Advocacy, policy and support on male sexualities

Naz Foundation International

Development manual

Developing community-based organisations addressing HIV/AIDS, sexual health, welfare and human rights issues for males-who-have-sex-with-males, their partners and families

Book 1

Introduction

Dedication

This series of books is dedicated to all those *kothis*, their partners and families who have died from AIDS alone and uncared for.

Thanks

We would like to thank all those who have participated in social and needs assessments, sexual health projects, interviews, workshops and meetings for their patience, honesty, openness, and friendship, people who patiently told us their stories in parks, tea-stalls, street corners, restaurants, rickshaws, and hotel lobbies. We would also like to thank those individuals and organisation that have taken up the challenge to develop appropriate service responses to the expressed needs of males who have sex with males, for whom this manual is written. This resource would not have been possible without them.

We would also like thank UNAIDS for their financial support and encouragement in upgrading this resource.

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This book, and the remaining books in the series can be obtained electronically from www.nfi.net or from our India office below. Additional language versions will be available, so please check the website for more information.

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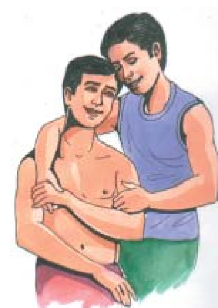
Introduction to the series



This is the first in a set of handbooks, that provides a theoretical framework, and a step by step approach to developing community based organisations addressing males to males sex and associated issues. This set has arisen out of the extensive community development work that the Naz Foundation International has undertaken in South Asia in addressing issues which affect males who have sex with males (MSM). Since 1996, the model detailed in this series has been used to develop more than thirty projects community based organisations (CBOs) addressing MSM issues. We hope that in its new format these handbooks will assist in the development of many more CBOs, to ensure that all MSM, their partners and families have access to appropriate sexual health, HIV/AIDS prevention, care and welfare services.

The series

This series of handbooks provides a comprehensive guide and tool kit towards developing a community-based male sexual health programme working with MSM and associated issues

It is designed to be MSM and associated issues specific, focusing on the most visible of MSM from low-income networks, those whose self-identify as feminised males, such as *kothis*. It is based on the principles of self-help and peer education, using trained MSM to train others to develop their own services.

Once trained, and appropriate services are developed, these key individuals are not only used to access others like themselves, but also to reach out to their partners, and other MSM, towards building a comprehensive male sexual health programme.

The set consists of 6 books:

Book one: Introduction
Book two: Setting the context
Book three: First phase: Social and needs assessment
Book four: Second phase: Implementing an MSM sexual health project
Book five: Tools for management
Book six: Other resources

The workshop outlines that are detailed follow a time-table and agenda that has arisen from the many workshops NFI had conducted. It recognises that for the majority, there would be almost no experience of HIV/AIDS, community-based working, or understanding of the context in which sexual health promotion takes place. However, these timetables and agendas are not set in stone, and can be amended as and when necessary.

NFI has used its own trained trainers to implement the development of MSM sexual health interventions, and it is recommended that those wishing to utilise this resource should thoroughly familiarize themselves with the theoretical perspective, language, and a deep understanding of the frameworks of MSM behaviours, identities, sexualities and masculinities before proceeding. Please contact NFI if you wish to access NFI's trained trainers.

Introduction to the Naz Foundation International

The Naz Foundation International (NFI) is an international non-governmental organisation that exists to improve the sexual health, welfare and human rights for MSM, their partners and families. It does this by advocating for their sexual, welfare and human rights, developing policies on these issues and by providing technical, financial and institutional support to MSM networks, groups and organisations in developing countries.

It works in developing countries to ensure that issues of male sexualities and sexual practices, and the health, welfare and human rights issues that arise from these, are appropriately and adequately addressed in the provision of HIV/AIDS, sexual health, welfare and human rights services.

Wherever possible, NFI will provide technical assistance, capacity building and support to local self-help sexual networks, groups and organisations, for the development of community-based and beneficiary-led HIV/AIDS, sexual health, welfare and human rights services and advocate for this.

What NFI believe's in

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

NFI's vision

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

With a primary focus on MSM, NFI's mission is to empower socially excluded and disadvantaged males to secure for themselves, social justice, equity, health and well-being through technical, institutional and financial support.

NFI's objectives

- To empower low-income MSM collectivities, groups and networks, through technical, financial and institutional support, to develop and deliver their own self-help sexual health, welfare and human rights programmes addressing their needs, and the needs of their partners and families.

- To work with other organisations to improve the lives and well being of MSM, their partners and families.

- To advocate on social justice and human rights concerns of low-income MSM, their partners and families.

