amongst males who have sex with males.
26. There was a lack of technical skills in developing community-based agencies whether it be around infrastructure, developing service delivery and implementation, management, financial accountability, outreach strategies, monitoring and evaluation, or producing budgets and accounts. This would need to be urgently addressed by accessing appropriate technical skills through national or international agencies working in this specific arena.
27. Community-based AIDS service agencies should not be seen as competitors to government services nor as alternatives to supplant government services. Rather they should be seen as partners, collaborating with government services in areas which would be difficult for government services to reach or address.
28. Governments would need to play a lead role in encouraging the development of community-based AIDS service organisations and would need to invest in and empower them to deliver appropriate services for males who have sex with males, through ensuring that such agencies have access to finance, appropriate technical expertise towards capacity-building, safety and security, independence and networks, for them to provide an effective service. Such support should not be seen as a short term strategy, but as long term. Funding should be developed not as an annual round, but over 3 to 5 years. Such financial support should be seen as an “investment in the future”.
29. Groups, networks, and service agencies often operate in isolation from each other leading to duplication of education resources, ineffective methodologies of working, lack of appropriate information and, to some extent, competition for resources. Agencies working in one locality, region or country may have learned a wide variety of lessons dealing with the complexities of the issues. Other agencies in other parts of the world may be able to learn from these experiences and implement them in their own programmes. It is therefore very important that agencies should work together, form alliances, actively network with each other, and share information. HIV/AIDS while being localised is also a global pandemic.

- 30.** Networking enables the development of appropriate skills, empowerment, access to appropriate training, as well as availability of appropriate education and prevention materials. Mechanisms would be needed to develop a range of forums which could lead to sharing of skills and information for the development of effective management, expertise, methodologies, cost-effective utilisation of resources, and strategic approaches. These networks should look at local, regional, national and international forums which community-based agencies could access and actively participate in through appropriate mechanisms. In particular, as agencies working with Central Asia and amongst Muslim communities, the issues of concern can be more readily understood, appreciated and articulated within shared and mutual agendas.
- 31.** As the number of community-based agencies addressing sexual health issues grows, so many such agencies will be dependent upon funding from a range of local, regional, national and international donors. Concerns about the sustainability of nongovernmental organisations were expressed, both in terms of access to funding as well as to the lack of technical skills. At the same time participants expressed concerns regarding the application of international guidelines on a range of HIV/AIDS issues at local, regional and national levels. Monitoring, ensuring appropriate and just implementation, and the existence of legal frameworks and penalties for non-compliance were concerns that were raised.

1. Participants believed it was extremely important for the development of effective management and control of STI/HIV/AIDS in the Central Asian republics to acknowledge the existence of males who have sex with males within their own countries as an issue of sexual health concern.
2. With such a recognition, participants also agreed that a deterrent strategy would not be effective or appropriate in preventing STI/HIV transmission amongst males who have sex with males. Participants agreed that a more pragmatic approach would be necessary and the only effective way ahead would be through the promotion of safer sex activities by Government encouraging and empowering males who have sex with males to develop their own sexual health service agencies.
3. It was believed that non-governmental community-based agencies would be the best way forward because it was understood that Government agencies would have difficulty accessing such behaviours.
4. Such an approach would require the recruitment of males from these male to male sexual networks, provide them with the appropriate technical expertise and finance, and enable them to conduct the delivery of a range of appropriate services. Here the beneficiaries of sexual health programmes would act as agents of change towards safer-sex practices.
5. This may well require Government to look at legal, regulatory and policy issues regarding male to male sexual behaviours which restrict accessibility to sexual health services and make the necessary amendments to encourage access.
6. Such processes of empowerment would require adequate funding, access to appropriate training and skills enhancement, as well as programmes for networking at local, regional, national and international levels, with advocacy support for males who have sex with males affected by or living with HIV/AIDS.

Recommendations

The challenge of HIV and AIDS confronts all countries and communities globally. Government, nongovernment and community-based agencies, as well as other institutions, should work together to face this challenge if there is to be any hope of effective strategies to control and manage HIV transmission so as to reduce the levels and rates of infection. Otherwise, more people will die from AIDS related illnesses.

Whilst there is a growing array of drug treatments to prolong life, and maybe one day provide effective treatment for HIV, the costs of these drugs are prohibitive and beyond the reach of the majority of countries. The only real hope currently is to ensure that each country has an effective prevention strategy that addresses all risky behaviours and practices. No country can afford to ignore or deny what occurs within it, whether a particular sexual practice or identity is deemed to be immoral, illegal or against its culture. Such denial creates ideal conditions for the growth and spread of HIV infections.

This consultation meeting brought together representatives from the National AIDS Programmes of the Central Asian republics to discuss a specific stigmatised sexual behaviour, one that is often denied in these countries, one that is highly invisible, but where there is growing evidence for a rise in HIV infections. The issue was male to male sexual behaviours.

