

Pukkar

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Will promoting condoms be sufficient to change behaviours in a sustainable way? What about other forms of safer sex behaviours? Other strategies for risk reduction? Can we not be more creative in our approaches to prevention of STI/HIV infection? What about masturbation, oral sex, thigh sex? Does not the exclusive focus on condom promotion actually enhance penetrative sex and accentuate phallic power?



an international HIV/AIDS and sexual health journal focusing on south asian masculinities and sexualities

Naz Foundation International is a development agency specialising in providing technical, institutional and financial support for the promotion of sexual and reproductive health of males who have sex with males in South Asia

Vision

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

Mission

With a primary focus on marginalised males who have sex with males, our mission is to empower socially excluded and disadvantaged males to secure for themselves social justice, equity, health and well-being by providing technical, financial and institutional support

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

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Naz Foundation International is a development agency focusing on male to male sexualities and sexual health concerns in South Asia. In its work Naz Foundation will fully consider the implications of males who have sex with males, for themselves, for any male or female sexual partners such males may have, and for any clients of those males who do sex work.

In this work Naz Foundation will be guided by the following principles:

1. promoting the reproductive and sexual health of males who have sex with males by encouraging sexual responsibility and safer sexual practices
2. encouraging males who have sex with males to access STD treatment whenever necessary
3. respecting confidentiality in the relationship between males and their sexual partners and/or clients
4. promoting the protection of children and non-consenting adults from abusive sexual relationships
5. promoting the reproductive and sexual health of any female partners of males who have sex with males by encouraging greater sexual responsibility of their male partners
6. encouraging communication of sexual health information between sexual partners and promoting partner notification of STD/HIV infection, irrespective of the gender of the partner
7. working with female reproductive and sexual health services in order to facilitate appropriate access to infected female partners of males who have sex with males.

Pukaar

Pukaar is the quarterly newsletter published by **Naz Foundation International**. It provides a forum for discussion, information, and advice, as well as general interest, regarding HIV/AIDS and sexual health, focusing on South Asian masculinities and sexualities.

The opinions expressed in *Pukaar* reflect the writer's views only and do not necessarily reflect the views of **Naz Foundation International** unless specifically mentioned.

We will always try to ensure that what we report is relevant to our readers, and we ask you, the reader, to keep us informed as to what is happening in your corner of the world. Send us your questions, letters, articles, stories (fact or fiction), poetry, drawings, photographs. Tell us about what you think and feel, whether it concerns HIV/AIDS, your sexuality, or whatever. Names will be changed and addresses will be withheld if required.

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Exporting Identity¹

By Sonia K. Katyal, Associate Professor of Law, Fordham Law School

There is no doubt that a gay revolution is sweeping the globe. Today, the term "gay" has been borrowed into Japanese, Portuguese, Spanish, Thai, Turkish, and other languages, signifying its increasingly perceived universality.² Gay and lesbian organizations now exist in virtually every continent and in many major urban centers throughout the world.³ A growing number of legislators and judges have taken up the cause of gay civil rights, and have actively supported protections based on sexual orientation in a host of areas, such as adoption, employment, domestic partnership, and immigration.⁴

Yet, at the same time, there has never been a better time to study the potential limitations and challenges faced by a global gay rights movement, particularly in countries where governments have mounted serious challenges to its development. For example, in Namibia, just last year, Home Affairs Minister Jerry Ekandjo told the National Assembly that the existence of homosexuality was entirely attributable to Western influences, observing "[w]e take everything [from Western culture] lock, stock, and barrel without carefully analyzing what is good and what is harmful to us. Today it is homosexuality, tomorrow the right to walk naked, the day after it will be the right to abuse drugs. At the end the so-called rights will lead to our own extinction."⁵ In this leader's view, "so-called gay rights can never qualify as human rights" because they are "inimical to true Namibian culture, African culture, and religion."⁶ As his commentary demonstrates, many political leaders attribute the formation of gay communities as an undesirable byproduct of foreign influence and globalization.

Indeed, across the non-Western world, the emergence of gay-identified communities has ushered in painful debates about the intersection between sexual identity, culture, and human rights. Nevertheless, the complicated social meanings that attach to same-sex sexual activity, as opposed to gay or lesbian identity, are often ignored by many Western-based activists, who regularly equate identity and conduct in their efforts to assist movements for lesbian and gay equality abroad. Yet these questions have undeniable legal consequences, particularly for the minoritizing discourse that animates the global gay civil rights movement. Traditionally, the law presumes that one's sexual orientation - heterosexual, homosexual, bisexual - is a fixed identity defined by the gender of one's chosen sexual partner. However, contrary to this view, some cultures view homosexuality as an activity, not an identity; others view it as a necessary phase in a quest for full-fledged adulthood; and still others equate it with transgenderism. Although there is certainly an appreciable emergence of self-identified "gay" or "lesbian" individuals throughout the world, many Western activists and scholars often fail to recognize that arguments for legal protection on the basis of sexual orientation often collide with, rather than incorporate, these pre-existing social meanings of same-sex sexual activity. In other words, the presumed equation between sexual conduct, sexual orientation, and sexual identity, so prevalent in Western legal thought, tends to swiftly unravel when viewed in a cross-cultural framework.⁷

These complexities are not just differences in translation; they have profound implications for the constitutional, civil and criminal rights affecting sexual minorities across the world. As many public health activists have argued, gay and lesbian activists have made a divisive mistake by singlehandedly focusing on identity-based protections in order to achieve equality for sexual minorities. When considered in a cross-cultural context, identity-based protections actually reveal their own inherently self-destructive limitations, demonstrating a central paradox of global gay rights discourse. Instead of liberating sexual minorities, the use of identity-based frameworks may paradoxically exclude them from protection. Therefore, a global gay rights movement must take into account sexualities and behaviors that fall outside of traditional categories of sexual orientation. If a constitutional framework for protection of

sexual minorities is to be globally effective, it must recognize that many individuals who fall outside of neatly circumscribed categories of sexual identity are just as deserving of a model of liberation that includes them.

While I would stop short of advocating a culturally relativistic approach to gay civil rights in general, the changing social meanings surrounding gay or lesbian sexual identities raise deeply complex questions that are often ignored by scholars and activists in the name of globalizing gay civil rights. For laws based on sexual orientation impose - and require - a certain relationship between identity and conduct that is deeply context-specific. By exploring other permutations of the relationship between identity and same-sex sexual conduct, we can come to a better understanding of some of the complexities that accompany nascent gay civil rights movements in other cultural contexts. This understanding, in turn, highlights the importance of sexual autonomy and sexual self-determination over identity-based categories of protection.

For example, the most prominent model of gay civil rights (particularly in domestic American law) is based upon a specific relationship between sexual identity and sexual conduct that I call "substitutive." The substitutive model assumes that one's public sexual identity and private sexual conduct are interchangeable; that is, individuals who engage in same-sex sexual conduct can be legally classified by a fixed and clearly demarcable gay, lesbian, or bisexual sexual identity. Based on this equation, gay civil rights activists tend to opt between two strategies of constitutional protection: privacy-based strategies (which protect same-sex sexual conduct) or identity-based anti-discrimination strategies (which protect against discrimination based on sexual orientation).

As we have seen in the United States, a reliance on the substitutive model in such contexts can be extraordinarily beneficial in terms of creating unity and as a tool towards mobilization. Gay civil rights advocates, traditionally, argue that to demand protection against harassment and discrimination based on one's sexual identity, it is often necessary to openly acknowledge one's sexual orientation; in other words, to perform the act of "naming oneself," that is, "coming out" as gay, lesbian, or bisexual. However, this prerequisite of "naming oneself," in practice, translates into excluding large numbers of individuals who engage in same-sex sexual conduct. For example, anthropologists and public health activists have argued that the presumed equation between sexual behavior and sexual identity clashes with preexisting social meanings of same-sex sexual conduct.

As a result, the vast differences in the social meaning of homosexuality across different cultures require a more nuanced and thoughtful formulation of the public and private aspects of sexual identity. Here, what is needed is an alternative paradigm to the problematic assumptions upon which identity-based categories are based. Consequently, instead of concentrating on sexual identity, legal scholars in the West and elsewhere might benefit from exploring other paradigms of equality which focus on sexual autonomy instead.

Public Health and Constitutional Strategy in India

In India, several prominent public health activists have concluded that the language of "identities" and Western constructions of sexuality are markedly inappropriate in delivering culturally specific HIV/AIDS health services to some men in South Asia.⁸ Instead of the term "gay" or "homosexual," they have opted to use the term "men who have sex with men" (MSM).⁹ The term MSM refers to men from all age groups, marital status, economic classes, educational backgrounds, caste and religious communities, sexual identities, and gender identities who engage in sexual activity with other men.¹⁰ Use of the term, they argue, is necessary for effective health interventions, because MSM do not possess a "gay" self-identity, do not see themselves as

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bisexual, yet are not "conventionally straight."¹¹ In other words, the term is used to denote those for whom homosexuality connotes a behavior, not an identity. Although I use India as a primary example of this phenomenon, largely due to the body of literature that has developed on this topic, I do not mean to suggest that the circumstances discussed here are entirely unique to India (or to males) alone.

Nevertheless in a basic sense, the existence of MSM - an identity based on conduct alone - forces us to think more critically about how to build strategies of inclusion when personal desires, sexual behavior, subjective identity, and public identities take vastly different expressions.¹² For these reasons, rather than enforcing a substitutive lesbian or gay identity, many activists have recognized the diminishing utility of such categories, and made the evaluation of categories of sexual identity an essential, active part of their platform. And, on a more abstract level, these evaluations challenge others to recognize cultural difference while preserving a framework of civil rights for sexual minorities.

Here, India offers Western activists an interesting case study. One might think that a gay and lesbian civil rights movement and a public health movement might be diametrically opposed in interests. The first, as we have seen in the United States, focuses on visibility though identity; whereas the second focuses on behavior, rather than identity. Yet, I argue that the Indian gay and lesbian movement's method of incorporating critiques of Western identity, while offering arguments for gay rights and sexual equality - aptly demonstrate the importance of integrating both of these perspectives in gay civil rights.

Although there are no laws which expressly criminalize homosexual status, in India, Article Three Hundred and Seventy-Seven, of British origin, criminalizes "unnatural offenses" and remains in force today.¹³ Because of Section 377's continued force in preventing both the public and private expressions of homosexuality, activists in India have launched a campaign for its repeal that concentrates specifically on the law's colonial origins. Significantly, the legal challenge in India focused squarely on men who have sex with men in their constitutional challenge, rather than gay-identified men. In doing so, the brief aptly demonstrates why eliminating sodomy laws will build a more inclusive community by removing a key obstacle to gay self-identification: criminalization of sodomy. In other words, activists recognized that consideration of MSM issues underscores the enormous need for protection of conduct and privacy-based protections.¹⁴

This strategy intersects privacy with two other elements: personal expression and sexual autonomy under the right to "life and liberty" under Article 21 of the Indian constitution.¹⁵ In India, the Supreme Court has interpreted this right to include "the right to live with human dignity and all that goes along with it, namely, the bare necessities of life . . . and also expressing oneself in diverse forms, freely moving about and mixing and commingling with fellow human beings."¹⁶ Significantly, in India, the right to privacy includes a right to identity, as a bedrock Indian case on the right to privacy makes clear: "any plausible definition of the right to privacy is bound to take human body as its first and most basic reference for control over personal identity. Such a definition is bound to include body's inviolability and integrity and intimacy of personal identity, including marital privacy."¹⁷

This interpretation of personal identity mirrors a similar preoccupation in gay rights circles in India with the right to determine both the interior and exterior aspects of a person's sexuality; in other words, to evaluate the relevance and importance of "coming out." But this difference also carries important lessons for gay rights strategies elsewhere. In other words, a strategy that focuses primarily on the right to privacy before identity-based protections allows an individual the autonomy to determine his or her sexual identity and preferences, instead of forcing them to adopt a particular identity in

order to access constitutional protection. In other words, by demanding the right to privacy, Indian activists are actually demanding the right to deliberate - and determine - the interior and exterior aspects of their sexual identity, for themselves, and not as a prerequisite for a particular legal entitlement.

This unique strategy has led to a remarkable coalition between progressive human rights activists, public health activists and gay and lesbian activists who opt to challenge both the enforcement of identity-based categories and the sodomy laws that exist in India. Its localizing of a strategy for gay rights, coupled with a re-examination of its foundational precepts, reflects an important reassessment of the global utility of the identity-based, substitutive model. Instead of the government serving as a defender of Indian cultural purity and heterosexual tradition, gay and lesbian activists demonstrated that the central tool wielded by the Indian government - section 377 - is nothing more than leftover baggage from colonialism. Like those who blamed the West for exporting gay identity, gay and lesbian activists similarly blamed the West for its exported criminalization of such behavior. In sum, the remarkable duality that this movement demonstrates - challenging the enforcement of substitutive categories of sexual identity, while challenging the criminalization of sodomy - exemplifies a profound possibility for powerful civil rights models.

Toward Sexual Autonomy

As the Indian experience suggests, current debates over gay rights involve much more than the simple legal question of whether or not individuals deserve protections based on the category of sexual orientation. Instead, in this changing era of globalization and cosmopolitanism, the questions posed by such debates (both legal and non-legal) are much more complex because they also raise questions about culture, tradition, and the response of law. Here, law has played a central role by serving as a tool for activists to demand constitutional inclusion and as a target that engenders further activism. Yet, the response of Indian activists suggests that it is possible to present the world with a dynamic, pluralistic view of law, culture and sexuality that transcends the limitations of an identity-based model.

As I have argued, the current choice between strategies of protection for sexual minorities - one focusing on privacy, another focusing on nondiscrimination on the basis of sexual orientation - are distressingly simplistic and under-inclusive of the different permutations between identity and conduct that exist with respect to human sexuality, both in the United States, as well as abroad. As I have argued, a person's subjectivity, or sense of self, may differ from the outward sexual identity which he/she may adopt. This dissonance between external identity, internal subjectivity, and conduct - when combined with the role culture plays in constructing each - throws the American framework of identity politics into question.¹⁸ What is needed, then, is a new legal framework for thinking about global gay rights that takes these potential, cultural differences into account.

One way to overcome the dissonance - cultural, legal, subjective - between one's conduct and one's social and sexual identity is to turn to another framework that encompasses both the expressive and private aspects of sexuality and sexual identity: sexual autonomy, or sexual self-determination. A focus on sexual autonomy is preferable to one based on identity for three primary reasons. First, a model based on sexual autonomy is a deliberative one, thereby encompassing potential dissonance between subjectivity and external representation. Second, a sexual autonomy model focuses more squarely on the protection of sexual conduct, so that it includes protection for individuals who may engage in same-sex sexual conduct but who view themselves as heterosexual. Third, protections based on sexual autonomy are expressive, in that they protect the freedoms of individuals to express their public gender or sexual identities, and publicly voice the need for such protections. Finally, because the right to sexual autonomy encompasses aspects of both identity-based and privacy protections, it provides a much more thorough conceptual and legal framework for protection than existing models, which

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Islam and same-sex relationships

by Jeremy Seabrook

Same-sex relationships do not regard religious, cultural or legal taboos and prohibitions. They exist in all societies, at all times. The tolerance extended to such relationships varies, but the most stringent constraints of the law and the most permissive of societies probably have less influence than is generally believed upon actually existing humanity and its needs. Much depends on public perception and declaration.

Whether or not Western versions of identity politics represent the most truly liberating conditions for the realisation of alternative sexualities is, despite the celebration of diversity, nevertheless questionable. The categories of lesbian and gay/bisexual/straight often strike people from other cultures as odd, even incomprehensible. They will point to the fluidity and absence of definition in same-sex relationships in other cultures, which accommodate different behaviours, rather than identities.

The idea that homoerotic, emotional or sexual relationships between men (and access by male foreigners to Islamic society makes it easier for a man to refer to male-male relationships than to those between women) are un-Islamic, have no place in Islamic culture and are inimical to divine teachings, is disingenuous. After all, Christianity was until recently scarcely a great friend of homosexuality; and the tolerance extended to alternative sexual orientation is very new indeed. The McCarthyite purge of homosexuals in the 1950s USA was no momentary aberration. It has been argued that Western tolerance is not even what it claims to be, but is, rather, the indifference of an extreme individualistic society, where people, profoundly preoccupied with their own personal lives, have no time to cast a censorious eye on the behaviour of others.

It is a question of how such relationships are structured and psychologically integrated into the culture in which they exist. The discovery of fundamental identities in sexuality in The West is the product of a specific moment in one particular culture. It does not represent universality, or even necessarily, the emancipation claimed for it, since even in Western societies, other interdictions are set up in place of the dissolution of sexual taboos. It is always dangerous to assume that the official version of any society represents the whole culture, and it would be as mistaken to read into the Western celebration of diversity an absence of prejudice, violence and even queer-bashing, as it would to read into the proscriptions upon homosexuality - or even draconian punishments for it - in Saudi Arabia the complete elimination of any such relationships. The testimony of the sexual abuse of young Pakistani, Bangladeshi and Indian men who work in the Gulf scarcely suggests that same-sex relationships are unknown. We are well aware of the discrepancy between theory and practice in our own culture; yet we are not able to see its mirror image in societies from which we recoil.

