



The World Social Forum was held in Mumbai, India between January 16th -21st, 2004, where over 70,000 people from across the globe attended. NFI was also an active participant with an information booth, along with a significant number from our partner agencies. Sharing the concerns of human rights for "sexual minorities" were many lesbians, gay identified men, kothis and hijras.

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.

Naz Foundation International's Ethical Policy

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.

Send all material to *Pukaar*, **Naz Foundation International**, Palingswick House, 241 King Street, London W6 9LP, UK.

visit our website
www.nfi.net

Pukaar is produced and published by:
Naz Foundation International
Palingswick House, 241 King Street
London W6 9LP, UK

Printed and distributed by:
Shivlok Enterprises
A/15 2nd Floor, Krishna Park,
Devli Road, New Delhi 110062, India

Naz Foundation International is a Charitable Company Limited by Guarantee (England).
Registration No. 3236205
Registered Charity No. 1057778

Registered Office
Palingswick House, 241 King Street,
London W6 9LP, UK

Naz Foundation International

Head Office
Palingswick House, 241 King Street,
London W6 9LP, UK
Tel: +44 (0)20 8563 0191
Fax: +44 (0)20 8741 9841
Email: london@nfi.net

Regional Office
9 Gulzar Colony, New Berry Lane,
Lucknow, 226 001, India
Tel: +91 (0)522 2205781/2205782
Fax: +91 (0)522 2205783
Email: lucknow@nfi.net

Chief Executive's Office
Email: shiv@nfi.net

Contents

- p3 Males, men and MSM
Martin Foreman
- p5 Male-to-male sex in South Asia
NFI
- p7 MSM in India - HIV prevalence
Michael Carter
- p8 Sexual health interventions among MSM - good practice
NFI
- p11 Censoring research on AIDS
Nancy S Padian
- p12 INN Meeting
NFI
- p14 MSM, HIV/AIDS and Human Rights in South Asia
Shivananda Khan
- p18 Response to guidelines for access to ART
Joe Thomas
- p21 40m bachelors and no women
The Guardian
- p22 Unsafe syringe use
The Indian Express
- p22 Sexuality and the law
Siddarth Narrain
- p23 5% of rural women know of AIDS
Joe Thomas
- p24 Promoting sexual health
Eli Coleman
- p27 How natural is normal?
Nivedita Menon

Males, men and MSM

Martin Foreman, consultant

For many years it has been recognised that HIV/AIDS programmes directed at "gay" men are likely to reach only a small proportion of their intended audience, particularly in the developing world. For many men who have sex with men, "gay" is a foreign concept; it is American, middle-class, effeminate, transvestite, transgender or a word they seldom hear. They have their own words, such as *panthi* [sic] in India, *cachero* in Costa Rica and the *kathoe*y in Thailand, which reflect local interpretations of sexual identity and sexual behaviour.

Furthermore, not every man who has sex with men does so because they want to. The man raped in prison and his violator might be exclusively heterosexual in the world outside, while the young man who has sex for money may go home to his wife and children. Few, if any, of these individuals would understand that safer sex messages for gay men were also intended for them. In other words, while the sexual acts were the same* across the world, HIV prevention was bound to fail if it did not address men in the terms they themselves used.

And so the term "men who have sex with men" emerged to describe all those involved in sex between men, whatever their circumstances, preferences or self-identification. Most importantly, it was a *behavioural* term, which describes what someone does, not an *identity*, which is how they identify themselves or how others identify them.

So far, so good. In a number of countries programmes were established which based prevention messages on local definitions of identity and sexuality and which saw significant changes in awareness and behaviour in men who have sex with men. However, a number of issues have begun to muddy the waters forcing us to re-examine this useful and comprehensive term.

The first of these is the fact that many of the men who have sex with other men are not men. Physically mature fourteen-, fifteen-, sixteen-year old boys and older have sex with other boys the same age and / or with older men, sometimes voluntarily, sometimes under coercion. (So do boys who have not yet reached the age of puberty, but that is the different issue of child abuse.) To ensure that prevention programmes reach these younger men, a number of groups, most notably in South Asia, have dropped the phrase men who have sex with men in order to refer to "males who have sex with males".

My head sympathises, but my heart screams. For me "male" is dehumanising and offensive, as it places us on a level with animals. (While the physicality of the sexual act is something we have in common with animals, our minds usually bring a dimension to sexuality that animals lack.) I would prefer to talk about "men and boys who have sex with men and boys", but I recognise the phrase is both cumbersome and subject to misinterpretation (e.g. some may think it includes prepubescent boys or others use it referring only to men and boys who have sex with both men and boys etc). I usually compromise by using "men who have sex with men" and prefacing any article or speech with the rider that by men I include sexually mature boys, but the rider isn't always heard and the viewpoint isn't shared by everyone.

Leaving that issue unresolved, my second problem is the almost universal reduction of the phrase "men who have sex with men" to "MSM". Again, there is a superficial logic; the phrase is long and can be clumsy. MSM is short and is merely one more in a world of acronyms – HIV, UNAIDS, PWA** etc. What harm can there be in these three letters?

Well, the first problem is that MSM creates a barrier for those unfamiliar with the term. It either prevents them from understanding whatever they are reading or hearing, or interrupts their flow as they search for the meaning. In other words it reinforces the privilege of insider information and, temporarily at least, ostracises those who do

not understand. "Men who have sex with men" is always clear and requires no explanation; it does not set up barriers between those who understand and those who don't, but includes everybody.

Secondly, acronyms that refer to people have a tendency to dehumanise, reducing them people to cyphers and statistics. MSM can be dismissive; "men who have sex with men" can also be pejorative but it is less likely to be so. And if the term is too long to be repeated, other alternatives can be used, such as "between men" or "sex between men" or "the men who..." or "such men", depending on the context.

Thirdly, and most importantly, "MSM" encourages lazy thinking. It leads people to think there is such a thing as a single identifiable group of MSM, while the reality is that the expression came into being because there is no such thing. Men who have sex with men are as varied as all men, as are the circumstances in which they have sex and the identities they give themselves.

Unfortunately, some people who work in HIV/AIDS say that they speak for MSM; they don't; no-one can. They talk about the MSM community; there isn't one. They talk about having an MSM identity; they can't. MSM leads people down the same mistaken path that gay did - it reduces the variety of men who have sex with men to a single identity and a single response.

We all come from, live in and work in specific geographical and social communities. None of us, no matter how well informed we are, can claim familiarity with all men who have sex with men. We can only claim to represent our own particular group. There are not even communities of men who have sex with men, because many men reject the notion that they share any values with other men who have sex with men. (The man who rapes another man is unlikely to think of himself as a member of a community of rapists, but he is definitely a man who has sex with at least one man.)

So, can we agree to banish MSM to history? It is not an identity, it is not a description and it is not a community. If you are only referring to one specific group of men who have sex with men, use the term appropriate to that community. And if you are genuinely referring to all men who have sex with men, including the many who you may have read about but are never likely to meet, then use the full - informative, respectful, thoughtful - term. Working with MSM limits our vision; trying to work with the many different men who have sex with men should be our goal.

And once we've agreed on that point, can resolve the question of males...?

**The sex is the same in the sense that male bodies can only interact in a number of limited ways; it is different in the sense that there are fashions in sex that change over time and from place to place and some sex acts may be more common in one community than in another. In the mid-20th century, for example, it seems that British gay men were more likely to do anal sex, while US Americans preferred oral sex*

*** People With AIDS, often supplanted by PLWHA (People Living With HIV/AIDS) or similar combinations. I prefer the increasingly used term Positive People.*

Response by Aditya Bondyopadhyay

First I agree that with the progress made in the intervention efforts with Men/Males who have sex with other Men/Males, the usage of the acronym MSM has increased and has increasingly been conflated with an identity construct by itself (you increasingly come across statements like "I am MSM" or questions like "is he MSM?"). This, as is rightly pointed out, is a problem as it defeats the very purpose

continued on page 4, col. 1

Males, men and MSM

continued from page 3, col. 2

behind the coinage of the phrase and its acronym.

But what I would like to add is to the appeal/desire of many to replace "Men" with "Males." I must say here that I have increasingly been convinced with the case for the change over to "males". Before I give my reasons I shall like to paraphrase two points that Mr Martin makes.

First, Mr Martin states that his understanding of why people say that 'males' should replace "men" is that it does not include mature boys who either have sex with each other or with other men. I shall explain later that this is a correct but limited understanding and that there is a far bigger reason for desiring this change/shift.

Second, Mr Martin states that the usage of males would somehow take away the humane element from human sexuality (of men). Again I would state that this argument, while may be true in some contexts, is actually again a limited understanding.

The limit that I ascribe to the two above positions adopted by Mr. Martin is the fact that Mr Martin does not take into account the role played by gender and gender constructs in male lives in many parts of the world including South Asia. Feminised males who adopt many indigenous identities (kothi, dhurrani, murat, zennana, hijra, kathoy, bakla, waria, faffafini, et al), do not consider themselves as "Men". They just possess the physical body of a "male" individual. Their self-definition, more often than not, is that they are "women" or "women like." Here the factor of import is the feminine gendered psychological makeup of biological males.

It is also now very clear that often it is the gendered males who are most at risk of HIV and also most disadvantaged (being largely penetrated in the sexual act and also having to deal with the baggage of societal patriarchy and the oppressions that it brings to bear on gender non-conformity). Therefore it is they that need greater attention of the limited intervention resources, if a meaningful dent in the HIV infection rates are to be affected.

In light of the above, I would suggest that as much as calling the "MEN" of the world "Males" is dehumanising and pathologising their sexuality, similarly called those who are "not-men" as "men" to suit the needs of the EGO of men is similarly dehumanising, oppressing, and unnecessarily patronising, if not outright inaccurate. Moreover it actually has the risk of keeping those most at risk and most in need of services out of the purview of all HIV intervention efforts.

The usage of 'males' is not debated by either side, nor contested as to its scientific validity. Only its dehumanising of "MEN's sexuality" is asserted. But since MSM was brought in to take the discourse away from (American/Western) gay politics (of gay MEN?) to a more scientifically accurate behavioural description, I feel the pathology of usage of the term "male" is more acceptable to the grave risk of denial of service that the MAN's ego can bring to bear on those who do not wish to conform to the stereotype of the MAN. They deserve better.

Editor's note: NFI increasing is using the term male-to-male sex in terms of HIV/AIDS prevention rather than MSM. The shorthand term does have a limited use without having to go through rather long-winded explanations ever time this is used. In terms of talking about rights and identities, we tend to use specific terms like kothi, hijra, etc. However, we must not forget that a significant number of non-identified MEN/MALES are involved in male-to-male sex, often as the penetrator, when it comes to hijras and kothis. How would these MEN be defined?

Bangladesh's gay prostitutes take a step out of the closet

Shunned since youth by their families, Bangladesh's male prostitutes are finding a furtive sense of community as they fight together against rampant discrimination.

Khokhon, 22, has sold his body for the past two years in the parks and transport terminals of this small town near the capital Dhaka.

He left his impoverished village in the eastern Narsinghdi district before his relatives could throw him out for being gay. But he remains a dutiful son, sending back to his family some of his earnings from the flesh trade.

"I knew I wanted to love another man and my family will never accept it. They will say I am bad," said Khokhon, who like other male prostitutes interviewed would only give his first name. Khokhon, who lives with a partner, also works at a garment factory.

"I am prostituting myself as I need the extra money to send home," he said.

Faced with common problems, the male sex workers, with some help from social workers, organise private meetings together to discuss their plight and compare techniques in countering violence at the hands of police and hooligans.

"They are slowly working to be united so that they can defend themselves and their rights from castigation and constant harassment," said Mohammad Nasiruddin of the Organisation of Development Programme for the Underprivileged, a non-governmental group here.

M. Salehin of another non-governmental organisation, CARE Bangladesh, said the number of sex workers was not necessarily increasing but demand for them was, in part due to more exposure to homosexuality through the internet and Western films in the Muslim country.

"There are two sides to consider when we say the gay population is growing because it could be that many led a secret life and are now coming out discreetly to meet like-minded people," Salehin said.

"Or thanks to the internet, younger people were being drawn into it thinking men having sex with men is normal because it is practised in the West," he said.

Tomiz, a smartly dressed 18-year-old, said his clients often felt compelled to pretend to be straight.

"I service married men who are women inside," he said. "They get married for social reasons or to get family property."

Bangladeshi laws dating back to the British colonial area describe homosexual intercourse as "unnatural." Prostitutes, men or women, face light jail sentences if arrested.

But male sex workers are worried less about court action than about physical attacks. Many of the prostitutes are quickly singled out for being effeminate.

Milan, 20, said he left home when his family learned of his orientation. After renting his first house on his own he was forced to move out when the owners also discovered his lifestyle.

"My family did not accept my way of life as they noticed I was feminine and so I started prostitution to feed myself. What else could I do?" he asked. Milan said he has been beaten publicly - and that the assailants would secretly come to him later for sex.

"They don't want to know us during the daytime," he said. "I want my right to move freely and earn my bread."

Posted by Al-Fatiha, 17/10/03

**NOT SOCIAL WORK, BUT
SOCIAL TRANSFORMATION**

**The word health is based on the
anglo-saxon word *hale*, which means whole

So does the word holy**

Male-to-male sex in South Asia

An NFI perspective

Sexual identities, masculinities and sexualities take shape within psychosocial and historical processes, which in turn are contextualised by religion, culture and language. Different cultures will often contextualise similar words and phenomena so as to take on different meanings with inherent subtleties typical of that culture. This is true of the South Asia region. While having several countries, the region shares a history and certain cultural and religious values that enables us to determine some common denominators within the phenomena of male-to-male sex.

In this context, and from the evidence, Euro-American understandings and discourses on "gay identities", heterosexuality, homosexuality, bisexuality, or even the use of the term "sexual minorities" can be misleading, and actual invisibilise to a significant extent the range and level of male-to-male sexual activities and those involved in them.

South Asian cultures are supremely patriarchal, gendered and hierarchal, so that the word MAN is defined not so much by biological age, but by gender roles and performance, religious rituals and family duties and obligations. Those who fall outside such normative masculinity would not be defined as MAN, but as NOT-MAN. In this situation, the penetrated sexual partner is seen as NOT-MAN, while the penetrator perceives himself, and is perceived by others, as MAN.

This perception is further reinforced by sociocultural realities as the invisibilisation of sexual behaviours, gender segregation, social policing of women, an acceptability of male homosociability and homoaffectionalism, male dominance over public space and public discourse, a culture of shame where family and community respect and honour holds sway, compulsory and arranged marriage, pressure of reproduction (particularly of male children), understanding of sex only in a reproductive sense, joint and extended families, and the negation of the self before the community/family. This behaviour is further defined by gender roles attributed to males and females within society, especially when important defining events in life like assumption of adulthood are defined by such gender roles.

In such phallo-centric patriarchal cultures with sex defined reproductively, masculinity is defined by the act of sexual penetration and not be "sexual orientation". Those who are penetrated would thus be perceived as less worthy, feminised, debased males, and would be highly stigmatised leading to a range of violence and abuses, as well as sexual accessibility without diminishing the masculinity of the penetrator. The male penetrator is not deviant and is a part of the general male population. It is the penetrated who is subjected to the perception of deviancy.

However, within a homosocial and homoaffectionalist culture, along with the general invisibility of sexual behaviours, sexual boundaries between males can easily be crossed in appropriate spaces, at the appropriate time, "under the blanket", and "in the dark".

What therefore seems to exist are a range of masculinities, sexualities, and genders, with differing contextualisation of sexual behaviours, sex partner choices, perceived sexual needs, pleasures and desires.

While for some MSM there are frameworks of specific male-to-male desire (based on object choice/gender), gendered identities and visibility which may make it easier to access and quantify numbers, for others who sexually access these males and whose desires are based around discharge and specific sex acts (and perhaps sexual object choice), and who perceive themselves as "manly" and 'normal men', it will be almost impossible to quantify. It could be any 'manly' male given the right situation and context.

The frameworks of male to male sex, often substantially divergent and exclusive, involve males who self-identify as zenanas/kothis/metis and are usually penetrated, males/men who take on the

penetrating role in male to male sex (known as giryas/panthis/tas by zenanas/kothis/metis) accessing zenanas/kothis/metis, hijras, and at times, adolescent males. These males are usually perceived by giryas/panthis as feminised males/females, which enables the girya/panthi/ta to maintain his sense of manliness and be seen as a part of the normative male society. Other dynamics include males who access other males for discharge and/or desire to be penetrated, males who desire male to male sex and do not gender themselves and usually indulge in mutual sexual activity - "giving and taking", friends having sex with friends for mutual pleasure, and males in all male institutions. Amongst the educated and urban elite, a Western gay sensibility and community is also emerging in parallel to this.

These networks of differing MSM contexts may at times interpenetrate, where individuals may shift along differing networks, but usually they are mutually exclusive. In other words there are complex dynamics and diffusion in relation to male-to-male sex.

The most visible of these networks are those involving zenanas/kothis/metis and hijras because of their public performative role, which is a part of their self-identification. In some cities in South Asia there will also be malashias (males who give massage) and other normative masculine males working as male-to-male sex workers.

This, if course, does not tell the whole story of male-to-male sexual behaviours in the region.