Participants were encouraged to discuss and debate the issues that such behaviours raise and seek strategies for appropriate HIV prevention strategies that would address the sexual health needs of males who have sex with males.

It was clearly recognised that because of denial, invisibility, stigmatisation and illegality, males who have sex with males may already face considerable risks of harassment, violence, and imprisonment. HIV/AIDS could possibly create another framework for further victimisation. It was therefore incumbent upon National AIDS programmes and AIDS service organisations to work towards preventing stigmatisation and victimisation of males who have sex with males, as much as towards preventing STI/HIV infections amongst them.

Participants discussed a deterrent strategy for the prevention of HIV transmission, but believed that this would only drive male to male sexual behaviours even further underground than it already is. Such a strategy would effectively prevent education and awareness programmes, rather than prevent HIV transmission.

It was therefore accepted that the only effective and appropriate HIV/AIDS education and prevention strategy would be to promote safer sex behaviours amongst males who have sex with males and ensure that appropriate and accessible sexual health services are available and accessible to them which respect their confidentiality and anonymity and build upon trust and respect.

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

Further participants accepted that males who have sex with males may not access services provided by Government agencies for a range of reasons, including a lack of trust and loss of confidentiality. It would be more appropriate and effective if the beneficiaries of services acted as agents of change. This means that it would be necessary to support the

development of peer-led community-based AIDS service organisations working with males who have sex with males.

Based on the agreed principles above, the following recommendations arose from the deliberations of the participants.

1. The Role of National AIDS Programmes and Government

- 1.1** National AIDS Programmes and governments must accept and acknowledge the existence of male to male sexual behaviours in their countries and take responsibility for ensuring appropriate education, prevention and support programmes are available and accessible to address the sexual health needs of males who have sex with males.
- 1.2** Governments should play a lead role in encouraging, investing and enabling the development of peer-led community-based AIDS service organisations by investing in, and empowering them, to deliver appropriate HIV prevention and sexual health services for males who have sex with males.
- 1.3** In order for this to occur, government and other agencies will need to ensure that they can gain the trust and confidence of males who have sex with males by ensuring confidentiality, safety, security and anonymity.
- 1.4** This requires a political and social commitment by Government and National AIDS Programmes to support peer-led initiatives developing HIV/AIDS education and prevention services, where the beneficiaries of change act as the agents of change.
- 1.5** Such an investment in the development of appropriate sexual health services for males who have sex with males would be in the form of:
 - 1.5.1 provision of long term financial support
 - 1.5.2 provision of, or unhindered access to, technical assistance
 - 1.5.3 access to capacity-building training
 - 1.5.4 addressing legal and regulatory constraints which may hinder the development of such peer-led community-based agencies
- 1.6** Recognising that not all males who have sex with males will be accessible to sexual health services, whether provided by government or community-based agencies, National AIDS Programmes will need to develop appropriate frameworks for a national programme on sexual health education amongst the general public that takes into account the sexual behaviours of males who have sex with males.
- 1.7** National AIDS Programmes should provide training and awareness programmes to government and non-government agencies providing sexual health services on the social and sexual health needs of males who have sex with males in order to address the lack of knowledge and understanding. Such programmes will provide unbiased information, sensitisation, as well as de-stigmatise the issue.
- 1.8** Where laws, regulations and policies hinder males who have sex with males to access sexual health services, or discriminate against them through intimidation, fear, harassment, violence, denial or the risk of imprisonment, then these should be amended or repealed to empower such males to access these services.
- 1.9** Each Central Asian country should have a National AIDS Advisory Committee to inform, advise, monitor and evaluate the implementation of their National AIDS Programmes. Such a committee should include representatives of non-governmental agencies and community-based agencies delivering sexual health services, including those working with males who have sex with males.