In Islam, sexual relationships are bound by the duties of family and kinship, which are all embracing. However, the observance of conjugal and paternal duties is one thing. Friendships, affective, erotic, possibly sexual, behaviour outside the hallowed precincts of the joint, extended or nuclear family are not, on the whole, subject to scrutiny, once the contractual duties to family have been observed.

Human relationships do not follow religious or ideological prescriptions, no matter what penalties are imposed upon departures from moral orthodoxy - whether the severity of Soviet Russia, where it was believed that sexual 'deviancy' was a relic of capitalist barbarism, or the legacy of the Raj in Section 377 of the Indian penal code, or indeed, the merciless punishments carried out against gay men in Iran or Saudi Arabia. In April 2000, nine men involved in cross-dressing and 'homosexual acts' in Saudi Arabia were sentenced to 2,600 lashes and up to six years in prison. The floggings were to be delivered at 15-day intervals, 48 - 52 lashes at a time. In a much publicised case in Cairo in 2001, 52 Egyptian men were arrested on a boat on the Nile and charged with debauchery and contempt of

religion. Twenty-three were sentenced to terms of jail between one and five years. The prosecutor told the court "Egypt will not be used for the defamation of manhood and will not be a hub for gay communities." To understand the more general way in which same-sex relationships function in such societies is, of course, makes such judgements appear all the more humane and unjustifiable.

The point about many such cases is that they are perceived as inspired by, and imitative of, a Western idea of 'gay'. The Western inflection given to such relationships is the source of anger. Dr. Abd Al-Hadi Misbah, a lecturer at Egypt's Al-Azhar University faculty of medicine, sates "We, as men of medicine and religion, must base our defence of religion on science, because the West tries to destroy religion and justify such acts with science." An article in Al-Akhbar in February 2002 was titled 'The West's Defence of These Perverts Causes Nausea and Repulsion in Egyptians.'

Generally, however, in Muslim, Hindu and other cultures, how people behave is detached from labels given by others to that behaviour. Individuals express their feelings of attraction, affection or desire according to the context.

The western obsession with a self-consciousness that cannot forbear to reflect upon what it is doing and why, and how it should name and present itself to the world, is an alien sensibility to many other cultures. That this represents the fullest liberation of human beings animates the contemporary consciousness of superiority of the West, and it is, in many ways, simply a reformulation of earlier ideologies of dominance. It is unthinkable that the paradigm which has evolved in the richest and most powerful societies in the world should not be exported - even to places where it strikes with great violence against other ways of being, other methods of dealing with the complexities of the most delicate human relationships and bonding. It is absolutely characteristic that this should be the object of messianic zeal, no less intense than other beliefs which the West has sought to wish upon the world, many of which they now repudiate with a zeal similar to that which they once pursued in imposing them - one has only to think of the racism which characterised their missions of conquest, and which the rulers of the West now disavow so noisily.

To seek to re-arrange patterns of relationships are just such another attempt to control. That it should be done under the banner of liberation comes as no surprise. After all, those who travelled into the dark places of the earth in the early colonial period did so in secure possession of the truth, and saw their 'mission' as one of enlightenment and emancipation of those in thrall to ancient superstition and misapprehension of the world. So it is with today's missionaries of sexual liberation. The trouble is, they want everyone *to be like us*; or as much like us as it is possible for them to be, given the disadvantages under which they labour.

This project gains plausibility from the fact that the Western societies have the wealth, coveted life-styles, security and space for individual self-expression, which others yearn for. As a corollary of this, surely, all other aspects of society must change, precisely in the direction of that taken by privilege. A readiness to acknowledge the superiority of the Western mould in almost everything stems from the economic power of the west. Whether this power can be replicated, along with the lifestyles, which accompany it, is a question that has not been fully examined.

The ideology, the convictions, the revelations by which the people of other religious and social faiths live, are not going to yield to external pressure, even though for the West, projects of conversion now have a social and economic, rather than religious, basis. The politics of identity strikes at more intractable characteristics than those 'fundamental' attributes of gender, sexual orientation or skin

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Asia could face the world's largest AIDS crisis

Asia could face the world's largest AIDS crisis if the region does not act quickly with preventive measures, a UN official warned Monday. So far, Asia has not been infected nearly as badly as sub-Saharan Africa, so the disease is not as visible and public awareness is not as high as in many developed Western nations, creating a climate of ignorance, said Peter Piot, head of UNAIDS.

People with HIV/AIDS can face discrimination in the work place in most Asian nations, and shame can keep the disease underground, making it harder to control, experts say. Some 7 million Asians are infected with HIV - with the greatest number in India, but higher percentages of infected people in Thailand, Cambodia and Myanmar, Piot told a news conference. "With HIV spreading very fast in many countries, it is now that one can stop an epidemic," Piot said. "The longer one waits, the bigger the bill will be and the more lives it will cost."

The London-based banking company Standard Chartered, which operates extensively in poor nations, plans to launch an AIDS awareness program in Asia that replicates its work to minimize the impact of the disease in Africa. Chief Executive for Malaysia John Kivits said the disease has caused major disruptions to the lives of many of the bank's 5,000 employees in 13 African countries and sharply raised operating costs. "On any one day, we have got 10 percent absenteeism in Africa on HIV matters - either they're ill or they're attending to relatives or attending funerals," Kivits said.

Piot said Asia's 7 million people with HIV comprise the second largest group outside sub-Saharan Africa. "The epidemic in Asia threatens to become the largest in the world," Piot said. "With more than half the world's population, the region must treat AIDS as an issue of regional urgency. The question is no longer whether Asia will have a major epidemic, but rather how massive it will be."

Reuters NewMedia - 7/10/02

Global war against AIDS runs short of vital weapon: donated condoms

Donations of condoms from rich nations to poor ones, already deeply inadequate, have declined over the past decade, just as a few countries have successfully used them to fight the ever-worsening AIDS epidemic. The world's poorest countries need between 8 billion and 10 billion condoms a year to help stem the spread of AIDS. But, according to the United Nations Population Fund, they receive less than 1 billion, and donations have slipped to 950 million from 970 million in the last decade.

The biggest decline in donations was from the United States, which gave the Third World 800 million condoms in 1990 but only 360 million in 2000. The UN and European aid agencies, notably Britain's, stepped in to try to make up the difference. American donations dropped for several reasons, said Mark Rilling, chief of the population commodities division of the United States Agency for International Development. In the 1990s, some major condom recipients, including Pakistan, Bangladesh, Nigeria and Zaire, became ineligible for foreign aid because of coups, wars, or shifts to other donors. Also, "buy American" laws meant that the federal government had to pay about 6 cents per condom, while the price from factories in India, China, Thailand and Malaysia, even with quality testing, is about 3 cents.

While lobbying by the religious right has cut federal budgets for related programs, Rilling contends that political pressure was "not a factor" in the decline of his agency's condom exports or new efforts to increase them. Along with billions more condoms, poor countries need another \$1.2 billion to help distribute them and teach their use, according to the family planning group Population Action International.

New York Times, 09/10/02

70 percent of Chinese teenagers get sex education from porn

Nearly 70 percent of Chinese teenagers get their information about sex from pornography, prompting experts to worry they may pick up "skewed" ideas, the China Daily reported last Thursday. The problem is a lack of sex education in the classroom and at home, forcing many youngsters to seek knowledge about sex from adult websites and porn videos.

"Both schools and families should set up appropriate channels and provide easy access to sex education for pubescent children," said Zhang Chungai, a Beijing-based psychologist. Teachers and parents currently fail miserably in performing that duty, according to a recent survey of youths ages 15-17 in Beijing, Shanghai and other large cities. The survey showed that just 1.7 percent got most of their sex education in school. Even fewer - 1.3 percent - said their parents had provided them with any useful knowledge about sexual matters, the survey indicated.

The issue of sex education is becoming increasingly urgent, because better health conditions mean most Chinese now reach sexual maturity at age 12 or 13, one year earlier than a decade ago, the paper said. Lack of sex education can have severe consequences, Zhang warned. China faces what the UN labeled in June a potential "AIDS catastrophe," due in part to ignorance about the spread of HIV via sex. *Agence France Presse 15/08/02*

Uganda story

Uganda has been the story of success for many years. And now infection rate increases. Note the comment that "After 16 years, people may be tired of listening to the same old messages" and that "The gains made over the last 16 years could very easily be reversed if Ugandans relax at this point". There is no appropriate time to relax in the fight with AIDS.

A new report compiled by the Ministry of Health says Uganda's HIV infection rate is no longer declining. The infection rate among pregnant women was at 6.5% at the end of 2001, compared to 6.1% in 2000. This is disturbing. After falling consistently for 10 years, the HIV infection rate is taking a new trend. It is possible that this is just a one-year twist, after which the rates will continue falling.

But there is a real possibility that the rates may be stagnating or even worse, rising. After 16 years people may be tired of listening to the same old messages, and therefore becoming complacent.

Another possible cause of complacency is the availability of life-prolonging drugs. Over the years the drugs have become cheaper and more available.

At the same time Uganda's falling HIV infection rates has been proclaimed loudly. This could have made some people relax, thinking the situation was not that bad.

Scientifically it is known that an infection that is present in more than 5% of a given population can easily explode. So Uganda is still within the danger zone despite consistent declines for a decade.

We need new strategies in the fight against HIV/AIDS. Ugandans need to know that anti-retroviral drugs do not cure AIDS, and there are complications like drug resistance and side effects. They improve the situation, but this is no cause for relaxation.

Without a cure, people need to be reminded that the best cure yet for HIV/AIDS is still abstinence, correct use of condoms or, faithfulness in the case of married couples.

The gains made over the last 16 years could very easily be reversed if Ugandans relax at this point. *www.bmj.org 12/10/02*

promoting behaviour change is about promoting risk reduction behaviours

China's looming catastrophe

China took some halting steps forward this month in its belated efforts to catch up with a widening HIV/AIDS epidemic. Health officials raised their estimate of the number of Chinese infected with the HIV virus, asked for international help in combating the epidemic and pressed for a sharp reduction in the prices charged for drugs needed to treat these patients. China is also preparing a \$90 million grant application to the new Global Fund to Fight AIDS, Tuberculosis and Malaria.

These are all encouraging signs that the world's largest nation may finally be stirring from its denial and lethargy on AIDS. But virtually nothing is being done yet to treat the vast majority of those sick with AIDS, and the government remains unwilling to tolerate open discussion of its health crisis. Before international donors start pumping in substantial sums to help contain the epidemic, China will need to release its most prominent AIDS activist, who disappeared last month and is believed to be in police custody.

The epidemic in China started in the early 1990's among heroin addicts who shared dirty needles, took a huge jump when contaminated blood supplies infected up to a million farmers in central China and is now spreading sexually through prostitutes into the general population. The United Nations warned in June that China is "on the verge of a catastrophe" and could, if it fails to take effective action, have the largest number of HIV-infected people in the world within a few years.

China's leaders must deal with the epidemic openly and realistically. The country's first application to the Global Fund was rejected in part because of China's penchant for secrecy and its largely unreliable statistics. China's latest estimate that one million of its people are infected, a boost from the previous estimate of 850,000, still falls far short of estimates made by foreign experts.

The government has made some positive moves, including a new five-year plan to combat AIDS, a modest increase in AIDS funding, pilot programs to slow the spread of the virus and stronger laws to protect the blood supply. But these policy changes have not triggered strong treatment and prevention programs, particularly at the local level where the battle must mainly be waged.

China is weakening its case for international support by failing to release Dr. Wan Yanhai, the missing AIDS activist who was instrumental in revealing the epidemic among rural farmers and in organising people with AIDS to demand that the government provide treatment. His family and colleagues say he is in government custody. If so, Beijing should acknowledge his whereabouts and set him free. There would be no better way to demonstrate the kind of openness that is critical to any successful campaign against AIDS.

New York Times - 16/9/02

Condom festival in S. India to fight spread of AIDS

A condom festival was launched in the southern Indian state of Andhra Pradesh as part of an HIV/AIDS prevention program, news reports said Thursday. According to a National AIDS Control Organisation study, condom usage in Andhra Pradesh is the lowest in the country, the Star News Channel reported. The study indicates that only one in every 200 couples in the state uses condoms. One of the reasons for the low condom use is said to be the high rate of sterilisation in the state. "People may think that because they have undergone sterilisation, there is no need for condoms," said Dr. Kadambari, head of Andhra Pradesh's HIV/AIDS program. Andhra Pradesh's Health Minister N. Janardhan Reddy added, "Because they are not following safe sex measures, AIDS is spreading. So we want to promote the use of condoms." Activists are going door-to-door and talking to couples about sex and condoms. Also, public demonstrations explaining how to use condoms are being held in more than 3,600 villages and towns across the state. The festival hopes to reach out to at least 10 million people in the state, where HIV is believed to be spreading faster than anywhere else in India. *internet: 16/10/02*

HC seeks Govt. reply on gay rights petition

The Delhi High Court today gave the Central Government a last chance to respond to a Public Interest Litigation (PIL) seeking amendment to Section 377 of the Indian Penal Code (IPC) which prohibits unnatural (sexual) offences, including homosexuality.

A division bench, comprising Justices Vijender Jain and R.S. Sodhi, also observed that the Government should be open and may consider the demands of gay rights activists that sex between two consenting adults be legalised. Such relations have existed in society since time immemorial so why should such persons not be given a chance to raise a family and live together, the bench said. The court gave the final chance as the Government did not submit a reply on the issue on three occasions. On November 7, 2001, the court had issued notice to the Government on the petition filed by Naz Foundation, a voluntary organisation working to prevent the spread of AIDS.

On January 28 this year, the court had asked Attorney General Soli Sorabjee to assist the court by informing what the Government view was in this regard. On April 23, Additional Solicitor General Mukul Rohtagi had asked for six weeks time to file the reply. The judges were informed that the Ministry of Home Affairs was examining the matter from legal, social (moral and ethical) and anthropological angles.

The petition sought amendment to Section 377 IPC, as it prohibited sex between two consenting adults, which was a hurdle in the AIDS awareness campaign run by the NGO.

New Delhi, Aug 26. (UNI)

Cambodian leader says AIDS more deadly danger than land mines

Prime Minister Hun Sen said Wednesday that AIDS is Cambodia's most dangerous scourge - deadlier than the millions of land mines that still dot the countryside after decades of war. Cambodia has an HIV infection rate of 2.6 percent, the highest in Southeast Asia, among its 12.5 million people. AIDS has killed about 90,000 people since the country's first case was discovered in 1991, and 160,000 more people are in various stages of the disease.

By 2010, the death toll could reach 230,000-250,000, and some 100,000 children will become orphaned, experts said at the country's second national conference on HIV and AIDS. HIV is the virus that causes AIDS.

"As far as the land mine problem is concerned, we are working toward zero casualties," Hun Sen said in a speech at the close of the three-day forum. "But it (AIDS) is now getting worse than land mines because it can be spread through the family from husband to wife and to child."

Nearly 1,000 participants - including HIV patients, government officials, aid donors and social workers - came to the conference to coordinate battle plans against the disease. Decades of conflict have left millions of land mines littering Cambodia, killing and maiming thousands of people.

According to the national land mine clearance agency, there were about 800 casualties in land mine and ordnance accidents in Cambodia in 2001, down from 1,100 in 1999. About 45 percent of villages are contaminated by land mines.

De-mining efforts, funded by foreign aid donors, have helped sharply reduce the danger from land mines, while the danger from AIDS is increasing, Hun Sen said.

He urged development planners and other concerned parties "to prevent it (AIDS) from worsening and becoming another killing field for the Cambodian people," he said.

The phrase "killing field" refers to atrocities carried out by the communist Khmer Rouge, who held power in the late 1970s, when an estimated 1.7 million Cambodians perished from execution, overwork, starvation, and disease.

Associated Press, 2 October 2002

India's shyness towards sexual education fuelling AIDS

by Santosh Jha

Social activists say the Indian government's shyness about sex education among young people - who are becoming increasingly promiscuous - is fuelling the spread of AIDS.

"There is a large population of about 300 million young people in the age group between 12 and 24 in India, and recent studies show their growing preference for pre-marital sex," said Rakesh Kumar, director of the non-governmental Centre for Health and Development. "The government has no plans for the sexual health education of this group," Kumar said. Nearly 4 million Indians have HIV - the largest HIV-positive population after South Africa's. Unofficial estimates put the figure closer to 5 million. Various social groups suggest that in the next 10 years, India will have the highest number of AIDS cases in the world.

"Led by a consumerist boom, the youth in India are actively indulging in sex. Their lack of education about safe sex norms exposes them to the AIDS trap," Kumar said.

A recent survey of Bombay youth concluded that 64 percent of those ages 14 to 19 were no longer virgins, and 43 percent had visited prostitutes. Another found that among young unmarried Indians, 69 percent of men and 38 percent of women reported pre-marital sex. Of those having pre-marital sex, 45 percent were ages 16 to 19; 27 percent were 15 or younger; and 28 percent were 20 or older.

"Young boys and girls in the age group of between 12 and 24 are most susceptible to unsafe sexual encounters and should be made the target group of government AIDS awareness programs," said Aditi Puri, a social activist and AIDS worker. "This is, however, not a government priority. There is no consensus in India over introducing sex and reproductive health education in the school and college syllabus."

Some government officials oppose introducing sex education in a country considered by many to have puritanical attitudes about sex. "Our society is not an open one. Inclusion of sex education in the syllabus can also have an adverse effect," said Ram Chandra Purbey, primary education minister in the state of Bihar.

