

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 2

Setting the context



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 updating 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. Please check the website for more information.

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Contents

Page

- 1 Introduction to the series
- 3 The context of social construction of masculinities in South Asia
- 7 The *kothi* framework
- 13 Actions for life
- 25 Community mobilising
- 33 A rights based framework for preventing the transmission of HIV among men who have sex with men
- 37 Acronyms
- 39 Acknowledgements

Introduction to the series

This is the second in a set of handbooks, that provides a theoretical framework, and step by step approach to developing community based organisations addressing issues affecting males who have sex with males (MSM). 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 MSM. Since 1996, the model detailed in this series has been used to develop more than thirty projects addressing issues that affect males who have sex with males. We hope that in its new format it will assist in the development of many more, to ensure that all males who have sex with male 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 males who have sex with males.

It is designed to be MSM 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 skill-up others to develop their own services.

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

The set consists of 6 books :

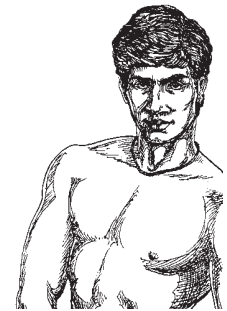
Book one:	Introduction
Book two:	Setting the context
Book three:	First phase: Social and needs assessment
Book four:	Second phase: Implementing an MSM sexual health project
Book five:	Tools for management
Book six:	Other resources

The workshops are detailed and follow a time-table and agenda that has arisen from the many workshops conducted by NFI with this particular population group. 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 such MSM sexual health interventions, and it is highly 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.

The context of social constructions of masculinities in South Asia

It is important to locate the issues of sexual health of males who have sex with males in a theoretical framework around the construction of masculinities in south Asia. This is necessary to contextually conceptualize the dynamics which gives rise to the violations and violence against MSM in conservative and discriminatory settings as found in south Asia.



Sexual identities take shape within psychosocial and historical processes, which in turn are contextualised by culture and language. Therefore one finds that different cultures often translate similar words and phenomena into different meanings with inherent subtleties typical of that culture. Therefore at the very beginning it is important to understand that eurocentric perceptions and values gives a definition to heterosexual, homosexual and bisexual identities quite different from how these phenomena are understood in South Asia.

In South Asian cultures, the behaviour and experience of the male is affected by socio-cultural realities such as the invisibilisation of sexual behaviours, segregation of the genders, acceptability of male homo-sociability and homo-affectionalism, male dominance over public space and discourse, a culture of shame where family and community respect and honour holds sway, compulsory and arranged marriage, pressure of reproduction, understanding of sex only in a reproductive sense, joint families, and the negation of the self before the community and family. This behaviour is further defined by gender roles attributed to males and females within society, especially when important defining events in life such as the assumption of adulthood, are defined by such gender roles.

The fact that medicalisation of sexuality and sexual behaviours in the 19th century, largely in Western cultures, has given rise to a whole new discourse and understanding of gender, sexuality and sexual behaviour. This was based on who one has sex with, rather than on behaviour itself, giving rise to a new “species” – the “homosexual”. But such a construction often has little relevance in the social and cultural context of much of South Asia. Therefore, to say that homosexuality is when a man expresses sexual attraction for another man, may not be exactly appropriate in the context of this region. This is so because in South Asia, dichotomised and oppositional structures of gender roles are the defining characteristic. A male who has sex with another male is defined as a homosexual in the Western understanding, whereas in South Asia, a more appropriate way of expressing the same would be to talk in terms of behaviour. In other words in South Asia one has to talk in terms of sex between biological males, for often it is found that one of the partners in the sexual act would not describe himself as a man, or would not be recognized as man by his male sexual partner.

It is not surprising that the term homosexual does not have a direct equivalent in South Asian languages. This fact also underlines the history of tolerance of same-sex behaviour that has existed in the entire South Asian region, but only for the penetrating male. For the penetrated male, the issue of stigmatisation was focused on crossing perceived gender roles. It is only with the advent of criminalisation of sodomy imposed by the colonial powers in South Asia that the notion of right and wrong, and normal and “abnormal” sexual behaviour became a reality in public discourse. However, this discourse has developed in the gendered context of South Asia, and the abhorrence and discrimination that has been a result of such criminalisation.

In the phallo-centric patriarchy that dominates social life in South Asia, sex is understood in a reproductive sense, and masculine power is defined by the act of sexual penetration. In this scheme anyone who does not penetrate loses the claim to be defined as a man. The penetrator always remains the “man” but the one penetrated becomes “not man

enough” and therefore somehow of a lower status and standing as compared to the “man”. Again, given the fact of accepted male superiority, such penetrated persons are also considered to be degraded and thus often abusively addressed as *mouga*, *chakka*, *hijra*, *koti*, *gotian*, *gandu* and so on.

The superior status of the “man” is enforced by the gender segregation of social spaces, and of labour, both these spheres being dominated by men. The perception of the male child as family capital, along with strictly defined gender roles both in terms of social duties and obligations, as well as in terms of liberties enjoyed, often translates into severe punishment and retribution against the male who transgresses his role and thus devalues this status. All this also means every male has severe societal and familial pressures to marry and reproduce (preferably to give children) so as to reassert his claim to be the “man” in the penetrator oriented phallo-centric society, that recognises and legitimises only reproductive sex.

In other words, it is marriage that makes the “man” a “proper” man, which institution effectively defines his becoming an adult. Thus, no marriage implies that a biological male has yet not become a “man” (an adult) and this perception affects him personally, and how he is understood in society irrespective of his age. In a sexual context, the only way to deal with all of the above complexities, even while preserving a semblance of the gender superiority of the man, is to invisibilise sexual behaviour. Of course South Asia does have a way out of this dilemma. An unmarried male could be defined as a *brahmachariya*, a *sanyasin*, a person of religious persuasion who “sacrifices” his “manliness” for the greater good.

This invisibilisation helps preserving the fiction of reproductive sex only within marriage, and complete absence of sex outside. It helps reinstate the reproductive logic of sex. And, most importantly, it sweeps the possibility of all sexual acts and behaviours outside the bounds of the above under the proverbial carpet, by rejecting public discourse on the subject. It further helps in inculcating a sense of superiority vis-à-vis all traditions that are expressive of sexual diversities, which are seen as dirty and perverted. This is a huge psychological apple cart, which is toppled by males who participate as the penetrated sexual partner in the sexual act. They challenge all the accepted and ingrained notions and therefore are punished. The punishment takes the form of demasculinisation, dehumanization and deprivation of their various rights.