- To foster cooperation, understanding and support between organisations developing responses to sexually transmitted infections (STIs)/HIV/AIDS, sexual health, welfare and human rights needs of MSM, their partners and families, and those with other constituencies.

- To undertake research to highlight the issues and problems that marginalised and socially excluded MSM face, identify solutions and pro-actively promote these findings, as well as understand the context of masculinities and sexualities, which

can lead to more effective and sustainable sexual health promotion strategies for MSM.

- To identify and lever appropriate funds, resources and technical assistance to sup port the above activities.

"I admire the work of Naz Foundation International, and its efforts to raise the profile of sexual health, a subject which has been ignored for too long.

It is important that subjects such as sexual diversity do not remain taboo subjects, but that through education and debate, these subjects are discussed and considered. This is the only way in which we shall be able to challenge the ignorance and prejudice that is prevalent."

Lord Dholakia OBE

Member of the House of Lords, (UK Parliament)

Naz Foundation International services

Regional self-help programme

Provision of training and technical assistance to empower local networks to develop their own self-help projects.

Regional training and resource centre

Based at the NFI's South Asian regional office in Lucknow, northern India, it provides a range of regional training programmes and an information library on gender, masculinities, sexualities, HIV/AIDS, sexual health, human rights and welfare issues.

Partnership programme

Working with its partner agencies, NFI facilitates networking, information and skills exchange as well as regional support.

Behaviour change communication resource development

Produces a range of behaviour change communication (BCC), education and information materials, on a range of HIV/AIDS/sexual health, welfare and human rights issues.

Advocacy

Working with a range of international, national and local institutions, agencies and organisations to advocate social justice, equity and well-being among vulnerable males, their partners and families.

Research and documentation

Develops, coordinates, collaborates, and advocates research and studies into issues that affect the health, wealth and human rights of vulnerable males their partners and families.

Glossary of terms used in the series

Binary

Implies masculinity and femininity or male and female.

Gender

Whilst there are some basic biological differences between female and male bodies, linked in part to their different roles in reproduction, beyond these differences, many societies define different roles, rights, and responsibilities for women and men. Gender is the term used to refer to these socially defined differences between men and women.

Perceived gender differences are based on widely shared beliefs and norms within a society or culture about male and female characteristics and capacities. These beliefs and norms about gender usually create inequality between men and women. In most societies, men have more political, economic, and social power than women. Such gender inequalities have a significant impact on women's and men's sexual health.

Gendered framework

The word gender is a classifying noun, but often when the term gender is used, it is focused on women, where men are absent as a gender in themselves. In this document the term "gendered" is used to describe a state. For example, in South Asia, where there is often fairly strict social "policing" of gender boundaries, and where the primary (and visible) framework of male-to-male sexual behaviours is constructed not around sexual orientation, but around gender identities, the term gendered framework is used as a short-hand description of this state of affairs, i.e. males who identified as *kothis*, do not perceive themselves as males, but as "not-males" or feminised males.

Hierarchical and oppositional framework

These terms are used where these genders and their qualities can be seen as a hierarchy and in opposition to each other. In other words, maleness is seen as superior to femaleness and in opposition to it.

Homosocial and homoaffectionalist culture

In South Asia, gender segregation in social spaces tends to be a strong form of social "policing" of cross-gender relationships. Primary relations are therefore usually between the same gender, forming homosocial cultures. Homoaffectionalism in the sense that the term is used in this text means social acceptance of the public display of male-to-male or female-to-female affection. For example, it is common in Bangladesh to see two males holding hands or arms wrapped around each other as they walk. Often male friends will also share beds when sleeping, wrapping themselves around each other.

Hijras

A self-identified term used by males who define themselves as "not men/not women" but as a "third gender". *Hijras* cross-dress publicly and privately, and are a part of a social, religious, and cultural community. Ritual castration may be part of the *hijra* identity, but not all *hijras* are castrated. Sex with other males is common. They also have their own language, known as *ulti*.

Kothis (in Nepal; *metis,* and in Pakistan; *zenanas*)

A self-identifying label for those males who feminise their behaviours (either to attract "manly" male sexual partners and/or as part of their own gender construction and usually in specific situations and contexts), and who state that they prefer to be sexually penetrated anally and/or orally. *Kothi* behaviours have a highly "theatrical" quality in social spaces. Self-identified kothis also use this term for males who are sexually penetrated, even when their behaviour is not feminised. This is the primary and most visible framework of MSM behaviours. *Kothis* state that they do not have sex with other *kothis*, although this is not always true. They may also be married to women.

Masculinity

Masculinity is interpreted as the predominant and "hegemonic" framework, which defines how a "man" should behave and act - personally, sexually, socially, and culturally. However, it is also recognised that there are different constructions of masculinity that vary across cultures, age groups, sexual orientations, sexual preferences, actual behaviours, gender identifications, economic classes, and religions.