Recommendations

- 1.10** National AIDS Programmes should also develop national educational strategies to educate the general population against discriminatory attitudes towards HIV/AIDS and sexual behaviours as well as to de-stigmatise male to male sexual behaviours through the use of mass-media.
- 1.11** Sexual health programmes that include male to male sexual behaviours should also involve schools, colleges and universities, families, business, the military and prisons.
- 1.12** National AIDS Programmes would also need to ensure that appropriate condoms suitable for anal sex and lubricants are readily available and accessible to males who have sex with males, ensuring good quality, affordable prices and adequate distribution in a variety of locations.
- 1.13** National AIDS Programmes, in collaboration with other government and nongovernment agencies, as well as community-based agencies at local, regional, national and regional levels, should work together in partnership to formulate effective and appropriate policies and programmes on HIV/AIDS.
- 1.14** This can be achieved through regular meetings, consultation, and the establishment of Partnership Forums.
- 1.15** There should be effective collaboration between National AIDS Programmes, community-based agencies, and international agencies such as UNAIDS, UNCEF, UNHCR and others, towards implementation of agreed policies, recommendations and guidelines, locally adapted to address concerns of human rights abuse, service development for males who have sex with males, accessibility to these services and to reduce discrimination.
- 2. Risk and needs assessments**
- 2.1** There is an urgent need to develop risk and needs assessments amongst males who have sex with males in the different Central Asian republics.
- 2.2** These assessments would need to be done through the auspices of appropriate peer researchers to ensure the validity of data, an appropriate analysis of the data, and adequate protocols on confidentiality.
- 2.3** It will be important to ensure that adequate funding is available for effective risk and needs assessments to be conducted.
- 2.4** Such research must assure respondents that data collected will not be used against them, that their confidentiality and anonymity will be respected and that collected data will only be used to develop appropriate strategies for the prevention of STI/HIV/AIDS amongst them.
- 2.5** This will enable culturally and behaviourally appropriate methodologies to be developed to effectively implement strategies for the control and management of STI/HIV/AIDS amongst males who have sex with males.
- 3. Community-based AIDS Service Agencies**
- 3.1** Acknowledging the lack of technical skills in developing community-based agencies whether it be around infrastructure, developing service delivery and implementation, project management, financial accountability, appropriate outreach strategies, monitoring and evaluation, resource design and development, needs assessments, or producing budgets and accounts, such agencies must be provided with assistance to access these skills through training and capacity building from appropriate consultants.
- 3.2** STI/HIV prevention programmes targeting male to male sexual behaviours will need to include short, medium and long term strategies towards ensuring that safer sex behaviours are not only encouraged but also maintained over the long term. This can be achieved through peer interventions and on-going peer-support.

- 3.3** Community-based agencies would need to be involved with the National AIDS Programme in its country in distributing appropriate sexual health products and educational resources (such as condoms, lubricants and literature) targeting male to male sexual behaviours.
- 3.4** Different distribution strategies should be explored such as social marketing, free distribution as well as a variety of private and public locations.
- 3.5** Appropriate peer education initiatives should be encouraged and supported. Safe spaces should be developed where individuals and groups can gain access to confidential information as well as discuss issues around sexualities and sexual health within an appropriate context.
- 3.6** Appropriate educational materials need to be developed, promoted and distributed amongst males who have sex with males in regard to STI/HIV/AIDS, safer sex practices, condom usage and sexual health issues.
- 3.7** Psycho-social support programmes need to be part of any on-going sexual health programme for males who have sex with males. These would include telephone lines (“hotlines”) providing free and anonymous advice and information, social support groups, sexual health discussion groups, and other services deemed appropriate and needful by males who have sex with males themselves.
- 3.8** There should be regular consultation between such community-based AIDS service agencies and National AIDS Programmes to ensure that issues, needs and service development is always reflected in any AIDS programmes and strategies.
- 3.9** Networking enables the sharing of appropriate skills, educational materials, knowledge and information which can enhance the capacity of an AIDS service agency. This should be encouraged and supported by Government through the provision of any necessary technical assistance so that agencies can access and actively participate in local, regional, national and international forums.
- 3.10** New networks could also be developed to include:
- a. a Turkic language network of males who have sex with males sexual health projects
 - b. Central Asian networks
 - c. a Muslim HIV service agency network
- 3.11** Community-based AIDS service organisations should be provided with long term funding which would include core costs as well as project costs and sustainability issues must be thoroughly explored with such AIDS service organisation to ensure programme continuity.

Working papers

1. The Silent Killer: AIDS and the Muslim world
Dr Munwar Anees, 1993
2. Naz Foundation response to this paper
3. Role of Religion and Ethics in the Prevention and Control of AIDS
Consultation document by WHO Eastern Mediterranean Regional Office, 1992
4. Sexuality and Sexual Health in South Asia
Shivananda Khan, 1993
5. The Islamic perspective on sex education
reproduced from the sex education forum report, UK, 1995
6. Developing Appropriate Strategies: Summary Report
Consultation meeting of NGO representatives from Muslim Countries working on HIV/AIDS prevention and care issues. A Naz Meeting, 1995

Other available papers

1. Cultural Constructions of Male Sexualities in South Asian Cultures
Shivananda Khan, 1995
2. Sexuality and Eroticism Among Males in Muslim Societies
a collection of essays printed in 1995
edited by Arno Schmitt and Jehoeda Sofer
3. Bacabozikj: male love, folksong and literature in Central Asia
Ingeborg Baldauf, 1990
an essay
4. sexualities, sexual behaviours and sexual health
workshops in Bangladesh and India for males who have sex with males
Shivananda Khan, 1997
5. Observations on male to male sexual behaviours in Bangladesh
Shivananda Khan, 1997
6. Culture, religion and human rights
social constructions of male to male sexual behaviours
implications for human rights
Shivananda Khan, 1996
7. Under the blanket
bisexualities and AIDS in India
Shivananda Khan, 1996
8. Through a window darkly
males selling sex to males in India and Bangladesh
Shivananda Khan, 1997

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