Sexual behaviour takes the place of sexuality. Male sexual desire becomes self absorbed and is reduced to one of discharge, rather than based upon a desire for another person. The silencing and denial associated with this leads to an exile like situation, where, closeted and schizophrenic states of mind easily emerge and subsume the person, wherein every expression of an alternate sexual desire has to be mired in shame and silence. All this has two significant fallouts, both curiously attached to the need of the “man”. The first is that sex is often seen as a means of releasing tension. That is why one hears terms like “I did sex to release body heat” or “I needed to release body tension”. The other is that sex takes the form of fun and play, where the stigma attached to it is sought to be reduced by defining it in a frivolous light. Terms like *masti* are used that are associated with sex. The term *masti* can be defined as fun or play, or both. It is not thought serious enough to be sex, it just happens as if a game.

We arrive at a state where sexual preference and sexual behaviour is not a matter of identity. It takes place in hushed circumstances, and is propelled by opportunity, accessibility and the need for discharge. It is almost negated by giving it the connotation of play and fun.

One needs to take this understanding into the detailed analyses of the *kothi* construct. *Kothi* is a term that has existed for a long time in the popular discourse of the sub-continent. It was especially a part of the various dialects that was spoken by the *hijras* of South Asia. It did not define an identity, but rather a behaviour. In the gendered

world of South Asia, a male person who acted in a feminised manner was called a *kothi*. The term was derogatory and abusive in nature, and was intended to stigmatise. There was always the hidden implication that because the person is female-like, he would be penetrated by a “man” in the sexual act. But such feminised males gradually adopted the term, so that often in their communication amongst themselves they called themselves *kothis*. It however still continued to describe a type of male and not a self-defining identity.

The “man” who penetrates can be anyone, and he is in fact everywhere. He need not hide or be ashamed, for he is penetrating in the act of sex. Therefore he is doing what “men” do. He is not doing anything deviant, in so much as he is having sex with those who are women-like. Also he can disappear into the mainstream of male life in society and therefore cannot be identified. He therefore cannot be targeted specifically either. And since, usually his entire sexual act is in secret, and is never spoken of, or acknowledged in the public, he can safely hide behind the security that anonymity and lack of knowledge provides. He can also violate the rights of those who do not conform to the “normal” gendered roles of society with impunity, and get away with it, for he himself cannot be targeted or shamed. He has been given the term *panthi*, *giria*, *parik*, etc. by the *kothis*. However, it should be kept in mind that the *panthi* does not call himself such. He need not, for he is the regular man in society. It is only *kothis* who call him such, in counter-distinction to themselves. As said in the first line of this paragraph, he can be anyone and he is in fact everywhere.

Society at large, however, has all the reason to target and abuse a *kothi*. He is not a penetrator, therefore he is not “man” enough to enjoy the privileges of “men”. He is less than “man”, but still being a biological male, he is available and more accessible in the social domain than females. Therefore, he can be accessed by “men” to fulfil their play, fun, and need of discharge. He is a cause of shame to the family and therefore is abused by it. He does not qualify and fulfil his expected role, and therefore has to be policed, often with violence. Most importantly, he is “perverted” because he does sex for reasons that could not be reproductive, and therefore poses a threat to social order.

It is with the advent of community building efforts as a part of HIV/AIDS intervention that the term *kothi* has been appropriated, and it has also become a matter of personal identity. The appropriation has actually reduced the stigma attached to the term and is seen to be gradually becoming a term of pride and community solidarity amongst *kothis*. It is a positive development, which may overturn or end the oppression of the society at some future date.

The self that is so negated by society, and which negation is deeply internalized by *kothis* themselves is responsible for the lack of self-worth and self-esteem of the *kothi*. The *kothi* is made vulnerable by the actions of society at large, and he increases his vulnerability by defining his self in the stereotype of the gender role of an oppressed female in a traditional society. Being told that he is not a “man” or less than a “man”, and feeling uncomfortable with the roles and responsibilities that “men” have appropriated for themselves, a *kothi* begins to identify as a female. But this identification is not in the image of an “empowered woman”. It is an exaggerated parody of the “vulnerable woman”. Therefore in the traditional societal structures, a *kothi* does not find the moorings of empowerment. He continues to languish in the self-defined and society determined disempowered role.

It is often observed that this sense of disempowerment translates into the *kothi* accepting the abuse and violations of his rights and bodily integrity as his due in society. He rarely fights back and he deals with the trauma of all the abuse by either turning on himself in self-destructive ways, or by suffering in silence. Psychological dysfunction is also observed in a lot of cases.

It also has economic ramifications. A *kothi* is hounded in educational institutions, so

Setting the context

he cannot study. His lack of literacy compels him into economic disadvantage. He is very often denied inheritance and is forced into sex work. Employers discriminate and harass at the workplace, compelling them to leave the job market or seek jobs that under-employ them.

In any HIV prevention intervention one has to take into account the above realities. In the contemporary world where it is widely believed that the real antidote to the HIV and AIDS pandemic is by securing, protecting and promoting the rights of those most vulnerable, it becomes imperative that we approach the work of intervening with *kothis* keeping these social factors in mind so that appropriate advocacy and other tools can be developed that empowers *kothis* to take on the role of protecting themselves, even as they enhance their self-worth and self-esteem and get nearer to becoming equal partners and participants in social life.

The *Kothi* framework

Introduction

It is often asked, “How many MSM are there in South Asia?”, usually by donors, consultants, and representatives of many AIDS NGOs. While the question seems to be reasonable and to make sense, it actually represents a misconception of the context of male sexual behaviours in the region. The way the question is phrased generates a conception of MSM as an exclusive group, an identity rather than a behaviour.