Males-who-have-sex-with-males

We use the term "male", to take account of the different physical ages, and constructions of malehood and gender that we find in South Asia, where for example, one does not become a "man" until a "boy" is married, and transgendered males do not always identifying as a "man". Many of the "men" we work with also report male-to-male sexual behaviour in what is traditionally thought of as childhood.

Panthis

A *kothi* label for any "manly" male. Male-to-male sexual behaviours are usually highly gendered in terms of sexual roles. Most male-to-male sex in South Asia appears to follow this pattern, where a *kothi* is defined as not a "man", thus enabling the penetrating partner to still see himself as manly. A *panthi* is by definition, a man who penetrates, whether it is a woman or another male. *Panthis* may also be married to women. Their occupations vary across the social class spectrum from rickshaw drivers to businessmen etc.

Pariks

A *kothi* label for the "husband" of a *kothi*. The *parik* may also be married to a woman and have sex with other women as well as males.

Sexuality

We use the word to mean the totality of how one perceives and defines oneself in the context of sexual desire, gender identity, actual behaviour, and sense of sexual self, within specific cultural contexts and how other others perceive and define this. It is also recognised that there are a multiplicity of sexualities within any given culture, that vary across age groups, sexual orientations, sexual preferences, actual behaviours, gender identifications, economic classes, and religions.

Social constructionism

A theory, which holds that masculinities, sexualities, and sexual behaviours (if not even sexual desires themselves) are socially constructed through social and sexual scripting processes.

Sexuality and sexual health in South Asia - a theoretical framework

The debate concerning the development of effective prevention programmes in regard to STIs and HIV/AIDS in South Asia, takes on a greater sense of urgency, as the prevalence of HIV in the region increases. Unless these programmes are specifically appropriate to the cultural frameworks of South Asia in which the sexual behaviours occur, then they will be ineffective, and may actually make the situation worse.

To begin to consider developing appropriate strategies and programmes, we must first explore the dynamics of gender constructions, sexualities, sexual behaviours and sexual health within South Asian cultures. For, if we do not construct the debate effectively, if we do not understand the complex personal and social aspects of sexuality, and the sexual cultures within which sexual behaviours arise and operate, then we will not be able to develop effective prevention tools.

Whilst India already has significant STI, Hepatitis B and HIV/AIDS epidemics, the surrounding countries are also showing increasing infection rates. The ability of South Asian governments to cope with the health care needs of people living with HIV/AIDS is already compromised by the existing strains placed upon health delivery systems. Primary, secondary and tertiary care are stretched beyond their capacity to deliver effective sexual health promotion and care, because of funding shortages, other priorities, denial, invisibility of issues, economic pressures, fear, sexism, sex-phobia, homophobia and ignorance.

The main route of HIV transmission in South Asia appears to be penetrative sex. Whilst World Health Organisation HIV prevalence estimates are defined within heterosexual/ homosexual dichotomies, stating that 70% of all transmission is through heterosexual intercourse, such use of this terminology can be challenged in the context of sexual dynamics and behaviours within South Asia, where there is considerable male-to-male sexual behaviour that is hidden, and not disclosed.

Within the context of South Asian cultures, heterosexual and homosexual frameworks do not describe well what we find. The diametric oppositional framework of this terminology creates an artificial understanding that has no specific relevance to the actuality of people's lives. Therefore, we cannot realistically say that there is a heterosexual or homosexual transmission. All we can say is that there is sexual transmission via a specific sex act route, i.e. vaginal or anal penetrative sex. What this means, is that whilst there is a range sexual behaviours found, they cannot be simply fitted into an identity based structure, which the terminology of "heterosexual" and "homosexual" implies.

The fluidity of South Asian male's sexual experience, the framework of sexual invisibility, gender segregation, South Asian homosociability, male ownership of public space, South Asian shame cultures, sexual invisibility, community *izzat* (shame), compulsory marriage and procreation, South Asian gender constructions, male and female roles as frameworks of adulthood, and so on, have a central impact on actual sexual behaviours that are not clearly defined within the terms "heterosexual" or "homosexual".

The impact of HIV on women, many of who's partners will be having sex with other males should be seen in this context. In other words, understanding male sexual practices in the larger context as well as the personal, is an essential component of understanding, and improving women's reproductive and sexual health.