Agence France Presse, 29/10/02

Study finds sex among straight black men

Confirming the existence of hidden "down low" homosexuality in African-American communities, a new study found that 16 percent of poor Los Angeles-area black men who consider themselves straight have actually had anal sex with men.

Thirty-seven percent of HIV-infected poor black men who call themselves heterosexual also reported having anal sex with men.

"We need to move beyond thinking of people as being just gay or straight," said study co-author Amy Rock Wohl, head of HIV epidemiology for the Los Angeles County Department of Health Services.

"People's behaviors are complicated and don't always fall into these predetermined categories, and prevention directed toward gay and bisexual men will miss these men who consider themselves to be straight," she said.

For years, experts have suggested that some black men live double lives, keeping their boyfriends secret from their families and girlfriends or wives. In slang terms, these men are "on the down low," and both the media and TV shows like "ER" have explored the phenomenon.

There's little research looking into the specifics of "down low" behavior among black men specifically, Wohl said. However, according to the New York Times, the Centers for Disease Control & Prevention reported in 2000 that a study of HIV-positive men who got infected by other men found that 25 percent of blacks called themselves straight. Only 6 percent of white men did.

In the new study, researchers examined statistics from surveys

Haryanvi grooms go begging for brides

by Rashme Sehgal

Rohtak: Two decades of female foeticide have caught up with the Haryanvis. Young men wanting to get married are left abegging. There are simply no brides available.

The situation is so grim that families are forced to buy girls from Madhya Pradesh, Bihar and West Bengal. They are then palmed off as member of their own biradari. "The scarcity of marriageable girls in our state akin to the shortage of grain in a famine," says Ram Kumar Hooda, a panchayat member of Bhali village in Rohatk district.

And Gyano Devi, sarpanch of Mayna village in Panipat district, has six lanky Jats warning her. "We will accept your sarpanchi only if you find brides for us." According to the 2001 Census, the districts with the worst sex ratio are Sonapat (783:1000), Rohtak (796:1000), Ambala (784:1000), and Kurukshetra (770:1000). This is in the 0-6 age group. Bhageani from Bhali village admits both her grandsons married girls from Gohra village in Sagar district of M.P. "What could we do? A boy reaches marriageable age after he turns 18. My grandsons were 27 and 28 years old. A close relative of ours whose son was 32 found a girl from Sagar district. We decided to follow suit."

Though Bhagwani denies paying a bride price, her neighbours insist she did. "Most of these girls being brought in from outside are paid for and end up being treated as bonded labour," one neighbour insisted.

The situation, says Richa Tanwar, Director, Women's Studies, Kurukshetra University, will worsen in the coming years as the sex ratio among the literate population has dipped: 618 girls to 1000 boys. The tricky part is convincing the villagers that these "outsiders" belong to the same caste as their husbands.

Most panchayats are willing to turn a blind eye as long as the girl is not an SC/ST. "Desperate boys are willing to marry girls from any caste, be it Kumhar, Lohar or even the backward class. They will however not marry SC/ST families."

Ram Ratri, a fellow panchayat member, adds, "Polygamy is common in Haryana; men will marry twice and trice to get a male child. But I won't be surprised if, due to the shortage of brides, families revert to the earlier practice of polyandry where one bride was shared by the male members of a family." Manisha associate programme co-ordinator for the government-aided Population and Development Education Programme says, "Having fewer women does not mean the premium on them increases. On the contrary, they are subjected to more violence and families are being forced to keep them cloistered inside their homes."

Times of India, Lucknow, 10/11/02

taken in 1997 and 1998 of 90 HIV-infected black men who attended Los Angeles county clinics and 272 uninfected black men from nearby neighborhoods. All the men considered themselves to be heterosexual.

The men in both groups were generally poor, Wohl said, "but it doesn't include men who don't seek health care, who are even more disenfranchised than this group." The findings appear in the current issue of the Journal of Acquired Immune Deficiency Syndromes.

All of the infected men and two-thirds of the uninfected men who had sex with men reported that they didn't always use condoms during anal sex. When asked about condom use during anal sex with women, 46 percent of the HIV-positive men and 37 percent of the other men said they didn't always use them.

"That does have implications for transmission to female partners, especially if the women don't know the HIV status of the male partners or their risk behaviors," Wohl said, reflecting a common concern in the black community about "down low" activity.

Anal sex with men was much more popular than oral sex. Only 12 percent of the infected men and 2 percent of the uninfected men reported having oral sex with men. *PlanetOut.com Network*

Hivare Bazar village to make HIV test mandatory

by Siddhartha D. Kashya

Even as the Maharashtra government has ruled out mandatory HIV tests before marriage, the village elders of Hivare Bazar, 16 km off Ahmednagar, have decided that any outsider tying the nuptial knots with any one from their village will have to undergo an HIV test before marriage.

While all the 225 families at Hivare Bazar have unanimously agreed to the mandatory Enzyme Link Immuno Sorbent Assay (Elisa) test before marriage, a final decision will be taken by the gram sabha. Once approved, the decision will be strictly enforced from April next.

The primary reason for initiating such a measure, as the village sarpanch Popatrao Pawar explained, is to save the villagers from the killer virus. "We don't want our children to become victims of HIV/AIDS," he said, adding in a lighter vein, "prevention is always better than cure, and in the case of HIV, there isn't any cure".

He, however, said the decision was taken after detailed consultations with all members in the village. When referred to the National AIDS Control Organisation (Naco) guidelines, which doesn't allow mandatory HIV testing, Mr Pawar only said, "Our state now figures among the top three states with about 1.5 to 2 per cent of the adult population falling prey to the virus, mainly due to their sexual behaviour".

Pointing out to the alarming rise of HIV cases in the state, he said there were many boys and girls from the village who get married to people outside Hivare Bazar every year. "There have been many such cases in our neighbouring areas where innocent women have been infected with the virus by their promiscuous husbands," he said, adding, "fortunately, our village hasn't had a single positive case so far".

According to him, the idea was conceived when a college-going girl wrote to the village elders if there could be any mechanism to prevent the spread of AIDS in the village. "We had asked a group of the village youngsters to write what do they feel about the village and the measures that need to be taken for betterment of its people,"

Pawar told TNN from his office at Ahmednagar. Mr Pawar, who helped transform a poverty-stricken and crime-ridden Hivare Bazar to prosperity through watershed management, said that efforts are already on to involve the district administration.

"We are just awaiting a final approval in the gram sabha, following which we will approach the district collector and other medical authorities," he said, adding the plans are also afoot to give some concession to the poorest families in the village to undergo the test.

State health minister Digvijay Khanvilkar, in a recent interview to TNN, had categorically ruled out mandatory HIV tests before marriage in the state, saying that such an act would only add to the social and ethical problems associated with the killer disease.

When pointed out that his Andhra Pradesh counterpart had announced plans to introduce a legislation in his state to make such a test mandatory for all people of marriageable age, Mr Khanvilkar said that such an act would amount to violation of the NACO guidelines. *Times News Network, 03/11/02*

AIDS, syphilis hit more youths in Korea

The number of young people who have contracted AIDS, syphilis, hepatitis and other infections has sharply risen this year, a lawmaker said, citing test results on donated blood. Rep. Shim Jae-chul of the Grand National Party said the number of those infected with such diseases in the first half of this year is double that of the same period last year. He cited data from Korea National Red Cross showing that, of 1.28 million blood donors, 922 tested positive for AIDS, 2,798 were infected with syphilis, and 2,746 had hepatitis. About 80 percent of the blood donors were in their late teens and 20s, he said. Blood samples from a total of 282,860 people were discarded due to the infections. *The Korea Herald, 10/09/02*

Unsafe sex ranks second in WHO list of world's top health risks

Unsafe sex is the second-largest health risk worldwide, according to a World Health Organization report released yesterday and summarized in the *Lancet*, *AFP/New York Times* reports. The report, titled "Reducing Risks, Promoting Healthy Life," lists the top 10 major health risks worldwide that together account for approximately 40% of all deaths (*AFP/New York Times, 10/31*). The number one international health risk is being underweight, which results from a lack of food and can contribute to low birthweight infants and other health problems.

According to the report, both underweight and unsafe sex are "far more prevalent" in developing nations than in developed nations (*Winslow, Wall Street Journal, 10/31*). HIV/AIDS is currently the world's fourth leading cause of death, the report said, adding that 2.9 million deaths per year can be attributed to unsafe sex, with the majority of deaths occurring in Africa (*Lovell, Reuters, 10/30*). Death from AIDS-related causes has reduced the average life expectancy in some areas of sub-Saharan Africa to 47 years, compared to 62 years in areas without the disease (*Capella, Agence France-Presse, 10/30*). The report advocates "cost-effective" measures to curb the top 10 health problems, including improved HIV/AIDS prevention education (*AFP/New York Times, 10/31*). The authors also encourage counseling to promote breastfeeding to increase child weight (*Wall Street Journal, 10/31*). According to the report, reducing the world's top health risks could add at least 10 years of "good health" to average lifespans worldwide, with an even greater improvement in developing nations (*AFP/New York Times, 10/31*).

NPR's "All Things Considered" yesterday reported on the analysis. The segment includes comments from WHO Analysis Director Christopher Murray and Columbia University Mailman School of Public Health Professor Ronald Waldman (*Silberner, "All Things Considered," NPR, 10/30*). The full segment is available in RealPlayer Audio online. *Internet, 1/11/02*

'Delay' condom proves popular

A condom that contains an anaesthetic to prolong lovemaking has smashed all sales records, its manufacturers say. Durex has sold 18,000 Performa condoms via the Internet in the past three months - outselling other types the company sells online by a margin of five to one. Each condom contains a small amount of lubricant cream inside the tip, which disperses with body heat. The cream contains Benzocaine, a mild anaesthetic that de-sensitises the tip of the penis, so sex can last longer. The Performa is currently only sold on the Internet but the company is aiming to make it available in shops in the UK by Christmas. Amanda Tucker, Durex UK marketing manager, said: "If interest through the Internet is any guide then this will change the way people think about condoms." *18/10/02 - internet*



Suicide and gay men

In the most extensive study of its kind, researchers found that urban gay men are at least three times more likely than heterosexual men to have planned suicide, attempted it or both. One in five gay men surveyed said they had gone as far as to actually make a plan to commit suicide, and 12 percent attempted it, usually before the age of 25.

"You're talking about one in eight men who have attempted suicide at some point during their lifetime," said psychologist Jay Paul, the study's co-author. "It underscores the stresses that gay men can experience in our society and the costs of stigmatization of gay and bisexual men."

No one knows how many gay men successfully commit suicide. Paul and researchers at the University of California at San Francisco's Center for AIDS Prevention Studies examined a 1996-1998 survey of 2,881 gay and bisexual men. All those surveyed lived in Los Angeles, San Francisco, New York and Chicago.

Suicidal impulses were especially common among those who make less than \$20,000 a year - 33 percent of them had planned it and 22 percent had attempted it, compared to 19 percent and 9 percent, respectively, for those who make more than \$80,000.

By contrast, an estimated 9-15 percent of heterosexual men make plans to commit suicide during their lives, and 1.5 - 3 percent attempt it.

"Psychologists are not sure how many suicide attempts actually result in deaths," Paul said. "Estimates have ranged from one in 10 to as few as one in 50 or 60," he said.

Men are nearly five times more likely to commit suicide than women. Of all age groups, men over 65 are most likely to kill themselves.

Indonesia dispatch

Indonesia faces an AIDS catastrophe as a campaign to educate sex workers and their clients is blocked in the name of Islam, writes John Aglionby.

Sex, blackmail, a floundering government, radical Islamic groups and an incurable illness threatening more than 15 million people are elements that, one would think, any media organisation would love to find in the same story. A riveting front-page splash followed by several days of follow-up articles as the story develops should be guaranteed.

Not so in Indonesia. For here it is the media that is being blackmailed by a tiny, extreme Islamic group outraged at hard-hitting advertisements warning sex workers, their clients and people in other high-risk categories to use condoms if they want to avoid catching HIV, the virus that leads to AIDS, and other diseases that can be transmitted sexually.

The controversy erupted last month when the advertisements, which had been sanctioned by the ministry of health and approved by the national censorship board, hit television screens. Almost immediately the Mujahidin Council, a radical Islamic group with only a few thousand members at the very most, in a nation of more than 210 million people, demanded the advertisements be withdrawn. *Guardian, 12/09/02*

Vietnam rounds up gays for "education"

Vietnam detained 30 men for allegedly engaging in homosexual sex at a massage parlour over the weekend and sent them to an "education" centre, police said on Thursday.

"Even though there were no prostitution activities in the location, such mass homosexual conduct breaches administration regulations and is harmful to social order," a Ho Chi Minh City police officer, who asked not to be identified, told Reuters.

"We have sent them to an education school to warn them against further similar infringements."

The policeman said the men could be fined before being released. *Internet, 07/11/02*

The new study found no major differences in the rates of suicidal impulses among black, white and Latino gay men.

The study is part of an overall investigation into the lives of gay men, with a focus on those who are HIV-positive. The findings appear in the August 2002 issue of the American Journal of Public Health.

Researchers found that HIV-positive men were only somewhat more likely to have been suicidal than HIV-negative men.

"The study only looked at gay men in several of the largest cities in the U.S., so it does not necessarily reflect the lives of gays in smaller cities and towns," Paul said. "However, most of the gay men surveyed were originally from somewhere else - including smaller cities and towns," he said.

In a surprising finding, researchers discovered that younger gay men - those born after 1965 - were the most likely to be suicidal, despite the tremendous gains in society's acceptance of gays and lesbians in recent years. Paul said that may be because gay men are coming out earlier in life, setting themselves up for harassment by others. "We're not as naive about sexual orientation as we were a few years ago," he said. "Kids are not as naive. They will label somebody as gay or any of the other pejorative ways of describing someone."

About half of younger men - born after 1955 - reported being harassed before age 17 because of their orientation, compared to only about 27 percent of men born before 1945.

Paul acknowledged that the older men may have forgotten about being harassed as teens. Regardless, the finding still points to an ongoing epidemic of harassment, he said.

"There has to be a policy where none of this is tolerable in school settings and in other kinds of settings where kids interact with peers," he said. <http://www.planetout.com>, 18/11/02

Vatican prefers chastity to condoms

The Vatican repeated its opposition to using condoms as a way to fight AIDS, saying Wednesday that chastity was the best way to prevent the spread of the deadly virus.

Monsignor Javier Lozano Barragan, president of the Pontifical Council for Health Workers, acknowledged that to some, the Vatican position may sound "ridiculous in the society in which we live."

But he said there was only one way to prevent AIDS and the HIV virus from spreading. "We say that prevention... is called chastity."

Barragan made the comments ahead of a three-day Vatican symposium on health care in Catholic hospitals and clinics around the world.

The Vatican has been criticized for its steadfast opposition to condom use, particularly in poor regions of the world like Africa which have been devastated by the AIDS epidemic.

More than 90 percent of the world's 37.1 million HIV -infected people live in developing countries. Sub-Saharan Africa accounts for 26 million, or 70 percent of the total, U.S. and U.N. statistics show.

The Church has argued that condoms don't offer 100 percent protection and only contribute to what Barragan called a "pan-sexual" society in which sex has been separated into an act of pleasure or procreation.

"In this separation, according to this mentality, it's absurd that the church says 'no' to condoms," he said. "But we have another ethical horizon: That is life."

Two years ago, a Vatican official hinted at a possible softening in the Church's position, writing in the Vatican newspaper L'Osservatore Romano that condoms were one of the ways to "contain" the spread of HIV.

The author, Monsignor Jacques Suadeau of the Pontifical Council for the Family, stressed that chastity was the only way to prevent the spread of the virus, but that in the case of Thai sex workers, for example, condom use was a "lesser evil."

Internet, 06/11/02

Oral sex and HIV probability

The probability of acquiring HIV through unprotected oral sex is "very, very low," according to preliminary findings from the first study specifically designed to isolate the risk factors for oral HIV transmission.

The study's principal investigator, Dr. Kimberly Page-Shafer, presented the preliminary findings Tuesday at the National HIV Prevention Conference in Atlanta.

The so-called "HOT study" - or HIV Oral Transmission study - is being carried out by Page-Shafer along with researchers at the Center for AIDS Prevention Studies of the University of California, San Francisco, and the AIDS Health Project, an HIV/AIDS education and counseling organization in San Francisco.

The HOT study involves 198 primarily gay and bisexual men who only engaged in oral sex during the study period. Introducing the project last October in a Salon.com interview, Page-Shafer said, "It's amazing to me how much supposed knowledge has built up around [the issue of oral HIV transmission] when there is actually no scientific data."

HIV researchers have assumed that some types of oral sex may pose a higher risk than others, but the HOT study is the first to try and isolate those risk factors, such as performing oral sex on someone with an STD, swallowing ejaculate, or performing oral sex with open sores in the mouth or active periodontal disease.

In a statement released Tuesday detailing the preliminary findings, Page-Shafer said, "We found that the probability of acquiring HIV through [oral sex] is very, very low."

Ninety-eight percent of the study's subjects reported having unprotected oral sex with a male partner, with 20 percent saying they had performed oral sex on an HIV-positive partner.