In summary what we can say about male-to-male behaviours in South Asia is that:

- For the majority of males involved in male-to-male sex, MSM is not an identity but most often a behaviour arising from a feminised gender identification. Such behaviours are not contextualised within a heterosexual - homosexual paradigm.
- This gendered framework is constructed within a *kothi/panthi* dynamic, where the *kothi* perceives himself and his desire for other males in the context of gender roles in South Asia, i.e. the “penetrated” partner. *Kothis* construct their social roles, mannerisms and behaviours in ways that attract what they call *panthis* - “real men”, identifying as feminised males. In this context these *kothis* are usually the visible MSM in a range of public environments and neighbourhoods, but *panthis* are not, for they could potentially be any “manly” male.
- These “real” men do not see themselves as homosexuals or less masculine because of their sexual involvement with *kothis*. They penetrate *kothis* who are not “real men” - they are *kothis*.
- In other words, we have a spectrum of masculinities
- In a culture that excludes females from public spaces, that socially polices females and controls their access by males, and where sexual behaviours are based on gender identification rather than sexual identity, it is possible that for many “manly” males, sexual access will be with *kothis*, or those deemed less “manly”, i.e. young males and adolescents.
- With this gendered dynamic it may be possible to physically count the number of *kothis* at a range of public sites, but this doesn’t address the so-called *goopon* or *gupti kothis* - the ones who are secret. Nor does this address the number of “manly” partners these *kothis* access in arenas other than the public spaces of parks, railway stations, and so on.
- Beside the *kothi* frameworks, there is another dynamic of male-to-male sexual behaviours, which because of a shame-based culture, cannot be readily accessed. This includes inter-family male-to-male sex, sex between friends. Such behaviours are not identity-based, where desire is based on same- biological sex, but rather on immediacy, “body heat” and felt “discharge” needs
- Such behaviours could be common since there is a limited social construction of heterosexuality - perhaps we can call this “behaviourally heterosexual” - and where sexual access to females is very limited. What appears to exist in South Asia and India is a core identity in terms of gender role, marital status and class.
- “Gay” relationships are based on a personal sexual identity, a mutuality, friendship and exchangeable sexual acts - they are companionate relationships formed within a same sex/same gender dynamic.

- *Kothi* relationships, however, are based on gender roles - a “husband and wife” relationship. *Kothis* are not friends with their *panthis*, but his “wife”. This is a relationship based on same sex/different gender identification dynamic. *Kothis* make friends with other *kothis* with whom they “never” have sex. For *kothis* this would be like having sex with their “sister” although in practice they can have sex with each other.
- This does not mean that *kothis* do not penetrate or that *panthis* are not penetrated. They do, but these behaviours are seen as crossing the gender barrier and are considered even more shameful. They are kept even more secret. And while *kothis* have a term for such behaviours - do-parathas, double-deckers, dubli, and so on, generally such individuals are looked upon with scorn. A panthi who is penetrated is called a gupti *kothi*, while a *kothi* who is known to penetrate another male is seen as not a real *kothi*.
- male sexual desire for another male should therefore be contextualised differently from male to male sexual behaviour.
- *Hijras* are a different framework altogether. They represent a sociocultural - religious identity, based on gender identification but not within the male-female binary opposition. While many people believe *hijras* are biologically hermaphrodites, this is not true. The vast majority of *hijras* are biologically male, where many will be fully castrated in a religious ceremony. Their social structures are based on the Hindu Guru system and female identified family structure. *Hijras* should not be perceived within hegemonic either/or gender opposition, but as a different gender altogether - perhaps as a “third gender”. Nor should *hijras* be called “eunuch”, or transvestites, transsexuals, or even transgenders. They are “*Hijras*”. (See Nanda, Serena: Neither man nor Woman - *Hijras* of India, Wadsworth, USA, 1990 and Jaffrey, Zia: The invisibles - a tale of the eunuchs of India, Weidenfeld and Nicholson, 1997.)

The context of male-to-male sex in South Asia

MSM should not be seen as an exclusive category of people, defined by a specific occupation or activity, unlike perhaps female sex workers, truck drivers and slum dwellers, categories used in South Asia by donor agencies, NGOs and national AIDS programmes. MSM can exist in a broad (often bewildering) variety of identities, behaviours, and practices. What seems to exist are a range of masculinities with differing contextualisations of a range of sexual behaviours, partner choices and desires.

Contemporary research on sexuality and gender have clearly shown that bipolar categories, such as man or woman as gender categories, and heterosexual or homosexual as sexual categories, are not useful to describe the range of identities, desires and practices” (personal discussion with Carol Jenkins, Care Bangladesh, 1999) existing in South Asia. The terms “gay” or “homosexual” are also too constricted by a specific history, geography, language and culture to have any significant usefulness in a different culture from their source. In this we should be talking about sexualities, genders, and at the least, homosexualities and heterosexualities. Where UNAIDS and others speak of behaviourally homosexual, we can also talk about behaviourally heterosexual in the South Asian context.

Beyond all this are the gender categories of man or woman. Self-identities amongst MSM in South Asia vary across the spectrum of divergent categories, where those most public in the expression of same-sex desire, usually identify themselves as a different gender category which is feminised, expressing themselves in feminine language, sometimes through dress, make-up and mannerisms, and who also have access to their own specific “secret” language (*ulti* - a derivative of the *hijra* language) which is unavailable to the majority population. These individuals call themselves *kothis*, but this is a socialising

and socialised role, where a “new” *kothi* with emergent sexual desires for other males (and often not so emergent, but in full force) will make friends with “older” *kothis* and learn the characteristics, roles, behaviours (including sexual), mannerisms and language. And it is this *kothi* framework that appears to dominate the MSM contexts in South Asia, in terms of the poor and low and middle-income sectors that represent over 70% of the population.

Kothis see themselves as the feminine in a masculine/feminine sexual partnership, and play out the perceived gender role in the culture. Most *kothis* feel relatively comfortable with their choice, although expressing a varying degree of shame in terms of the shame-based culture of South Asia. Those men who access these *kothis* for sex, and sometimes for sexual relationships and partnerships, are seen as “real men” by the *kothis*, men who play the “dominant”, “active” and “penetrating” role. Such men do not see themselves as “homosexuals”, since the people they have sex with are not “men”, but feminised males, *kothis*. They do not have a sexual identity term for themselves, but practice a sexual behaviour, often based on “discharge” and “body heat”. They see themselves as manly men. The label *panthis* is used by *kothis* to describe them, meaning a “real man”, a man who will penetrate them, and who most likely will also have sex with women. Many *kothis* speak of all men as potential *panthis*, accessible to them as sexual partners, accessible, not based on male-to-male desire, but because of what was perceived as an urgent need for sexual discharge.

As part of their public gender performance, many low-income group *kothis* take oral contraceptives (many can’t afford, or can’t access, hormone injections) as a means of developing breasts, stating that *panthis* like to “squeeze” their breasts as a part of their sexual practice. From the range of discussions, taking oral contraceptives by these males is a significant activity, not as a means to become more like women, but as a tool to attract *panthis* as sexual partners.