To develop appropriate strategies for addressing these issues, we therefore need to understand the dynamics of sexuality, the constructions of gender, the psycho-social frameworks of sexual behaviours and the contexts in which they exist. And these must be developed and understood within appropriate cultural frameworks. Unfortunately,

too often in the development of HIV and STI prevention and outreach programmes within South Asia, sexuality, identities, and sexual behaviours have been conceptualised within Western understandings and constructions. The whole discourse on sexuality and sexual behaviours, and thus prevention strategies, arises from Western constructions of individuality, personal identities and sexualities. Gender identities, sexual roles and thus personal identities, arise within the context of a psycho-social and historical dynamic. Perceptions of who we are, what we are, and what we do, will therefore have different meanings within different cultures.

The urgent necessities that have arisen from the rapid spread of HIV infection and the lack of any specific "cure" for AIDS, has meant that the only strategy available to governments is prevention. There are really only two specific prevention messages:

1. "Don't do it!"
2. "Do it safely!"

The first approach regarding sexual behaviours, is often the one most favoured, because of its tone of high morality. Both governmental and non-governmental agencies, particularly in developing countries, utilise this approach, stating a recourse to a perceived historical dynamic and "corrupt" Western influences. In other words, they suggest risky sexual practices have arisen in South Asian cultures because of the influence of the West. The other part of this strategy is to utilise specific religious and scriptural texts to support the "don't do it" strategy. Neither of these approaches will work. Firstly, because there is a denial of sexual histories within these countries, and in a perverse way, this denial, and often suppression of such histories, arise within a Western context, as part of their "guilt" cultural frameworks. Thus some officials can say that in South Asia, there are no homosexual behaviours, or there is no extramarital sex, or premarital sex, or if they do exist, it is at very small levels. The actual evidence shows dramatically otherwise.

The use of religious and scriptural texts as the mechanism of prevention often denies actual human behaviour, and the histories of these religions, and their social interactions in the cultures which sustain them. After all, professing to be a Hindu, Muslim, Christian, Sikh, Buddhist, etc., has not always stopped behaviours that have been deemed against the specific tenants of these religions. And of course, what about those who have no specific religious faith? The truth of the matter is that South Asian cultures, based on the dramatic differences between public and private spaces, and framed within concepts of shame and honour, this can often lead to risky sexual behaviours which will be psycho-socially invisible. Public messages around culture, religion, anti-West, etc., will not have the desired effect because they ignore constructions of sexual behaviours. Or, why do people do what they do? How? When? Where? Whom?

Sexual behaviours do not arise into practice out of nowhere. They have a context, a history, based both on time and place, and they arise from frameworks of desire which also have a construction based upon cultural and social dynamics.

For example, in a culture where girls and women are "policed" in terms of their behaviour, particularly sexual, where female virginity is prized, where family and community duty and honour is centrally important, where males "own" the social spaces, where marriage and procreation is seen as compulsory, where adulthood is defined by these parameters, a culture which is particularly homosocial, where income levels are low, where sexual access to women is therefore marginalised, limited, and sometimes costly, where sexual behaviours are not so much constructed around personal identities but rather around the "penetrator" and the "penetrated", a culture where non-penetrative sex is not seen as sex but as *maasti* - "play"; who is the most sexually available object?

The denial of the histories of gender constructions, sexualities and sexual behaviours by various discourses of both Western and South Asian origin have had a central impact on understanding the conceptualisation of gender identities and sexuality in

South Asia. No Indian research institution has dealt with this denial. Instead they have only perpetuated the invisibility of these histories. Further, the current construction of sexuality arising from Western discourses is often ahistoric and the only sexuality that is seen as relevant, is that of penetrative heterosexuality. Perversely, any other form is categorised as deviant and Western.

This reduces the rich histories of sexualities to an oppositional dichotomy between concepts of heterosexuality and homosexuality, which are the consequence of certain Western historical frameworks and understandings of sexuality.

Further, the construction of patriarchal social systems, the enforcement of compulsory marriage, procreative necessity of boy children, and the frameworks through which sexual behaviour and desire manifest themselves over the centuries, has created a pattern of destruction, marginalisation and denial concerning alternate sexualities and their histories. A dominant sexuality has historically emerged which has claimed precedence over all others as a system of social control which enables male power to take on a singular social role.

Alternate histories which often existed as traditions on the periphery are being lost at various levels, due to the dominance of procreative ideologies at the rural level, and the overwhelming construction of any tradition from that of solely procreative heterosexual basis. Older alternate mythologies and histories are manipulated, deformed, and mutilated to suit rural male patriarchal ideologies, which leads to women being the repository of tradition but not its interpreters. This creates rural economies where there is a gender segregation of labour, boy children as rural capital, and control of land, economic and cultural resources by men, which are recreated within urban spaces. This also leads to the construction of desire and sexuality only from the standpoint of the rural patrilineal male which is then romanticised by various urban discourses as traditional authenticity. In other words denial of alternate sexualities and matrilineal traditions are perpetuated both from within and without.