Of the 198 participants only one tested positive for HIV. Page-Shafer said that individual acquired the virus prior to the study

period and may not have acquired it through oral sex.

"We did not detect any new infections, and we have not been able to identify infection attributed to oral sex," Shafer said, according to HealthScoutNews. "Statistically, the probability is zero for our study group."

But in the statement she went on to say that with such a small sample group (198 subjects), "we cannot rule out the possibility that the probability of infection is indeed greater than zero."

The HOT study findings seem to contradict another recent study that found that as many as 8 percent of people newly infected with HIV acquired the virus through oral sex.

Referring to that study in the October interview, Page-Shafer said, "You have to be careful not to overinterpret that study. It's not a random sample of people who get tested. Also, four of the eight they identified as being orally infected had had receptive anal sex with condoms. That's dangerous to include, since anal sex with condoms has a greater risk of transmission through condom breakage or slippage. But most importantly, the population sample in which those eight were discovered is not representative of the HIV-infected population."

"The take-home message is that oral sex is safer sex than other types, such as anal sex or even protected anal sex," Page-Shafer said Tuesday, HealthScoutNews reported

She emphasized, however, that oral sex is *safer* sex, not *safe* sex.

"While our study is the first to attempt to systematically define the risk, case reports exist of infections acquired through oral contact. I want to emphasize that, while rare, acquiring HIV infection orally is possible and that many other sexually transmitted diseases such as gonorrhea, chlamydia, and syphilis are transmitted orally," added Shafer.

<http://www.planetout.com>, 18/11/02

Indian AIDS patient thrown out of home by wife, shunned by family

An HIV-infected truck driver in the eastern Indian state of Bihar was thrown out of his home by his wife and then shunned by his father at the prodding of paranoid villagers, officials said Wednesday.

Local magistrate Vijaya Laxmi told AFP that villagers from Roh in Bihar's Nawada district, 150 kilometers (93 miles) from the state capital Patna, forced family members of an AIDS patient, 35-year-old Shamim Khan, to turn their back on him. Khan's wife, fearing ostracization, threw her husband out of their home the moment he told her he was HIV-infected. Later, Khan went to his father Nais Khan for help, but he had come under the same pressure and asked his son to leave Roh to spare the family a "total social boycott."

"The district civil surgeon investigated the incident and found that Khan's plight was shocking," said Laxmi. "The state authorities have admitted Khan into a government-run hospital and given him financial aid to get treatment."

Some 3.5 million Indians have been declared HIV-positive, more than in any country other than South Africa, although unofficial estimates put the figure closer to five million.

"Cases of social boycott are rampant here because of ignorance surrounding AIDS," said C.K. Anil, director of the Bihar State AIDS Control Society. "We are trying to convene village meetings to lift the social boycott placed on the families of AIDS patients. People have to be educated about AIDS." He said treatment was crucial, because otherwise AIDS patients have little incentive to learn how to avoid passing on the disease. *AFP le 16/10/02*

living with dignity
social justice for all

Sex education enters China's classrooms

Middle school students in Beijing have begun receiving sex education lessons for the first time. Nine middle schools in the Chinese capital's western Haidian District began teaching sex education courses this semester.

Hu Xinyi, deputy director of the Haidian District Education Commission, said middle school teachers were being trained to teach sex education courses, and that the programme would be expanded to another 200 Haidian middle schools later in the year.

"Many children want to acquire knowledge about the adolescent period, but they have no proper channels," Mr Hu said, according to the Xinhua news agency.

The newly published set of sex education textbooks has four editions, tailored for junior and senior middle school students, university students and teachers. They represent a joint effort by experts, parents and students. A female middle school student provided the vivid, colourful illustrations.

Aids crisis

Aids and venereal disease are among the topics covered in the textbooks.

China recently admitted to having a major Aids problem, announcing that about one million of its citizens had been infected with HIV.

Other subjects in the new textbooks include sexual harassment, emergency contraception measures, "cyber love" and premarital sex.

Schools are obliged to offer sex education classes under a new population and family planning law that came into effect on 1 September.

In addition to Beijing, about a dozen other Chinese cities, including Shanghai, Guangzhou, Wuhan, Chongqing, Harbin and Xian, have begun offering sex education classes in middle schools.

BBC New Online UK, 11/09/02

To dip or not to dip is not the question

HDN Key Correspondent

Dipping...surely, this won't be the most relevant information from the 94 conferences on MSM prevention held in Barcelona but it's all very symptomatic of a real gap between the western gay world... and homosexuality in the rest of the world.

Dipping, the word and the sexual activity it represents have made quite an impression on the gay community who made the trip to Barcelona's AIDS Conference. This describes penetrating one's partner once or twice without a condom and retract oneself before coming. Studies presented in Barcelona (no less than three from the US on that specific topic) have shown, with plenty statistics, the risks linked to that practice even without ejaculation due to the sensitivity of anal mucous.

From San Francisco with love

The United States continues to model our gay vocabulary. Cruising, relapse and from now on, dipping, a practice which is only new for its name, but which comes in our vocabulary to immediately become a pathology. With 37 conferences, the Anglo-Saxon world showed its (quantitative) superiority over Europe and its thin representation in the gay research sector. Most studies presented by the western researchers dealt with the increase of unsafe practices and the recrudescence of sexually transmitted diseases (syphilis and gonorrhoea) observed in the gay communities of large urban areas.

The majority of conferences had to do more specifically with the sexual behaviour of HIV positive persons or recently infected people. The researchers leant on populations more prone to take risks (young people, sauna and drug users) with a more cautious eye at the various communities in the USA (Afro-American, Latinos or gays living in rural areas). This labelling, which seems to be the trend for US researchers was nevertheless disputed on several occasions in Barcelona: a sociologist who presented an investigation on MSM of the Bronx neighbourhood underlined how these coloured men which regularly have sexual relationships with other men, do not identify with terms like gay or even homosexual. The practice of labelling,

apparently respectful of differences, seems to be based on two (debatable) dogmas of homosexual research in occident: Firstly, a model which leans to "coming out" and acceptance of oneself and which sees in gay identity the end of a path towards which we should all direct us independently of our cultural identities. Secondly, recognising oneself as gay is the guarantee of a better attention to our health and thus of minor risk-taking.

I'm not gay like you.

Or rather: "I am gay but not like you" was the name of a workshop which has, to some extent, crystallised the problems involved in this model which affirms "it's great to be gay!", and considers that people who do not recognise themselves as such are at a lower stage in their identity search. Even though the MSM abbreviation seems rather sophisticated and seems to belong to the only world of AIDS prevention, its use is not anecdotic. MSM is an attempt to cover a reality, of men who share common sexual practices but do not share a common identity, do not recognise themselves nor do not wish to declare themselves as homosexual and do not embrace the Western gay model.

The number of MSM studies coming from poor or developing countries obliged us to reconsider the question of homosexuality by taking guard not to see it only under Western light. In spite of that, we're somehow forced to recognise that there seems indeed to exist a geography of MSM prevention parallel with different stages in the construction of a community identity.

Small treaty of MSM prevention geography

The Indian area (Bangladesh and Pakistan included) was by far the World MSM protagonist of the conference followed by Brazil: of the 94 conferences addressing this topic, a third was devoted to India, in particular to the Hijras or Kotis populations in Mumbai. The Indian and South-American studies showed as a whole that the recognition

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Knowing the odds

Imagine if you could know the odds of getting AIDS before your sex partner's zipper even dropped. Federal statisticians believe they've figured it out for you.

Have sex with a stranger without asking about his HIV status, they say, and you'll multiply your risk of getting infected by 43 times. Be a "bottom" with that man, without using protection, and face a one in 2,000 chance of getting infected.

Those odds appear in a new report that assigns risk levels to the most common sex acts. "They are not precise estimates, but they're good enough for giving people a general idea," said study co-author Dr. Thomas Peterman of the Centers for Disease Control & Prevention.

But AIDS experts warn that relying too heavily on their estimates could be foolhardy because sex doesn't work by the numbers. "These researchers are approaching people's sex lives like it's a Chinese menu — you can choose one from column A, two from column B and none from column C," said Michael Allerton, who oversees HIV policy in Northern California for the Kaiser Permanente Health Plan.

The impetus for the study came from epidemiologists who wondered how changes in sexual behavior have changed the AIDS odds. "People are doing different things," Peterman said. "A lot of gay men, for example, have switched from anal sex to oral sex. The question is how much impact that has had on their risk, how effective these different strategies are relative to each other."

The report appears in the January 2002 issue of the medical journal *Sexually Transmitted Diseases*.

The researchers took a variety of statistics into account. They factored in the prevalence of AIDS (20,000 new cases a year in the

U.S.), the risk of condom failure through breakage or misuse (estimated at 5 percent) and the accuracy of HIV tests (about 99.9 percent).

In their calculations, the researchers assumed that 10 percent of homosexual men are HIV-positive and 1 percent of heterosexual people are. They also figured that some negative AIDS tests will be inaccurate because infections occurred too recently to show up.

As many gay men might suspect, receptive anal sex — being a "bottom" — is the most risky sexual activity, 100 times more risky than receiving oral sex.

Compared to receiving oral sex, insertive anal sex (being a "top") is 13 times as risky, and giving a blow job is twice as risky.

The most dangerous activity listed — with a 1 in 2,000 risk of AIDS transmission — is receptive anal sex with a man whose HIV status isn't known. The risk fell to 1-2.5 per 100,000 if the gay male took one safer-sex precaution, such as wearing a condom or making sure a partner tested negative for HIV.

While that rate may seem low, it's still too high for comfort because the overall risk grows over time as a person has more sex, the report said.

"Gay men should be taking a couple steps to reduce their risk, not just one, because if they do just one, their risk will still be high," Peterman said.

The researchers also estimated that sex with an HIV-positive man is 430 times more risky than with a man who tested negative for HIV. Sex with a man whose HIV status is not known is 43 times as risky.

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NFI News Update

providing technical, financial and institutional support to MSM sexual health interventions, groups and networks in South Asia

January 2003

Issue No. 9

NFI Training of MSM Trainers Programme

2nd Programme, 2nd Phase, 9th - 14th September 2002

Conducted by Shivananda Khan, ED of NFI, and held at our Regional Liaison Office in Lucknow, 35 people participated in the programme. Coming from management staff of a range of MSM sexual health projects (16 in all) in Bangladesh, India and Nepal which have previously had technical assistance and support from NFI, the workshop was also attended by Calle Almedal, UNAIDS Geneva, Rajiv Dua, FHI India, Elavarthi Manohar, Sangama, Bangalore and Nguyen Van Trung, Vietnam.

This 6-day workshop was the follow-on from the First Training of MSM Trainers course held in February, 2002. It develops skills around project design, implementation and management.

Day One

Following introductions to each other, participants reviewed the 1st Training of Trainers course, and in particular, developing a situational and needs assessment of MSM. In small groups, participants were then asked to develop a presentation of such a situational assessment as if they were presenting the results of the study to a group of donors, NGOs, and State AIDS Control Society. Questions that were asked were

- * Had the issues been clearly identified?
- * Have the needs been defined?
- * What were the recommendations for action?
- * How did you collect information?
- * Is the issue significant enough for donors to take an interest in supporting and intervention?
- * What was the framework of MSM in the locality?

Following the presentations and discussions arising out of them, the group discussed what MSM means and what it represents.

The meaning of sexual health was explored, and participants discussed the WHO definition and what this would mean in the context of provision of sexual health services for those who were socially excluded, stigmatised and marginalised.

This led to a discussion on behaviours, identities and contexts in South Asia, and whom should projects target. Frameworks of visibility and invisibility were explored, and there was a consensus that initially projects would target the most visible and readily accessible, which were kothis.

A discussion on kothis, their frameworks of identities and behaviours was held, and the need to also access not only their partners, but also other frameworks of MSM.

The final session explored issues around supporting behaviour change and how these can be achieved. In particular, participants utilised the NFI framework of behaviour change: Desire, Knowledge, Skills, Will and Power to discuss mechanisms in which a holistic approach can be developed.

From this, a framework for service delivery towards promoting and supporting behaviour change emerged and compared with the NFI primary service model.

Day Two

Participants explored sexual practices of a range of MSM frameworks. They focused on the kothi framework and non-kothi frameworks. Data from Bandhu's survey was provided. Taking the service model evolved from the previous day's discussion, participants then looked at how such a model could incorporate these differing frameworks.

A range of concepts were developed which included developing specific spaces for differing frameworks of MSM, collaborating with other NGOs working on specific groups, such as street children and



women's reproductive health, as well as ensuring that NGOs working with male populations such as truck drivers and slum dwellers, where anal sex is also addressed as an integral part of any sexual health and HIV/AIDS programme.

This led to discussions on social justice and human rights and the need for advocacy work as a part of any MSM sexual health programme.

A discussion was then held on a framework or guidelines for a set of ethical principles in working with socially excluded groups.

The final session explored the meaning of the terms in the context of developing a proposal:

Goal, Purpose, Strategy, Activities, Input and Output Indicators, Verifiable Indicators, Means of Verification, Outcomes, Assumptions, Targets, Project Logical Framework, Work Budget, Work Plan

Day Three

Participants were given the task to develop a presentation proposal based on the Goal: To Develop An Enabling Environment For..... for the reduction of risk from

Each of the groups would define the population group with which they wished to work with and the specific risk reduction they wished to achieve.

Groups were to develop a Project Logical Framework utilising the DFID model (Goal, Purpose, Outputs, Activities) in a four-column matrix (Narrative, Indicators, Means of Verification, Assumptions), as well as develop a Work Budget and Work Plan.

Day Four

The morning session and part of the afternoon session was taken up with each group presenting their Project Proposal, which were individually critiqued.

This led to a discussion on the principles of monitoring and evaluation and methods of collecting data. The NFI monitoring was presented as a possible tool for individual project use.

The afternoon session looked at specific staffing levels for the group projects, and how to develop a job description that identifies the necessary skills and person specifications for the work identified in the group proposals. This raised the issue of the level of skills amongst those with whom the project will work with, the provision of technical assistance, and staff development in the context of development of a community-based organisation and their difference with non-government organisations.

Proposal organograms were then developed and critiqued.

Day Five

A discussion was held in regard to financial monitoring procedures.

Following this initial plenary session, a presentation was given on management procedures and principles, and participants were asked to explore these in their groups in regard to:

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What's in a name

In response to an NFI posting (September 2002) which appeared in *lgbt-India*, a critique was made in regard to the statement: "MSM sexual health projects" that was used. The respondent felt that the use of the acronym MSM in this context led to a sense of MSM being an identity term, when it is not.

There is a growing use of the term MSM as an identity label across South Asia, particularly where self-help sexual health projects have emerged.

In a highly gendered sexual environment, male-to-male sex is usually perceived as one of gendered roles acted out by *kothis/hijras* as the penetrated and feminised partner, and where the penetrating partner (the *panthi/giriya*) sees himself as a normative man. Thus the *panthi* perceives himself as having sex, not with another man, but with a "not-man", and his sense of masculinity is maintained

In local and regional languages, positive terms that signify men desiring men, men loving men, men having sex with men, may not be available. While the term *gay* (and even *homosexual*) have been widely disseminated, their association with Western frameworks of sexuality and the English language may preclude their general use in meaningful ways. So for many men who have sex with men, based on desire and as a potential orientation, there does not appear to be a term readily available without taking on the feminised label of *kothi/zenana*. MSM appears to be fitting the bill in this regard.

Thus the original critique may have some validity.

NFI is therefore asking you all as to what would be the most appropriate term we could use. We recognise that the term MSM is shorthand for a complex phenomena, and with our focus on low-income, socially excluded and stigmatized males who have sex with

males, of whom the majority identify as *kothis/zenanas*, MSM may not be the appropriate phrase for NFI to use. What do you suggest? Write to shiv@nfi.net with your suggestions.

Here are the points to think about.

* While we as a sexual health network focus on the most vulnerable MSM, those who are economically disadvantaged, those who are gendered, and those who are stigmatised and socially excluded, i.e. *kothi-identified MSM* and their partners, during the recent TOT programme in Lucknow we discussed broadening this to include other frameworks of MSM behaviours, whether such males have a self-sexual identity label or not. Perhaps we should have been calling our partner projects 'kothi sexual health projects', but this ignores the other dynamics of male-to-male sex we work with?

* MSM - males who have sex with males, or men who have sex with men (your choice) - is a behavioural term, and our sexual health work needs to look at behaviour as much as the range of identity labels that some males choose to give themselves. This includes the *kothi/zenana* labels, *panthis/giriyas* (many of whom identify with the term *man* rather than with a sexual orientation/identity), *dublis/doparathas/double-deckers/AC-DC*, etc.

* In a sense we are developing sexual health services that address male-to-male sexual behaviours.

* A further comment made by the respondent is that we should talk of "sexual health projects targeted at MSM".

I am not sure, but I find the word 'targeted' problematic based on the nature of how we as individual projects work and speak of empowerment and enabling environments. Maybe we should say: Working with MSM collectivities, or Working with MSM sexualities, or Working with MSM, or Working with male-to-male sexualities (MMS). What do you think?