Sociocultural, religious and family pressure ensure that the majority of *kothis* will eventually marry and produce children, no matter how long they attempt to delay this process. The choice is often stark. Stay with your family, or leave! And with no social welfare system available, there is a perception of no choice. This intense pressure produces a range of psychological effects, a depression and fear of non-performance with their wives, to a constant search for a “real man” who will “marry” them and look after them. In the discussions several *kothis* stated that they would even sometimes use female sex workers “for practice”.

Some of the *kothis* from low-income groups become sex workers as a source of generating and income. Usually this income was to support their family. But it should be noted that not all male sex workers are *kothis*, and not all *kothis* are sex workers.

Panthis are less clearly defined, being men of all ages and types, married and unmarried, across the spectrum of income and employment, who at least at times, enjoy sex with other men or stated they could not access females, and they could not control their “body heat” and “needed to discharge”. There was a strong sense of immediacy, urgency, opportunity and availability to their sexual behaviours with the *kothis*.

And of course all *panthis* will either be married or will get married eventually, fulfilling the social, religious and family expectations for all men in South Asian cultures.

But beyond this “public” framework of identities, desires, and behaviours is a context even more invisibilised, an issue also relevant to HIV prevention. An unknown proportion of males experience male-to-male sex while young, often before male-to-female sex and often with family relatives such as cousins or uncles, or even with friends. Such behaviours are outside the “public environments” taking place in neighbourhoods, private homes, hostels, guesthouses, hotels, and a range of vendors’ shops and other private places. Here the contexts may well play out a *kothi/panthi* framework, but

Setting the context

often it is where access, immediacy and opportunity play a significant role in prevalence of this behaviour. Very often both of the partners involved in the sexual activity do not express a sexualised identity, but rather speak of need and urgency, “the heat of the moment”, or “I did it in my sleep”.

Some may well find that their experience of sex with other males resonates with their own sexual desires and gender role preferences, and should they meet with *kothis*, develop their own *kothi* identity. Others give no voice or name to their experiences, and may well stop upon marriage, or continue in their neighbourhoods with local *kothis* and boys.

Kothis by their very number, “nature” and practices have access to a broad range of other males whom they access for sex, and can be seen as an entry point to MSM in South Asia.

Perhaps where the term “behaviourally homosexual” has been used by UNAIDS and others, we should use the term “behavioural heterosexual” as well to get even a glimpse of the range of masculinities, male sexual behaviours, genders, identities, and the multiplicity of male to male sexual frameworks.

Situational identities

Such beliefs and practices lead many *kothis* to act out what could be called situational identities. That is, within the family home and neighbourhood they will perform as young (or not so young) men, while in specific environments, they will perform as *kothis* with other *kothis*, or to draw the attention of potential “manly” male sexual partners. This behaviour often involves an exaggerated sway of the hips, loose wrist actions, eye movements, touching the mouth with a finger, use of *ulti* and so on. These gestures demonstrate sexual availability to the *panthis*.

Situational identities act as a device to invisibilise identity choices, desire and behaviours, maintain social and family stability, and reduce levels of tension, potential harassment, and violence. This also means that the *kothi* identity has a significant level of performance as part of it. This has been clearly borne out in a range of the discussions where several *kothi*-identified males stated that they performed as a *kothi* with other *kothis* to be able to be a part of a social network that accepted them, rather than because of their sexual behaviour and identity choice, i.e. they saw themselves as men with both “active” and “passive” sexual encounters.

Support and friendship systems

For *kothis*, their key support and friendship systems are provided by other *kothis* and their own families. This also expresses the gendered framework with which the majority of *kothis* identify with, as well as the living out situational identities.

In South Asian cultural systems, men and women rarely make friendships. The public arena is male dominated. And male-to-male friendships are expressed in the public domain.

But *kothis* see men as potential *panthis*, and often treat them as such. It is seen as rare for a *kothi* to develop a non-sexual friendship with a “man”. *Kothis* expressed the desire to “find a husband”, but even in this context *kothis* recognised that this “husband” will get married and live with his wife.

In a situational context *kothis* will perform as males in other public contexts and in the home, and thus will develop friendships with other neighbourhood males and relatives, keeping his identity choice and sexual behaviour secret. But even in this arena,

kothis sometimes speak of sex with friends, with these male friends. But never, never, with another *kothi*.

Support systems tended to be expressed within a narrow arena of *kothi* friendship networks, usually in a public environment, although sometimes *kothis* will visit other *kothis* at their homes, particularly so when that *kothi* has a room to himself. Here again this space can often become sexualised as *kothi* friends will bring their *panthis* to access the privacy of the space. *Kothis* who have strong bonded relationships, will often call each other in feminine relationship terms, such as sister, aunty, mother, and so on.

Here there are several lateral and vertical relationships based on female family structures, which requires acknowledgement, but sometimes it also generates “sibling” rivalry and discord over access to apparel, make-up, appearances, and potential sex partners.

Kothis will always turn to other *kothis* for moral, emotional and financial support where the family could not, or would not provide this.

Family

Joint and extended familial links are strongly held together by custom, tradition, belief, practice and economic need. Their value lie in providing a form of social security and welfare in a society that has neither. The elders are supported, as often are the unemployed, the unmarried, the range of children, the disabled. It is considered a moral duty for the family to stay together in this mutual support system, whether the staying together is physical or psychological. For example, leaving a small town or village to migrate to a major city for work, the individual will often stay with an extended family member already in that city.

Such extended family systems can be a liberating experience in terms of the social conditions of individual members. To rely on the family for such support, emotional, physical, or financial, relieves much of the burden for sustaining the self. But as a consequence, the concept of individuality becomes lost. Personal choice and desire becomes subsumed within family choice and desire. Marriage, children and duty to parents are the focus.

Marriage

In South Asia, marriage is a social, cultural and religious necessity, a central issue within people’s lives and a mainstay of family and community life. It should be seen as a socially and religiously compulsory duty towards maintaining family and community bonds. Marital status signifies adulthood, social responsibility and the achievement of personhood.

Traditionally, marriages are arranged between two extended families. Such arrangements are based around economic and inter-family connections. In urban environments there may be a matter of choice and concepts of “love marriage” are growing in the middle classes, but ultimately marriage is no choice. As Herdt states in his book *Same Sex Cultures*, “...full personhood is not achievable until people have married and produced children” (p5).

To remain unmarried is often seen by the family and others as an aberration, a sickness, bringing shame and dishonour upon the family, creating social and family disorder. To have no children can be seen as a curse.