Further with the impact of various forms of colonialism, dating from Vedic times, monotheism, orientalism, various forms of nationalism, fundamentalism, orthodoxy, etc., have all contributed to the destruction of much localised alternate traditions, whether of dance, theatre, literature, visual art, songs and lifestyles. This has meant an almost complete invisibility of alternate sexualities. Rather than a pluralistic vision emerging, only procreative and penetrative sexuality is seen as socially acceptable. Traditions expressive of sexual diversity are seen as dirty, deviant and perverted, and the work of evil, over sexual, devouring women.

This overwhelming denial and silencing of histories and cultures of sexualities means that the only framework available is that which has emerged in the Western countries. Though these can be useful as comparative tools, they cannot be the main basis of understanding the complex psychosexual social matrix of South Asia.

The world view as expressed in South Asia, has been formed by the central concepts of Vedic Brahmanism, Islam, Christianity and also of Ayurvedic and Western medicalisation of the body and sexuality. Male and female roles have been strictly defined, and any public transgressions of these roles is severely punished through stigmatisation, social exclusion, exile, physical abuse and even death.

The resultant psycho-social constructions of sexualities, the denial of different expressions of sexualities, the socio-political control of sexualities, has resulted in a cultural development that demands compulsory marriage and procreation, that gives no validity and social space for autonomous women, that demeans unmarried individuals, particularly single women and that only confers adulthood and thus social status and responsibility to married people. Sexual behaviour takes the place of sexuality. Women's sexual behaviour becomes controlled and marginalised, if not denied. Male sexual

behaviour becomes self-absorbed, and is reduced to one of discharge rather than based upon a desire for the other person. Sex behaviour becomes depersonalised. Sexuality has no construction. The sex act becomes brutalised whether it is between male and female or male and male. For women who desire other women, there is no social space for such a development. Concepts of personal choice, of privacy, become lost. There can be no development of individuality.

Desires have a history, both personal and social, as well as political, in the way they are expressed and manifested. They do not cease to exist as these histories are changed and reformulated. Nor do they cease to exist if such histories are denied or made invisible. But desires are constructed to fit in with the social constructions.

As a consequence, the contemporary South Asian situation with regard to sexualities and their physical expression, indicate a brutalised sexual behaviour, shown by the significant levels of vaginal and anal tearing; of almost indiscriminate sexual activity by men - without regard to the gender of the sexual partner - which is not defined by any form of identity, but rather by the concept of availability and discharge; and by the levels of severe sexual repressions which lead towards moments of brutalised sexual release. But, because of this terrible silencing and denial of these histories from various ideologies, an almost total exile situation has emerged. In trying to resist this exile, a closeted and schizophrenic state of being has emerged, where the person tries to assimilate into society through marriage and having children, yet expressing alternate sexual desires in purdah, in darkness, shame, and in silence.

Within the context of the current concerns (if not panic) about sexual health in South Asia, in particular, rape, cervical cancer, STIs, Hepatitis B and C, and HIV infection, as well as the alarming increases in reported sexual dysfunction amongst women and men, it becomes an urgent necessity to explore the issues outlined above, to formulate strategies that make visible these alternate histories, that deconstruct the frameworks of contemporary sexuality, and to reconstruct them in the light of the historical discoveries being made.

If we are to move towards societies that enable all people to express their best, that gives people the opportunity to develop personhood, that enables people to make choices about their sexuality and sexual and emotional desires, that empowers people to make positive decisions about their own and other's sexual health, then this whole voyage of discovery becomes a social imperative. It is only through such positive choices that any effective prevention programmes can be developed, and that male and female sexual health be addressed appropriately.

Summary

Within South Asian cultures, personal identities are not based upon the sense of self, but rather on the extended family. This consists of siblings, biological parents, uncles, aunts, brother and sister-in-laws, all their resultant children, and so on. In other words, who we are arises from where we are in the extended family network. The person has a family and a community identity, in which the sense of personal identity is subsumed. The focus of the self is not upon individuality but upon kinship. Our languages clearly express this, in that we have terminologies for all these relationships.

Within these cultures there are specific understanding of malehood and femalehood. These are defined by duties and obligations to the marriage partner, family and community, The man is not a man until he is married. The woman is not a woman until she is married and with her first child (often this could mean a boy-child). To be a single person after a certain age is seen as shameful, a dishonour to the family, often an aberration or sickness. Marriage is often seen as a "cure" for loneliness.