Men who have sex with men (MSM)

Point of view, by Shivananda Khan

- * MSM is not an exclusive category or "target group".
- * However, it does include those with specific sexual identities, such as *gay-identified men*, and those with gendered identities, such as self-identified *kothis*.
- * MSM is not a "target population" unless you wish to speak of the category *MEN* as a population group.
- * MSM does not break into "heterosexuals" or "homosexuals," or even "bisexuals".
- * But how do we define the term *MAN*?
- * The word *MEN* can be problematic in different cultural frameworks because of its association with other dynamics than biological age, such as marriage, religious rituals, duty.
- * Not all MSM are at risk of STI/HIV infection in terms of their male-to-male sexual practices. Not all practice high-risk sexual behaviours. Risk depend on specific practices.
- * We should be talking about male-to-male anal sex as a high-risk behaviour.
- * We need also to be talking of male-to-female anal sex as well.
- * Male-to-male sexual behaviours may well be a normative sexual

practice, yet hidden and invisible.

* The use of orientation labels for HIV transmission is also problematic, i.e. heterosexual or homosexual transmission.

* Male-to-male sexual behaviours as a term makes more sense than men who have sex with men.

* In South Asia (and probably elsewhere in the world) gendered identities play a more significant role in male-to-male sex than the concepts of heterosexual or homosexual orientations.

* This means that the "manly" (penetrative) partner perceives himself as a *MAN*, while the penetrated partner is perceived (and often by himself also) as *NOT-MAN*.

* Thus the penetrating partner would perceive himself (and is perceived by the *kothis* whom he penetrates) as a "heterosexual".

* Thus the experience of male-to-male sexual behaviours includes broad categories of males, such as street males, males in all male institutions, males across the spectrum of occupations and classes, males who are deemed as "normative" as well as those males with differing gendered identities and sexualities, males who sell sex to other males males who identify as *gay* or *homosexual*, males who are married.



participants at the NFI MSM TOT programme



Shivananda Khan at a Mithrudu social at its Secunderbad project



Sahodaran star staff



Developing Ethical Guidelines for MSM Sexual Health Projects

ARMAN
ASIAN REGIONAL MSM AIDS NETWORK

During the NFI Training of MSM trainers programme last September, the participants agreed that it was time to move beyond being called NFI partners network. Capacity had been built, and each of these MSM projects were independent, autonomous agencies. Further, it was also recognised that participants in a range of NFI programmes also included representatives from Cambodia, Indonesia, Myanmar and Vietnam.

After a great deal of discussion, the acronym ARMAN was finally accepted by mutual consensus - Asia Regional MSM AIDS Network. Arman also means "that which you wish/desire for." A good name.. so now we are all Armanis!

NFI Regional Office has agreed to provide secretariat services for the time being.

Along with this, the participants also discussed a range of ethical issues which network partners should hold to.

The following ethical principles and guidelines were developed by participants attending the NFI Training of MSM Trainers Programme, held at the NFI Regional Liaison Office, 9th - 14th September 2002. They have not been produced in any specific order.

"This Agency focuses on male-to-male sexualities and sexual health concerns, particularly those who are from socially excluded, marginalised and stigmatised collectivities and are economically disadvantaged. In its work the Agency will fully consider the implications of males who have sex with males for themselves, for any male or female sexual partners such males may have, and for any clients of those males who do sex work.

In this work we will be guided by the following principles and guidelines:

1. Promote the reproductive and sexual health of males who have sex with males by encouraging and supporting sexual responsibility and safer sexual practices.
2. Encourage and support males who have sex with males to access early STD treatment whenever necessary.
3. Respect confidentiality in the relationship between males and their sexual partners and/or clients, along with issues concerned with self-identities, sexual practices, or STI/HIV status.
4. Promote the protection of children and non-consenting adults from abusive sexual relationships and encounters.
5. Promote the reproductive and sexual health of any female partners of males who have sex with males by encouraging greater sexual responsibility of their male partners.
6. Encourage communication of sexual health information between sexual partners and promoting partner notification of STD/HIV infection, irrespective of the gender of the partner.
7. Work with female reproductive and sexual health services in order to facilitate appropriate access to infected female partners of males who have sex with males.
8. Collaborate with other HIV/AIDS NGOs and CBOs to promote safer sex among all males and their sexual partners
9. Pro-actively address concerns relating to social justice and human rights abuse that directly and indirectly affect males who have sex with males.
10. Respect the right of each individual to self-identify with whatever label, name, or framework which they choose, and not impose

identities upon them.

11. Respect the differing frameworks of sexualities, gender identification, behaviours and their expressions along with those who invisibilise personal sexual practices or do not wish to be labeled for reasons of their own.

12. Respect each other irrespective of differing social, educational and economic backgrounds, religious affiliation, caste, age, colour, place of origin, sexual choices, and self-identification.

13. Provide safe spaces and programmes which empower and enable those from socially excluded, marginalized and stigmatised collectivities through principles of equity, equality, fairness and social justice.

14. Ensure that appropriate policies are implemented by the Agency that deal with beneficiary and staff complaints, disciplinary and dismissal procedures, grievance procedures, equal opportunities, staff development, and fair terms and conditions of employment.

15. Ensure that the Agency is transparent in all its work, especially in regard to financial management and working practices.

Along with these Guiding Principles, participants also developed a common set of office and working rules for MSM sexual health projects.

RULES OF CONDUCT

- * There will be no discrimination based on Caste, Colour, Class, Religious Affiliation, Political Affiliation, Language, Region, Gender Identification and/or Sexual Identity, or Age.
- * Confidentiality will be respected at all times.
- * No staff should speak to any form of media about the Agency without the express permission of the Project Director.
- * Personal issues and inter-personal differences must not be brought into the office or field-work.
- * All Staff are requested to behave with basic courtesy and consideration towards each other and towards service users.
- * Obscene behaviour in the office and drop-in centre is unacceptable.
- * Sexual behaviours within the office and drop-in centre is unacceptable.
- * Physical and verbal abuse is unacceptable.
- * Sexual harassment of other staff and service users is unacceptable.
- * Alcohol and/or illegal drugs are not allowed on the premises.
- * Neither can a person come to the office/drop-in centre in an intoxicated manner, either from alcohol and/or drugs.
- * Any damage to furniture and equipment must be reimbursed.
- * Respect our neighbours. Inappropriate public behaviour will lead to a poor reflection upon yourself, other MSM and the Agency and its work. You are asked to be considerate of this.

These ethical principles and Agency rules of conduct were unanimously accepted by all the MSM Sexual Health Projects present at the Workshop and adopted as General Principles for ARMAN (Asia Regional MSM AIDS Network).

The Arman logo was designed by Willie Christy of Mithrudu, Hyderabad, India.

NFI Training of MSM Trainers

continued from page 13, col.2

Staff management; Programme management; Financial Management

The groups were asked to define the tools necessary for management to ensure:

equity, equality, justice, fairness, achieving outputs and performance targets, dealing with grievance, discipline and dismissal, user satisfaction

Following this, group presentations were made and critiqued. It was suggested that participants thoroughly read the NFI model documents on these issues in the Handbook and Resource Book.

Day Six

A review was conducted of the previous five days, and a range of outstanding questions addressed. Feedback from the participants were noted in regard to course content and delivery and an evaluation form was completed.

This led to a discussion on accessing NFI technical assistance and support in:

- * Developing proposals
- * Providing support to review presentations and reports
- * On-going technical support
- * Developing new projects
- * Networking
- * Mutual information sharing and exchange of tools and resources

From this, participants suggested developing a regional network for mutual support and information sharing. The final choice was

ARMAN (in Hindi and Urdu - desire for what you want to achieve) - Asia Regional MSM AIDS Network.

Following participants request, the Network would be housed within the NFI Regional Liaison Office, and NFI would facilitate information exchange.

The workshop ended with the presentation of certificates of attendance,

Other discussions

Throughout the workshop, participants were given opportunities to explore a range of issues including:

- * Genders, masculinities and sexualities
- * Kothi dynamics as a different form of masculinity
- * Changing identities and behaviours
- * Circumcision as an HIV prevention tool
- * Access to NFI resources and library
- * Ethical principles and quality assurance standards

Methodology

Group discussions

Presentations

Plenaries

Small group work

NFI resources and tools

Tools

NFI MSM Project Development and Training Handbook

Resource Handbook for MSM CBOs towards developing sexual health programmes.

3rd Regional NFI MSM Partners Regional Consultation And Capacity-Building Meeting

LIVING WITH DIGNITY

social justice for all

5th - 7th April 2003. New Delhi, India

SCOPE AND PURPOSE

The Meeting brings together representatives from all the NFI partner agencies in South Asia, including management and field staff, delivering sexual health services for males who have sex with males, as well as providing access to a number of technical experts. It also brings representatives from other MSM sexual health programmes and agencies in the region and experts on the issues of our concern.

It will enable intensive networking among these projects, as well as skills and information sharing.

Ten 3-day capacity building workshops will be conducted towards enhancing service delivery of these projects, with over 160 participants involved.

Representatives from government, AIDS institutions, donors, and others will also be invited to participate.

The 3-day training workshops will be:

- a. Voluntary and Post Test Counselling
- b. Self Help and Care and Support
- c. Developing Research Skills
- d. Reaching out to non-kothi MSM - developing a strategy
- e. Advocacy and Social Justice
- f. Developing a Communication Strategy for MSM
- g. Masculinities, Sexualities and MSM
- h. Monitoring and evaluation issues
- i. Psychosexual issues and Counselling
- j. Poverty and Male Sex work

Facilitators will be drawn from the NFI Trainers and Advisory Networks as well as guests with specialized skills. Delegates will pre-select their workshops.

Para 55 - working across the Commonwealth on HIV/AIDS issues

Para 55 is the name of a group of Commonwealth associations and other partners, including the Naz Foundation International, which was formed in 2000 and arose out of the Durban Commonwealth Heads of Government meeting, held in 1999. At this meeting, Heads of Government,

“expressed grave concern over the devastating social and economic impact of HIV/AIDS, particularly in sub-Saharan Africa. They agreed that this constituted a Global Emergency, and pledged personally to lead the fight against HIV/AIDS within their countries and internationally. They urged all sectors in government, international agencies and the private sector to co-operate in increased efforts to tackle the problem, with greater priority given to research into new methods of prevention, the development of an effective vaccine and effective ways of making affordable drugs for the treatment of HIV/AIDS accessible to the affected population.”

Particular highlights of work include:

- * Organisation of, and report on, a Commonwealth think tank on a multi-sectoral approach to combating HIV/AIDS in Commonwealth countries (report available from Commonwealth Secretariat (+44 (0)20 7747 6342))
- * Convening conferences and expert meetings, on topics such as mother to child HIV transmission, of which a report of this expert meeting is available on the Para 55 website.
- * Organised a conference entitled “HIV/AIDS – a global emergency, a multi-sectoral response for the Commonwealth”, in Melbourne, Australia in 2001, report on website.
- * Development of the Commonwealth Awards for Action on HIV/AIDS, which in 2001 made an award to The Naz Project (India) Trust for their pioneering care and support work.
- * The group is now developing a proposal to discover how a multi-sectoral approach happens at a local level, involving three sites in Ghana, and how this compares with what happens at a national level
- * Future activities include organising an expert meeting on human rights issues and HIV/AIDS and addressing business responses to HIV/AIDS in the workplace.

For contact details to obtain any of these reports or for more information on Para 55 access their website as www.para55.org.

Unaided Victims

Vankudot Sukuna, Andhra Pradesh

When Vankudot sukuna injured her wrist and developed gangrene, her furious father chopped off her hand, and to stop the bleeding, dipped it in boiling oil. Numb with pain and shock, Sukuna, an HIV suspect, went to Osmania General Hospital, where she was turned away by doctors. Back home near Hyderabad, her family and neighbours too threw her out. It was a local AIDS activist who brought her to the notice of the state Government. Minister of State for Home Vidyasagar Rao, who brought Sukuna into media glare, hugged her in front of the cameras to drive home the point that the virus doesn't spread by casual contact. Rao has donated Rs.50,000 to enable Sukuna to buy a small shop. She will get a house under the Indira Awas Yojana and a state-funded artificial palm. But will her fail in humanity be restored?



Rattan, Manipur

Chained to a post, Rattan's ruptured ankles bleed profusely. He is among the 124 HIV positive men and women tied by Dousel Zenkhoman, 62, and he husband, both former government servants working at the Gamnuam Christian Home in Churachandpur district of Manipur. As they take Rattan away from prying eyes, Zenkhoman says, "They taste spiritual rejuvenation here." The girls have worse in this "alternative universe". They are shackled to their cots or confined in cage-like spaces and not allowed to mix with the boys. A few yards away is Happiness Home, a veritable prison for HIV positive drug users. Moia, a 26-year-old inmate, says that they are denied medicines and if they protest, are starved from a day to a week. A neighbour, working in the state Education Department, insists the confinement is to get church funding. Anyone listening?

India Today, December 9, 2002

Living on the edge

Johnson T A (Bangalore), Vani Doraisamy (Chennai) & TS Preetha (Kochi)

On March 3 this year, a 14-year-old boy was found barely conscious in a shed in Bangalore. His face was bloated and his body bore marks of sexual assault. Local NGOs who rescued the boy later learnt that Akheel was a street kid and had been assaulted by some men he knew. Given the 'on the edge' kind of lives led by street children, they are considered more vulnerable to AIDS than the general population, say experts. In Karnataka, there have been only a handful cases of AIDS reported among street children but going by the number of cases of sexually transmitted diseases detected among the children, there is every possibility that the situation could turn grave. A recent survey of street children, conducted by the market research group ORG-MARG and presented to the Karnataka State Aids prevention Society, reveals that street children, often indulge in behavior that invites AIDS.

The survey conducted in eight districts showed that 22 per cent of street children – in the age group of 11 to 18 years – in urban areas and 26 percent of street children in rural areas have unprotected sex, either with the other street-dwellers or prostitutes. Strangely, the survey also found that street children in urban areas were less aware of the dangers of AIDS than their rural counterparts. Startling facts A recent baseline study undertaken by two NGOs in Chennai, Karunalaya and Mottukkal, showed that the street children were vulnerable as any other high risk groups to HIV since some of them were exposed to unprotected sex, as early as seven years. And with the preventive measures being far from adequate, the numbers are expected to increase.

The study by Karunalaya throws up some startling facts. In North Chennai alone, nearly 27 per cent of the street children had some kind of sexual experience or the other, while 91 per cent did not know what safe sex meant. About 98 percent never heard of HIV and 96 percent said they would never be able to recognize the symptoms for STDs like HIV. Surprisingly, 58 per cent were aware about use of condoms. More than 8 per cent of the street children worked as small time pimps, the most popular hangouts being bus stands and railway stations.

Homosexuality and group sex were quite rampant, especially as

street-bonding led to peer pressure. However, child prostitution was confined only to a few areas, especially along Chennai's long coastline. Armed with the study, both the NGOs, with the help of Chennai Corporation and the Chennai Aids Prevention and Control Society (CAPACS) set out to create awareness about use of condom and safe sex. They plan to have regular counseling and interactive sessions, followed by educational outreach programmes, health aids and constant monitoring of the mapped areas to ensure that new 'recruits' are not roped in. No positive cases in Kerala, the studies on HIV in street children are rare.

Statistics of HIV patients are not complete and nobody knows how many street children are exposed to the risk of AIDS. Though the health and social workers here agree that the street children are more prone AIDS, they are of the view that there is no reason to panic as Kerala is a literate state. "Quite often, street children take used syringes to inject drugs into their veins.

This is a major health hazard", says Fr Varghese Painadath, administrator of Don Bosco. "But our studies have shown that there are no positive cases of HIV among street children." Don Bosco, which runs relief shelters for boys and girls from the streets, regularly conducts awareness camps for its inmates, complete with posters, slide shows and lectures. The institute also conducts regular AIDS tests for its inmates and so far no positive cases have been detected. However, the issue of HIV in street children has been totally neglected as most of the NGOs concentrate on sex workers and construction workers.

Indian Express, 03/11/02

The term Men Who Have Sex With Men does not signify an exclusive category or "target group". It reflects a behaviour - of male-to-male sex, which in South Asia involves a significant proportion of males, both those with sexual/gendered identities, as well as males from the general population

Men feel female condoms threaten patriarchy

Zarina Geloo

Sonile Zulu is very comfortable using the female condom 'Femidom' as it is popularly known. She says she just cannot understand all the fears and criticism around its use in Zambia that successfully scuttled a campaign to make it the ultimate empowerment tool for women when it was launched.

Most women shy away from using Femidom. The two most common reasons cited are its alleged unreliability as a contraceptive and a mistaken perception that it is only for sex workers, as a safeguard against the Human Immunodeficiency Virus (HIV). Most Zambians think HIV is contracted from having multiple partners. Zulu dismisses the first reason as "juvenile talk". "I am quite irritated by all this juvenile talk about female condoms. The bottom line is that people do not know how to use the Femidom. It offers the same protection as the male condoms and if they cannot understand that, they should not be having sex at all."

The second criticism, Femidoms' association with sex workers, is the result of "skewed" advocacy, fumes Judy Brown, a family planning advisor and HIV/AIDS activist. Femidom is packaged in Zambia as a prevention tool for HIV and sexually transmitted diseases and targeted at sex workers who are in the high-risk category. Brown can see why it has happened this way. "There is a kind of urgency in stemming HIV infections and so it seems to make sense to concentrate on sex workers - (unfortunately) the fact that it is also a contraceptive is obscured," she laments.