But such marriages are not usually based on mutual friendship, desire and love. Extremely few of married MSM have informed their wives about their extra-marital behaviour with other males, or for that fact, other woman. They believe that all they

Setting the context

need to do is to function adequately as husbands in terms of economic support for their wives and engage in sexual intercourse in order to have children. Marriage is considered a duty and sex with one's wife as a means to have children.

The wife is seen as the bearer and mother of his children, not as a friend and lover. Marriages are not seen as companionate and egalitarian. And because of the dominant male ideology and male social spaces, a male should be seen spending more times with other males, otherwise he would be seen as being weak and perhaps "womanly".

Psychosexual issues

Sex education is largely absent. Knowledge of the male and female bodies, of reproduction, of the sex organs, is almost non-existent.

This leads to a variety of myths, beliefs and practices, which are accepted as true and helpful. A considerable tension exists regarding masturbation as a source of body and mental weakness, which reduce the virility, and functioning of the penis, if not producing damage of one sort or another. Constantly questions are asked about medical treatment for nocturnal emissions, masturbation, penile sizes and shapes. Many men use "quack" remedies from street vendors for their perceived weaknesses.

At the same time, the lack of knowledge of their own and female bodies lead to a range of risky practices, such as rapid discharge, or anal or vaginal bleeding, achieved through dry and rapid penetrative acts.

Reproduction also carries its own myths and beliefs, where many young males have no idea how babies are born, or even formed.

Gender

In terms of men who have sex with men there appears to be a range of masculinities, a spectrum of possibilities, where at one end are *hijras*, then *kothis* and then what *kothis* define as "real men", *panthis*. *Kothis* are not men believing they are women, or even want to become women. They appear to see themselves as "less than men", but "more than women". While they identify with the feminine, much of the identification is around performance as a means to attract these "real men" as sexual partners.

Male and female gender roles are strictly divided through sexual positions, appearance and dress, mannerisms, and work functions. These roles are hierarchical and oppositional. Women are "passive", "servile", "domiciled", wife and mother. *Kothis*, through their gender identification are also supposed to "passive", "servile", "domiciled" and "wife" to their *panthis*. Many *kothis* speak of "finding a husband", seeking for a "real man" with an akka likam (meaning a big penis).

But there are often intense contradictions here. *Kothis* in a public space (like *hijras*) can be extremely voluble, sexually assertive (it is often the *kothi* who usually approach the panthi in the cruising sites), and will often dominate the sex act, even though he is being penetrated. And it should be recognised that many *kothis* also play the role of husband and father with their wives.

It cannot be taken as a given that because *kothis* identify with the feminine, that they only take the receptive role in the sex act, and use feminine terms for each other, that they are passive. There is much diversity in all of this.

But it should be recognised that because *kothis* play out the socially accepted gender roles, that their self-definitions, language and behaviours sustains a patriarchal framework of gendered relationships and sexual behaviours, this increases their risk of STI/HIV infection and transmission.

Actions for life

Introduction

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



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

It continues to be true that the only real hope is to ensure that the countries of South Asia and beyond, develop an effective STI/HIV prevention strategy that addresses all risky behaviours and practices. No country can afford to ignore or deny what occurs within it, whether it is a particular risky sexual practice or a stigmatised identity that is deemed to be immoral, illegal, or supposedly against its culture. Such denial and stigmatisation creates ideal conditions for an increasingly rapid spread of HIV infections across the country.

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

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

Further, whilst many in authority, both religious and secular, government and non-government, would prefer to promote sexual abstinence before marriage and faithfulness within marriage (this what is usually taken to be by the phrase ‘behaviour change’), there will always be those for whom these are essentially public acts of obedience, whilst in private other more secretive behaviours often come into play.

The corollary to this is to fully accept that the only effective and appropriate HIV/AIDS education and prevention strategy to ensure that the spread of STDs and HIV/AIDS was controlled would be to also promote safer sex behaviours amongst males who have sex with males. This is what NFI means by a ‘risk reduction strategy’. Such promotion to

be successful would also need to ensure that appropriate and accessible sexual health services are available which also respect their confidentiality and anonymity and build upon their trust and respect.

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

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

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

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

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

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

Behavioural, epidemiological, and anthropological research

If we are going to develop effective and sustainable strategies for changing risky sexual practices towards safer practices, and in the context of there being no vaccine or cure against AIDS, where maintaining such safer practices over a lifetime is a necessity, then we need to understand actual sexual practices and cultures. But understanding sexual behaviour does not arise from what individuals actually do, or many times they do within a given period. It arises from placing such behaviours within a given socio-cultural context. What influences such behaviours? Why do people do what they do?

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

This requires appropriate behavioural, sociological and anthropological research methodologies that include the subjects of such research both as subjects and as observers.

Such inclusion will facilitate access as well as ensure that those being studied are involved in managing the study and what happens to the results following such a study. For this to be achieved, academics and research institutions will need to develop different approaches to such research and understanding.

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

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

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

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

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

Risk and needs assessments

What is the STD/HIV/AIDS situation in a given locality? What are the socio-cultural factors that can impede safer sex practices? What is the sexual culture(s) in this area? Who is involved in risky practices?

Before strategies for positive change can be implemented, there will be a need to develop appropriate risk and needs assessments amongst males who have sex with males within different sexual networks, and amongst those expressing differing sexualities, identities, genders, and behavioural frameworks. Such information is a pre-requisite for ensuring local participation and involvement in programme design and implementation. With

local involvement in both management and conducting these risk and needs assessments, there is often a greater likelihood of ensuring the validity of data, an appropriate analysis of the data, and adequate protocols on confidentiality.

It is therefore important to ensure that adequate and sufficient funding is made available for these risks and needs assessments to be conducted. At the same time such research must assure respondents that any data collected will not be used against them, that their confidentiality and anonymity will be respected, and that the information will only be used to develop appropriate strategies for the prevention of STD/HIV/AIDS amongst them with their support and assistance.

Developing community-based AIDS service agencies

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

At the same it is recognised that in the South Asian context, providing prevention services that address anal sex as well as male-to-male sex behaviours can be extremely problematic in an environment of shame, stigma and violence. Who can you trust? It is also recognised that non-government community-based agencies are often more effective in accessing stigmatised groups and behaviours and empowering behaviour change.

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

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

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

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

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

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

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

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

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

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

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

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

Other male-to-male sexual communities which would not access services provided by the kothi networks will also need to be developed. Such service development could be organised by the other emergent male-to-male sexual communities, perhaps those who are gay-identified, with appropriate support and assistance.