Male-to-male sex work is a significant factor in South Asian cities. A broad range of frameworks also exists here. Hijras, zenanas/kothis/metis, malishias, male youth, and other males, will sell sex to men because of poverty and unemployment. Without a welfare system, and with significant levels of unemployment or low level incomes, male sex work can be a way out in terms of supporting the self and family. This is not to imply that males involved in sex work do not enjoy the sex with other males. Often they will also have a regular partner - a pucca dost/parik.

It needs to be recognised that the male being anally penetrated by another male is highly stigmatised and those who are perceived to be recipients are usually treated with contempt. A girya/panthi or malishia or any man/male who is sexually penetrated, orally or anally, will make extensive efforts to hide his practice and/or desire, both from his friends as well as from zenanas/kothis/metis and others in their sexual networks to avoid such stigmatisation. It cannot be assumed that gendered sex roles are exclusively maintained at all times. It further needs to be recognized that a similar crossing of "gendered" boundaries exists amongst zenanas/kothis/metis. It is not unknown for some zenana/kothi/мети-identified males to also penetrate other males. But like the penetrated girya, this behaviour would also be kept secret from other zenanas/kothis.

Such stigmatization further produces a range of human rights abuses, blackmail, violence, and male-on-male rape by local men, thugs and beat constables.

While there were substantial networks of zenanas/kothis/metis of all gradations in urban centres - from the very feminised and cross-dressing type to those who have moustaches and dress in shirt and trousers - there sexual partners could well be any masculine male.

Malishias and other similar male sex workers are not only being accessed by men for masturbation and discharge as part of the massage process, they were also being accessed by males across the economic and class spectrum for penetrative sex. Women also access many of these malishias for sex.

There are other networks of male-to-male sex, not only in a range of male only institutions, or between young male friends in neighbourhoods, but also between older men and adolescent boys. These frameworks can be seen within contexts of :

continued on page 6, col. 1

Male-to-male sex in South Asia

continued from page 5, col. 2

- a. desire for a specific sexual act, i.e. anal sex
- b. "body heat" that requires discharge
- c. mutual desire for male-to-male sex
- d. desire for adolescent boys known in the historical literature as "beardless youths"

Accessing masculine male sexual partners is not considered difficult. All urban areas appear to have sexualised spaces, such as parks, toilets, railway and bus stations, specific bazaars, streets, and other public areas where zenanas/kothis/metis would go to meet potential giryas/panthis, often marketing sexual availability through their feminised social behaviours. Many "real me" go to these sites, not only to meet such accessible males, but often for quite ordinary purposes, where they can get caught up "in the heat of the moment" and access zenanas/kothis/metis there at the time.

What is clearly seen is that language, behaviour, and identity is to a large extent gendered, within a hidden context of polymorphous behaviours, and that behaviour and sexual practice are more significant markers for the majority of males involved in male-to-male sex than a specific sexual identity. In a way it could be said that there are limited numbers of MSM with specific gay/homosexual identities, but significant levels with a gendered identity or with perceived masculine 'body needs' which shaped sexual practices.

One more point needs to be made. Relationships between the various networks (I use this term advisedly rather than groups) are often self-stigmatising, tense and sometimes abusive, because of the social construct of penetration being seen as equivalent to feminising. Gender "politics" and relationships come to the fore. Thus malishias/masculine male sex workers may abuse zenanas/kothis/metis because of their feminisation, zenanas/kothis/metis will abuse male sex workers because they also are penetrated, giryas/panthis abuse zenanas/kothis/metis, and substantial tensions exist between hijras and zenanas/kothis, since zenanas/kothis because they are not hijras. These tensions can explode into verbal and physical abuse at times.

The issue of female sexual health is also highly pertinent. Cultural tradition makes marriage socially compulsory. Many MSM, of whatever framework or gender identification, are married or going to be married, even those who self-identified as zenanas/kothis/metis. Many manly sex partners from the general male population would also be married or going to be married.

Pakistan government says nearly 100,000 HIV cases in country, launches expanded education programme

The government of Pakistan has launched an HIV/AIDS education campaign for high school students and religious leaders amid reports that the estimated number of HIV-positive people in the country has reached nearly 100,000, Pakistan's Daily Times reports.

There are currently 235 reported HIV cases and 1,785 reported AIDS cases in the country, according to Dr. Asma Bukhari, national coordinator of the country's AIDS Control Program. However, government officials said that they believe there are an additional 70,000 to 80,000 unregistered HIV/AIDS cases, the Times reports.

The country's HIV/AIDS program currently targets religious leaders, female health workers, teachers and opinion and policy makers. In addition, the program seeks to educate sex workers, men who have sex with men, women who have sex with women, injection drug users, long-distance truck drivers and young people ages 15 to 25. In an effort to better reach young people, the government has decided to offer HIV/AIDS education as an extracurricular subject in the country's high schools, Bukhari said.

Posted on the internet by Saathi on 4/3/03

What your parents never told you about the birds and the bees

same-sex behaviour is common among animals

from The New York Times, reprinted in The Asian Age, 14/2/04

Roy and Silo, two male penguins at the Central Park Zoo in Manhattan (New York, USA), are devoted to each other. For nearly six years now, they have been inseparable. The exhibit what in penguin parlance is called "ecstatic behaviour": they entwine their necks, they vocalise to each other, they have sex. Silo and Roy are gay penguins.

At one time, the two seemed so desperate to incubate and egg together that they put a rock in their nest and sat on it, keeping it warm in the folds of their abdomens, said their chief keeper, Rob Gramzay. Finally he gave them a fertile egg that needed care to hatch. Things went perfectly. Roy and Silo sat on it for the typical 34 days until a chick, Tango, was born. For the next two and half months they raised Tango, keeping her warm and feeding her food from their beaks until she could go out into the world on her own.

"They did a great job," Mr. Gramzay said.

Roy and Silo are hardly unusual. Milou and Squawk, two young males, are also beginning to exhibit courtship behaviour. And Wendell and Cass, a devoted male African penguin pair, live at the New York Aquarium in Coney Island. Indeed scientists have found homosexual behaviour throughout the animal kingdom.

This growing body of science has been drawn into charged debates about homosexuality in American society, despite reluctance from experts to draw conclusions from animals to humans. Gay groups argue that if homosexual behaviour occurs in animals, it is natural, and therefore the rights of homosexuals should be protected. But some conservative religious groups condemned the same practices, calling them "animalistic."

Paul L. Vasey, a professor of psychology and neuroscience at the University of Lethbridge in Canada, who studies homosexual behaviour in Japanese macaques, said, "For some people, what animals do is a yardstick of what is and isn't natural. They make a leap from saying if it is natural, it's morally and ethically desirable."

But he added: "Infanticide is widespread in the animal kingdom. To jump from that to say it is desirable makes no sense. We shouldn't be using animals to craft moral and social policies for the kinds of human societies we want to live in."

What homosexual animal behaviour does show, said Marlene Zuk, a professor of biology at the University of Californian at Riverside, is that "sexuality is a lot broader term than people want to think."

"Sexual expression means more than making babies," Ms Zuk said. "Why are we surprised? People are animals."

Editor's note

See: *Bagemihl*, Bruce: **Biological Exuberance - animal homosexuality and natural diversity**, Profile Books, 1999. An excellent book filled with theory and academic studies on same sex behaviours among a broad range of animal species.

National Geographic Channel transmitted an excellent programme in November 2003, called **Out In Nature**.

Both are in the NFI Resource Library in Lucknow.

it's more than just disease prevention

it's about well being

Men who have sex with men in India have high HIV prevalence and multiple risk factors for HIV

HIV prevalence is significantly higher among men who have sex with men in India than among men reporting only sex with women, according to a study published in the March 1st edition of the *Journal of Acquired Immune Deficiency Syndromes*. The study also revealed that the majority of men reporting sex with men were married, and that HIV-positive men who reported having sex with men were also likely to report multiple risk factors for HIV, including drug use, multiple sex partners and exchanging sex for money.

India has the second-highest number of HIV-positive people in the world, and evidence suggests that heterosexual sex is the main mode of transmission. The prevalence of HIV amongst men who have sex with men in India is not known, and, unlike the situation in many other countries, men who have sex with men in India often do not conform to a homosexual identity.

Investigators therefore wished to determine the prevalence of HIV and other sexually transmitted infections among men reporting oral or anal sex with another man in the Chennai slums.

The study was a cross-sectional population-based one, and recruited a random sample of 774 men in 2001. Participants provided details of their sexual and drug use behaviour to trained counsellors and provided a blood sample for HIV and syphilis testing and a urine sample for chlamydia and gonorrhoea testing.

A total of 46 men (5.9%) reported ever having sex with another man, and 6.5% of these men were HIV-positive compared to only 0.9% of men who did not report sex with another man.

Men who had sex with men were also more likely to report a history of sexually transmitted infections (odds ratio 2.66, 95% CI: 1.18 -

6.02), or to report having discharge from the penis (OR = 3.96, 95% CI: 1.87 - 8.38), than men who did not report sex with men.

The investigators also found that men reporting sex with other men were also significantly more likely to engage in other HIV risk behaviours, including the use of illicit drugs (OR = 4.94, 95% CI: 2.61 - 9.34), more than four life-time sexual partners (OR = 3.22, 95% CI: 1.78 - 5.83), and exchanging money for sex (OR = 5.50, 95% CI: 3.12 - 9.96).

"Overall [men who have sex with men] are more likely than non-[men who have sex with men] to be infected with HIV and more likely to have a history of ST[Is]," comment the investigators. However, they add that HIV-positive men who have sex with men are also more likely to report other risk activities that could result in HIV infection. Although the investigators did not gather information is sexual identity, they noted that 57% of men reporting sex with another man were married, "reflecting the fluidity of sexual behaviour in India."

The investigators conclude, "Our study suggests that unsafe sex among men who have sex with men is one of several high HIV risk behaviours that this subgroup of individuals engages in. Rather than targeting this group in the context of sexuality, HIV interventions might address a range of HIV risk behaviours, including a number of unsafe sexual practices, including sex with men."

Reference

Go VF et al. High prevalence and risk behaviours in men who have sex with men in Chennai, India. *JAIDS* 35: 314 - 319, 2004.

This article was written by Michael Carter and published on <http://www.aids.com>

Virus may extend life for men with HIV

Randy Dotinga, *Gay.com / PlanetOut.com Network*, 4/3/04

It sounds too strange to be true, but new research appears to confirm that a seemingly harmless virus related to hepatitis actually helps people with AIDS live longer.

The workings of so-called "virus G" are unclear, and no one is suggesting that AIDS patients run out to inject themselves with it. But findings released this week are certain to point scientists in another direction as they ponder new treatments and a potential AIDS vaccine.

"We should try to figure out how it works so you could mimic it with a drug," said Dr. Roger Pomerantz, a virologist at Thomas Jefferson University, who wrote a commentary about the new study in the *New England Journal of Medicine*.

Scientists first stumbled upon virus G - also known as GB virus C - in the mid-1990s. At first, they thought it was a type of liver disease, perhaps a strain of hepatitis. (Some people still call it hepatitis G.) But unlike the main types of hepatitis, virus G doesn't appear to cause any symptoms. It does, however, spur the immune system to take action to get rid of it.

Like hepatitis A and B, which both are common among gay men, virus G is spread through exposure to blood and sexual contact. "It does not seem to cause disease and is very common in healthy humans," said study co-author Dr. Jack Stapleton, director of the University of Iowa HIV Program.

An estimated 13 percent of blood donors show signs of infection in the past, while another 1.5-2 percent are currently infected.

The rate was even higher - 85 percent - among 271 gay men who

developed HIV infection while taking part in a research project in the late 1980s and early 1990s, before the advent of lifesaving AIDS drugs. Most were not still infected with virus G but instead showed signs of previous infection.

In the study, released in Thursday's issue of the *New England Journal of Medicine*, researchers found that the uninfected men were 2.78 times more likely to die within five to six years than those who were persistently infected with the virus. In a twist, those who appeared to clear the virus G infection actually died earlier, possibly because HIV robbed the virus of immune cells to attack.

Researchers aren't sure what's going on, but "we do know that (virus G) is doing something to the immune system," Pomerantz said. "It's making the immune system stronger."

Considering the results of the study, will AIDS patients clamour for injections with virus G? Researchers hope not.

"I don't think there's going to be a black market for G virus," Pomerantz said. "It's extremely difficult to grow."

Not to mention that scientists aren't entirely sure that it is harmless. Then again, researchers suspect that some germs in the world may survive by helping their hosts, not hurting them.

"We're finding more and more infectious agents that infect humans and do not appear to cause disease," Stapleton said. "It's not unreasonable to think that, evolutionarily, these infections have some benefit or they wouldn't stay around."

After all, he explained, viruses don't want to "flame out" and disappear. Instead, they want to live and spread themselves.

"HIV is very effective because it doesn't cause disease on average for seven to 10 years," he said, "so people are healthy and they can transmit the infection without any clue they're infected."

Sexual health interventions among males who have sex with males in South Asia

A framework of good practice based on the NFI experience

Introduction

Since 1996, Naz Foundation International (NFI), based on its knowledge and experience of working with males who have sex with males (MSM) frameworks and networks, has provided technical assistance and support to develop some 28 CBO MSM sexual health projects in the South Asia region, 18 of them in India.

Experience had shown that the countries of South Asia, such as India, Nepal and Bangladesh, have common frameworks of male-to-male behavioural dynamics, shared terminologies and gendered frameworks, and the same significances and meanings placed on sexual behaviours, gendered identities and social constructions of masculinities.

Based on this experience NFI has developed a range of replicable development tools and resources that support local CBO MSM sexual interventions. The model of service delivery by Bharosa in Lucknow, India, is the same as that used by Bandhu Social Welfare Society in Bangladesh, Blue Diamond Society in Kathmandu, Nepal, and Vision in Lahore, Pakistan, as are the management and programme tools and resources that they use.

While NFI has primarily worked through focused interventions with feminised males (kothi-identified), it has encouraged the resultant CBOs to work with female sexual health programmes, and with those working with specific groups of vulnerable males from the general male population, including truck-drivers, clients of female sex workers, IDU projects and so on. It has also encouraged its partner agencies to provide assistance to hijra and gay-identified networks wherever possible, along with male sex worker networks and other dynamics of male-to-male sex.

Which strategy?

There are only 2 main strategies for promoting sexual health

THE MORAL STRATEGY - DON'T DO IT

THE PRAGMATIC STRATEGY - DO IT SAFELY

Which strategy would be most effective in reducing the spread of HIV/AIDS?

It needs to be clearly stated here that behaviour change does not mean promoting abstinence or changing the male-to-male sexual behaviours and gendered identities to male-to-female behaviours, both of which are unrealistic and arise from a moralistic approach to HIV prevention. It means empowering MSM to reduce their own risks to STI/HIV infection through changing their risky behaviours to less risky behaviours and creating an empowering environment where this becomes possible. It is a risk reduction strategy that NFI promotes.

Good practice

As far as NFI knows, no legitimate and independent study has been done on best practices for MSM sexual health interventions in South Asia (although we believe that one is being conducted in Bangladesh with Bandhu Social Welfare Society at the time of this writing). Nor, as far as can be determined, any national impact study been done in regard to sustained changes of levels of risk reduction or consistent condom use among MSM accessing sexual health services, either NGO or CBO led.

We are therefore hesitant to discuss best practice models in this context in this paper. What we have done is to therefore identify key elements in the NFI model of service delivery for marginalised MSM that have been successfully replicated in a number of different localities where NFI has provided technical support for locally-based MSM sexual health community-based organisations to be developed,

and suggested that these be defined as Good Practice.

A study had been undertaken by Tim Mackay, consultant to the Department for International Development, UK, which looked at Bandhu Social Welfare Society in Bangladesh and Sahodaran based in Chennai, India, where both these agencies had accessed NFI technical expertise to develop MSM-led sexual health interventions. Both had utilised NFI's training and development manuals, key monitoring tools and financial management, as well as service delivery models. The study was conducted in 1999.

From the report

A major result of the work undertaken so far has been the testing of a number of key strategies and service delivery components that make up a response to the sexual health needs of males who have sex with males and their female partners in South Asian countries. These strategies can be characterised as an integrated, flexible "framework" or "model" that can be adapted and used in different locations and circumstances.

In the work reviewed the "framework" has demonstrated a strong value. There are observable weaknesses but these relate more to quality of implementation and circumstances beyond the control of the projects than any inherent fault in the concept. The framework is not rigid or static and will evolve as further work is undertaken.

While the results to date are impressive there remain enormous challenges if the full potential of the organisations, and the main goal of the work, is to be realised.

And...

Conclusion

The framework or model, which has been generated by NFI, Bandhu and Sahodaran to respond to the needs of males who have sex with males is sound, has proved to be adaptable and has produced exciting results so far. It can be used as a starting point for individuals and agencies in other locations in South Asia to create their own responses to their specific needs.

Key Signifiers

Most key stakeholders (international, national and local), including UNAIDS, based on their global experience, now recognise that for an effective, appropriate, and sustainable, HIV/AIDS prevention programme that focuses on any marginalised and socially excluded population, certain key indicators are required. These are:

⇒ **Focused participatory interventions**

Strategic focusing of participatory prevention programmes for populations most at risk.