South Asian languages do not have specific expressions for homosexuality, heterosexu-

ality, bisexuality as nouns or as adjectives. What exist are terms that express differing forms of sexual behaviours, but these terms are often abusive and male dominated and refer to specific acts of penetration. In the context of these terms, the viewpoint is very much embedded within what is malehood and femalehood. Sexual behaviours are allowed within constructions of what is deemed appropriate behaviour for men and women. In these constructions, who does the penetrating in a sexual act becomes important for self-definition.

Sexual behaviour therefore is not always an expression of a personal identity. Rather, it often becomes one of opportunity, accessibility and personal desire for sexual discharge. The phrase "body tension" is an expression of this discharge.

In terms of the cultural frameworks that construct South Asian sexual behaviours, the following points need to be remembered:

- Marriage is considered a duty and family obligation, not one based upon personal desire and choice.

- Marriage is also seen as compulsory. To be single is seen as an aberration. Cultural beliefs dictate that a person is not an adult until married.

- The central objective of marriage is the production of children, specifically male children.

- Sexual pleasure based upon desire, or lust, for one's wife is sometimes considered shameful. The Wife holds a special place in this regard. She is the "mother" - a place of honour, for it is she who is charged with the responsibility of upholding family tradition, and the rearing of children. Sex with one's wife is often seen as a duty. This leads to a concept of sexual pleasure being permissible outside of the marriage context.

- Since there is no identity structure around the gender choice for sexual pleasure, what matters for males is more to do with the sense of malehood and concepts of masculinity.

- Thus, concepts of identity revolve around ideas of penetration. The penetrator is still "manly", the penetrated is "not a man". Further, what matters is not the pleasure of the partner, but the pleasure of the self. Sexual behaviour becomes one of sexual discharge.

- Gender segregation, female virginity, loss of honour, and so on, often make it easier for males to access other males for sex than females.

- Such accessibility is also made easier because of the extended family systems, with lots of social mixing with family members, and the homosociability of South Asian cultures.

- The sense of shame and dishonour arises from a public (community) perception about personal behaviour and the need to fulfil one's public duty.

- Since the concept of sexuality and sexual behaviours is bound up within concepts of sexual discharge, this often leads to frequent sexual partners, rather than forming continuous sexual liaisons with a single person.

- Often the gender of the sexual partner may be irrelevant. This can be expressed by the statement: "The person has a relationship with his wife, but has sex with others".

Introduction

- Women are much more supervised and policed by family and community, than men. This makes it somewhat difficult for women to carry out socially illicit sexual encounters/relationships. The penalties for women are of a much greater intensity.

- Within these contexts, women's sexual and reproductive health is to a large extent dependent upon male sexual behaviours and the methodologies of their practice. Their constructions are also framed by space, time, availability, gender roles, personal desires and opportunity.

What's in a name? Using correct terms

A lot, when the name is derogatory like "AIDS victim", or "AIDS carrier". Language conveys meaning, and the meaning often attached to the terms which surround the HIV/AIDS pandemic and sexual health in general are often derogatory, overly scientific, unclear, wrong and often rude! Below are some examples of inappropriate terms, and alternatives.

"Innocent" and "guilty" "victims"

HIV is transmitted in three main ways; through unprotected sexual activity, via infected blood and from an infected mother to her unborn or newly born child. This has lead to the notion that some people are to blame for their infection, i.e. those who indulge in unprotected sex and inject drugs and others are "innocent victims". Innocent in as much as they were not to blame for their infection, and "victims", because this "bad" infection was "done" to them. The dialectic between "innocent" and "guilty" "victims" helps reinforce stereotypes and prejudice about how people become infected. This stereotyping and prejudice does and can effect the type of prevention work that is done and the services people who are infected get. "Victim" is a term more commonly used to describe someone who has been attacked or suffered badly from some event. "HIV" being see as the perpetrator of this "violence". Using the term "victim" only helps to further the idea that there are some "innocent" and some "guilt" people who get infected!

Rule 1: There are no innocent and guilty victims. Do not use these terms!

"AIDS sufferer"

People living with HIV and AIDS, can and do "suffer" from a variety of illnesses and discrimination. To use the term "sufferer" though implies a kind of universal "suffering", something which is not true. People with HIV and AIDS often, especially with the introduction of effective antiretroviral drugs lead "normal" and active lives and often experience long periods of good health. The term stigmatises people infected with HIV and those living with AIDS. The term is also negative and does not imply any positive aspects to living with the virus.

Rule 2: Do not use the term "AIDS sufferer". Instead use a "person living with AIDS".

"AIDS test"

AIDS is a scientific classification and not an isolated result from a single test. When this term is used, usually what is meant is a test for either the antibodies or antigens of the HIV virus. Using the term "AIDS test" is misleading in as much that the actual test is only a test for either one body's reaction to the virus and for the viral particles themselves. It is also implies that if you get a positive HIV test result, that the person will automatically develop AIDS. This is not necessarily true.