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

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

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

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

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

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

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

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

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

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

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

Education for prevention

Changing sexual behaviours requires not only appropriate knowledge, but also desire, will, skill and empowerment. In South Asian countries, sexual knowledge, accurate information about STDs and its treatment, correct understanding of HIV and AIDS is sorely lacking. There is an urgent need to address the high levels of incorrect beliefs about sex, sexual functioning, the male and female body, and all aspects of sexual behaviours. These beliefs are damaging and impede any effective development of STD/HIV prevention.

The lack of appropriate and accurate sex education should be urgently addressed and would require government action in order to provide an effective sex education pro-

gramme which should be made available for both the formal and informal education sectors. Such education should be aimed at children, youth and parents, be available in educational establishments, hostels, male institutions, informal sectors, factories, et al.

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

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

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

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

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

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

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

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

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

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

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

- How appropriate is the framework of education?
- What language is it in?
- What words and images are used
- Is it appropriate to the cultural frameworks and context of delivery?
- Who controls the agenda?

Setting the context

- Who produces the information?
- Who receives the information?
- Who delivers the information?
- How is this information delivered?
- Can we differentiate between culturally sensitive and culturally appropriate?
- Do services exist to cater for expressed needs that such information may generate?
- Who staffs these services?
- What do they deliver?
- How do they deliver services?
- How appropriate are they?
- What skills do they have?
- What messages are being delivered?
- Don't do it
- Do it safely
- What is the objective?
 - to inform?
 - to change behaviour?
 - to reduce the rate of HIV transmission?
 - to halt the spread of HIV?
 - to increase reproductive health of women, of men?
 - how will this be achieved?

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

Sexual health resources

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

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

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

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

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

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

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

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

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

STI treatment

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

Women and sexual health

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

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

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

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

Psycho-sexual counselling

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

The role of national/state AIDS programmes

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

Such an investment should be in the form of:

- Provision of long term financial support.
- Provision of, or unhindered access to, technical assistance and financial support access to appropriate capacity-building training.
- Addressing legal and regulatory constraints, which may hinder the development of such peer-led community-based agencies.

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

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

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

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

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

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

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

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

NAPs should also develop national education strategies for the general population against discriminatory attitudes towards HIV/AIDS and sexual behaviours as well as to de-stigmatise male to male sexual behaviours through the use of mass-media and educational forums.

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

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

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

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

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

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

Community mobilising



It is understood that safer sex practices amongst males who have sex with males can only be encouraged and maintained over the “long haul” if such practices become a normative behaviour amongst males who have sex with males. To achieve this goal, it therefore requires such safer sex practices to be adopted as a community behaviour, which requires the whole community to be involved in promoting and adopting such practices. However, this pre-supposes that an MSM community exists as a cohesive force. This is not a valid assumption in South Asia, where no such community(ies) exist.

There is therefore an urgent need to understand the psycho-social-sexual constructions of male to male sexual behaviours, their frameworks within South Asian cultures, and their particular socio-sexual dynamics. From such an understanding appropriate strategies can be developed towards utilising shared characteristics as a form of “psychological community” as a means of mobilising shared actions.

Naz Foundation International, working with networks and groups of males who have sex with males in a number of cities in South Asia has developed a process for enabling such males to form their own HIV/AIDS prevention service agencies. A process of community building, mobilising, and empowering males who have sex with males towards providing and managing their own sexual health services.

This is part of a parallel process of ensuring that male to male sexual behaviours are acknowledged in any sexual health promotion programme.

- Community building and ownership by males who have sex with males for others who share similar frameworks, where the process utilises the already existent emergent community networks amongst some males who have sex with males, though accessing the shared sense of self, gender identity, and behaviours. This would also be true for gay-identified men.
- Encouraging all reproductive and sexual health programmes, STD treatment centres, and HIV/AIDS prevention programmes, incorporate the issues of anal sex behaviours (between males as well as between males and females) into their education, treatment, and service provision. This enables access to those males who penetrate other males but do not belong to any behavioural community, as well as those males involved in discharge or masti sex with other males, but who also do not belong to any behavioural community.

Behavioural summary

In South Asia, the vast majority of males who have sex with males fall within a range of behavioural dynamics. These are:

Kothis

Males who feminise their behaviours (usually in specific situations/context) and who state that they prefer to be sexually penetrated anally or orally. For a *kothi* to take on the role of penetrator is seen as shameful and where this occurs is kept secret. Most male sex workers are self-defined as *kothis*, but not all *kothis* are sex workers.

Panthis

A term given to males who sexually penetrate *kothis* by *kothis* themselves. The vast majority of *panthis* do not label themselves as such.

Do-parathas, dublis, double-deckers

Those who practice mutual sexual behaviour. Another term given to such males by *kothis*, where such males are not respected as such by either *kothis* or *panthis*.

Others who may practice male to male sex as:

- A regular part of their sexual repertoire
- On-access to females
- All male institutions
- “Hotness”
- Opportunistic discharge
- Desire
- Curiosity

Most of these males are considered *gopon/gupti* or secret.

Gay identified males

In the main small, English speaking, educated male networks.

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

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

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

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

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

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

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

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

Since the primary community frameworks and social identities within South Asia revolve around family (the joint and extended family system), rural origins, i.e. shared village

experiences, locational (where you live), work affiliations (truck-driver, rickshaw driver, student, etc.), marriage and children, making shared behaviour characteristic a basis for community building becomes a major initiative and a challenge to the social basis.

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

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

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

Process

What makes a community?

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

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

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

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

- Affiliation to a shared consensus
- Solidarity as a “community
- Mutual support mechanisms
- Social support services
- Shared ideologies and social characters
- Socialising frameworks
- Mutual concerns
- Shared needs
- Shared rituals

Setting the context

These agencies thus manage a *kothi* sexual health promotion project. (perhaps under the title male sexual health project as a ‘screening’ device in conservative societies)

However, the sexual partners of *kothis* and male sex workers are also being drawn into these service framework through contacts established by *kothis* and through collaboration with other sexual health promotion agencies and services.

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

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

Development

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

Outreach/networking

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

Using site-based key informants (although the term informant is problematic, and we would rather use the term “site-buddies”) who can provide supportive frameworks to the field worker with their knowledge and insight into specific sites and provide continuity within a site when the field worker is not present.

Socialising meetings

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

Personal skills development

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

Employment and accommodation networks

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

Savings and loans club

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

Advocacy

Police and maastan/goonda harassment are common factors amongst *kothis* who use public environments as social spaces, for sexual encounters and to sell sex. By developing legal aid services, challenging human rights abuses, and providing counselling and support, a framework of service use

and access can be developed which can be seen as a “community service”, encouraging affiliation to an “emergent sexual community”.