⇒ **Ownership of the issue**

Those most at risk will also need to acknowledge their own risk and own the issues involved.

⇒ **Beneficiaries as service providers**

For a sustainable programme on risk reduction, those most at risk must be directly involved in developing, implementing, and providing prevention services for their peers.

⇒ **Self-help community-based organising**

To ensure involvement of, and management by, beneficiaries, key individuals within marginalised populations should be recruited, provided training and skills building, and empowered to develop their own service organisation.

⇒ **Access to appropriate and affordable STI treatment services**

It is essential that clinicians providing STI treatment services are sensitised to the specific sexual health needs of vulnerable MSM,

which includes providing STI management in regard to anal STIs and symptoms. Such services should be confidential, not only around STI status, but also with regard to sexuality and behavioural choices.

⇒ **Access to appropriate HIV voluntary testing and counselling**

Ensuring that confidential testing along with pre-test and post-test counselling appropriate and sympathetic to the needs of MSM is essential.

⇒ **Access to appropriate treatment, care and support services**

Many MSM living with HIV/AIDS are not only stigmatised by the positive status, but also by the route of infection and their feminised sensibilities. Treatment, care and support programmes need to be sensitised to these different frameworks of stigmatisation and address them appropriately.

⇒ **Access to affordable appropriate condoms and water-based lubricants**

Reducing the risks of STI/HIV infection is central to any effective HIV/AIDS prevention programme. The most significant risk is through anal sex, both for the penetrated as well as for the penetrator. Regular use of condoms for anal sex is an essential component for any risk reduction strategy. However, in addition to this, ready access to appropriately packaged water-based lubricant is also an essential component of this, since anal sex by its nature increases the stress on condoms itself as well as reduces rectal damage.

⇒ **Access to appropriate IEC materials**

These materials need to be appropriate to the issues and concerns of MSM in languages, terminologies and imagery that are meaningful and understandable to them.

⇒ **Long-term technical and financial support**

It is most likely that the level of technical knowledge to develop, implement and manage an HIV/AIDS prevention and care programme for peer beneficiaries will be low if existent at all. Developing these skills and knowledge will require a sustained effort to share such information with those developing the service. At the same time, these self-help initiatives must also ensure of appropriate levels of funding over a sustained period of time in order to develop these skills and continuity of service provision.

⇒ **Advocacy on legal, judicial and social impediments to promoting HIV/AIDS prevention and sexual health among MSM**

Along with advocacy on the above signifiers, advocacy on addressing the legal, judicial and social impediments to HIV/AIDS prevention and care programmes focusing on MSM is an essential requirement towards developing an empowering environment so that affected populations can reduce their risks to HIV/STI infections and modify their sexual practices in order to achieve this.

In addition to the above it needs to be remembered that many MSM have no gendered or sexual identities and that primarily they perceive themselves as normative males who penetrate non-men. Such men

Bandhu Social Welfare Society workshop in Dhaka



are invisible within the general male population. It will therefore be essential to ensure that education, awareness and STI treatment programmes for occupational groups and the general male populations along with condom promotion should also address anal sex as a risky sexual behaviour.

Why not use an existent non-government agency to implement an MSM HIV/AIDS intervention?

The difficulty for donors, whether private or government, is that very few community-based MSM service providers exist. In such an environment, where the epidemic growing and spreading and an urgent response is required, and where other non-government agencies exist, the tendency has been to fund these NGOs to deliver HIV/AIDS prevention services to MSM populations.

However, such a strategy tends to utilise a "top-down" approach, which does not lead to ownership or empowerment of the beneficiaries towards maintaining safer sex behaviours and has been shown to lack



social meeting at Mithrudu drop-in, Hyderabad

long term sustainability of behaviour change.

One approach, if non-MSM NGOs are to be used, is that these NGOs should work with specific groups/networks of MSM towards building up self-help organising through technical support, and empowering such self-help groups to develop their own community-based response through promoting community-based organising/organisations.

This is the NFI approach.

However, many NGOs are involved in HIV prevention and sexual health programmes for other risk populations as well as the general male population. Such NGOs should be sensitised in regard to male-to-male sexual behaviours and include issues of risk and risk reduction in their programmes. After all MSM as a category and behaviour crosses all risk populations.

Some key components in developing any intervention focused on self-identified MSM

- Identifying key MSM individuals and MSM networks within the specific target city/area
- Provide such individuals with appropriate skills building and on-going technical support
- Map and network within the focused city/area
- Form self-help groups and build their knowledge and management skills towards developing their own CBO
- Identify safe spaces for group meetings, education programmes and socializing activities towards community-building
- Ensure adequate supplies of condoms and water-based lubricant
- Ensure ready access to appropriate STI clinical services
- Provide adequate long term funding

continued on page 10, col. 1

MSM sexual health interventions: good practice

continued from page 9, col.2

- Address legal, judicial and social impediments

There are four primary components in such an MSM-led HIV/AIDS prevention and care programme:

Field Services, which should include

- Outreach and friendship building
- Community development and mobilising
- Education and awareness
- Advice and information
- IEC materials distribution
- Condom/lubricant distribution
- Referrals to drop-in centre, STI treatment, counselling and HIV testing

Centre-based services, which should include

- Drop-in services;
- Social group meetings
- Skills-building vocational classes,
- Sexual health awareness-raising and condom and lubricant distribution;
- Counselling;
- Telephone helpline;
- Recreational activities
- Community-based research

Health Services, which should include

- STI treatment and management
- HIV testing and counselling
- Access to treatment for opportunistic infections and ARVs
- Psychosexual counselling
- Support and care programmes
- General health care

Technical Assistance, which should include

- On-going access to technical support and assistance when requested

- Training and skills building
- Access to a range of BCC and training resources
- Research
- Advocacy
- Participation in policy development
- Networking and developing partnerships

While the above signifiers and components of an MSM sexual health intervention are believed to be crucial to build a sustainable, effective and an appropriate programme that is MSM-led, without an effective sero-and behavioural surveillance programme conducted by external evaluators, impact and outcomes for such a programme cannot be measured. Appropriate monitoring and evaluation at all levels are essential, in terms of process, management, finance, service delivery, and change. Such M & E is not just data collection of how much condoms are distributed, and so on, but includes qualitative evaluation of process and outcome. An annual sero and behavioural surveillance programme significantly adds to this by providing an effective tool to measure the impact of such interventions.

Conclusion

To ensure that MSM who are at risk from STI/HIV infections have access to appropriate sexual health services and that risk reduction strategies can be implemented effectively requires knowledge, understanding and openness by key stake-holders to the realities of the sexual lives of so many males. It requires a strong commitment and leadership from donors and policy-makers to invest adequate funds to protect the lives of so many people. It requires creating an enabling and empowering legal, judicial and social environment in which positive actions can be taken, and that networks of MSM can take charge of their own lives and well-being. It can be done. It should be done. It must be done.

* *Centre for Sexual and Reproductive Health: Sexual Health of Males who have Sex with Males in South Asia - an evaluation of the work of Naz Foundation International and two of its partner projects- Bandhu Social Welfare Society, Dhaka and Sahodaran, Chennai, November 1999 - Tim Mackay. Undertaken by JSI (UK) on behalf of the Department for International Development, UK.*

Emergent terms

Metrosexual: urban male with a strong aesthetic sense who spends a great deal of time and money on his appearance

Toxic Bachelor: selfish and wary of commitments

Manscaping: shaving and trimming of a man's body hair

Post-gay: a homosexual who defines his or her identity by something other than sexual preference

Hetroflexible: someone open to relationships with people of the same sex

from *Asian Age*, 29/2/04

Odds and Ends

Drawn from the *Life* section of *The Guardian*, 4/3/04

• Hugging is a basic need. It changes your internal environment. The skin is the largest sense organ and scientists have found that positive touching subdues the "fight or flight" response, relaxing blood pressure, the digestive system, body temperature, muscles and heart rate.

• A paper in the *Journal of Neuroscience* stated that an increasing amount of biological research... indicates that a parent's [positive] physical attention helps the stress system in the infant's brain develop and function normally. This system and its hormones help to carry out physiological adjustments to stressful events.

• Silvia Cardoso, a behavioural biologist at the State University of Campinas, Brazil, found that only 10 or 20% of laughing is a response to humour. Most of the time it's a message to other people that communicates a willingness to bond, *New Scientist* reported

NFI apologies to USAID

In Issue 44 of Pukaar, published in January 2004, we published a report that stated that the "US cancels HIV/AIDS programme for Brazil" (page 5). This story had been posted on the internet by JVNet 1/10/03, and the source was DKT International/US Newswire, 15/9/03

The report was incorrect. USAID never cancelled it's HIV/AIDS programme in Brazil, and continues to support the Brazil National AIDS Programme strategy through a substantial HIV/AIDS bi-lateral agreement. Furthermore USAID's bi-lateral support includes an important focus on prevention among MSM.

We would like to apologise for this mistake.

Give us a hand (or your money!)

For UK self assessed tax returns for the year 2003/4 and later, you will be able to donate directly any tax repayments you are due to the Naz Foundation International, by quoting our name and/or our unique reference number YAN23SG. Every little counts, and we desperately need funds to support the scaling up of our activities in South Asia, so please make use of this tax free way of giving.

Censoring research on AIDS

By Nancy S. Padian

I was in Bangalore, with a team of international researchers who are working to prevent the spread of AIDS on the Indian subcontinent, when I learned that my name and my research were on a "hit list" of researchers and projects apparently targeted for additional scrutiny and possible loss of funding by the National Institutes of Health, the federal agency that sponsors the research.

The targeted projects mainly deal with sexual behaviour and risk of infection from sexually transmitted diseases, including HIV/AIDS. The assault on NIH-sponsored projects was particularly chilling because my research, like that of my colleagues at UC San Francisco who were also targeted, had gone through extensive scientific and ethical peer review before receiving NIH funding. Why were the red flags being thrown at this point in the game?

It soon emerged that the "hit list" was prepared by the Traditional Values Coalition, a conservative advocacy group. The TVC objects to homosexuality, all forms of abortion and all contraceptive interventions. In fact, the TVC objects to all sex outside marriage - hence its effort to withdraw funding from any project that attempts to mitigate health problems associated with sex outside of marriage by using any means other than abstinence.

The TVC's unprecedented scare tactic sent a wave of anger and resentment through the entire international community of public health and medical researchers. Even more alarming, although the TVC has acknowledged authorship of the list, NIH is still preparing a report for Congress about the research projects listed.

One may ask how a lobbying organization with such a strong sectarian political and religious viewpoint could initiate an investigation of approved research projects. Evidently the TVC feels that it enjoys an open invitation to change the priorities and goals of government-approved scientific research, outside all established procedural channels.

To understand why this tactic is so insidious, the public needs to understand how scientists win federal funding for NIH-sponsored scientific research projects, and what is at stake if this system is eroded for ideological reasons.

All the projects targeted by the TVC - indeed, all government-funded science projects - go through rigorous academic peer review. That is, as proposals compete for funding, they are judged by teams of accomplished, unbiased and internationally respected scientists in related fields. The results of these investigations are continually reported in international, peer-reviewed medical journals.

The integrity and independence of this peer-review process is essential for the continued vitality and quality of American medical and public-health research. It cannot be subjected to an extremist litmus test.

Disease does not respect political or religious affiliations, nor does it observe any international boundaries. Medical research is bound by the strictest ethical standards. It must have the freedom to find answers to how diseases are caused and spread, and how to develop ethical and effective treatments for them.

Infectious diseases attack whole populations, not just individuals. Thus, controlling infectious diseases means focusing on all of the populations affected. It is neither morally nor medically defensible to withhold research or treatment just because the behaviour of one segment of society is distasteful to another. The ever-present risk of the spread of infection from any segment to the larger community - including people who fear and dislike those affected by disease - requires understanding how disease spreads and how to develop appropriate, effective interventions for everyone. Rigorous scientific research makes successful interventions possible.

All of the research targeted by the TVC witch-hunt promotes the improvement of public health. No outcomes are prejudiced in advance by the research; lack of bias is a hallmark of quality scientific investigation. The overarching goal of all of the research in question is to change behaviour in order to save lives, a long-term goal of American and international public-health policy and practice. The targeted programs have included thousands of vulnerable individuals at risk for sexually transmitted infections, including HIV. We have already seen benefits of much of this work at national and international levels. It is amazing that these values, which are truly traditional and durable, even need explanation, let alone defence.

It is time for the Bush administration to distance itself firmly and explicitly from any kind of scientific McCarthyism. The unthinkable alternative is the erosion of this country's high standards for public health and medical research, and higher rates of infection from diseases that need to be cured and controlled. There is too much at stake to play politics.

Nancy S. Padian, a professor of obstetrics, gynecology and reproductive sciences at UCSF, is director of international research at the UCSF AIDS Research Institute.

San Francisco Chronicle, 06/11/03

Senator Corzine calls for HIV/AIDS programme to include India

Senator Jon S. Corzine today announced plans to offer legislation making India eligible for assistance under the Emergency Plan for AIDS Relief. The Senator will offer the legislation as an amendment to the State Department Authorization bill scheduled for consideration on Thursday by the Senate Foreign relations Committee.

The Emergency Plan for AIDS Relief is a five-year, \$15 billion initiative the President announced in last year's State of the Union to help combat the global HIV/AIDS epidemic. The plan, which became law in May 2003, focused these resources on fourteen countries in Africa and the Caribbean. Congress subsequently directed that a fifteenth country be identified.

Senator Corzine pointed to the growing AIDS epidemic in India, noting that more than 4.5 million people in India are estimated to have the HIV virus, and that the epidemic is spreading rapidly from urban to rural areas and from high-risk groups to the general population. "India faces a critical moment in its efforts to combat HIV/AIDS. An

immediate increase in resources to combat this crisis is needed to avert a catastrophe," said Senator Corzine. "India's political leaders, public health officials, non-governmental organizations, and medical and scientific communities have taken important steps to combat this epidemic, but significant gaps remain that require sustained U.S. engagement and assistance."

He also suggested significantly expanding the President's AIDS program to include other countries.

"We must also continue to expand the list of eligible countries and increase the overall funding to combat HIV/AIDS. In addition to accelerating assistance to Africa and the Caribbean and including India, we must expand the reach of the Emergency Plan to reflect the global nature of this pandemic," he added.

Senator Corzine is a member of the Senate Foreign Relations Committee.

From Kaisernet 3/3/04

make safer sex fun

8th National Convention of the Indian Network of NGOs on HIV/AIDS

21st – 23rd February 2004

Vulnerability, Stigma and Discrimination What has changed since 1994?

The Indian Network of NGOs on HIV/AIDS (INN) is a platform that brings together over 300 NGOs from across India in a sharing of professional concerns and needs, as well as joint action for advocacy and services to those most affected by this challenge. The need for such a network was felt over a decade ago in the midst of national confusion and lethargy toward clear indications of the growing crisis in India. A small group of activists met in 1992 to organize stronger networking and mutual support within civil society. Their efforts led two years later to the First National Convention of INN in Ahmedabad. In 1994 INN was formally registered as a trust and society with an elected Governing Council drawn from its member NGOs.

The annual INN Conventions have served as major opportunities for sharing experience and mutual learning from within and outside India. The Conventions have mobilized inter-regional and interdisciplinary partnerships, helping an expanding membership to understand new challenges and new opportunities, as well as building morale within a sector besieged by indifference and ignorance.

At the 7th Convention held in Madurai in February 2003, the Network recommended that the 2004 Convention be held in Lucknow, Uttar Pradesh.

Naz Foundation International agreed to host the 8th Convention along with its partner agency, Bharosa as a means towards “mainstreaming” sexual health and human rights concerns for males who have sex with males. That was part of the “upstreaming” of NFI’s advocacy work.

Funding was provided by Sexual Health Resource Centre, HIVOS, UNAIDS, NACO, UPSACS and NFI.

The Chief Guest at the Inaugural Session was Ms. Aradhani Johri, Project Director of Uttar Pradesh States AIDS Control Society, who despite being wheel-chair bound following an earlier accident, still presented a strong supportive speech. The President of INN, Dr. Radium Bhattacharya gave the opening speech. Following this, Ms. Romila Patel, a positive woman working with GAP in Gujarat, spoke of her experiences, while Shivananda Khan of NFI welcomed all delegates on behalf of Bharosa and NFI.

In the first plenary session, a broad range of issues were addressed. Shivananda Khan spoke of stigma, vulnerability and MSM; Ajay Kanchan, UNICEF discussed adolescent reproductive and sexual health education; Luke Samson of Sharan talked of intravenous drug users and their issues, needs and concerns with a special reference to the north-east of India; Dr. Balwant Singh of India HIV/AIDS Alliance made a presentation on the rights of those living with HIV/AIDS; finally Ms. Nishe Pande of Academic Staff college, UGC, Lucknow discussed the vulnerability of women.

Working Groups in the afternoon discussed the issues raised by the morning sessions, which was followed by a technical paper presentation on clinical trials of microbicides and the role of NGOs in these trials by Ms. Neelam Joglekar of NARI (ICMR) Pune, and Ms Mangala Patil of Jagruti Seva Sanstha in Pune.