Rule 3. Do not use the term "AIDS test". Use the term "HIV antibody" or "HIV antigen" test, depending on what you are referring to (the antibody test is by far the most common type).

"AIDS carrier"

This implies that AIDS can be transmitted from one person to another. This is not true. It is the virus HIV, the virus which can cause AIDS that can be transmitted. HIV is not contagious like a common cold, but is only transmitted via infected body fluids (from

sexual or other contact), including contaminated blood products and from an infected mother to her child. Whilst it is true that once infected with HIV, most people remain infected, levels of virus in their bodies and the chances of them passing this to other people can vary enormously. Therefore there are no “AIDS carriers”, just those living with the HIV virus.

Rule 4. Do not use the term “AIDS carrier”, instead you can use a term like “a person living with HIV”.

Scientific terms

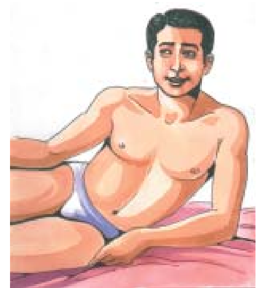
AIDS and HIV are both themselves accurate scientific descriptions of a medical condition and virus respectively. The medical condition, the diseases which can occur because of a depressed immune systems, the drugs used to prevent these, the virus itself and the drugs used to “attack” the virus can and do have complicated names and scientific modes of actions. Sexually transmitted diseases and sexual health issues also deal with a variety of scientific descriptions of micro-organisms, drugs and conditions. It is vitally important that we understand our “audience” when communicating with them on HIV/AIDS and sexual health issues. Most “lay” people will have a low understanding of science and therefore one should be careful to use language that is easily understandable. For example you could use local common names of diseases rather than scientific ones. HIV/AIDS and sexual health are about much more than science. Don’t let science “cloud” out the other important social and cultural issues that arise.

Be positive and not negative

People living with HIV are just like anyone else, apart from the fact that they are infected with a specific virus. People living with an AIDS diagnosis are just like anyone else, apart from it has been determined that their immune system has been damaged by HIV. It is important that we do not use language that promotes discrimination, or suggests that HIV/AIDS is a “death” sentence and those living with HIV/AIDS cannot and do not lead active and positive lives.

Language can exercise power and is very important. As with any power, use it wisely and responsibly.

NFI's ethical statement



NFI focuses on male-to -male sexualities and sexual health concerns. In its work, NFI will fully consider the implications of males who have sex with males, for themselves, for any male or female sexual partners such males may have, and for any clients of those males who do sex work.

In this work, NFI will be guided by the following principles:

1. Promoting the reproductive and sexual health of males who have sex with males by encouraging sexual responsibility and safer sexual practices.

2. Encouraging males who have sex with males to access STI treatment whenever necessary.

3. Respecting confidentiality in the relationship between males and their sexual partners and/or clients.

4. Promoting the protection of children and non-consenting adults from abusive sexual relationships.

5. Promoting the reproductive and sexual health of any female partners of males who have sex with males by encouraging greater sexual responsibility of their male partners.

6. Encouraging communication of sexual health information between sexual partners and promoting partner notification of STI/HIV infection, irrespective of the gender of the partner.

7. Working with female reproductive and sexual health services in order to facilitate appropriate access to infected female partners of males who have sex with males.

NFI process model for MSM sexual health interventions

Introduction

NFI has developed a model for the implementation of interventions for MSM, their partners and families, to prevent HIV transmission and other sexually transmitted infections, and improve the general health, welfare and human rights of MSM, their partners and families. The model has a number of key features, key processes and utilises a number of key tools. These are described below, and a summary of the model appears at the end.

Key features of the model:

1. An intimate knowledge of MSM issues and needs

This is gained from:

- A range of studies and needs assessments that NFI has undertaken and documented over the last few years.
- Ongoing monitoring and evaluation from existing community based initiatives.
- Ongoing development of new research partnerships to address specific concerns.

2. A clearly defined community development strategy

This includes the development of CBOs addressing MSM behaviours, which in turn develop district-level activities within their state, with ongoing support from NFI.

3. A strong advocacy, policy and ongoing support strategy

The model includes a strong component of upstream advocacy and policy development, to help create a positive political, social, legal and policy environment for the work to be sufficiently well resourced and enabled. NFI also provides a range of ongoing support activities to MSM intervention programmes.

Key processes:

1. State/country MSM CBO programme development

Using an NFI developed framework and tools, NFI provides training and support to develop new or existing state or country partner organisations to undertake needs assessments and develop MSM led CBO programmes.