STI treatment services

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

Condoms and lubricants

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

Needs assessments

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

Such needs can be:

Social needs:

- Education
- Employment
- Economic development
- Human rights
- Family, marriage and children
- Vocational skills
- Socialising spaces

Personal and emotional needs:

- Sexual abuse and violence
- Counselling
- Personal hygiene
- Friendship
- Identity and desire
- Emotional support
- Empowerment
- Personal skills development
- Personal health issues.

Setting the context

Sexual health needs:

- Appropriate condoms
- Appropriate lubricant
- Sexual spaces and privacy
- Access to appropriate treatment
- Psycho-sexual issues
- Counselling
- Knowledge
- Empowerment
- Negotiating skills.

Responding to needs

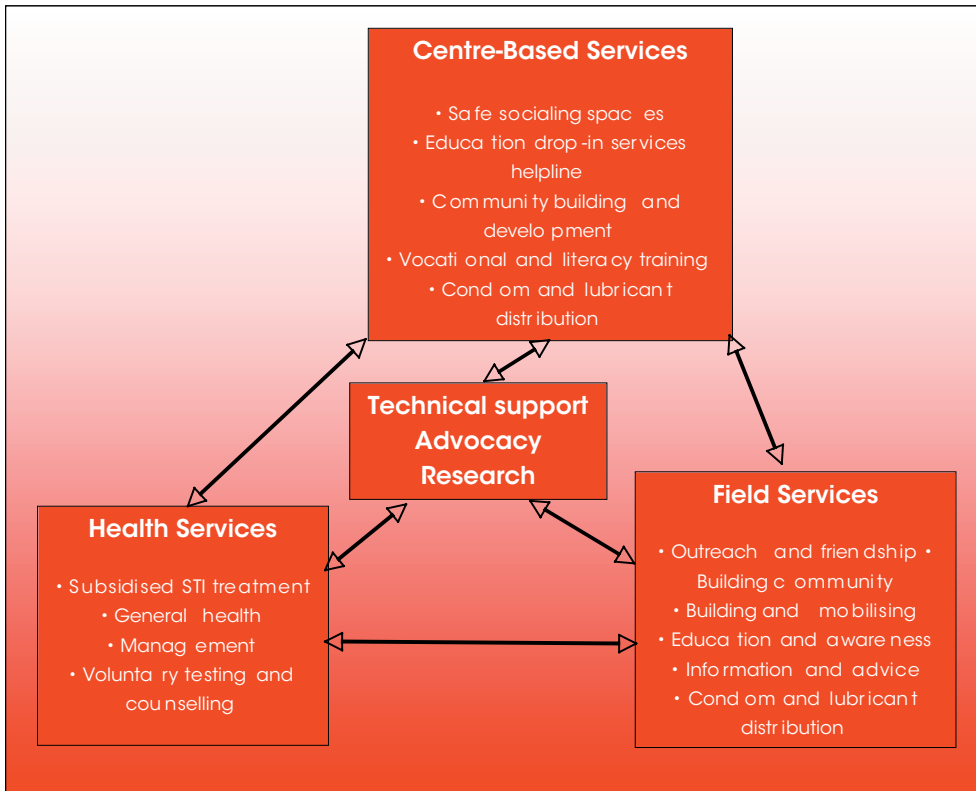
It is essential that the service provision should build upon these needs and find appropriate ways to ensure that these needs are being adequately and appropriately addressed.

Thus, for example:

- A health service that can look at non-sexual issues and provide appropriate treatment and care, i.e. chest infections, TB, and other potential illnesses
- An employment agency/network
- Vocational skills development including reading and writing
- An emergency housing network
- Address poverty issues, such as subsidised medicine and treatment, and access to low interest credit and small savings
- Socialising spaces that allow non-sexual friendships to be developed amongst *kothis* and non-*kothi* identified MSM
- Access to legal aid
- Addressing discriminatory laws and regulations
- Addressing police and maastan/goonda harassment
- A sexual health service that is appropriate and sympathetic and easily accessible
- A non-judgmental service provision irrespective of class, economic group, work affiliation, sexual behaviour/desire and feminisation
- Development of socialising rituals for community bonding, such as dance, music, prayer, songs, food rituals, etc.

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

MSM CBO sexual health promotion model



A rights based framework for preventing the transmission of HIV among men who have sex with men

Paper prepared by Miriam Maluwa¹, UNAIDS² Law and Human Rights Adviser. Presented at an Inter-Agency meeting³ on “Working with Men who have Sex with Men for HIV/AIDS Prevention and Care, 1 November 2002, Room C102, World Health Organisation, Geneva Switzerland

1. The Framework

International human rights law protects all persons equally, without distinction or discrimination. The broad range of human rights- civil, political, economic, social and cultural- should be equally enjoyed by all groups of individuals. The protection of the basic human rights of men who have sex with men is therefore, grounded in a human rights framework that all people are worthy of equal respect and dignity whatever their situation.

The core international human rights Treaties and Conventions adopted by the General Assembly, inter-alia, the Universal Declaration on Human Rights,⁴ Convention Against Torture, Inhuman and Degrading Treatment,⁵ International Covenant on Civil and Political Rights,⁶ the International Covenant on Economic, Social and Cultural Rights,⁷ the International Convention on Elimination of All Forms of Discrimination Against Women⁸, and the Convention on the Rights of the Child⁹ guarantee all human beings freedom from discrimination on many grounds, including sex, colour, language, religion, political opinion, birth, national or social origin, property, civil, political and social or other status.

The principle of non- discrimination has also been adopted in regional human rights instruments such as the African Charter on Human and People’s Rights,¹⁰ the American Convention on Human Rights¹¹, and the European Convention on Human rights.¹²

In the context of HIV/AIDS, the United Nations Commission on Human Rights has resolved that “...discrimination on the basis of AIDS or HIV status, actual or presumed, is prohibited by existing international human rights standards, and that the term “or other status” in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS.”¹³

Thus, no one should be discriminated against on the basis of their HIV status or suspicion of it. In reality, however, members of populations perceived to be at higher risk of HIV infection, such as men who have sex with men or their families and associates are “presumed” infected and, thus discriminated against.

The United Nations human rights treaty bodies that monitor’ compliance of States, at national level, with their obligations to ensure respect, protection and fulfilment of human rights of all persons provide (i) an important avenue for raising HIV-related human rights issues, (ii) elaborating how principles of international human rights law apply to HIV/AIDS, including on issues of men who have sex with men and (iii) helping States better to understand and comply with their obligations as they apply to HIV/AIDS.