On the second day, three oral presentations were given: communication exercises that assist dialogue with urban women on issues of reproductive health, equity and gender by Ms. Riddhi Manna of IED Gujarat; sexuality and abuse by S. Saravanna from



Mrs Aradhna Johri, Joint Director, UPSACS addressing the Convention with Arif Jafar, Executive Director, NFI Regional Office

Jagruti, Bangalore; and finally Laxman Meena talked about his personal experiences of living with HIV/AIDS.

The theme of the following session was Needs and Opportunities: current policies for mobilisation towards HIV/AIDS prevention and control - segmented or joint action? Papers were presented by M.L. Prabhakar of SIAAP (Abstinence, Be Faithful, and Condom Use [ABC]), Dr. Vijay Edward of World Vision (ART for children), Ms. Patralekha Chatterjee, researcher and journalist (Meaningful Involvement of PLWHA), and Binod Mohanty of WHO-India (Voluntary Counselling and Testing).

Working groups then followed these presentations to discuss the issues raised.

A technical paper on the Search for an AIDS Vaccine: The Government of India and International AIDS Vaccine Initiative was presented by Ms. Anjali Nayyar and Ms. Sweta Das, Country Coordinator (IAVI).

An interactive session called Understanding the Issues was then held where the topics for discussion were Public Health Systems - is

Kim Mulji, Executive Director, External Affairs, NFI, chairing the opening plenary session



HIV/AIDS a burden? (Professor Ramakant, Gandhi Memorial and Associated Hospitals), Gender issues in the Access to Public Health Systems (Dr. Radium Bhattacharya on behalf of Dr. Alok Bannerjee, Consultant, Parivar Seva Sanstha, and Insurance for People with HIV/AIDS (Rumeer Shah).

The Annual General Body Meeting of INN was then held.

In the final day, the first session was on Communication Strategies of the National AIDS Control Organisation - Challenges and Opportunities presented by Ms. Sadhana Raut, NACO Joint Director (IEC). This was followed by Andrew Pillar of DKT India, who presented a paper on the Rationale for the Social Marketing of Condoms. Four skills building workshops then followed this: Reaching the Unreached - MSM facilitated by Arif Jafar of NFI; Working with the Media facilitated by Bobby Ramakant of HDN; Communicating effectively with children infected and affected by HIV/AIDS facilitated by Dr. Radium Bhattacharya, President of INN; and Developing Self-Help Support Groups of PLWHA, Montu Ahanthem, Manipur Network of Continuum of Care.

A Valedictory Address was given by Sam Avrett, consultant, on Advancing a Common Forum for Microbicides Treatment and Vaccines.

The Convention ended with concluding remarks by Dr. Radium Bhattacharya.

From NFI's perspective, two key Working Groups focused on which were 1) MSM: Vulnerability, Stigma and Discrimination and 2) Reaching the unreached: addressing male-to-male sexual behaviours

Actions that were arrived at by the Groups included:

1. For INN

- Developing an education and information pack for INN members on MSM issues, needs and concerns
- It was clear that INN members need to develop an understanding of MSM issues and concerns, and that such a pack could be used to educate them as well as an advocacy tool

- Thus INN itself could become an advocacy network that can work with MSM programmes and CBOs towards sensitising appropriate bodies towards developing an enabling environment

2. For Health Providers

Working with the health sector towards ensuring proper medical training that address all questions related to sexual health, including anal sexual transmitted infections and other problems; sensitising and training of clinical staff and others on MSM issues and needs; working with clinical services to ensure that they provide a comfortable, secure and appropriate services to MSM clients/patients.

3. Legal and Judicial Concerns

INN members to work with legal and judicial reviews to advocate for the review, repeal or amendment of laws and other instruments that impede sexual health interventions for MSM, such as IPC Section 377. Laws that impede the right to accurate and meaningful sexual health information, as well as laws and policies that conflict with human rights of MSM for freedom of association, freedom from fear, etc., will also need to be addressed.

4. Social Environment

A range of various interest groups, stakeholders and so on need to be sensitised to the issues and needs of MSM in regard to sexual health and sexual rights. These include police, bureaucrats and the judiciary, along with general society, the media, and so on. It was also believed that issues of sexualities, sex education, and educational programmes should also address these questions.

5. The Problem of the Dominant Masculinity

Much of the vulnerability, stigma and discrimination arises from the concepts of manhood and the dominant masculinity that fears femininity in males. INN and its members should be trained to address questions of dominant masculinity and the resultant vulnerabilities that this produces amongst a range of socially excluded populations, including the diverse populations involved in male-to-male sexual behaviours.

Working for the community



Bright, spacious and friendly, the NFI Regional Office training room newly built and ready for use. Local NGOs in Lucknow can access this space, depending on availability, at no cost.



NFI Regional Office feels that it is a part of the local community where the office is based. As a part of its community responsibilities, NFI has regularly offered neighbourhood children free tuition classes, along with advice, support and help to local families wherever possible. A significant consequence of these activities has been the acceptance, integration and participation of NFI within the local community.

**Don't walk in front of me
I may not follow
Don't walk behind me
I may not lead**

**Walk beside me
and just be my friend**
a Native American saying

MSM, HIV/AIDS and human rights in South Asia

Shivananda Khan

Chief Executive, Naz Foundation International

It is my aspiration that health will finally be seen not as a blessing to be wished for, but as a human right to be fought for.

United Nations Secretary General, Kofi Anan¹

Realisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS

Page 24, Booklet of the Declaration of Commitment on HIV/AIDS: United Nations General Assembly, Special Session on HIV/AIDS, 25-27 June 2001, United Nations

Sexual health is the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love.

Education and Treatment in Human Sexuality: The Training of Health professionals (p6, WHO, 1975)

Introduction

It is increasingly being recognised by people of good will that responses to the global HIV/AIDS pandemic and its local manifestations cannot be effective unless the human rights of those infected with and affected by the virus are clearly and unequivocally addressed. The virus is not only about personal behaviours; it is also about the social, economic and cultural environment in which such behaviours take place and have meaning. This is particularly true with regard to sexual behaviours and practices, and none more so than for those who are termed "men who have sex with men", or MSM. Denial, ignorance, illegality, myths, fears, violence, abuse, exclusion, invisibility, all these feature in current discourses on MSM issues. At the same time, exclusionist discourses on sexual identities, orientation, and "sexual minorities" tend to ignore the simple fact that the majority of MSM are exactly that - "men" with a specific sexual behaviour without a sexual orientation or identity. Such understandings will have a significant impact on rights-based approaches to HIV/AIDS.

But what do we mean by the term "men who have sex with men"? Who are these "men who have sex with men"?

For many it has become synonymous with "homosexuals", or of "gay" men, while it is often signified within the context of discussions of "vulnerable groups", or "target populations", or "at risk groups". Further, the use of the term "men" in MSM creates a universal category of MAN, ignoring the local cultural constructions of manhood and masculinity.

In other words MSM is often taken to mean a specific and exclusive "sexual identity" in opposition to "heterosexuality", where MSM form an exclusive and bounded group. Too often programmatic decisions are taken within this limited view of what is essentially a behavioural term.

While this paper addresses the human rights concerns of "men who have sex with men" in South Asia in regard to vulnerability to HIV/AIDS, I wish to initially address a query in regard to language and terminology that arises from the specific cultural contexts within this region.

The word "men" can be problematic in that this is also a culturally loaded word. In South Asian cultures, manhood (and adulthood) is defined by specific responsibilities, duties and obligations, and not by biological age. Marriage and the production of children (particularly male children) are cornerstones in this sociocultural definition of manhood.

A second point that I wish to make is that adolescence and youth (whatever that means) does not preclude sexual activity of all kinds, and such activities may well be consensual.

Thirdly, those who do not confirm to normative sociocultural definitions of masculinity are not deemed men by their male sexual partners (and often do not perceive themselves as such) although they



These are not transvestites, or transsexuals. These are *kothis* are biological males²

It was with these concepts in mind that Naz Foundation International began to use terms such as "male-to-male sex" and "males who have sex with males". While this may not appear to be of any great significance in the larger debate it does have an impact upon what we are addressing when we discuss human rights issues and concerns. It is also central to the discourses that reflect rights based approaches on sexual orientation, and/or on sexual health.

In this context, which rights-based approach will be utilised in address MSM, HIV/AIDS and human rights is critical in ensuring equal access for all to health and liberty. If we only address equality and rights based on identity/sexual orientation, then what happens to those males whose sexual behaviours with other males are outside the purview of such rights because they do not see themselves possessing a sexual orientation other than a normative masculinity as men?³

MSM, Vulnerability and Stigma.⁴

Not only does poverty, class and education level stigmatise individuals along with the fact of HIV infection, but also the specific gendered role and identity that some MSM identify with. Thus *zenanas/kothis/metis* are doubly stigmatised because as biological males they are sexually penetrated - and thus not perceived as men. Their feminisation, their crossing of the gender roles and barriers accepted as social norms, reinforces the stigmatisation, leading to exclusion and denial of access to services and to the social compact. This often results in such males who are living with HIV/AIDS to be stigmatised by others who are also living with HIV/AIDS but whose routes of infection are deemed "normal".

Such feminised males are vulnerable, not only because of poverty, but also because of the sexual and gender roles they play within male sexual practices which often leads to significant levels of manly sex partners, sexual abuse, violence, rape, and harassment, often from an

early age.

In other words, social justice and human rights issues for MSM are a complex matrix of issues, concerns, and needs that reflect personal psychosexual histories, economics, poverty, gendered roles, social-cultural policies and attitudes, as well as legal concerns, that create a context for MSM, but particularly for feminised males, of low-esteem, disempowerment, and marginalisation that leads to further abuse, violence and social exclusion. It is a vicious circle that constantly reinforces itself.

On the other hand, the masculine partners of *zenanas/kothis/metis* easily merge into the general normative male society, their sense of masculinity maintained because they are the penetrators, not of other men, but of "not-men".

Power inequality dynamics arising from South Asian constructions of masculinity, social attitudes towards feminised males and their sexual practices, sexual abuse, assault and rape, stigmatisation and poverty, discrimination and disempowerment, all configure the lives of most *zenanas/kothis/metis*. As a consequence they play a significant role in the emotional, sexual, physical and economic exploitation of feminised males, and give rise to a range of physical, psychological, and emotional problems, which further increase vulnerability and disempowerment. This disempowerment creates significant levels of suicidal impulses and self-damage, an expression of self-hatred and despair. And this of course leads to significant increases to risks of STI/HIV as well as impeding successful implementation of risk reduction strategies.

Those who are meant to be protected, sustain abuse and violence. Many *zenanas/kothis/metis* not only face harassment, sexual violence and rape from law enforcement agents, but also from those whom they have called friends in schools and colleges, from those in positions of trust such as relatives, neighbourhood elders, elder friends, and teachers. Gang rape is not uncommon. And of course such forced sex is always unsafe and often results in serious physical injury such as a ruptured rectum, internal haemorrhage and so on.

One of the central issues that has arisen from NFI research and understanding is that often it is effeminacy and not the factual knowledge of male-to-male sexual behaviour that leads to harassment and violence. That harassment and sexual violence results from the fact that many *zenanas/kothis/metis* do not live up to the expected normative standards of masculine behaviour.

It is this belief that leads to the notion that those who are feminised can be exploited and abused, that being feminised somehow weakens the person, a notion often harboured by the *zenanas/kothis/metis* themselves.

I don't mind if my 'husband' beats me up. It only shows how manly and powerful he is.

When my parik beats me, I feel as helpless as a woman. Since I want to be a woman, it actually makes me feel good.

Accepted notions around effeminacy are therefore one of the major factors that lead to disempowerment and opens *zenanas/kothis/metis* to abuse and assault and to a refusal of service provision. The fact that *zenanas/kothis/metis* themselves have internalised these notions so strongly, means that specific tools will need to be developed for *zenanas/kothis/metis* in order to empower them to start valuing their lives and enhancing their self respect.

It is clear that legal, judicial, political and social advocacy is urgently needed that not only is about living with HIV/AIDS or about social justice and human rights for MSM. It will need to include challenging accepted notions of masculinity and femininity so that discrimination and stigmatisation, social exclusion and marginalisation can be effectively challenged as they confront the daily lives of *zenanas/kothis/metis*.

MSM and Human Rights

Sexual and social vulnerability, poverty, marginalisation, violence,

and social exclusion lead to a disempowering environment, which fuels the AIDS epidemic. The disempowerment and daily violence that so many MSM experience because of their sexuality and/or feminisation substantially increases their vulnerability and invisibilises them in human rights discourses.

A leading player in the increasing levels of harassment and violence of many MSM is the policy conflict between home ministries and health ministries in the region and the government responses to HIV/AIDS in their countries. AIDS has increased the visibility of MSM as a phenomenon, by bringing it into the public domain for discussion, debate and responsiveness. But because of unresolved ministerial and policy conflicts, it has resulted in increased fear, abuse, harassment, violence and intimidation.

While a range of international and national agencies working in the field of HIV/AIDS have recognised that for effective and sustainable strategies to prevent the spread of HIV/AIDS and to control emergent epidemics in a range of localities, countries and regions, MSM should be seen as a vulnerable "group" and their sexual health concerns need to be addressed in ways that enable "community-based" responses. A range of papers, documents, and policies have all been written about empowerment, creating and enabling environment, community-based strategies and so on, towards risk reduction, along with the tools to produce such a change. However, without addressing the day-to-day violations that confront so many MSM, vulnerability to HIV/AIDS will remain high.

In a study conducted in 2000 by NFI consultant Aditya Bondyopadhyay with Bandhu Social Welfare Society in Bangladesh⁵, significant findings included:

- * 33% reported assault of a sexual nature⁶, or rape at the hands of friends' i.e. those who the respondent knew and trust, which was next only to sexual assault or rape at the hands of *mastaan/goonda* (traditional terms for hoodlums or bullies) and the police.
- * 48% of the respondents reported that they have been sexually assaulted or raped by policemen, and 65% have reported that they have been sexually assaulted or raped by *mastaans/goondas*.
- * 64% of the total respondents reported facing harassment of one kind or the other at the hands of the police.
- * Rape and sexual assault also results when *kothis* or male sex workers refuse to pay the extortion demands of "hoodlums" or police. It may be noted that all the male sex workers in this study were self-identified *kothis*.
- * Reported gang rape by policemen was significant, where *kothis* were rounded up and taken either to police barracks or the police post and raped by groups of policemen. Such forced sex is always unsafe and often results in serious physical injury like ruptured rectum, internal haemorrhage etc. It is also generates risks for the police officials.
- * The other factor that contributes to the abridgement of the basic safety of MSM and *kothis* in public areas is that *mastaans* are often in cohorts with the beat policemen. *Kothis* therefore do not receive any protection from the police when any harassment or assaults by the *mastaans* are actually reported.
- * Other than sexual assault, rape, and gang rape, the other harassment that respondents reported facing at the hands of police range from, extortion on the threat of imprisonment, prolonged blackmail, beatings, restriction of movement in public places, and disclosure of sexual practices to *mastaans* and family, amongst others.
- * 71% of the total respondents stated that they had faced some or the other form of harassment from *mastaans*. Other than rape, these are, extortion [38%], beatings [45%], threats and blackmail [31%].
- * 87% of the respondents stated that they had been subjected to sexual assault or rape simply because they are effeminate. This is of course an indication of the whole issue of feminised males and gender, which is dealt with hereafter, but it is also indicative of the high percentage of MSM who suffer sexual assault and rape.

continued on page 16, col. 1

MSM, HIVAIDS and Human Rights

continued from page 15, col. 2

* 41% of those who had faced some form of harassment at the hands of the police say that the police guessed that they were MSM from their feminised behaviours. 55% of those who had faced harassment from *mastaans* also reported that the *mastaans* guessed they were MSM from their feminised behaviour.

* Victimisation by family members was not uncommon. Of the 25 respondents whose near relatives were aware of their sexual behaviour, 19 said that they had not accepted it. Their families had reacted negatively with beatings, forced marriage, disinheritance, throwing the person out of the house, taking them to doctors for curing them of homosexuality and so on.

* 48% of the respondents stated that fellow students or teachers had harassed them in school or college because they were effeminate. 55 out of the 60 respondents who said that they have faced harassment by teachers or fellow students also said that their studies have suffered due to this, and that they could have progressed more if such harassment had not taken place.

* Of the 59 respondents who have said that they did not face harassment in the educational institutions, 40 had studied up to 4th standard or less, 13 up to secondary level, and 5 up to higher secondary level. All those who had gone to university reported sexual harassment in either school or college.

* 36% of the respondents reported that they had faced harassment from religious leaders due to their sexuality.

* Such regular experiences along with the fact that such feminised males live in culture which constantly validates normative masculinity creates internalised pain, shame and trauma along with deep sense of failure as men. This usually leads to self-blame, a lack of hope, and self-destructive behaviour.

* 33% of the respondents reported that they have either thought of or tried to commit suicide at some point in their lives.

* 77% of the respondents stated that they know of others who have also faced such harassment. Of this 96 who admitted to knowing such other persons, 46 stated that they know of less than 5 such persons, 33 stated that they knew between 5 to 10 such other persons, and 17 stated that they knew of more than 10 such persons.

It was also clear from the study that beat constabulary often target outreach workers of sexual health projects too with extortion demands, and if such demands are not met the work of outreach is obstructed. This has a direct impact on vulnerability and risk of HIV.