2. Scaling-up across a state/country – support for local MSM CBO programme development

Building on established state-level MSM CBO programmes, NFI provides support and training for these CBOs to develop locally based MSM led CBO programmes across their states.

3. Upstream advocacy and policy development and ongoing support

A range of upstream advocacy and policy development work is undertaken to create the necessary political, social, legal and policy environment for the resourcing and enabling of state an district level MSM CBOs services to take place. NFI also provides a range of ancillary support services to the MSM CBO programmes, which includes regular training events, provision of a monitoring and evaluation service, help in developing intervention resources and organisational development support.

Key tools:

NFI has developed a broad range of comprehensive tools for MSM CBO development which includes:

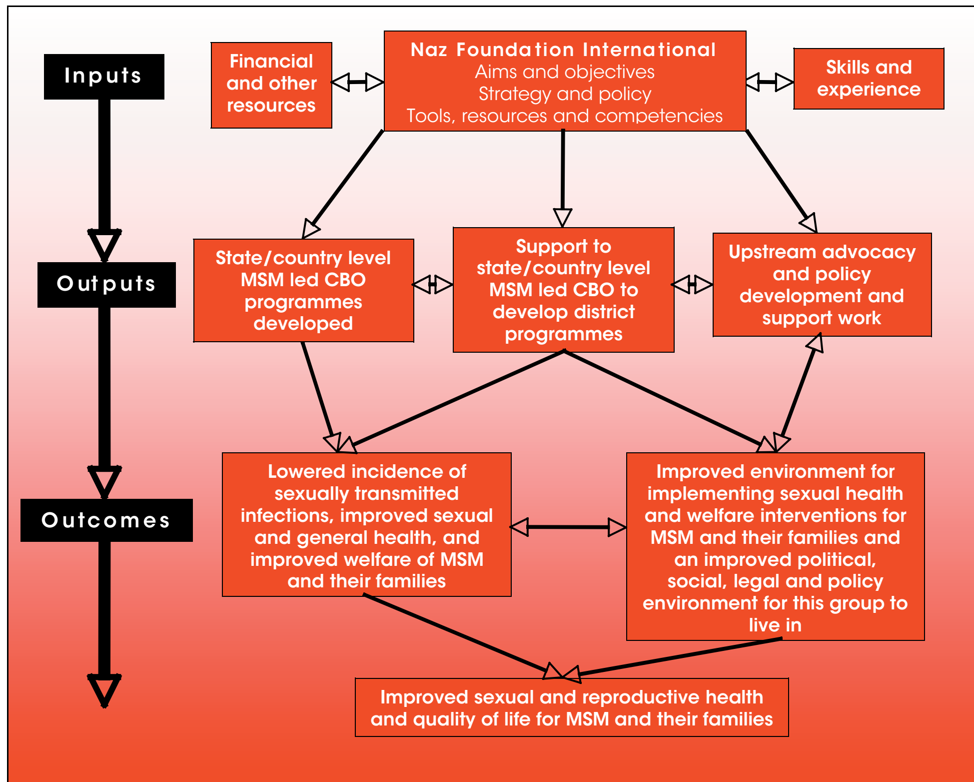
- Training manuals, guidelines and handbooks specific to the needs of MSM led CBO programmes.
- A monitoring and evaluation system.
- Model behaviour change communication resources for MSM CBO programmes.

Under development:

- An enhanced and computerised version of the monitoring and evaluation system.
- Multiple languages of the NFI MSM CBO development tool-kit.
- Anal sexually transmitted infection algorithm.
- Advocacy tool-kit.

Model Summary

A summary of the model, in terms of inputs, outputs and outcomes, processes and activities is described in the figure on the next page:


Inputs
Outputs
Outcomes
Financial and other resources
Naz Foundation International
Aims and objectives
Strategy and policy
Tools, resources and competencies
Skills and experience
State/country level MSM led CBO programmes developed
Support to state/country level MSM led CBO to develop district programmes
Upstream advocacy and policy development and support work
Lowered incidence of sexually transmitted infections, improved sexual and general health, and improved welfare of MSM and their families
Improved environment for implementing sexual health and welfare interventions for MSM and their families and an improved political, social, legal and policy environment for this group to live in
Improved sexual and reproductive health and quality of life for MSM and their families

Acronyms

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral
BCC	Behaviour change communication
CBO	Community based organisation
IDU	Injecting drug user
IEC	Information, education and communication
HIV	Human immondeficiency virus
MSM	Males who have sex with males
MSM	Male sex worker
NGO	Non-governmental organisation
NFI	Naz Foundation International
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNAIDS	United Nations Joint Programme on AIDS

Acknowledgements

We would like to acknowledge the following sources:

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