A condom use survey conducted by the Society for Family Health (SFH) in 2000 appears to bear out Brown. The survey, which was conducted on over 3,000 people across Zambia, says only 2 percent of married respondents had ever used a female condom and it was more experimental than something they used regularly. In addition, men felt Femidom threatens patriarchy. "By using a condom my wife is demonstrating a liberation I am uncomfortable with. It is as though she cannot trust that I can protect her," the survey quotes Gideon Nambeye, a primary schoolteacher who forbade his wife from using the Femidom. "For prostitutes yes, they have to look out for themselves, but married women, I don't think so," he firmly stated.

So are sex workers in Zambia using the female condom? "The condoms are noisy, our clients complain it distracts them, and we are also not confident in using them for fear of it moving out of place or getting stuck inside," says sex worker Tari Munkombwe.

According to her, her colleagues complain that insertion was "cumbersome" because the condom needs lubrication at times and also the plastic erodes sensation, reducing the sexual pleasure for both partners. At times clients tell them to reduce their charges if they use a female condom because it comes in the way of having "rough" sex, in case it moves or slips further into the vagina, says Munkombwe. "No one is willing to give it (the female condom) a chance," rues Zulu, who wonders why if men do not get "rough" after putting on a condom, why should they expect the female condom to be different.

She says of all the people that have used it even once, no one has said the condom moved or slipped or got lost. They expressed fears of that happening but not that it actually happened, she adds. The female condom is made from strong thick plastic, polyurethane, and held in place by soft plastic rings. It sticks to the vaginal walls and can be inserted two to eight hours before intercourse. Medical personnel say it would be impossible for it to get "lost" in the vagina. Clear instructions on the packet caution users against "leakages" by giving very specific instructions on how it is to be worn. The pack also includes a lubricant for easier application.

Other problems dog Femidom in Zambia. Munkombwe says male condoms are easily accessible in grocery stores, kiosks and pharmacies, but female condoms are to be found at family planning clinics, if at all.

The reason for this has everything to do with profit, says pharmacist Rafik Moosa. When Femidom was introduced in 1994 all pharmacies

and shops were given supplies. Both the male and female condoms were sold at K1000 (about 20 U.S. cents) but only the male condoms moved. He says: "I was stuck with the female ones until they expired and had to throw them out. I have never ordered them again and I don't know anybody who does. I think it is only the government clinics who stock them."

Alex Katambala, spokesperson of the Planned Parenthood Association of Zambia (PPAZ), said Femidoms, like the male condoms, will just have to take getting used to. "The issues that are coming up with the female condoms are the same ones we had with the male condoms, it is just a matter of people getting used to them. There seems to be problems, but these will fade away just like they did for male condoms."

Not many organisations advocate the use of Femidoms. "In many ways there is a sense of fatigue. We tried so hard to get acceptance with the male condoms, we now have to go through the whole rigmarole with the female condom - we just distribute what people prefer - the male condom," says advertising executive Tandiwe Zulu. Given Malama, a banker who has used a female condom "once or twice" says it is a gender thing. She says marketing firms know that it is men who have the purchasing power so they concentrate on consumables for men. "In fact I do not see any adverts or messages about Femidom at all. I have not seen adverts making it appear sexy, attractive or clever, which is what I see in the male condom advertisements," she asserts.

Malama calls for a renewed crusade to make women aware they have the right to protect themselves. Femidom should be an option as a contraceptive as well, especially when a woman wants to stop using chemical contraceptives like the pill or the loop. She concludes: "It is lack of information that is making Femidom die out." *Source: AEGi Inter Press Service, 24/10/02*

Social justice for all?

Despite the size of the AIDS epidemic in India, the high rates of HIV prevalence in localised areas, such as Andhra Pradesh, Maharashtra and Tamil Nadu, the increasing numbers becoming infected in other regions of the country, the 4 million or so already infected, harassment of outreach workers working with socially excluded and marginalised networks and communities continues on. Prevention programmes for female (and male) sex workers, intravenous drug users, males who have sex with males, hijras... the economically disadvantaged are often threatened and accused of supporting so-called anti-social behaviours. Staff and beneficiaries are arrested and thrown into jails. Field staff are not allowed to continue their education programmes, beneficiaries are threatened and often driven underground, making it even more difficult to reach. This has happened in UP, Kerala, Andhra Pradesh, Maharashtra, Tamil Nadu, well the list goes on.

Is this the way to ensure that the AIDS epidemic in India can be stopped?



As AIDS spreads, India struggles for a workable strategy

by Amy Waldman

This is the sight of a wave, years in building, crashing onto shore.

Women with HIV - plump women, skeletal women, always frightened women - fill two wards of the Tambaram tuberculosis sanitarium in the southern state of Tamil Nadu. With few exceptions, they are not the commercial sex workers who helped spread the epidemic in its early stages and who have since been taught that condoms can help curb it.

Most of them are wives, or widows, infected years ago by their husbands, the only sexual partners they have ever known. Many have watched their spouses sicken, and die.

Now their turn has come.

Each month at this hospital, the Government Hospital for Thoracic Medicine and which has become the largest AIDS care facility in India, the number of patients with HIV or AIDS, especially women, seeking care is on the rise.

The number of new outpatients with HIV, the virus that causes AIDS, has nearly doubled in the past year, rising to 1,151 last month from 613 in October 2001. From March 31 to August 31, the number of reported AIDS cases in the state rose to 22,826, from 16,677, by far the highest in the country.

With no more empty beds, the hospital in Tambaram, a suburb of this city, has taken to offering patients straw mats on the floor. "We never expected this," said Dr. S. Rajasekaran, the deputy superintendent.

Tamil Nadu, with a population of around 62 million, has been at the vanguard of the AIDS epidemic in India, the country with the world's second-highest number of H.I.V. cases. The state had among the country's highest rates of HIV infections - but also led efforts to contain it through outreach to high-risk groups and other preventive means.

Now, with both opportunistic infections from HIV and cases of full-blown AIDS climbing, Tamil Nadu faces a question that the country as a whole must confront: in a nation of limited resources, but where government is committed to providing basic medical care, what kind of investment can and should be made in caring for people who are already infected?

There is no easy answer, given that most states lag dangerously behind Tamil Nadu even in prevention efforts. But in this lush state, many of those who have led the prevention campaign are now starting to talk about care. They are arguing that India also needs to develop a better health infrastructure for those already infected, and that even if it cannot provide antiretroviral therapy to the sick, it can help them live longer, more productive lives.

The good news is that Tamil Nadu offers hope that with enough prevention, India, where the overall rate of infection remains a fairly low .8 percent among adults, can avoid an Africa-like pandemic. After a decade of focusing on high-risk populations like truck drivers and sex workers, Tamil Nadu's rate of antenatal infection, the most reliable way of tracking the epidemic's spread to the general population, appears to be stabilizing or even dropping.

But without similar efforts at prevention in other states, many experts here and abroad fear the worst. India now has, by conservative estimates, four million people infected with HIV, and the United Nations warned this year that India could soon surpass South Africa, where nearly 5 million have HIV, in having the most cases in the world. A recent analysis by the United States National Intelligence Council predicted that India could have as many as 25 million by 2010.

Recognizing that India's epidemic is at a pivotal point, on Monday the Bill and Melinda Gates Foundation will announce a \$100 million commitment over 5 to 10 years to combat the spread of HIV and AIDS in India. As in Tamil Nadu, the foundation hopes to focus especially on prevention among mobile populations - sex workers, truckers, migrants - who carry the virus from state to state.

But the long lines snaking inside the outpatient clinic at Tambaram, the forest of outstretched hands waiting for medicines that will help them stave off illness, the direly weak 25-year-old widow whose 9-year-old orphan-in-waiting sleeps on the cold floor at her side, all suggest that India will face a competing, and increasingly urgent, claim in its approach to AIDS.

"I heard he doesn't want to give for care," said Dr. Suniti Solomon of Mr. Gates, who will announce the foundation grant in Delhi on Monday. Dr. Solomon, who runs the YRG Center for AIDS Research and Education in Chennai and diagnosed Tamil Nadu's first HIV case in 1986, added, "What I'm going to try to tell him is, unless you fund care, how is prevention going to work?"

Dr. Solomon used to argue that prevention was all that mattered. She began rethinking her position as the price of antiretroviral drugs dropped, and as studies showed that over time, they save money by reducing hospital visits and lost work days. She has become such a strong believer in the notion that HIV is a disease that can be lived with that she has started helping couples safely conceive a child even though one or both has tested positive.

There is also the fact that prevention efforts in Tamil Nadu are at a difficult juncture. The successes of the groups that tackled the AIDS epidemic, like the Tamil Nadu State AIDS Control Society and the AIDS Prevention and Control Project (APAC), which was financed by the United States Agency for International Development, were concentrated among high-risk populations.

Spending about \$6 million a year, they used peer educators and advertising, among other methods, to spread the word about safe sex and condom usage. The proportion of commercial sex workers using condoms increased to 88 percent in 2001 from 56 percent in 1996, according to an APAC study, and among truckers and their helpers to 78 percent from 44 percent.

But the patients who are coming into the Government Hospital for Thoracic Medicine are members of populations that had been considered low-risk. At least a third of the new patients are women, most of them monogamous housewives. Seventy-two percent of new cases are from rural areas, once thought to be largely shielded from the epidemic. In 1996, the hospital had 10 cases of children with HIV; now it has 250.

Reaching sex workers concentrated in a red-light district is one thing. Reaching, in a deeply conservative society, into not just diffuse villages, but the marital home, to teach infected men to start using condoms and their wives to demand that they do so, is quite another.

Dr. Bimal Charles, the project director for APAC, said he was trying to figure out how to get condoms to rural areas so that husbands could discreetly buy them to use with their wives. Right now, "someone who goes to buy is a marked person," in a culture where the stigma of AIDS remains intense, Dr. Charles said. The biggest problem, Dr. Charles said, are "those who are positive and do not know it." Men who were not tested passed it on to their wives. Women not tested passed it to their babies.

Most of the women in the wards were not tested even after it was clear their husbands were HIV positive, but rather only when they became seriously ill.

His organization now wants to encourage more voluntary testing. But even if testing becomes more widespread, what happens when a positive result comes back?

Many private doctors and hospitals refuse outright to treat HIV/AIDS patients. One study of rural medical practitioners in Tamil Nadu found that of the 99 who said they had "treated" an HIV or AIDS patient in the previous year, 80 percent had simply referred the patient to a government hospital and 9 percent had actually refused to treat the patient at all. And even many government hospitals, which in theory provide free care to everyone, are unwilling or unable to

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S is for sex: seeking modern solutions

by Suzi Godson

Ever since I was a little girl I have preferred the way I look when tanned. But as I spent most of my pale, wan childhood in an Irish boarding school, holidays with daddy in LA were my only opportunity to squint skyward. I happily fried myself in olive oil while the neighbours donned factor 30 and frowns. They warned me that I would end up an old prune like Brigitte Bardot. But I was young and immortal. Ageing was ages away and skin cancer was something that affected other people.

Over the years I haven't changed, but the tanning industry has. Great fake tan is probably the only reason that I haven't developed skin cancer yet. Just yesterday, I noticed that my local beauty salon, which used to offer a 20 -minute St Tropez, now offers Jennifer Aniston's favourite, the three-minute spray-on tan. Which is fantastic. As fake tanning gets better, cheaper, quicker and more accessible, fewer people feel the need to blitz and burn. However shallow, fickle and exploitative the cosmetics industry is, this particular appliance of science has had a positive effect on public health.

Unlike the Department of Health (DoH) approach to skin cancer (photos of melanomas and clinical advice), the cosmetic companies realise that scare stories don't stop people wanting what they think will make them feel and look good. Instead, they have developed products that put that feel-good factor into a bottle and enabled people like me to achieve in three minutes what used to take three weeks, and safely. It's a pity the DoH, pharmaceutical companies and condom manufacturers don't apply the same approach to safer sex. Instead of peddling the same old shock tactics and advocating condom use, might it not be better to put money into developing a product that protects people but doesn't make you feel like you are having sex with a balloon on your penis or a crisp packet up your vagina?

We all know that unprotected sex puts us at risk of contracting STIs, but barrier methods are so primitive that it's hardly surprising Lady Luck is still in business. Manufacturing technologies may have improved (we now have ribbed, flavoured and extra fine) but condoms

are still a 2,000-year-old solution to a 21st-century problem. Though many men use them, all men would prefer not to. Besides the fact that you need a PhD in sausage-making to get them on, they interrupt sexual continuity and that can be more than awkward for men who aren't confident about their erectile capabilities.

Once a man starts thinking about staying hard, the time it takes to get a condom on can be just long enough to render the process unnecessary. When condoms become associated with anxiety and erection loss, men are understandably reluctant to use them. This point is particularly pertinent to older men and offers one simple explanation as to why gonorrhoea rates in men over 65 have risen by 467 per cent since 1996.

Young men don't like condoms either, but for a different reason. Price. Boots Shaped condoms are pounds 7.99 for 12. Durex Ribbed are pounds 9.99 for 12. Surely the first step in trying to get teenage boys to use condoms is to make sure that they can afford them. What is the point of spending millions on advertising if your target audience has to make a financial choice between a bus pass that will get him around to his girlfriend's and a packet of condoms that don't seem so vital because she's on the pill. Other barrier methods are not much better. Femidoms are unsightly, uncomfortable and expensive, and as for diaphragms - my friend had one of those and now she has three kids.

Safer sex methods fail because they don't address people's need. Nothing on the market parallels unprotected sex and though research is being carried out on microbicide gels which could line the vagina and protect against STIs, clinical trials are years away. Why is it taking so long? Instead of throwing good money after bad promoting the use of condoms and barrier methods (the sexual equivalent of the brick mobile phone), it is in everyone's interest to see governments, scientists and manufacturers funding R&D to develop a product more sophisticated than the rubber johnny. At the moment that's all there is but we deserve better. Because we're worth it. *Sunday Independent, UK, 06/10/2002*

Syringe disposal: a point of order

\$100 million for safer immunisation, none for the deadly waste that results

Welcoming Bill Gates, Chandrababu Naidu, Chief Minister of Andhra Pradesh, announced that the ongoing immunisation program will be carried out using a new kind of 'safer' plastic syringe, the auto disable or A/D (which can be used only once), in place of the 'unsafe' glass syringe. However he did not address the serious question of what will happen to all the plastic waste which will be generated at scattered rural and district health centres as a consequence of this.

With the new worldwide trend of opting for A/D syringes, it seems that the days of the glass syringe, which was sterilised and reused, are numbered. Evidence of high diseases incidence - between 80,000 to 160,000 people being infected through unsafe injections and needle stick injuries besides new studies indicating a connection between AIDS transmission and injection reuse - seems to have sealed the fate of the glass syringe. In India alone over 4.2 billion injections are administered annually, even though many of them are considered unnecessary. Some 4.2 billion A/D syringes can result in a lot of plastic and sharps waste!

Injection safe experts argue that A/D syringes will prevent reuse, but, when it comes to the disposal of waste, they resort to the obsolete and polluting technology of incineration: Not having considered the problem of waste the syringe will create, they are now left to defend this without considering other solutions. In fact, countries in Africa, Central Asia, South Asia, Southeast Asia, Mongolia and China are being encouraged to install small rudimentary brick or metal type furnaces to burn the syringes, irrespective of the deadly environmental

pollution and resultant human health concerns they raise.

Hundreds of such obsolete burners now dot their countryside in growing numbers, installed as part of immunisation drives. This is being done under the nose of agencies like the WHO and UNICEF, who are well aware that the incineration of waste is being internationally discouraged in climate change and chemical treaties.

A recent report surveying these small incinerators in a few countries, released by the international NGO, Health Care Without Harm, clearly shows that these incinerators become dysfunctional after less than a year of use, and though meant for syringes alone are used for all types of medical waste. The technology being proposed does not meet the weakest of environmental standards and falls far short of Indian regulations. In fact no developed country would even venture close to it and the question why insufficient attention is paid to this aspect when it comes to protecting environmental health in developing countries crops up once again.

Unquestionably, better immunisation practices will save lives, and are critical for protecting us from deadly diseases like measles and Hepatitis B, but this does not have to be at the cost of the environment. Among the growing number of cleaner and safer solutions are a combination of deep burial, small-scale steam sterilisation — some using solar energy, simple devices such as needle cutters, and innovations like the needle puller done by the organisation known as PATH.

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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, World Health Organisation, Geneva Switzerland.

I. 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 rights¹².

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 fulfillment 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

II. 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 counseling 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.

III. 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 rights ²⁴ 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.

IV. 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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1 Attorney at law. LL. B (Hons.) (Bachelor of Laws) and LL. M (Masters of Law) University of London, UK.

2 The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the main advocate for global action on HIV/AIDS, leading, strengthening, and supporting an expanded response to prevent the transmission of HIV and alleviating the impact of the epidemic. UNAIDS is a unique joint venture between UNICEF, UNDP, UNDCP, UNFPA, UNESCO, WHO, ILO and the World Bank to bring together expertise in sectors ranging from health to economic development.

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

Special report: glimpses from India, 2002

Patricia Nell Warren's Left Field

With the Barcelona AIDS conference come and gone, it's a good time to keep a global vision. Growing globalism puts many Americans in the awkward position of having opinions about countries that we glimpse only in fleeting TV footage. Many of us have strong opinions about what other countries should be doing about AIDS, yet often we lack the personal experience for an informed opinion. Thus our perceptions about those countries are often galaxies away from the gritty reality of daily life there. Few U.S. media people have the open-mindedness of Rolling Stone reporter Rian Malan, who spent a year in South Africa and found himself unable to document some things about their AIDS epidemic that are accepted as gospel by most Americans.