Many times local constabulary make arbitrary arrests under the laws related to powers of detention on suspicion. This is a law that is abused with impunity to target outreach staff and MSM in the field. This law is also used as an excuse to justify any detention of MSM.

Sufficient evidence exists, and regularly reported to NFI from its partner agencies, that similar levels of abuse occur in the other countries of the region.

It is a largely excepted premise that the fights against HIV/AIDS must be allied with addressing human rights concerns of the most vulnerable, along with protecting the rights of those affected and/or infected by the virus.

Governmental policies for combating the HIV pandemic are often in conflict with the penal laws of the countries within the region. Therefore we find that on the one hand the health policy of the government seeks to address male-to-male sexual behaviours for HIV intervention. But on the other hand we also find that the continuation of the criminalisation of such behaviours discourages those in need of information and services to seek the same. It therefore means that the delivery of services cannot be optimised. Further the outreach staff of intervention agencies and the targeted audience are susceptible to police excesses because the criminal laws are in direct conflict with the HIV policies. They are also open to

abuse as due to the criminality in law, they are deterred from seeking any remedy. This directly impedes HIV outreach.

In Bangladesh, India and Pakistan, legislation left over from British colonial times hangs over effective and appropriate HIV interventions amongst MSM like a Damocles sword, where in several cases outreach staff and others have been harassed and/or arrested and charged with "corrupting society", "aiding and abetting the commission of a crime" (the act of sodomy), and publication of obscene literature (use of materials for education purposes).

The particular legislation in question is the infamous Section 377 of the Bangladesh/Indian/Pakistan Penal Code, which states:

Anyone who voluntarily has carnal intercourse against the order of nature with man, woman or animal, shall be punished with imprisonment of either description which may extend to life, or to ten years and shall also be liable to fine

The explanation appended to the sections states *Penetration is sufficient to constitute the offence as described in this section.*

In India, the meaning of penetration has been broadened to include oral sex, mutual masturbation and inter-femoral (thigh) sex also through a range of court judgements over the last 50 years or so!

The existence of this so-called anti-sodomy law has a range of adverse consequences:

* Proper intervention efforts cannot be organised since such interventions can be construed as an abetment of a criminal act.

* It helps in the further marginalisation of an already vulnerable "community" - MSM, afraid of attracting criminal sanction, do not come forward to access care, help and information.

* Most importantly, it is no more only a moral or legal issue. It is a tool of harassment and extortion in the hands of public authorities and is therefore also a corruption issue.

* It is very difficult to prove, but easy to charge with, which is the reason it is abused more often than it is used. This abuse in turn leads to the MSM going underground and not accessing information and help, thereby increasing vulnerability to HIV/AIDS.

* It violates the privacy of the individual and is based on premises that have been scientifically established as false and untenable, yet it remains in the statute books and continues to be an impediment to intervention efforts.

* Unless it is repealed there can be no effective advancement of the other rights of the MSM population such as recognition of common law partnerships, inheritance, adoption and maintenance rights.

Another concern that any effective intervention efforts amongst MSM face are the Obscenity laws, and laws pertaining to loitering and public indecencies/nuisance, and abetment.

These laws are often invoked to impede the intervention process and the process of dissemination of safer sex and health information. They are also used to target MSM in public spaces of socialisation, which are used by intervention agencies for dissemination of information. Most importantly, the laws on abetment are vague

Social Justice for All - delegates at the 3rd NFI Regional MSM Consultation Meeting





a kothi giving a mujhra performance at the BDS drop-in in Kathmandu

enough to attract sanction against intervention agencies as abettors of a criminal offence.

It has been recognised and articulated by UNAIDS and others that for building sustainable risk reduction strategies in the context of HIV/AIDS prevention and care, community ownership, mobilising and active participation of those most at risk, are central for success. For vulnerable networks such as varieties of MSM, the lack of safe spaces and space for socialisation is a fallout of 377. Criminalisation also gives the state the authority to break up or disallow any such interaction. Further, this lack of safe spaces in turn also gives rise to incidents of violence, blackmail, extortion and threats, which closets the population and discourages the spread of safer sex information and prevention efforts, and increases vulnerability to HIV/AIDS.

Lack of support structures is also the fallout of discriminatory laws and the lack of safe spaces. This leads to isolation of individual MSM and causes psychological and other distress. It also opens up the MSM to abuse and does not allow him to have proper access to legal/medical redress when abused or hurt.

Further systemic and sustained interventions are a casualty, and this affects the entire population by making them vulnerable to HIV/AIDS and other STIs. Thus most MSM, particularly those with feminised identities and/or anal problems, usually cannot access care and health facilities as knowledge of their sexual behaviour may attract criminal sanction. Existing laws therefore violate the right to health, which is a guaranteed fundamental right under Article 21 of the Indian Constitution, along with similar articles in the Constitutions of the other countries in the region.

In a paper prepared by Miriam Maluwa, Law and Human Rights Advisor to UNAIDS⁷, a strong case was argued that current international human rights treaties and conventions, along with those dealing with HIV/AIDS created "the human rights framework which 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".⁸

However, this author believes that there is an inherent weakness in this in that the discourse is being taken to mean sexual orientation. While this of course is extremely important, it is inadequate in addressing many of the concerns highlighted above. These are that the human rights and sexual health concerns of the range of gender variant males amongst MSM which reflect stigma, discrimination and social exclusion, and the abuses that arise based on nonconformity to normative masculinity, are not being included.

Another concern this author has is that a rights based approach singularly focused on sexual orientation (or even gender variance) and which argues that "sexual minorities" such as lesbians, gay men, kothis, transgendered persons and hijras (and other gendered identities) should have the same rights as any other minority as legislated in the

different countries in the region and often embedded within their Constitutions, would still be inadequate to address all the human rights concerns of MSM. Such an argument does not address the behavioural choices of those who do not identify as a "sexual minority".

In Sonia Katyal's essay "Exporting Identity"⁹, the argument for the rights to privacy, gender choice, the right to form associations, to meet, and behavioural practices where consensuality is involved, may be a broader and more inclusive approach to begin to the above identified concerns.

It is suggested that any rights-based approach to the sexual health needs of MSM should not only take into account the World Health Organisation's definition of sexual health as a cornerstone, but also must address the rights to privacy and freedom of association, along with repealing any and all laws, regulations, and policies that impede the right to sexual health for all.

The time for action is now. Concerted efforts must be made to ensure that all peoples, and within the context of this paper, all varieties of MSM have the rights to "life, liberty and the pursuit of happiness" that is often talked about, but no meaningful action is taken.

1. From 25 Questions and Answers on Health and Human Rights, Health and Human Rights Publication Series, Issue No. 1, July 2002, World Health Organisation
2. See NFI reports on a number of Situational And Social Assessments on MSM in a range of cities in South Asia accessible on its website www.nfi.net
3. See: The risks of categorisation, Shivananda Khan, Pukaar, Issue 21 April 1998; Varieties of homosexuality in Bangladesh, paper presented by Dr. Carol Jenkins at the 12th World AIDS Conference, Geneva, June 28, July 3, 1998, Pukaar, Issue 24, January 1999; Men and HIV: sociocultural constructions of male sexual behaviours in South Asia, Shivananda Khan, Pukaar, Issue 28, January 2000; Males who have sex with males in South Asia - a kothi framework, Pukaar, Issue 31, October 2000. Pukaar is the quarterly journal of Naz Foundation International and available on its website www.nfi.net as pdfs
4. See NFI Briefing Paper No. 7: Social Justice, human rights and MSM
5. See study report The Impact of legal, sociocultural, legislative and socioeconomic impediments to effective HIV/AIDS interventions with MSM, June 2000, NFI, Aditya Bondyopadhyay, Bandhu Social Welfare Society, Bangladesh, funded by UNDP.
6. The cultural understanding of rape involves the act of penetration. The law on rape in Bangladesh as it stands in the Bangladesh Penal Code also reinforces this belief. However many times a person is sexually assaulted in a way where he may receive grave psychological and/or physical injury, but it may not involve anal penetration. This fact was explained to the outreach staff in the workshops, and they were asked to include all grave assault of a sexual nature {as opposed to minor harassment of a sexual nature} that may not have resulted in actual penetration in the response to the questions on sexual assault.
7. Presented at the special UNAIDS convened Inter-Agency meeting on Working with Men who have sex with men for HIV/AIDS Prevention and Care, 1st November 2002,
8. See NFI Briefing Paper No. 10, statement by Miriam Maluwa
9. Exporting Identity, published in Yale Journal of Law and Feminism, Volume 14, Number 1, 2002

A mantra for sexual health

tell me, and I will forget
show me, and I will remember
involve me, and I will understand
a chinese proverb

Response to the programme implementation guidelines for a phased scale up of access to antiretroviral therapy (ART) for people living with HIV/AIDS (PLHA)

From Joe Thomas, posted on the internet by AIDS-India, 4/3/04

The Affordable Medicines and Treatment Campaign (AMTC), is a national campaign in India, aiming to demand and create an environment that will ensure sustained accessibility and affordability of medicines and treatment for every individual in India, including access to affordable Anti-retroviral Therapy for persons living with HIV/AIDS (PLHAs). As you know the Government of India has announced a free ARV treatment plan in six high prevalence states to be rolled out on 1st of April 2004. We take this opportunity to congratulate NACO for responding positively to and accepting one of the long-standing demands of PLHAs for ARV treatment. Such a paradigm shift from prevention focused strategies to an approach that recognises the synergies between treatment and prevention is an essential component of any rights based approach to the HIV/AIDS epidemic.

Having studied the "Programme Implementation Guidelines for a Phased Scale up of Access to Antiretroviral Therapy (ART) for People Living with HIV/AIDS" (accessible at <http://www.naco.nic.in/nacp/arvimp.htm>), the AMTC, has come up with a response to the government plan. We appreciate the fact that mass provision of ART is a complex process and have attempted to raise some issues of concern which are vital to the success of the programme and its implementation.

The same is pasted below and has also been submitted to NACO. We hope this document may provide us all with an opportunity to address key concerns regarding access to treatment. We invite comments, critiques and ideas on these issues.

A recent development of significance has been the announcement made by Ms. Sushma Swaraj, the Minister of Health & Family Welfare, Government of India on the eve of World AIDS Day last year, of the government's intention to finally provide ART through the National AIDS Control Program from 1st April 2004. This is indeed a welcome decision. We are happy that the Government and NACO has positively responded to and accepted one of the long-standing demands of people living with HIV/AIDS, networks of PLHAs, human rights and public health NGOs, activists, groups and campaigns such as the AMTC. It is clear that this has been due to the sustained advocacy efforts by several individuals and organisations including Networks of people living with HIV/AIDS, NGOs working on HIV/AIDS and campaigns like the AMTC, which many of these networks and NGOs have created and are a part of.

With this plan there is recognition that the HIV/AIDS epidemic has indeed impacted a large number of people in India, many of whom are in urgent need of treatment that they cannot afford. It is also a recognition that such treatment can actually be provided. Further, it is a recognition that India has a relative advantage, having a vibrant generic drug industry, an advantage that has not thus far been used to its full potential. Most significantly, it is an attempt to re-constitute HIV as a treatable condition and thus, to reduce the stigma and fear that surround it, to encourage more voluntary testing and thus to bring about the normalisation of HIV/AIDS. The government deserves to be congratulated for the institution of the programme.

The document titled "Programme Implementation Guidelines for a Phased Scale up of Access to Antiretroviral Therapy (ART) for People Living with HIV/AIDS (PLHA)" shows a paradigm shift from a prevention focus to an approach where the synergies between care/support and prevention are to be put in action. While we eagerly await the realization of the objectives of the program, we have some concerns related to the manner in which the program is envisaged and suggestions to improve the concept and implementation of the ART rollout.

The mass provision of ART is a complex process, which can backfire seriously if not carried out properly. Sustainability and context sensitivity of such a program is of prime importance. The risk of resistance to the drugs is high and, as has been seen with the experience of the development of MDR TB. A careless program could lead to a more complicated epidemic. Similarly, the high level of toxicity and experiences of severe side effects make it necessary

that the mass provision of ART be a part of a more comprehensive program for the provision of care and support. Further, the impending changes to patent laws could soon drastically reduce the government's ability to actually procure these drugs and new line regimens at affordable rates. As such, the program itself needs to be one that is based on the experiences in and of the public health system, the experiences of people providing and receiving ART in the Indian context, and retaining as the base, a human rights approach to public health.

Although feedback from civil society, on the rollout plan, has not yet been widely solicited by the government, the AMTC is here presenting a preliminary response to it. The following points have been articulated by members of the campaign and other friends, over email and through discussions. These comments are intended to be taken in the spirit of constructive suggestions.

Main points of concern:

Strategy to bring about an enabling environment - The inherent logic of the program is that the provision of treatment will contribute towards the creation of an enabling environment, whereby people have an incentive to voluntarily access testing facilities and health care services. This establishes the relationship between care/support and prevention. While such recognition is positive, there remains some ambiguity in the document, where it refers to the 'identification' and 'tracking' of people who may test positive. There is no doubt that in order to receive treatment, people must first recognize themselves as needing it. This implies large increases in testing and access to healthcare services. The question here is, how is this increased testing envisaged? In this regard, the plan identifies certain 'entry points' for ART, including STD clinics, PPTCT centres, Blood Banks, TB DOTS centres and government hospitals. The ambiguity in the document lends space for mandatory screening of all those who access these services. This may have the undesired impact of actually decreasing access to these services, despite the promise of treatment for those who need it. The present minimal amount of voluntary testing is indeed more complicated - stigma around HIV/AIDS, in other words, is brought about by more factors than the inaccessibility of treatment.

The document needs to clearly recognize the difference between creating an enabling environment where people are encouraged to use the services of VCTCs and tracking down people for the purposes

of providing treatment. The NACP identifies itself as being based on a 'human rights approach'. This should include addressing concerns such as the need for informed consent, confidentiality and non-discrimination. The commitment to these principles needs to be clearly stated. At the outset, it needs to be ensured that a promise of treatment does not amount to a justification for doing away with adherence to rights on these issues.

Maintaining confidentiality - Scaling up of ART requires a careful consideration of how confidentiality will be maintained. This is more so when considering the mandate of enabling adherence to the treatment. While the document does contain a reference to the need for maintaining confidentiality, there is no clear conceptualising of protocols and systems through which confidentiality will be ensured. Where, for example, the document talks about providing identity cards to persons on ART, there is no mention of how the problems that such a system may pose to the maintenance of confidentiality will be dealt with. This again, would impact the efficacy of the program. Hence, we feel that confidentiality norm should not be compromised at any stage of the treatment.

Funding and Sustainability - ART is not a one-off treatment but is meant to continue for life. Interruption of the therapy has been seen to significantly raise the risk of resistance to the drugs and a drastic decline in health. In this context, sustainability of the treatment program is of central importance. As of now, there is no reference in the plan to the budget which has been allocated for purchase of ARVs, the estimated price of purchase, how much money has been set aside, from what source, to buy medications at what price, and from whom. Without this information what we basically have is a training manual for ARV scaling up without an assurance of sustainability.

Some estimates place the expected cost for the treatment plan as Rs 500 Crore per annum. Of the GFATM commitment of USD 140 million (Rs 700 Crore), spread over a period of 5 years, only USD 100.08 million (Rs 500.40 Crore) is for HIV/AIDS. Additionally, this commitment is geared towards ART programs being run by NGOs. It is not clear whether the government plan is dependent on resources from the GFATM. At the same time, the government does not seem to have moved the Planning Commission or included the cost of the program in its interim budget. As such, there is no hint of where the resources for the program are expected to come from.

The document recognizes that India has an established 'domestic drug manufacturing base'. It also needs to recognise that this relative advantage may not survive much longer if strategies such as pushing for a TRIPS review, and building the capacity of public sector industry to provide drugs are not simultaneously considered.

Procurement - While it has been mentioned that the procurement will be done by NACO based on estimates provided by SACS the plan for the procurement of drugs, facilities and services has not been fully spelt out. The constant reference to 'public - private partnerships', seen in conjunction with the impending amendments to the Indian Patent Act, which will seriously harm the generic drug industry implies that the government may soon be in a position where it could be held to ransom by the multinational pharmaceutical industry and have to depend on charity of the drug industry.

Further, there definitely need to be mechanisms to ensure transparency of the process of procurement, a concern that needs to be addressed at the inception of the program itself.

Who will get the treatment? The plan document does not specify how many people will be given treatment when. It refers to providing treatment for 100,000 "starting on April 1st, 2004". The actual extent to which the rollout plan will address treatment needs in the epidemic right now is ambiguous. It needs to be noted here that the evaluation of number of people who need ART is to be carried out by SACS, and that the deadline is very short.

At present the government plan limits the coverage of the program by identifying certain categories of people as beneficiaries. At present, the only beneficiaries identified are (i) sero-positive mothers who have participated in the PPTCT programme; (ii) seropositive

children below the age of 15 years; and (iii) people with AIDS who seek treatment in government hospitals. It is important to know, but to difficult to estimate, how many individuals such a scheme would cover. There has been estimation of the number of pregnant women who would be covered with this new scheme.