The Human Rights Committee, which monitors the implementation of the International Covenant on Civil and Political Rights, has, for example, addressed the issue of the right to privacy, noting that Article 17¹⁴ of the International Covenant on Civil and Political Rights is violated by laws which criminalize private homosexual acts between consenting adults.¹⁵

Specifically in the context of HIV/AIDS, the Committee has found that the “criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS ... by driving underground many of the people at risk of infection ... [it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention.”¹⁶

Further, the Committee has also resolved that the term “sex” in article 26 of the Covenant on Civil and Political Rights, which prohibits discrimination on various grounds,¹⁷ includes sexual orientation.¹⁸ Furthermore, the Human Rights Committee has also confirmed that the prohibition against discrimination requires States to review and, if necessary, repeal or amend their laws, policies and practices to proscribe differential treatment that is based on arbitrary HIV-related criteria.¹⁹

2. Vulnerability of all

Discrimination against men who have sex with men and other disadvantaged groups²⁰ increases such person’s vulnerability to the risk of HIV infection, as well as the likelihood that they will be targeted for coercive measures, such as mandatory testing, arbitrary arrest, segregation, detention and deportation.²¹

Such discrimination also compromises the health of the general population as those affected, actively avoid detection and contact with health and social services. The result is that those most needing information and, education and counselling are driven underground.

Safeguarding human rights in the context of HIV/AIDS is, therefore, not only vital in itself as a principle, but it is also pragmatic. Its aim is to encourage those who are infected to cooperate with the authorities so as to slow down the epidemic. This can be achieved only if people have assurances that their rights will be respected.

3. Accountability of States

As members of the United Nations and as States Parties to the said international human rights instruments, States have obligations to respect protect and fulfil human rights.²²

The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of human rights.²³ The obligation to protect requires States to take measures that prevent third parties from interfering with human rights²⁴ and the obligation to fulfil requires States to adopt appropriate legislative, budgetary, judicial, promotional and other measures for the full realisation of human rights.²⁵

States have also willingly made political commitment to implementing human rights in the context of HIV/AIDS.²⁶ States must be held accountable for these legal and political commitments.

4. Conclusion

The human rights framework gives access to existing procedural, institutional and other accountability and monitoring mechanisms which can be used to monitor and advance a rights based approach to HIV programmes, including those addressing men who have sex with men.

Given the magnitude of the HIV epidemics, “human rights for all” should not be rhetoric. The fundamental human rights principle of non-discrimination should lay the foundation for effective responses to the global HIV epidemic, and hopefully to the protection of the right to health for all, equally, irrespective of status.

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- ³. Convened by UNAIDS Secretariat and WHO.
- ⁴. Adopted by the General Assembly on 10th December 1948 under Resolution 217 A (III)
- ⁵. Adopted by the General Assembly on 10th December 1984 under Resolution 39/46 of December 1984. Entered into force on the 26th June 1987.
- ⁶. Adopted by the General Assembly under G.A resolution 2200 (XXI), UN GAOR, 21st session, Supplement No. 16, UN Doc. A/6316 (1966). Entered into force 23 March 1976.
- ⁷. Adopted by the General Assembly on 16 December 1966 under G.A. Res. 2200 (XXI); UN GAOR , 21st Session, Supplement No. 16 at 49, UN Doc. A/6316 (1966).
- ⁸. Adopted by the General Assembly under GA Resolution 34/180 of 18 December 1979. Entered into force 3 September 1981.
- ⁹. Adopted by the General assembly under GA res. 4/25 of 20 November 1989. Entered into force 2 september1990.
- ¹⁰. Adopted on 26 June 1981. Entered into force 21 October 1986.
- ¹¹. Adopted 22 November 1969. Entered into force 18 July 1978.
- ¹². Adopted 4 November 1950. Entered into force 3 September 1953.
- ¹³. Commission on Human Rights Resolutions 1995/44; 1996/43, 1999/49; 2001/51 and Sub-Commission Resolution 1995/21.
- ¹⁴. Article 17 states (i) “ No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. And (ii) Everyone has the right to the protection of the law against such interference or attacks.
- ¹⁵. Communication No. 488/1992, Nicholas Toonen V Australia, (Views adopted on 31 March 1994, fiftieth session). See Report of the Human Rights Committee Volume II General Assembly Official Record Forty-ninth session (Geneva, 18 October to 5 November 1993); Fiftieth session (United Nations Headquarters, 21 March to 8 April 1994) Fifty-first session (Geneva, 4 to 29 July 1994), (A/49/40) . <http://www.unhchr.ch/tbs/doc.nsf/Pages/226-237>, paragraph 8.2.
- ¹⁶. *ibid*, paragraph 8.5.
- ¹⁷. “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”.
- ¹⁸. *ibid*, paragraph 8.7.
- ¹⁹. *ibid*, paragraph 11.
- ²⁰. Such groups may also include women, children, minorities and indigenous populations, those living in poverty, migrants and other aliens and injecting drug users.
- ²¹. See examples of HIV/AIDS related litigation at: <http://www.tac.org.za/>: Carrasco E (2000); and Access to Treatment as a Right to Life and Health. Canadian HIV and AIDS Policy Law Review; 5:4. Available at: <http://www.aidslaw.ca/maincontent/otherdocs/Newsletter/vol5no42000/carrascodurban.htm>.
- ²². See Committee on Economic Social and Cultural Rights General comment 14. The right to the highest attainable standard of health adopted 11 August 2000.. E/C.12/2000/4, paragraphs 34-37. see also <http://www.unhchr.ch/html/menu2/6/cescr.htm>.
- ²³. For example, refraining from identifying or limiting equal access of all persons, including men who have sex with men, preventive and curative HIV/AIDS health services and care or abstaining from enforcing discriminatory practices as State policy.
- ²⁴. For example, adopting of legislation to ensure the equal access to health care and

Setting the context

health related services provided by third parties; to control the marketing of medicines and medical equipment and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.

²⁵. For example, adoption of a national health policy with a detailed plan; promotion of HIV/AIDS education, as well as information campaigns and vaccine research.

²⁶. For example, recent relevant political commitments have been made in the United Nations Millennium Declaration (2001), the UN General Assembly Special Session Declaration on HIV/AIDS (2002), The Declaration and Program of Action of the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance (2001) and The Declaration from the World Summit for Social Development (2002).

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 immunodeficiency 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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