India is a case in point. She is no longer the India that Americans glimpsed in 1940s newsreels, when Gandhi's resistance movement ended British colonialism and Muslim Pakistan seceded. With a half century of transformation, India is now the world's second most populous country, a nuclear power rattling her missiles at Pakistan. Indian soil supports more than 860 million people with an agricultural output now third in the world, after the U.S. and China. Vibrant new industries like software, fertilizer, and pharmaceuticals put India firmly on the world trade map. In recent decades, U.S.-India relations are strained, as the U.S. often sides with Pakistan.

Yet the past still weighs heavily. For Americans whose measure of multiethnic is New Orleans, Indian culture is ancient, non-Christian, densely layered as the Himalayas themselves, embracing countless ethnicities, fifteen languages, several hundred dialects, and dozens of spiritualities, including Islam, Hinduism and Buddhism. Census figures still note the different castes and tribes. The traditional hijras (*transgendered sex workers - sic*) - many still ritually castrated in the old temple traditions - are part of the social landscape, numbering as many as 1.5 million. India battles to end poverty, but it still lingers. This means that public-health concerns are overwhelming, whether nutrition or malaria or water-borne diseases carried by India's vast rivers where pilgrims still bathe. Indian health - or lack of it - will impact the Far East deeply.

On Colours, a recent India Today broadcast dwelled on the phenomenon of widespread self-medication. "Every person is a doctor in India," the newsanchor said drily. Trying to avoid high doctor fees, most Indians buy prescription drugs over the counter and tailor their own treatment - a practice that the Indian government discourages. But little is said about AIDS.

For updates on Indian AIDS, one of my resources is my friend Ashok Row Kavi, who tells me that this is still a subject that many Indians prefer not to discuss. Ashok is co-founder of Humsafar Trust, the country's only NGO dealing with gay male health (*sic*). Living in Mumbai (Bombay), he is a tireless human-rights fighter with strong opinions. Last year, in an e-mail to me, Ashok glowed about Humsafar's success in a street program: distributing bottles of clean drinking water daily to Bombay sex workers. He says that the basic Indian social unit is still the family, not the individual, pointing out: "Eighty percent of the gay men in Bombay are married. There is a huge gulf between married gay men and single gay men because single gay men can have a gay identity, as you have in the West, which presupposes individuality."

As he was packing for Barcelona, I interviewed Ashok by e-mail. Patricia Nell Warren: In your view, how does the Indian AIDS epidemic differ from that in sub-Saharan Africa?

Ashok Row Kavi: The dissimilarity of the two epidemics is becoming clear in the new millennium. The gender ratio of HIV infected in Africa, for example, is nearly one to one (that is, mostly as many women as men are being infected by HIV). But in India, eighty percent of those infected are still men—ten years into the epidemic! In other words, HIV is a male sexual health problem, and women and children are a "vulnerable segment" of the population. The biggest



Ashok Row Kavi of Humsafar Trust, leading gay activist in India

single risk factor for women in India is that they are married to men. When I say this, a lot of people get furious with me for saying misanthropic statements but it is true. When you want to fight malaria, you study the female anopheles mosquito's habits. Similarly, if you wish to fight HIV/AIDS you need to study the sexual habits of the Indian male, and you have conquered half the problem.

PNW: What do you feel are the most pressing problems facing AIDS workers in India?

ARK: Quick and fast access to resources - financial, health facilities. Education around sexuality. Social reforms to empower women. Help and visibility for sexual minorities. Most important, massive investments in primary public-health services. Just twenty-five kilometers outside Bombay, there isn't a decent primary health center, whereas Bombay has the most sophisticated medical services in the world. This is ridiculous.

PNW: Is there any recent improvement in the civil-rights climate facing gay people and AIDS work in India?

ARK: Well, yes and no. As gay visibility rises, so does the prejudice against gays. India is a huge mosaic of minorities. The largest and most monolithic minority is, ironically, the Sunni Muslims who are a little over 100 million strong in India. But India is also the home of the oldest living civilization on earth. Its philosophy is liberating in that it does not have the ingrained religious homophobia that is a genetic inheritance in the Judaic siblings - Christianity and Islam. The sad part is that homosexuality in Asia has still no construct as a "political identity." And yet the high-risk behavior of behaviorally homosexual men is what puts them directly in the path of higher rates of HIV transmission. Thus we fight two ogres [instead of] one as in the West. The first is the fight for an identity and the second is to say that this identity itself puts us at risk. India never had laws against homosexuality till 1889 when Lord Macaulay slapped on Section 377 of the Indian Penal Code that talks of "unnatural sex." Of course, unnatural sex means oral and anal sex with man, woman, or animal. [These laws] are still on the statute books.

PNW: What, in your opinion, are other pressing health problems that can weaken an Indian citizen's immune system?

ARK: The Humsafar Trust has offered health services to over 2,000 gay and transgendered men in metro Mumbai. Over the last fifty years the Indian State has made herculean efforts to eliminate bacterial STIs [sexually transmitted infections] and it has succeeded to a larger extent. The viral STIs are totally out of control. Herpes simplex is [at] forty-seven percent prevalence, HIV is twenty-eight percent prevalence, hep B is over eleven percent, hep C is nine

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I love a man in a uniform

Sias Strydom and Brent Browning are policemen in a deeply conservative South African town. They are also gay and married to each other.

When Sias Strydom arrived at his wedding in the small South African town of Klerksdorp, the first thing that he saw was a group of giggling police officers hiding behind a wall. They were clambering up to see if Strydom, a man who had joined the police force a year previously, was wearing a white dress. To their disappointment, Strydom and his sweetheart both got married in traditional dark suits, crisp white shirts and silk ties.

Strydom and Brent Browning are South Africa's first gay, married police officers. They were "wed" in a lay ceremony in September of last year, seven years after the end of the apartheid regime under which homosexuality was considered such a serious crime that suspected gays could be killed on sight without a trial.

Under the Sexual Offences Act, a police officer or any member of the public could arrest someone they suspected of committing sodomy - and they had the right to kill the suspect if he tried to resist arrest. But as Strydom made his way down the aisle three years after that law had been repealed, it was the officers, one-time persecutors of the gay community, who were being forced to change their ways.

In 1998, South Africa became the most progressive country in the world, on paper at least, when a clause was written into the constitution designed to end all discrimination against gays, lesbians, transsexuals and bisexuals. The country's big cities have relished the change. Gay weddings have become commonplace and Cape Town now sells itself as a "pink" destination. But small-town South Africa is finding the transition more difficult. Most small South African towns, or dorps, have retained a strong sense of Afrikaner and Christian tradition. A neon cross, elevated high above the town, is a common sight in a dorp. Religion is pervasive and oppressive; homosexuality is still believed by many to be the work of the devil.

Klerksdorp is no exception and, to an outsider, a small town best known for its high-security prison seems like the last place two young gay men could find an accepting home.

But the couple are intent on a life in Klerksdorp. "We don't want to move. My husband is from Klerksdorp and we like it here," says Browning. In fact, neither of the men has ever even visited Cape Town.

They met on their first day of Police College after Browning saw Strydom on the bus and knew he was "the one". After initial indifference on Strydom's part, they got together and, within a year, Browning proposed. The state still doesn't recognise gay marriages so they drafted a pre-nuptial contract to legalise their relationship. The couple hold on to a strict sense of propriety, a value that is perhaps the legacy of a disciplined Afrikaans upbringing. Nowhere is this sense of respectability more apparent than in the agreement they both signed. The contract states that if either partner committed adultery, he would immediately have to leave the house without the right to remove any of his property and, as his actions shouldn't affect the other partner's quality of life, he would have to continue indefinitely to pay his share of all household bills despite no longer living there.

"Everyone thinks a gay man is a slut, but I am more committed to my marriage than half the population in the world," explains Browning. He becomes infuriated by what he sees as the uncommitted nature of many gay relationships: "I don't understand how some gay relationships work. After years together couples will still have an open relationship. That confuses me. Our relationship is not at all open," he says.

Once they finished college, they had "a hell of a battle" to convince the police service to post them to the same town. Without a marriage certificate they couldn't apply for a joint posting. But after months of wrangling, they got their way and not only ended up at the same station, but were able to work their beat together.

For the past five months they have had the highest arrest rate at their

station, a success they attribute to their relationship and their ability to "read" one another.

"When we get a serious complaint, say for an armed robbery, as we get out of the vehicle we know exactly what the other one is doing," says Strydom. He says that if he couldn't work in tandem with Browning, he would rather be taken off duty and do office work. He only feels truly safe when they work together.

According to a senior officer, gay policemen often work better than straight ones. Browning agrees: "Straight policemen just want to hang around and look at women," he says. "We work at work and play at home. There's no intimacy and sappy stuff when we're in our uniforms."

In Klerksdorp, Browning and Strydom initially had problems of acceptance. Browning only decided to be open about his sexuality after meeting Strydom - a decision that led to all his childhood friends breaking off contact with him. At the station there have been sporadic confrontations. An infuriated policewoman once tore off Strydom's engagement ring. On another occasion he refused to work for one of his superiors after repeated bullying. But both men have been single-minded in their determination not to compromise; small-town people will have to adapt to them.

But Strydom and Browning are part of the new generation of gay men. They weren't sexually active at the height of apartheid and didn't feel its cruelty at first hand. As the enforcing arm of apartheid, the police did untold damage to the gay community. They frequently raided underground gay clubs and would burst into the homes of couples under suspicion of being gay to find them in bed together - enough evidence to drag them down to the station and press charges.

Even within the police force there was a rule of terror. Psychometric testing was used to filter out homosexuals and officers suspected of being gay were investigated and sacked - a policy that led to a number of suicides. As late as 1993, in the same year that the ANC announced its support of gay marriage, police commissioner General Van de Merwe made a public statement that there were no gays in the South African police force, an announcement that was bound to lead to humiliation.

Four months later, Van de Merwe unwittingly brought one of the force's most active gay voices to prominence. He awarded Inspector Dennis Adriaio the title "policeman of the year", the prize for which was a trip to Britain. After a visit to the London club, Heaven, the young inspector realised for the first time that he was gay. His sexuality had long confused him but because of a lack of sex education under apartheid his perception was that all gay men were paedophiles. When he saw men openly having fun together and kissing publicly, he realised there was another side to life - a side that he wanted to be a part of. Adriaio was the first in the force to come out, two years after his trip to London. And he did so on a high-profile television show. After the show, he received letters from other gay officers who felt so isolated in the force that they had been on the verge of suicide.

The same year, he began a lesbian and gay network for police officers, modelled on the British police's equivalent. As well as working on behalf of gays in the police force, he works outside to repair police relations with the gay community.

Within the black community, homosexuality is often seen as an evil brought in by the white man to ruin black culture. Many gays still complain that the police ignore attacks or rapes against gay men and women because they believe the rapes were intended to cure them. An HIV-positive lesbian who lives in Soweto and has been the victim of several rapes says: "The constitution is written but it is not practised."

Strydom and Browning have been something of a first in the gay community. But there is still some way to go before all the laws are changed and gays have equal rights. Gay rights groups have so far

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Gay Egypt in the dock: the big crackdown might reflect Cairo's own insecurities

by Joshua Hammer

Harassment of homosexuals is hardly a new problem in Egypt. But in recent months an unprecedented vilification campaign against gay men has drawn international opprobrium - and cast new light on the often violent collision between traditional and Western values that is convulsing the developing world. The crackdown began last spring, when 52 allegedly gay men were arrested at a Cairo discotheque and in nearby apartments and hauled before Cairo's State Security Court, normally reserved for trying terrorist suspects. There they were accused of crimes ranging from contempt of religion to false interpretation of the Quran. After a highly publicised trial, 23 were sentenced in November to prison terms of up to five years; the rest were acquitted. Then, two weeks ago, security forces arrested eight men in the Nile Delta town of Damanhur on similar charges. Described in the local media as a "network of perverts," the men are being held without bail. The crackdown has been a severe embarrassment for the government of President Hosni Mubarak, which has sought to present itself to the West as a bastion of moderation in a region fraught with radicalism.

It also appears to be a calculated gamble by an insecure regime. The crackdown on gays, as diplomats and political analysts see it, reflects government concern about growing freedom of statement in Egypt - fuelled by the proliferation of Internet chat rooms and Web sites beyond the regime's control. The government may also have contrived the prosecutions to bolster its Islamic credentials at a time when Egyptians are angered by an imploding economy and the arrests of fundamentalists. The strategy may be working. Although condemned abroad, the trial of the "Cairo 52" has met with nearly universal approval at home. "Being gay is not a fundamental right in Egypt," says a Western diplomat in Cairo. "It's seen as a perversion."

Until recently, it was also buried deeply in the Egyptian closet. The media and the government pretended that homosexuality was a Western "disease" that hardly existed in Egypt. As a result, many gays grew up in self-loathing and isolation, desperately searching for soulmates. "When I first had these feelings, I believed I was the only one," says Ramzi, a 24-year-old Cairo lawyer. "Then I met someone, and we thought we were the only two. Slowly we found our way into the community." That community has maintained a vibrant yet fragile existence in urban centres such as Alexandria and Cairo. The capital's affluent neighbourhoods offer a handful of nightclubs, discos and bars where gay men can fraternise, although police harassment occurs regularly. Last summer Ramzi was picked up with 150 other gay men in a sweep of hang-outs in central Cairo; he says he was punched, tortured with electric shocks and held in a cell, without charges, for three nights.

In the last two years, activists say, gays in Egypt have become more assertive. Dozens of Internet chat rooms have started up, allowing gay men to establish support networks, organise parties and arrange dates. (Online dating can be perilous: last year, gay activists and diplomats say, one man was lured to a Cairo rendezvous by a date who turned out to be a security agent; he was arrested and spent time in prison.) Overseas-based Web sites such as Gayegypt.com poke fun at Egypt's autocratic regime with an irreverence no domestic site would dare express. One photograph on the site shows Mubarak pinning a medal on the uniform of a young soldier; the caption reads that the president is "choosing the prettiest gay cadet."

Then came last year's bust. The target was the Queen Boat - a three-deck floating discotheque and nightclub moored on the Nile whose Thursday-night parties attracted a sizeable gay clientele. Police had raided the boat several times; usually releasing suspected gay men in a matter of hours or days. This time it was different. In the early hours of Friday morning, May 11, last year, security agents rounded up dozens of men on the Queen Boat. After releasing the

foreigners, the police jailed the Egyptians, then tracked down other gay men at home, using confiscated mobile phones and address books. Arguing that their actions defiled Islam and thus constituted a risk to the state, prosecutors tried the case in State Security Court, a tribunal established by the emergency laws passed after Anwar Sadat's 1981 assassination. In the past, the one-judge tribunal has been primarily used to try fundamentalist militants from the Muslim Brotherhood and Egyptian Islamic Jihad; the tribunal traditionally hands out stiffer sentences than ordinary courts. Verdicts must be approved by the head of state, and defendants have no right to appeal.

The case laid bare the revulsion felt toward homosexuals by Egyptian society. Local human-rights groups refused to provide support to the accused men, arguing that their ability to defend other victims of government abuse would be fatally compromised. "We're already vilified as fifth columnists who take money from abroad to ruin the country's image," says Hisham Kassem, director of the Egyptian Human Rights Organization. "If we'd taken this on, we would have killed the concept of human rights in Egypt for 10 years." A respected professor of medicine in Cairo suggested a "sure cure" for homosexuality: castration. Many lawyers refused to touch the case, and those who did based their defence on denying that their clients were homosexuals. Prosecutors forced all the defendants to submit to anal examinations; Sherif Farahat, a health-club masseur who was described as the "ringleader" of a homosexual "network," drew a five-year prison term; 22 others were sentenced to between one and three years.

Why did the government crack down so heavily? With about 15,000 Islamic militants in prison, and the government stranglehold over Egypt's mosques becoming ever more extensive, some experts believe the prosecution was intended as a sop to the country's conservative masses. The Egyptian government regularly doles out severe punishments for "defiling religion," although the Queen Boat trial may be the first time sex was involved; last week a young man went on trial in central Cairo for, among other offences, describing the house of the Prophet Muhammad as a "pile of stones." Other observers speculate that the government wanted to intimidate Cairo's increasingly visible gay population. Western diplomats believe that Egyptian security forces learned through the Internet that several activists were contemplating launching a gay-rights movement in Egypt and applying for Western funding; a gay activist in Cairo confirms that he and several others have discussed such a project. "It's possible that the security forces said, 'Oh no - we won't let that happen'," says the Western diplomat.

Whatever the cause of the crackdown, the consequences for Egypt's gay community have been drastic. Gays are avoiding their old public gathering places, including the Queen Boat. Many members of the community stay away from private parties as well, fearing they'll be turned in to the police by informers. "Everybody is terrified," says "Horus," a pony-tailed 34-year-old who runs an Internet chat room and monitors government abuses of homosexuals for international human-rights groups. Gay Web-site users, fearful that their real identities will be ferreted out by eavesdropping security agents, are logging off in droves; the number of subscribers in Horus's chat room has dropped from 400 to nine since the Queen Boat convictions. Horus, one of a tiny handful of gay Egyptians who have 'come out' to their parents and friends, regards the anti-gay crusade with a grim sense of irony. "We've spent years just trying to prove that we exist," he says, smiling wearily. "Now everybody knows that we exist - but they all think we're monsters."