These estimates have been drawn on assumptions from National Sample Survey (NSS) 52nd round, National Family Health Survey 2 and NACO on the following parameters: estimated number of women in age group 15-49 percent that seek antenatal care, percent that visit government facilitates and estimate of HIV prevalence among ANC attendees (assumed 1 percent prevalence). Based on these assumptions, it was estimated that about 55,000 pregnant mothers who were HIV positive would seek care in government facilities. Of these about 8,000 pregnant HIV positive women would be ART eligible in a year, and the target for the new policy. NSS and other statistics indicates that a much lower percent of all those who seek care - about 18 percent seek care in public facilities for their illnesses. If the population who are ART eligible is taken at 7,50,000 then about 1,35,000 individuals would be accessing public health facilities. This of course includes the pregnant mothers as well. Even if all the pregnant mothers were added here, we get 1,43,000 individuals who will be covered by the new programme. Adding 13,000 who are already being covered currently, we arrive at 1,56,000 individuals who are going to be covered by ART. This still leaves a gap of about 6,00,000 individuals who are not covered by ART.

It needs to be emphasised that a miniscule number of women living with HIV/AIDS have access to the PPTCT program. Many may not participate for a range of complex reasons. In fact, in rural pockets in areas of high HIV prevalence most deliveries are done at home, and a majority of the rural poor do not access government hospitals for normal deliveries. Of those who do participate, not all are in need of ART. Similarly, there is no explanation why only those who seek treatment in government hospitals will be provided treatment, considering the high rates of discrimination and refusal of treatment in the public sector in many parts of the country. The problematic presumption here is that the public health care system is already a functional site for treatment of PLWHA, one which is repeatedly disproved by real life experiences.

Third, the document does not link up with the indicators for ART as identified in the (draft) guidelines on ART published recently by NACO. These guidelines lay out in detail the government's own prescription for when and in what conditions ART is to be started. In the presence of these guidelines, the reasons for using other indicators, such as participating in PPTCT programs, or of qualifying as an 'AIDS patient' are unclear. Identification of these sites will limit the benefits of this programme to certain sections of the population.

The experience of refusal of treatment and of discriminatory behaviour in health care is magnified for marginalised populations. It was the lack of MSM friendly services, for example, that justified focused 'targeted interventions'. Basing the treatment plan in government hospitals is thus a tacit exclusion of these populations from the treatment program. There is no justification provided for such exclusion. This plan would lead to a moralistic framework of "treat the victim", which has been demonstrated the world over as an ineffective strategy in dealing with prevention or reducing stigma or ensuring access to care - three key elements in HIV interventions

Role of PLHA Net Work, Civil Society Organisations and NGOs: Over the years many NGOs are providing ARV treatment and developed expertise in the area. However, the plan covers only government hospitals and gives only minimal role to NGOs and civil society organisations such as home visits follow up of cases etc. The plan should make use of the experience of these organisations. This is important because studies show that the majority people do not depend nongovernment hospitals for health care. Moreover the GFATM proposal of the government envisaged rendering ART to

continued on page 20, col. 1

Response to programme implementation guidelines

continued from page 19, col. 2

15,000 PLHAs at four sites, of which two are NGOs. It is not clear whether those are covered under the new initiative. It is very clear from all success stories in ART (and there are a number of them) that a continuum of care into which ART is embedded is the only strategy that ensures early voluntary testing, greater degree of positive living, destigmatisation, high level of access and good adherence. The role of civil society and PLHA networks is much wider than just follow-up visits.

How and where will the treatment be provided? The document identifies three phases of the rollout program. The first phase involves preparing 15 centres in the six 'high prevalence states' to provide treatment, the second extends this to all government hospitals with medical colleges and the third to all district level hospitals in these states. To this end, health care workers at these various sites will be trained over a period of five days on a range of issues relating to the provision of ART. Two main concerns need to be emphasised here. First, the reasons for a focus on high prevalence states are unclear, especially where the provision of care and support is being seen as related to a prevention strategy.

Second, systemic and infrastructural issues of preparedness are not addressed by the program, which presumes that five days of 'training' will be sufficient to enable an effective system of ART provision. It needs to be pointed out that even sites of PPTCT are merely administering ART for mother to child transmission, and do not have any experience or systems in place for treating people with CD4 counts >200.

Finally, almost all the centres where the treatment will be provided are located in cities, with a concentration in Chennai and Mumbai. It needs to be emphasized here that if access to treatment is to be a reality, rather than simply a populist measure, the centres must be closer to those who need the treatment, must be PLWHA friendly, and must match patterns of health seeking behaviour in the populations.

Nutrition - The rollout plan recognizes that nutrition is a requirement that needs to be provided for alongside the rollout program. Unfortunately, it does so in terms of provision of anabolic steroids, which by themselves are controversial hormonal drugs that are to be used in very particular circumstances. The provision of everyday low cost nutritious food in different settings is not addressed.

Gaps in training of care providers - The plan has a detailed description of the training workshops that will go towards building the capacity of the centres to provide ART. Almost all the sessions are medical in nature, and the complex socioeconomic issues that need to be considered in the provision of ART have been ignored. Given the hierarchical composition of medical teams, if the socioeconomic and gender issues are not highlighted in the training, they will definitely not happen in practice. There has to be an equal role for civil society and PLHA networks to ensure equity in access and support in adherence.

In a context where discrimination in healthcare continues to be a widespread experience, creating 'preparedness' will involve a more serious engagement with these issues as well. Whereas there is a half-hour slot for discussion of 'legal and ethical issues', there is no scope for a focus on human rights issues and protocols, in terms of attitude or actual systems through which confidentiality and informed consent will be ensured. Further, there is minimal scope for learning from people's experiences at the field level.

Testing facilities not addressed - The provision of ART requires not merely ARVs, but requires as well accessible and affordable CD4 and may be Viral load testing facilities. These again, are not addressed by the rollout plan, although the NACO -WHO workshop on 28th-29th January 2004 did have presentations by private corporations on their

capacity to provide such testing facilities. Again the growing dependence on private corporations needs to be regarded with caution. With respect to such testing facilities in particular, the field level experience in some parts of the country seems to be that governmental facilities, however limited, are more reliable than those provided by private companies. NACO should make efforts to establish at least one CD4 testing labs in every district and at least one PCR lab in every state.

Regimens being offered - The framework of the rollout plan envisages a standardisation of drug regimens, based on WHO recommendation on a 'public health approach'. Unfortunately, this goes against experiences in clinical practice. As such, the standardisation of regimens is an aspect that still needs to be debated and cannot be taken for granted as the desirable strategy. How the specific requirements of individuals are to be addressed is not envisaged in the document. Further, there seem to be some problems with the regimens prescribed in certain circumstances - for example, whereas it is recognised that women receiving NVP as part of PPTCT programs may have developed resistance to it, and thus, that the recommended first line regimen of d4T/3TC/NVP may not be effective, the only alternative that is provided to them is replacement of NVP with EVP. EVP as well, unfortunately, is not indicated in pregnant women. In this context there other options available in western markets that have not been suggested.

NVP was adopted as the strategy for PPTCT despite its rejection in healthcare systems in Europe and the US due to the high risk of resistance, which could impact on treatment options in the future. It is the effect of this decision that we are now faced with where a certain segment of the population that needs ART will not have effective options. This is an articulation of the implications of the politics of health. The rollout plan does not recognize or address this.

Language and presumptions - Finally, a note needs to be made of the largely insensitive language of the document, and the continuing use of phrases that fuel stigma and discrimination against people living with HIV/AIDS. Terms such as 'HIV infected' and 'indulging in "disinhibition"' are scattered through the document. If this document is to be the basis for training in the public health system where stigma is a definite problem to be addressed, then a certain degree of sensitivity needs to be incorporated into it. Second, the identification of beneficial and adverse affects of ART have been made in a manner as to already place the blame of any failure of the program on people living with HIV/AIDS, for example, through the emphasis on the phenomenon of 'disinhibition', which thus far has only been identified in specific western contexts. Similarly, concerns with respect to adherence in the document seem to be an exercise of the political construction of the 'third world patient'. The fact that evidence that forms the basis of these concerns comes from particular western experiences needs to be clearly stated.

In fact, studies are showing that while in the developed countries, there have been reports of reduced responsibility in sexual behaviour, in developing countries, access to ART has led to increased responsibility.

Since the document says "the document will be reviewed frequently so that it keeps up with new regimesalso reflects the backward and forward linkages between programmes for treatment and interventions for prevention of HIV/AIDS and care and support of people living with HIV/AIDS". We hope that the above suggestions would be incorporated in the coming days.

For AMTC: Anand Grover, Lawyers Collective HIV/AIDS Unit, Ashok Rau, Freedom Foundation, Bangalore, Sanghamitra Iyengar, SAMRAKSHA, Bangalore, Dr. Jayasree, FIRM, Trivandrum, D Noorie, South India Positive Network, Chennai, Dr. Tokugha Yephthomi Secretaria: Lawyers Collective HIV/AIDS Unit, 2nd Floor, 7/10 Botawalla Building, Horniman Circle, Fort, Mumbai, India 400 023 Phone: +91 22 2267 6213/19, Fax: +91 22 70 2563 Email: aidslaw@vsnl.com, E Group: amtc_india@yahoo.com

40m bachelors and no women

the birth of a new problem for China

China, the most populous nation on Earth, could find itself dealing with the combined frustrations of as many as 40 million single men by 2020 because its one-child policy is creating a shortage of female babies.

In an unusually frank speech on China's looming demographic crisis, Li Weixiong, who advises the country's political consultative conference on population issues, said a cultural preference for boys was creating an artificial disparity between the number of boys and girls that represents "a serious threat to building a well-off society".

Mr Li said the dearth of women would lead to a dramatic rise in prostitution and the trafficking of women. "This is by no means a sensational prediction," he said.

The search for love is leading traditionally staid Chinese men down unfamiliar paths. There are reports of men placing ads in major newspapers begging women to respond. If the ads are anything to go by -with some ads emphasising the possession of a good bathroom - the way to a modern Chinese woman's heart is a spacious apartment and a decent salary.

Wealthier men are reportedly taking their search beyond China's borders, a risky tactic given that many Chinese, households have been less than welcoming to foreign brides.

Unmarried men with less money often have no choice but to turn to illegal brokers, who dupe rural women into moving to the city with bogus job offers.

The widespread introduction of ultra-sound testing has enabled a much larger number of Chinese couples to choose to abort female foetuses in the hope that the next pregnancy will produce a son.

Mr Li said the gender ratio had stayed relatively normal up until 1982 - two years after the Chinese authorities imposed the one-child rule - at 100 girls born for every 108 boys. But by 2000, the ratio had shifted significantly to about 117 boys to 100 girls.

The disparity is even bigger in rural areas, where the boy-to-girl imbalance is estimated to be as high as 130 to 100.

Abortions are not the only cause of the imbalance. There is alarming evidence that the intense pressure on couples to make sure their only child is a boy has prompted a resurgence of female infanticide, despite official attempts to stamp out the centuries-old practice.

Rural families are said to be particularly tempted to kill female offspring, such is the pressure to produce a child capable of coping with the physical demands of farming and prevent cash-strapped farming households from being plunged even deeper into poverty.

In some cases, according to reports, other girls are hidden from the authorities, or die at a young age through neglect.

Even in urban areas, boys are generally preferred because they are regarded as more able than girls to provide for their families, care for elderly relatives and continue the family line.

The government, stung by accusations from child welfare groups that it is turning a blind eye to the practice of girl-killing, has allowed some provinces to grant couples permission to have more than one child provided they pay a fine to register each extra birth.

In some villages, local officials have placed dozens of posters bearing the message: "Daughters are as good as sons!"

Despite growing evidence of the enormous social cost of their one-child policy, officials in Beijing insist there are no plans to relax the measure, which they regard as the most important weapon in China's battle to keep its population below 1.6 billion until 2050.

Statistically, the policy has had some success. The communist authorities say it has prevented well over 300 million births since it was introduced in 1980 and is fulfilling its initial aim of ensuring that China can combat rural poverty and improve standards of living across the board.

According to the UN, China's population stood at 1.3 billion in

2003 but independent estimates believe couples with extra children are hiding them from census authorities, meaning the actual figure could be as high as 1.5 billion.

As the country's economy continues to grow and transform at an unprecedented rate, pressure to relax the policy looks likely to intensify if Mr Li's worst-case scenario of social unrest, exploitation of women and crime turns out to be correct.

"Such serious gender disproportion poses a major threat to the healthy, harmonious and sustainable growth of the nation's population and would trigger such crimes and social problems as abduction of women and prostitution," he said. His claims are supported by official figures showing that police freed more than 42,000 kidnapped women and children in 2001 and 2002. Many of the victims are believed to have been sold into marriage or prostitution.

Elisabeth Croll, professor of Chinese anthropology at the School of Oriental and African Studies in London, said she welcomed Mr Li's warning as it would remind China's leaders of the magnitude of the problem they face.

"It is not a new trend", she said. "Demographers in China as well as foreign analysts have been expressing concern for some years. In the last census it was quite clear that this was an upward trend and it is forecast that there will be a shortage of potential marriage mates which will lead to some social instability".

Several years ago the government prohibited doctors from telling couples the sex of their child, but the measure seems to have had little effect. Mr Li called for a ban on mid-term abortions, except in cases with health concerns.

China's experience could prove a lesson to other countries in the region whose populations are also being skewed by gender imbalance.

Prof Croll said: "It is an Asia-wide problem affecting many countries including Taiwan, South Korea, Vietnam and India. It is something that is increasing with development instead of decreasing."

The professor, who wrote about the issue in her recent book *Endangered Daughters: Discrimination and Development in Asia*, said it was a mistake to blame girl infanticide in China only on a resurgence of "old ideas".

For many families, she said, the preference for a son makes simple economic sense as they are less likely to leave the family home after marrying and, as higher earners than women, are more able to provide for the extended family.

Prof Croll said more families in China's rapidly expanding cities were favouring sons, partly because a decline in pensions over the past decade had made older people less secure and more reliant on their children.

If the authorities are reluctant to lift the birth limit, possible long-term solutions to the looming dearth of eligible women may be even more unpalatable. They include altering the traditional marital balance of power and bringing women's pay more into line with that of men, enabling them to better support their families.

The Guardian, 9/3/04

In India: 0-6 years of age

<i>Average ratio is</i>	<i>927 females to 1000 males</i>
<i>Punjab</i>	<i>793 females to 1000 males</i>
<i>Harayana</i>	<i>820 females to 1000 males</i>
<i>Uttar Pradesh</i>	<i>879 females to 1000 males</i>
<i>Sikkim</i>	<i>986 females to 1000 males</i>

In Pakistan

<i>Average ratio</i>	<i>921 females to 1000 males</i>
----------------------	----------------------------------

Bangladesh

<i>Average</i>	<i>941 females to 1000 males</i>
----------------	----------------------------------

In 60% cases, a shot in the arm may be a shot in the leg

Toufiq Rashid

The Indian Express, 17/1/04

Unhygienic syringes have long needled India, but a new report shows that two-thirds of the injections given in the country - with a high rate of injection administration - are unsafe.

According to the report submitted to the Ministry of Health last month, around 65 per cent of injections administered in India fall in this category. In other words, the country may be looking at 20 lakh (2,000,000) new Hepatitis B cases 4 lakh (400,000) new Hepatitis C cases and 30,000 new HIV-positive cases, in a year.

The report on injecting practices in India was prepared by the India branch of an international organisation IndiaCLEN and sponsored by the World Bank. The Clinical Epidemiology Unit of AIIMS (All India Institute of Medical Science) and the Ministry of Health and Family Welfare were partners in the study. Among the things covered were questionable sterility, re-use as well as wrong habits of those administering the injections.

The consequences are especially serious for India as the magnitude of injection administration is very in the country: an average of three injections per person per year. It is highest in the below one year age group (5.8), and a little less above one year of age (2.8).

In all, 84 centres - 69 medical colleges, nine NGOs and six public health institutes - conducted the study across the country. Practices at 2,400 government and private facilities, and 1,200 immunisation centres were studied. Around 1,800 injection procedures were observed and 1,200 people interviewed.

The findings

About 23.8 per cent of the injections administered were unsafe due to "questionable sterility" while re-use of injection syringes was behind 16.2 of the cases. But in most cases (50.7), the danger crept in from wrong injection habits.

* Government hospitals (68.6 per cent) and immunisation clinics (73.9 per cent) are more likely to be unsafe. But private facilities are only a little better, at 59.7 per cent.

* Glass syringes (81.1 per cent) are more unsafe than plastic ones.

* In government hospitals, 95.1 per cent of the injections were given

by pharmacists or nurses, health workers or compounders, 6.4 per cent by helper trainees or assistants, and only 8.2 per cent by doctors or prescribers. In private hospitals, however, 61 per cent of the injections are given by doctors.

* Syringe-disposal techniques are faulty across the country. An estimated 8 per cent of the plastic syringes end up with ragpickers. Around 3.2 per cent of these syringes can be traced back to government hospitals, 15.1 per cent to private clinics, and 2.9 per cent to immunisation clinics.

Unsafe injections were judged on both major and minor criterion set by the Government. The major criterion included the use of opened/used syringes and needles, injections given over clothes, needles wiped with a swab, needles touching any surface before use, or use of one syringe needle for more than one patient.