Newsweek International, 02/11 /02

Glimpses from India - 2002

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percent. So you see the first thing is sex education and awareness. And, of course, poverty is the greatest disease. Poverty makes you do things that put you at higher risk. What do you expect when you can't access condoms, for example, if you are into sex work?

PNW: Are you happy with the Indian pharmaceutical Cipla's move to ignore the patents of multinational corporations (MNCs) and manufacture cheaper generic AIDS drugs in India?

ARK: I completely agree that it takes piles of money to research and get drugs into the market. But the way they rip you off with high pricing is obscene. And that goes for Cipla, too. Cipla has the highest growth rate among pharmaceutical companies in India and, believe me, they don't sell cheap to Indians either. It's just cut-throat competition and may the best man win. What Cipla is doing is saying that the international patent laws are too loaded on the side of the MNCs. Even in America, if you look honestly, the pharma companies have benefited from public money invested in research in institutes like the NIH and CDC. It's time for the global pharma industry to have a public policy that is transparent and honest. Licensing of life-saving drugs must be beneficial to the ultimate beneficiary—the consumer.

The real horror is going to come in 2005 when India bends down to the WTO pricing policies. The simplest anti-dysentery medicine is going to cost ten times the present price. People are already switching over to herbs and roots from the indigenous Ayurvedic brand of age-old Indian medicine. And now those companies are making a killing. Rape-seed husk, used in Isabgol, for example, is now costing twice

as much. It was used in anti-dysentery drugs in villages for over 3,000 years and MNCs are just now catching onto its qualities.

PNW: How independent do you feel that India should be in charting her own course?

ARK: I don't wish to blame foreigners for our mistakes. We Indians always do too little too late. We procrastinate, we pontificate, we preach, and we presume problems will go away. For example, the first \$35 million [from USAID] was left unutilized in the early 1990s. Now the largest ever USAID grant (\$40 million) is about to be dispersed and already two years have lapsed.

Controversy rages as to how many Indians are affected. In its latest "Report on the Global HIV/AIDS Epidemic 2000," UNAIDS estimates that 310,000 AIDS deaths occurred in India in 1999. But India's National AIDS Control Organization (NACO) says that only some 11,000 AIDS deaths occurred in that period. "These figures are just too high and not based on any sound epidemiological evidence," said a health-ministry official, commenting on UNAID estimates.

But the biggest issue, as Ashok points out, will surely be treatment cost. India may be better situated than South Africa to dig in her heels and insist on concessions from the World Bank and pharmaceutical companies. Indeed, as she develops her own AIDS policy, India may well assert her fifty-year independence in surprising ways.

(reprinted from the web)

freedom from fear
freedom from disease

Working with men who have sex with men - a rights based approach

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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 September 1990

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 <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 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)



We should never forget in our safer sex promotional work amongst MSM, that in South Asia, the vast majority will either be married, will get married, and/or also having sex with females. In fact we should ensure that all sexual health promotional work includes issues regarding anal and vaginal sex.

At the same time, NFI data from assessments conducted in Hyderabad and Bangalore indicate that some 11% of MSM interviewed were also using drugs, with the majority injecting. This means that all IDU projects should also include condom use in terms of anal and vaginal sex.

What this means that we should be aware isolating vectors from each other, male-to-male, male-to-female, and needle use.

I love a man in uniform

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been strategic in their decision not to push for state-recognised gay marriage out of fear that they might lose because of lagging public opinion and the religious lobby. South Africa is a deeply religious country with a strong rightwing lobby that opposes gay rights and gay marriage. The African Christian Democratic party wants to remove altogether the sexual orientation clause from the constitution. And even the ANC, in spite of its professed support of gay rights, has opposed every precedent-setting case brought to court by the gay lobby.

So while there are pockets of optimism in a country that is slowly shedding its horrific past, there is still some way to go and still some considerable opposition to men like Strydom and Browning. The gay community of South Africa, no matter what the constitution says, can't yet heave a sigh of relief that the bad old days are truly over. *The Guardian UK, 31/10/02*

Syringe disposal

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It appears that in the anxiety to hasten the adoption of new A/D syringe, the associated question of final disposal in the well accepted 'cradle to grave' approach is being ignored. The immunisation community is apprehensive about the concerns environmentalists are raising, instead of taking them on board. Immunisation targets and resultant benefits are more visible in the short run than in the unseen health consequences of improper disposal. Once again sustainable development has become rhetoric in practice.

From all evidence, improving medical waste practices needs a combination of staff training improved housekeeping, the utilisation of multiple technologies and safe final disposal. Otherwise, the 23,000 primary health centres in India will be saddled with extremely polluting incinerators, at the cost of over Rs.700 crore — more than the \$100 million Bill Gates has so generously donated. *Indian Express, 20/11/02*

India struggles for a workable strategy

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treat HIV/AIDS cases.

So most poor patients are sent to the Government Hospital for Thoracic Medicine in Tambaram, which began admitting HIV positive patients in 1993. More than one-third of new HIV patients are coming from Andhra Pradesh, the neighboring state, where infections are spreading like wildfire.

The Tambaram hospital feels like the backwater tuberculosis sanitarium it once was. Pigs roam freely through its run-down grounds and open-air wards. Over the summer, three HIV patients committed suicide by hanging themselves from the trees.

Most patients, some 300 a day, come for outpatient treatment, a monthly supply of Siddha - an indigenous form of medicine developed in Tamil Nadu whose efficacy in fighting HIV-related infection has yet to be clinically proved. The drugs are provided free to patients, at a cost of about \$2 a month per person to the government.

The hospital offers antiretroviral therapy only for staff members who may have been infected, and, for one or two months to patients on the brink of death - right now, about 50 to 60 out of 300. The cost is about \$30 a month per patient.

The decision to spend money to give respite to the near-dead reflects the struggles of caregivers overseeing a de facto hospice instead of a hospital. Asked what the point was of giving antiretroviral therapy for only a month or two, Dr. Rajasekaran, the deputy superintendent, replied, a touch defensively, "Saving a life is the point."

In the future, Dr. Charles of APAC says more care will be "home-based," intended to give a "dignified end" to a terminal illness. "There's no way you can start care centers in every community," he said.

But activists like Rama Pandian, who has been HIV positive for a decade, see that as shirking responsibility for developing a public health system that can deal with AIDS.

"Don't leave the burden on the community, on the family," he said, and allow doctors and hospitals to continue to avoid treating AIDS patients.

For now, the burden is mostly on the individual, particularly women whose husbands have already died.

In a village of 300 families about 100 miles east of here, villagers say that the army man may have died of AIDS. The truck driver almost certainly did, and Shekhar the cow trader definitely did. That was why they insisted hospital workers dig up his body after he died and cremate it.

Now some say the cow trader's wife, Shanthi, has HIV, too. In front of her neighbors, she denies it, blaming her weakness on a heart problem, her husband's death on his drinking.

But in the privacy of her own barren, one-room hut, she breaks down. Her husband died of AIDS six years ago. She tested positive for HIV seven months ago, after she became sick. Her clothes are growing looser, her skin more lesioned. Her panic over her children's fate is mounting.

Her greatest concern is that no one in the village know what is making her ill, even if they suspect. "If they know, they will isolate my children," she said.

The main thrust of the counseling she received after testing positive was this: "If you want to stay in your village, don't tell anybody." She earns 300 rupees - about six dollars - a month at a shoe factory, and is spending 60 of them on an ayurvedic "anti-infective therapy" prescribed by a private doctor. Similar drugs may be free at Tambaram, but she cannot travel there - although in all likelihood, as the disease progresses, that is where she will end up.

For now, in the dimness of her thatched hut, she whispers the rest of what the counselor told her: Death is natural. It comes to everyone. Do not be afraid.

New York Times, 11/11/02

Exporting Identity

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normally focus on either framework to the exclusion of other possibilities.

This view of deliberative sexual autonomy yields several real-world advantages. To begin, as this article has suggested, current pressures in gay civil rights - to come out, to speak out - often simplify, and hence reduce, the value of public deliberation about the intersection of sexual autonomy and sexual orientation generally. By linking gay civil rights to sexual orientation alone, the substitutive model diminishes the value that a deliberative autonomy model offers. However, because a deliberative autonomy model focuses on personal choice, this model honors not only the complexity of sexual orientation, but it confers value on the act of deliberation itself. Unlike the substitutive model, which draws lines between gay/straight and out/closeted, a deliberative autonomy rationale honors people's choices on personal identity while still engaging them in the debate over gay rights.

As we have seen, some identity-based models can be appropriate vehicles of constitutional protection for some individuals who readily adopt the category of "gay" or "lesbian." Yet such models often require individuals to "name" themselves or "come out" as an implicit prerequisite. However, a sexual autonomy framework allows for protection on the basis of both privacy and identity. It requires only that individuals have the right to determine their own preferences, orientations, and identities. And, as the Indian experience has shown, a sexual autonomy framework, quite unlike the current over-reliance on a substitutive equation between identity and conduct, avoids the accusation that it is a Western export because it builds on preexisting localized jurisprudence and civil rights movements for its efficacy.

Consequently, reassessing the utility of the substitutive paradigm carries important lessons for gay rights activists in any locality. And ultimately, by studying how different frameworks are excluded, we can create a more sophisticated, inclusive approach that integrates protections for sexual minorities with preexisting social meanings. By utilizing a vision of deliberative sexual autonomy while seeking civil rights protections based on both privacy and identity, we can honor the complex process of identity formation while still recognizing the need for equality on the basis of sexual orientation.

1 This essay is reprinted by permission of Yale Journal of Law and Feminism, Inc. from Yale Journal of Law and Feminism, Vol. 14, Number 1, pp. 97-176.

2. Stephen O. Murray, Increasingly Gay Self-Representations of Male-Male Sexual Experiences in Thailand, in LADY BOYS, TOM BOYS, RENT BOYS: MALE AND FEMALE HOMOSEXUALITIES IN CONTEMPORARY THAILAND 82 (Peter A. Jackson & Gerard Sullivan eds., 1999); Deborah P. Amory, Mashoga, Mabasha, and Magai: 'Homosexuality' on the East African Coast, in BOY-WIVES AND FEMALE HUSBANDS: STUDIES OF AFRICAN HOMOSEXUALITIES 70, 76 (Stephen O. Murray & Will Roscoe eds., 1998).

3. Oliver C. Phillips, Constituting the Global Gay, in LAW AND SEXUALITY IN THE GLOBAL ARENA 17 (Carl Stychin & Didi Herman eds., 2000); Barry D. Adam, Jan Willem Duyvendak, & Andre Krouwel, in Introduction to THE GLOBAL EMERGENCE OF GAY AND LESBIAN POLITICS: NATIONAL IMPRINTS OF A WORLDWIDE MOVEMENT 1 (Barry D. Adam et al. eds., 1999).

4. See generally THE GLOBAL EMERGENCE OF GAY AND LESBIAN POLITICS, supra note 3 (detailing worldwide developments).

5. Namibian Call to 'Eliminate' Gays, PLANET OUT NEWS, at <http://www.planetout.com/news/article/2000.10.02/1> (Oct. 2, 2000).

6. *Ibid.*

7. In this article, I define "sexual orientation" as the "erotic or affectational impulse to the same and/or opposite sex." JOHN C. GONSEIRECH & JAMES D. WEINRICH, HOMOSEXUALITY:

RESEARCH IMPLICATIONS FOR PUBLIC POLICY 1 (1991). I define one's "sexual identity" as the outward expression of one's sexual orientation, although others have used the term to refer to one's gender identity as well.

8. Shivananda Khan, Culture, Religion and Human Rights, 15 NAZ KI PUKAR 18 (Oct. 1996).

9. Shaffiq Essajee, Interview with Anjali Gopalan, Executive Director of the Naz Foundation, TRIKONE MAG., Oct. 1996, at 7 ("Not to say there are no gay men in India but this identity is sort of a luxury that doesn't really extend beyond the educated upper classes. The majority of men who have sex with men don't see themselves as gay or even homosexual.")

10. Deep Purkayastha, MSM Networks: Identity Categories versus Identity Continuum, 27 NAZ KI PUKAR 16 (Oct. 1999).

11. JEREMY SEABROOK, LOVE IN A DIFFERENT CLIMATE 141 (1999). According to Shivananda Khan, use of the term MSM slowly came into being because the term "gay men" or "homosexuals" inadequately conflated identity with behavior. However, as Khan points out, even this term fails to include transgendered entities, like the waria of Indonesia; the bakla of the Philippines, and hijras in India. See Shivananda Khan, The Risks of Categorization, 21 NAZ KI PUKAR 3 (Apr. 1998).

12. See Shivananda Khan, The Language of Sexuality, 5 NAZ KI PUKAR 14 (Feb. 1994) (noting that differences in language, religion, gender constructions and roles affect whether the terms lesbian, homosexual, bisexual are appropriate terminology).

13. See SEABROOK, supra note 11, at 162.

14. *Ibid.*

15. In India, the right to privacy, like the United States, is a judge-made instrument. See Martha C. Nussbaum, India: Implementing Sex Equality Through Law, 2 CHI. J. INTL. L. 35, 48 (2001).

17. *Ibid.* at 53 (citing Sareetha v. T. Venkata Subbaiah, 70 AIR AP 356 (1983)) (emphasis added).

18. See Peter Jackson and Gerard Sullivan, in LADY BOYS, TOM BOYS, RENT BOYS, supra note 2, at 19.

Knowing the odds

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But Frank Myers, an epidemiologist at San Diego's Scripps Mercy Hospital who has studied AIDS, said there are many other factors that affect risks. Sex is riskier if the levels of lubrication are low, he said, and oral sex becomes more dangerous if someone swallows semen.

Not taking those factors into account is "like thinking that you had the recipe for pasta sauce because you had the grocery list to make it. There is a lot more information that goes into it," he said.

However, gay men can use the odds to figure out how risky activities are compared to each other, Myers said.

Allerton, the Kaiser Permanente AIDS expert, said it's more important to understand how gay men make decisions. "There's such a disconnect between the advice that can be given on a statistical analysis and what people do on a Saturday night," he said.

<http://www.planetout.com>, 18/11/2002

**fight against social exclusion,
stigmatisation, and for social justice**

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Dipping

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of a MSM population and thus of a community is a milestone before considering taking care of its medical needs.

The opening of Community centres as in Manila since 92, even if justified by a medical emergency, was itself a heavy political act which allows men, often harassed by the police forces, to find themselves in protected places and to build a common identity. The simple fact of speaking of homosexuality constitutes, in Moslem countries such as Indonesia, a real coming out of the topic, an essential stage before taking further health-related actions. Brazil seems to have overcome that stage of community recognition and various studies showed how gay associations were involved in the making of government prevention policies. Research, in majority originating from Sao Paulo studied the various segments of MSM population, its behaviours and lives and thus were quite similar in their approach to western world studies.

Politically correct Clinton and Mandela, lengthily acclaimed by the participants in the closing ceremony, were both presented as "AIDS money makers", ready to serve as ambassadors of the AIDS cause to the powerful of the world. Mandela told a story of a young scholar which he personally helped and which could be saved only because she had the strength to speak of her disease to him. Mandela later made a call to HIV positive people asking them to tell publicly of their disease "for it is no shame to be sick and suffer, because not telling is signing your death warrant". Clinton, recognising the founder role of the gay activists in the fight against AIDS, spoke of a member of his staff at the White House, married, father and gay. One of the great conquests of the AIDS epidemic undoubtedly stays in this new ability in speaking of sex related issues: Aids has taught entire countries to speak about sex and to speak about it to all segments of the population thanks to associations doing ground work.

Unfortunately, a number of recent campaigns in Thailand, in Cambodia or in the Dominican Republic are worrying signals of a new type of

medical terrorism: the whole responsibility of safe sex is given to prostitutes themselves, some are forced, under police control to undertake an HIV test and if found positive, chased out of brothels to later find themselves working in the streets. Customers are sometimes asked to say, on photographs posted in the brothels, which woman gave them a STD or which accepted to have sex without a condom. Caution must be given to "politically correct" appearances in the fight against the AIDS in the Third World, which could generate more injustices and exclusions than social progress.

A posting from INTAIDS - intaids@healthdev.net, 20/08/02

Islam and same-sex relationships

continued from page 5, col. 2

colour, as defined by the West. The power of religious belief cannot be wished away or washed away even by affluence beyond imagination: the experience of a county like Saudi Arabia ought to be instructive in this respect.

If Islam embodies a 'pre-modern' consciousness, this also leaves large areas of human interaction in penumbra, where people act, behave, have sexual and emotional relationships, love one another, without perceiving anything in this which involves definitions of identity. In this context, friendships and attachments, sexual and emotional relationships exist, free of scrutiny, self-consciousness or self-reproach. Only when named 'gay' or 'homosexual', do they become problematic.

A more subtle and reflective evaluation of other cultures would recognise, not only *their* failings, but also the inadequacies of the dominant culture, which the people of the West inhabit. But no inadequacies are admitted in the individualistic, competitive and reductively primitive society, which exports itself globally with such exuberant and *intolerant* self-confidence.

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