Minor criterion included not wearing gloves or washing hands before giving an injection, drawing drugs from a broken vial, re-capping needle and not flushing glass syringe after use.

Unsafe Injections

How Many

	Total	Plastic	Glass
Unsafe	60.5	54.3	81.1
Questionable Sterility	23.8	17.7	45.2
Reuse	16.2	11.8	31.8
Wrong habits of injection givers	50.7	46.1	65.8

Where All

Government facilities	68.6	61.3	84.1
Private facilities	59.7	55.8	80.8
Immunisation clinics	73.9	64.0	86.3

Figures in percentages: World Bank study with AIIMS and Govt. as partners

Sexuality and the law

Siddharth Narrain

A movement is taking shape opposing the government stand against the repeal of Section 377 of the IPC, which criminalises private consensual sex between adults.

At stake is the human right to be different, the right to recognition of different pathways to sexuality, a right to immunity from the oppressive and repressive labelling of despised sexuality.

Upendra Baxi, in his foreword to the recently released People's Union of Civil Liberties (Karnataka) Report on Human Rights Violations against the Transgender Community, 2003. One of the main demands of the campaign for the rights of sexual minorities in India has been the repeal of Section 377 of the Indian Penal Code (IPC), which criminalises sodomy. In 1994, the AIDS Bhedbhav Virodhi Andolan (ABVA), a human rights activist group, filed a public interest petition in the Delhi High Court challenging the constitutional validity of Section 377. The petition was filed in the wake of the report of a medical team that visited Tihar Jail in Delhi and reported a high incidence of sodomy in the wards. However, the ABVA became defunct soon afterwards and the petition never came up for hearing.

It was only in 2001 that the legal process was revived, when the Naz Foundation [India Trust], a non-governmental organisation (NGO) working with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS)-related issues, approached the

Delhi High Court with a request to read down Section 377 as not criminalising private consensual sex between adults. Both petitions have now been clubbed together, and the hearing is yet to take place.

The petitioners have argued that Section 377 affects HIV/AIDS prevention efforts and that criminalising predominantly homosexual acts in effect provides moral and legal sanction for continued social discrimination against sexual minorities. They argue that private consensual sexual relations lie at the heart of the privacy zone protected by the right to liberty under Article 21 of the Constitution.

The history of anti-sodomy laws can be traced to the King James version of the Bible in Leviticus, 20:13, which says: "If a man also lies with mankind as he laith with a woman, both of them have committed an abomination they shall surely be put to death; their blood shall be upon them." Along with this, the destruction of Sodom and Gomorrah is seen as the source of legitimacy for laws that criminalised sodomy in England. The English Buggery Act of 1533 penalised acts of sodomy with hanging. Re-enacted in 1563 by Queen Elizabeth I, the Act became a charter for the criminalisation of sodomy in the British Commonwealth later. This meant that criminal sanction was employed to rid society of sexual practices that were viewed as reprehensible by the Church. In 1967, on the recommendation of the Departmental Committee on Homosexual Offences and Prostitution chaired by Sir John Wolfendon, the British Parliament passed the Sexual Offences Act, 1967, which decriminalised homosexuality and acts of sodomy

continued on page 28, col. 1

Only 5 per cent of women have comprehensive knowledge about ways of preventing HIV/AIDS.

Joe Thomas

According to the findings of the latest National Family Health Survey (NFHS) only 5 per cent of Indian women have comprehensive knowledge about ways of preventing HIV/AIDS. There is an urgent need to review the policy and program implications of NFHS2 HIV/AIDS data.

The National Family Health Survey (NFHS) has now come to be regarded as a storehouse of demographic and health data in India. NFHS-2 collected a range of social, health and demographic indicators. Data was collected from around 1,00,000 households from 18 states. Indian AIDS policy makers, researchers and activists must take note of the HIV/AIDS related data from the NFHS-2 particularly the findings on HIV/AIDS awareness among ever-married women.

S. Irudaya Rajan, K S James (2004), Usha Sambamoorthi, Rakhee Timothy, Wenhui Wei and S Irudaya Rajan (2004) have analysed the relationship between antenatal care and AIDS awareness and knowledge of methods of prevention, and shows a strong connection between the two. But AIDS awareness and knowledge among married women is disturbingly low.

They utilised this data to understand the levels and determinants of AIDS knowledge. The sample was restricted to women in the childbearing age groups between 18-45 years who had given birth in the previous three years. This is on the assumption that during the antenatal period, they receive correct information on AIDS from the health worker. According to Irudaya Rajan and colleagues, though the government of India spends millions of rupees on awareness campaigns, the findings show a dismal record. The majority of women had not heard about AIDS and among those who had 37 per cent did not have any knowledge of preventive measures. Only 5 per cent had comprehensive knowledge about ways of preventing it.

Usha Sambamoorthi and colleagues reported that overall, the rate of AIDS awareness was low, with only 36 per cent of women having heard about AIDS. The rate of awareness significantly varied by the receipt and type of antenatal care. Approximately 43 per cent fewer married women without antenatal care than women with antenatal care had heard about AIDS (53 per cent versus 9 per cent).

They also observed significant differences in AIDS awareness by

type of antenatal care. Women who had received prenatal care from doctors had the highest rate of awareness (57 per cent). There is significant and consistent group differences by socioeconomic status. Women of higher socioeconomic status as measured by educational levels and standard of living were significantly more likely to have heard about AIDS than women with less education and lower standards of living. The rates were highest among women who were highly educated (94 per cent) and lowest among women without any education (11 per cent). Similarly, women with high income were more likely to have heard about AIDS (73 per cent) than women with a low (16 per cent) or moderate (37 per cent) standard of living.

A significantly higher proportion of women (66.2 per cent) living in areas where antenatal incidence is at least 1 per cent than women living in areas where infection among high-risk individuals is 5 per cent or higher (36.6 per cent) had heard about AIDS. Women with access to prenatal care through doctors were about three times as likely to have heard about AIDS as women without receipt of antenatal care than other women

According to the authors, outreach and intervention efforts therefore need to focus on promoting comprehensive knowledge about prevention of AIDS, especially through the broadcast media.

Considering the unique representativeness of the data; geographical as well as sample size, it is necessary to subject further review and analysis of HIV/AIDS related NFHS2 data. The findings on urban rural differences and state specific data should inform national HIV/AIDS policy. It is important, that the technical resource groups of NACO, HIV social researchers and leading national academic institutions to review the policy and program implications of NFHS-2 HIV/AIDS data

References:

S. Irudaya Rajan, K S James (2004) *Second National Family Health Survey: Emerging Issues. Economic and Political Weekly February 14, 2004*

Usha Sambamoorthi, Rakhee Timothy, Wenhui Wei, S Irudaya Rajan (2004). *Antenatal Care and AIDS Knowledge among Married Women. Economic and Political Weekly February 14, 2004*

Study finds HIV superinfection in gay men

Christopher Lisotta, *Gay.com / PlanetOut.com Network*
Tuesday, February 10, 2004 / 05:36 PM

Researchers in California have shown that in a study of HIV-positive men who are not taking anti-AIDS drugs, the annual rate of virus superinfection may be 5 percent.

The Web site AIDSmap.com reported a San Diego researcher studied 78 HIV-positive people (90 percent were gay men) between 1997 and 2003, and found that superinfection took place anywhere from five months to a little over a year after initial HIV infection. Three superinfected individuals - all gay men - were identified; but since the three all had multiple sex partners, researchers were not able to figure out when and where the men got infected. All three men also saw their viral loads increase and CD4 cell counts decrease after superinfection.

For years superinfection, which is the reinfection of someone who is already HIV-positive with another version of HIV, was a controversial issue, since many medical experts weren't sure if it was possible.

In July 2002 a researcher at the international AIDS conference in Barcelona reported a Boston man had become reinfected with a different strain of HIV. In September 2002 a group of Swiss scientists published a piece in the *New England Journal of Medicine*

documenting the case of a 38-year-old man who was apparently infected by a second subtype of HIV through unprotected sex.

In April 2003 the medical journal *AIDS* reported on a man in California who had been infected with both a drug-resistant and less virulent strain of HIV. The California man was also one of the men identified in the San Diego study.

The study noted that it was possible that the men were infected with both strains of the virus at the same time, but that either way the 5 percent superinfection rate may be a conservative underestimate of current infection rates.

Superinfection is of great interest to vaccine researchers, since rising rates of superinfection could make the creation of a viable vaccine more difficult.

**When you are right, you cannot be too radical;
When you are wrong, you cannot be too
conservative.**

Martin Luther King, Jr.

Promoting sexual health and responsible sexual behavior: an introduction.

Journal of Sex Research, Feb, 2002, by Eli Coleman

We are at a unique juncture in history and have a rare opportunity to develop global, national, and community strategies to promote sexual health for the new century. This opportunity has been created by the fact that the world is experiencing a new sexual revolution and a public health imperative. Much like the sexual revolution of the 1960s and 1970s, it is a revolution fuelled by incredible scientific advances, as well as dramatic social and economic change (Coleman, 2000; Inglehart, 1997; Reiss, 1990; Reiss, 2001; Reiss & Reiss, 1997). We also face a myriad of sexual health problems, which is creating an enormous burden on societies. These two factors are putting pressure on health ministries to develop comprehensive approaches to sexual health promotion.

The last major attempt at developing global strategies for promoting sexual health was fuelled by the previous sexual revolution of the 1960s and 1970s. In 1975, the World Health Organization (WHO) produced a document *Education and Treatment in Human Sexuality: The Training of Health Professionals* (WHO, 1975). This historic document called upon societies around the world to develop the necessary sexuality education, counselling, and therapy to promote sexual health and to provide the necessary training for health professionals. This document also served as a stimulus for the development of the field of sexology and sexual resources centres throughout the world.

In order to promote sexual health, a basic definition of sexual health was needed and articulated in this document. Although the authors recognized the difficulty of arriving at a universally acceptable definition, the following definition was presented:

"Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love" (p. 6). The authors further state that fundamental to the concept of sexual health is the right to sexual information and the right to pleasure.

The document went on to cite Mace, Bannerman, and Burton (1974) who described sexual health as containing three basic elements: (a) capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic; (b) freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationship; and (c) freedom from organic disorders, diseases, and deficiencies that interfere with sexual and reproductive function. In spite of difficulties at arriving at this definition, this definition has endured and has been used throughout this last quarter century.

In 1983, the European Region of the WHO held a technical consultation meeting to further clarify sexual health strategies that could be implemented in Europe and to develop overall objectives of health for all by the year 2000. The report was published in 1986. In this report, there was an attempt to define sexuality, as without that basic definition promoting sexual health would be difficult (Langfeldt & Porter, 1986). At that time, the WHO defined sexuality as follows: *Sexuality is an integral part of the personality of everyone: man, woman and child. It is a basic need and an aspect of being human that cannot be separated from other aspects of human life. Sexuality is not synonymous with sexual intercourse, it is not about whether we have orgasms or not, and it is not the sum total of our erotic lives. These may be part of our sexuality, but equally they may not. Sexuality is so much more: it is in the energy that motivates us to find love, contact, feel warmth, and intimacy it is expressed in the way we feel, move, touch and are touched; it is about being sensual as well as sexual. Sexuality influences thoughts, feelings, actions and interactions and thereby*

our mental and physical health. (Langfeldt & Porter, 1986, p 5)

This definition has also been used throughout the past decades and has been important to distinguish the simply biological aspects of sex and the broader concepts which encompass our sexuality.

The European Region of the WHO held another meeting in 1987 (WHO, Regional Office for Europe, 1987). The purpose of this meeting was to clarify the concepts of sexual health by (a) focusing on different groups of people within the region, (b) identifying factors contributing to sexual ill-health and the means of promoting sexual health, (c) suggesting indicators that could be used to evaluate the effectiveness of programs and policies, and (d) making recommendations for further steps forward. This meeting was important because it clarified that any definition of sexual health was a heavily value-laden concept. Therefore, sexual health promotion would need to take into account different cultural and regional values and differences.

Responding to the current need to promote sexual health and responsible sexual behaviours

Unfortunately, except for the European Region of the WHO, none of the other regions immediately followed up on developing strategies for their region. However, since the publication of these WHO documents, we are facing a new public health imperative to develop strategies to promote sexual health and responsible sexual behaviour. These previous reports are clearly out of date. Many developments have occurred in our societies in the field of human sexuality and in other related fields of knowledge. These developments have increased our understanding and awareness of the complexity of sexual education, counselling, and treatment. Research has identified approaches and interventions that are effective, and those that are not. The emergence of new problems, notably the HIV/AIDS pandemic, has raised our awareness of current urgent needs for enhanced sexuality education and a much more conceded and comprehensive approach to addressing sexuality problems.

In response to the need to articulate new strategies, there have been several simultaneous efforts to develop global, regional, and national strategies. On a global level, the International Conference on Population and Development (ICPD) created the Programme for Action (POA) in Cairo. The ICPD POA was adopted by 184 countries. The POA provided governments with guidance to address the sexual and reproductive health of their populations in a comprehensive integrated manner. The importance of this document was the inclusion of sexual health into general reproductive health strategies. The document defined reproductive health as including sexual health... the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases (Para 7.2; United Nations, 1999). The POA contained two important objectives pertaining to sexual health: "To promote adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals" (Para. 7.36; United Nations, 1994), and "To ensure that women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities" (Para 7.36b; United Nations, 1994).

On a regional level, the Pan American Health Organization (PAHO) Regional Office of the WHO, in collaboration with the World Association for Sexology, held a consultation meeting as a first step to revise the 1975 WHO document on a global scale and to develop new strategies for the promotion of sexually healthy societies. During this meeting, the expert group revisited and put forward new basic

definitions of sex, sexuality, and sexual health (PAHO, Regional Office of the WHO, 2000):

1. Sex: Sex refers to the sum of biological characteristics that define the spectrum of humans as females and males (p. 6).
2. Sexuality: Sexuality refers to a core dimension of being human, which includes the individual and social capabilities and conditions for eroticism, emotional attachment/love, sex, gender, and reproduction. It is anchored in thoughts, fantasies, desires, beliefs and values and is expressed through identity, attitudes, values, roles, behaviours, and relationships. Sexuality is a result of the interplay of biological, psychological, socioeconomic, cultural, ethical and religious/spiritual factors. (p. 8)
3. Sexual Health: Sexual health is the ongoing process of physical, psychological, and sociocultural well being in relationship to sexuality. Sexual health can be identified through the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching life within an ethical framework. It is not merely the absence of dysfunction, disease and/or infirmity. For sexual health to be attained and maintained it is necessary that sexual rights be recognized and exercised. (p. 9)

Among many goals and strategies that were developed, this document adopted the Sexuality Information and Education Council of the United States (SIECUS) List of Life Behaviours of Sexually Healthy Adults (SIECUS, 1998). In addition, it took a bold step and defined the characteristics of a sexually health society (PAHO, Regional Office of the WHO, 2000, p. 13). Thus, it clearly laid out the responsibilities for societies to ensure that the right conditions exist which will promote sexual health and sexually healthy adults. The basic premise was that the promotion of sexual health would be accomplished if efforts were made to include sexual rights as basic and fundamental human rights. Consequently, this document recommended that international organizations, such as the World Health Organization, promote and serve as advocates to achieve consensus on the World Association for Sexology's Declaration of Sexual Rights (World Association for Sexology, 1999).

The document also included specific actions and strategies to promote sexual health. There were five overarching goals and corresponding strategies:

1. Promote sexual health, including the elimination of barriers to sexual health;
2. Provide comprehensive sexuality education to the population at large;
3. Provide education, training, and support to professionals working in sexual health related fields;
4. Develop and provide access to comprehensive sexual health care services;
5. Promote and sponsor research and evaluation in sexuality and sexual health, and the dissemination of the knowledge derived from it.

As a follow-up to the PAHO/WAS consultation, the WHO, again in collaboration with the WAS, recently held an international consultation to finalize a global document to promote sexual health (January, 2002). It is hoped that the document that emanates from this consultation will serve as a stimulus and a template for countries around the world to develop their own strategies given the particular sexual health climate and unique needs.

Developing national and local strategies to promote sexual health

These global and regional recommendations need to be reviewed and articulated at national and local levels. Several countries have already embarked on developing their own national strategies as well as strategies for specific populations (Australian Institute of Health and Welfare, 2000; Commonwealth Department of Health and Family Services of Australia, 1997; United Kingdom Department of Health, 2001). In the case of Australia and the United Kingdom, the strategies to promote sexual health are more specifically tied to HIV prevention. However, most recently, a broader strategy to promote sexual health and responsible sexual behaviour was unveiled by the U.S. Surgeon

General entitled: The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behaviour (U.S. Surgeon General, 2001). This document clearly outlined the public health challenge and imperative that the United States faces at this time (high rates of HIV infection, sexually transmitted infections, unintended pregnancies, abortion, sexual dysfunction, and sexual violence). The Surgeon General also acknowledged the serious disparities in the populations affected. The economically disadvantaged, racial and ethnic minorities, persons with different sexual identities, disabled persons, and adolescents bear the heaviest burden.

In order to put forth strategies, a basic definition of sexual health was articulated as well as a definition of responsible sexual behaviour. The definition of sexual health is consistent with previous definitions of sexual health, yet it emphasizes the importance of individuals to understand and weigh the risks, responsibilities, outcome, and impacts of sexual actions - essentially to act intentionally and responsibly. *Sexual health is inextricably bound to both physical and mental health. Just as physical and mental health problems can contribute to sexual dysfunction and disease, those dysfunctions and diseases can contribute to physical and mental function, nor is its importance confined to just the reproductive years. It includes the ability to understand and weigh the risks, responsibilities, outcomes, and impacts of sexual actions and to practice abstinence when appropriate. It includes freedom from sexual abuse and discrimination and the ability of individuals to integrate their sexuality into their lives, derive pleasure from it, and to reproduce if they so choose. (U.S. Surgeon General, 2001, p. 1)*

Responsible sexual behaviour was also defined. Responsible sexual behaviour emphasized both individual and community responsibility. *Sexual responsibility should be understood in its broadest sense. While personal responsibility is crucial to any individual's health status, communities also have important responsibilities. Individual responsibility includes understanding and awareness of one's sexuality and sexual development; respect for oneself and one's partner; ensuring that pregnancy occurs only when welcomed; and recognition and tolerance of the diversity of sexual values within any community. Community responsibility includes assurance that its members have access to developmentally and culturally appropriate sexuality education, as well as sexual and reproductive health care and counselling; the latitude to make appropriate sexual and reproductive health choices; respect for diversity; and freedom from stigmatization and violence on the basis of gender, race, ethnicity, religion, or sexual orientation. (U.S. Surgeon General, 2001, p. 1)*

The strategies to promote sexual health and responsible sexual behaviour covered three fundamental areas - increasing awareness, implementing and strengthening interventions, and expanding the research base. As a first step, the Surgeon General called for a mature and thoughtful discussion of sexuality to find solutions to our society's myriad of sexual health problems. Research was deemed essential because of the basic assumption that any efforts to promote sexual health and responsible sexual behaviour should be based upon the best available science. While the document's recommendations were based upon the extant research, the Surgeon General recognized the need for more basic research in human sexual development, sexual health, and reproductive health, including social and behavioural research on risk and protective factors for sexual health. The Surgeon General also recommended that the research base cover the entire human life span - from children to the elderly. Research should also focus on developing, disseminating, and evaluating educational materials for sexuality education. Research should also be expanded to evaluate community and school- and clinic-based interventions that address sexual health and responsibility.

Conclusion

In response to a changing sexual climate and a myriad of sexually

continued on page 26, col. 1

Promoting sexual health

continued from page 25, col. 2

related problems, there have been a number of attempts to develop global, regional, and national health strategies to promote sexual health and responsible sexual behaviour. There is remarkable consistency throughout these documents. They have all contributed to a clarity in our definitions of sex, sexuality, and sexual health. They call for leadership of the health sector to create better climates for discussion of sexuality, access to information and education about sexuality, prevention strategies to include community-based interventions, access to care for sexually related concerns, and more research in human sexuality and evaluation of programs designed to promote sexual health and responsible sexual behaviour. In order to move the research agenda forward, this special issue of *The Journal of Sex Research* is devoted to reviews of the existing research on topics relevant to the promotion of sexual health and responsible sexual behaviour. Since 1975, we have far more evidence of the risk and protective factors of sexual health and have evaluated many interventions. It is hoped that these scientific reviews of the literature will help guide further efforts at articulating strategies for sexual health promotion, both here in the United States and around the world. But, it is clear that more research is needed. Therefore, the second aim of these reviews is to stimulate and point the way toward further research, which will guide our sexual health promotion strategies. As governments and health ministries try to grapple with the complexities of the sexual problems in societies, they will need to turn to the sexual scientists—who have the understanding of human sexuality and the capacity to create more knowledge. We can, in partnership with other sectors of society, promote a sexually healthier world.

References

- Australian Institute of Health and Welfare. (2000). Australia's health 2000: The 7th biennial report of the Australian Institute of Health and Welfare. Canberra, Australia: AIHW Retrieved March 23, 2002 from the World Wide Web: <http://www.aihw.gov.au/publications/health/ah00/>.
- Coleman, E. (2000). Revolutionary changes in sexuality in the new millenium: Sexual health, diversity and sexual rights. In E. M. Ng, J. J. Borras-Valls, M. Perez-Conchillo, & E. Coleman (Eds.), *Sexuality in the new millenium* (pp. 1-9). Bologna, Italy: Editrice Compositori.
- Commonwealth Department of Health and Family Services of Australia. (1997). The national indigenous Australians' sexual health strategy 1996-97 to 1998-99: A report of the ANCARD working party of indigenous Australians' sexual health. Canberra, Australia: Australian Government Publishing Service. Retrieved March 23, 2002 from the World Wide Web: <http://www.health.gov.au/oatsih/pubs/ancard.htm>.
- Inglehart, R. (1997). *Modernization and postmodernisation: Cultural, economic, and political change in 43 societies*. Princeton, NJ: Princeton University Press.
- Langfeldt, T., & Porter, M. (1986). *Sexuality and family planning: Report of a consultation and research findings*. Copenhagen, Denmark: World Health Organization, Regional Office for Europe.
- Mace, D. R., Bannerman, R. H. O., & Burton, J. (1974). *The teaching of human sexuality in schools for health professionals* (Public Health Paper No. 57). Geneva, Switzerland: World Health Organization.
- Pan American Health Organization, Regional Office of the World Health Organization. (2000). *Promotion of sexual health: Recommendations for action*. Washington, DC: PAHO. Retrieved March 23, 2002 from the World Wide Web: <http://www.paho.org/English/HCP/HCA/PromotionSexualHealth.pdf>.
- Reiss, I. L. (1990). *An end to shame: Shaping our next sexual revolution*. Amherst, NY: Prometheus Books.
- Reiss, I. L. (2001). Sexual attitudes and behaviour. In N. J. Smelser & P. B. Baltes (Eds.), *International encyclopedia of the social and behavioural sciences* (Vol. 21; pp. 13969-13974). New York: Elsevier.
- Reiss, I. L., & Reiss, H. M. (1997). *Solving America's sexual crises*. Amherst, NY: Prometheus Books.
- Sexuality Information and Education Council of the United States. (1998). *Making the connection: Sexuality and reproductive health*. New York: Author. Retrieved March 23, 2002 from the World Wide Web: <http://www.siecus.org/pubs/cnct>.
- United Kingdom Department of Health. (2001). *National strategy for sexual health and HIV*. London: The Department of Health. Retrieved March 23, 2002 from the World Wide Web: <http://www.doh.gov.uk/nshs/strategy.htm>.
- United Nations. (September, 1994). *International Conference on Population and Development Programme of Action. Report of The International Conference on Population and Development*. Cairo, Egypt. (United Nations: Sales No. E.95.XIII. 18). Retrieved March 23, 2002 from the World Wide Web: <http://www.iisd.ca/linkages/cairo.html>.
- U. S. Surgeon General. (2001). *The Surgeon General's call to action to promote sexual health and responsible sexual behaviour*. Rockville, MD: Author. Retrieved March 23, 2002 from the World Wide Web: <http://www.surgeongeneral.gov/library/sexualhealth/>.
- World Association for Sexology (1999). *Declaration of sexual rights*. Retrieved March 23, 2002 from the World Wide Web: <http://www.worldsexology.org/wdeclara.htm>.
- World Health Organization (1975). *Education and treatment in human sexuality: The training of health professionals*. Technical Report Series Nr. 572. Retrieved March 23, 2002 from the World Wide Web: <http://www2.hu-berlin.de/sexology/>.
- World Health Organization (2002). *Challenges in sexual and reproductive health: Technical consultation on sexual health*. 28-31 January, 2002.
- World Health Organization, Regional Office for Europe (1987). *Concepts of sexual health: Report of a working group*. Retrieved March 23, 2002 from the World Wide Web: http://whqlibdoc.who.int/euro/-1993/EUR_MUR_521.pdf.

Address correspondence to Dr. Eli Coleman, 1300 S. 2nd Street, Suite 180, Minneapolis, MN 55454; e-mail: colem001@tc.umn.edu. Copyright 2002 Society for the Scientific Study of Sexuality, Inc. in association with The Gale Group and LookSmart. Copyright 2002 Gale Group

Sex is the elixir of life

Hindustan Times, 14/2/04

According to a report in 'The Mirror' (published in the UK), sex actually has masses of health benefits and scientists are now discovering that lovemaking can make your life longer and happier. Women benefit from loads of sex, as it lowers the risk of breast cancer. Scientists believe that the interaction between oxytocin, a hormone in the blood surges to five times its normal level during orgasm, and the sex hormones oestrogen and testosterone is responsible for it, the report adds.

A study in the British 'Journal of Urology International' quoted by the report, says that sex helps men reduce their risk of prostate cancer by a third if they ejaculate more than five times a week. This is because cancer-causing chemicals in the blood are flushed out with seminal fluid. Sex also acts as a natural painkiller and brain scans show that the part that kills pain is activated on climax. Messages are sent out to release chemicals called endorphins and corticosteroids, which are natural painkillers. The extra oestrogen women produce while having sex can also ease period pain and PMS symptoms.

Consultant neuropsychologist Dr David Weekes studied 3500 people for 10 years and found that those who had sex at least three times a week, looked 10 years younger than those who made love less frequently. Passionate kissing also helps in toning facial muscles, thighs, stomach, buttocks and arms and relieves depression.

Finally, humping and pumping also helps in burning the extra calories, around 200 each time you make love

Section 377: How natural is normal?

Nivedita Menon

The recent episode of a lesbian couple in Kerala having to seek court intervention to stop police persecution initiated by their parents, starkly underlines the fearsome question that lies unrecognized at the heart of the furor around Section 377 of the Indian Penal Code: Is it natural to be normal? Introduced into Indian statute by the British parliament in 1872, this section penalizes sexual activity "against the order of nature". So? A handful of perverts should worry. At most, the wider body of ubiquitous 'human rights activists' who hold the absurd belief that as long as consenting adults are involved, sexual preferences are private matters from which the law should keep out. Should anyone else care?

Well, here's bad news for normal society - "normal" sexuality is no private matter. The assumption is that "normal" sexual behaviour springs from nature, and that it has nothing to do with culture or history. But if we recognize that sexuality is located in culture, we have to deal with the uncomfortable idea that sexuality is a human construct, and not something that happens "naturally." Consider the possibility that rules of sexual conduct are as arbitrary as traffic rules, created by human societies to maintain a certain sort of order, and which could differ from place to place - for example, you drive on the left in India and on the right in the USA. Further, let us say you question the sort of social order that traffic rules keep in place. Say you believe that traffic rules in Delhi are the product of a model of urban planning that privileges the rich and penalizes the poor, that this order encourages petrol-consuming private vehicles and discourages forms of transport that are energy-saving - cycles, public transport, pedestrians. You would then question that model of the city that forces large numbers of inhabitants to travel long distances every day simply to get to school and work. You could debate the merits of traffic rules and urban planning on the grounds of convenience, equity and sustainability of natural resources - at least, nobody could seriously argue that any set of traffic rules is natural.

Let us apply this argument to sexuality. First of all, if "normal" behaviour were so natural, it would not require such a vast network of controls to keep in place. Take some random examples. Item one - gendered dress codes. Imagine a bearded man in a skirt in a public place: why would this shake the very foundations of "normal" society? Unless "he" is recognizably a hijra, and that puts him on the margins of normal society in a different way. Just the wrong kind of cloth on the wrong body, and the very foundations of natural, normal sexual identity start to quake! Two - the disciplining of thought through schools, families, the media, education, religion. All telling you that desire for someone of the same sex is a sin, or insane, or criminal. Three, if all else fails - violent coercive measures to keep people heterosexual, from electric shock therapy to physical abuse to using the coercive apparatus of the state, as the parents in the Kerala incident did. Four - laws. Why would we need laws to maintain something that is natural? Are there laws forcing people to eat or sleep? But there is a law forcing people to have sex in a particular way!

The point of real interest though, is that human beings do not in fact, live particularly "natural" lives. The whole purpose of civilization seems to be to move as far away from nature as possible. We clothe our naked bodies (indeed, the same people who condemn homosexuality as unnatural would insist that natural nudity be covered up). We cook raw food derived from nature, we build elaborate shelters from the natural elements. We use contraception (again, most of those who condemn homosexuality on the grounds that sex is only for procreation would not question the need for contraception). Clearly, equating "unnatural" with "immoral/wrong" is simply a way of suffocating debate.

But the more important question is - what is the social order that the rules of "normal" sexual behaviour keep in place? Why is it so crucial to ensure that men have legitimate sex only with women? (Note the

word legitimate, because of course sex between people of the same sex is as old as human civilization). Why the need to ensure that women only have sex with the men they are married to (because again, everyone knows that the rules of chastity and monogamy are enforced strictly only for women). Remember the scene from the Hindi film *Mrityudand* in which the visibly pregnant Shabana is asked "yeh kiska bachha hai?" It is very evident that the baby is inside her body, that it is hers, but the absurd question makes absolute sense in a patriarchal society - who is the father of this child, is what the question means. Whose caste does this child bear, to whose property can he lay claim?

This brings us to the institution of the family that is at the core of the present extremely inequitable social order. A Delhi High Court judgement in 1984 ruled that the fundamental rights to equality and freedom have no place in the family. To bring constitutional law into the home, the learned judge ruled, is like "taking a bull into a china shop." And of course, he was absolutely right. The family in India is indeed premised on extreme inequality - beginning with the wife changing her surname on marriage, to the property to which no sister has equal rights with her brother, to the sexual division of labour, which legitimizes the unpaid domestic labour of women. The rights to equality and freedom would certainly destroy the family as we know it.

If families were only about material and emotional support structures, then any such group of people would be recognized as a family. Isn't it also more likely that humans experience sexual desire in a variety of ways, of which the heterosexual is only one? But the point precisely is that only the heterosexual, patriarchal family is permitted to exist. And this family is about the passing on of property and lineage through men. The 'normality' that this requires is produced, maintained and rigorously policed by the state, laws and social institutions. It is far from being natural or private.

In short, section 377 does not refer to some queer people out there, whom normal people can gaze upon like anthropologists at a bizarre tribe. Section 377 is about the painful creation of Mr and Mrs Normal - it is one of the nails holding in place the elaborate fiction that "normality" springs from nature. *Posted on lgbt-india 3/1/04*

Uncircumcised Indian men have 8 times higher HIV risk

Uncircumcised men have an eight fold higher risk of becoming infected with HIV compared to circumcised men, according to a study of 2298 Indian men presented on Thursday at the 41st Annual Meeting of the Infectious Diseases Society of America by Dr Steven Reynolds of Johns Hopkins University, Baltimore.

The research was part of a larger study investigating risk factors for HIV-1 infection based on men attending one of three STD clinics in Pune, India. Between 1993 and 2000, 2,298 men who tested negative for HIV-1 were enrolled in the study. During subsequent visits (an average of three visits in 11 months), 2 of 191 men who were circumcised and 165 of 2,107 who were uncircumcised tested positive for HIV.

Demographics, sexual risk behaviours (including having sex with a prostitute), and condom use were remarkably similar between both groups, said Dr. Reynolds. Despite the similarity in risk profiles, researchers determined the incidence rate of HIV-1 among circumcised men it was 0.7 percent, whereas among uncircumcised men it was 5.5 percent, an 8-fold increase. The relative risk of infection among circumcised men, after adjusting for calendar year, age group, level

continued on page 28, col. 1

Sexuality and the law

continued from page 22, col. 2

between consenting adults.

In India, historically, same sex relationships were by and large tolerated. Influenced by the Victorian campaigns for sexual purity, the British tried to change Indian marital, sexual and familial arrangements, which they saw as 'primitive'. The British introduced anti-sodomy laws in India in 1861. Section 377 criminalises anyone who "voluntarily has carnal intercourse against the order of nature with any man, woman or animal". Says Alok, a gay rights activist: "Though statistics show that this law has been used mostly in cases of non-consensual acts, it has been used by the police to blackmail, extort and harass the homosexual community in India."

Sadhana Vohra, a clinical psychologist based in Delhi, says: "Most people with an active homosexual life have had to deal with harassment from the police." In fact, in 2001, when a petition was filed before the National Human Rights Commission (NHRC) asking it to give directions to the Indian Psychiatric Association to state clearly that homosexuality was not a disease, the commission did not find it fit to take further action, using the excuse of Section 377. The petition was filed after a boy's complaint that he had been administered aversion therapy and non-prescriptive drugs to 'cure' homosexuality. This decision came close on the heels of the Uttar Pradesh government's decision to arrest HIV/AIDS outreach workers and the raids on the offices of the Bharosa Trust and Naz Foundation International in Lucknow in July 2001 (Frontline, September 14, 2001).

The Division Bench, comprising Acting Chief Justice Devinder Gupta and Justice B.D. Ahmed, asked the Union government to submit a detailed affidavit. The government, in its affidavit, submitted that while the right to respect private and family life is undisputed, interference by public authority in the interest of "public safety and protection of health and morals is equally permissible". According to the government, deletion of the section can "open the floodgates of delinquent behaviour and be misconstrued as providing unbridled licence for the same".

The government has also argued that Section 377 has been used to deal with cases of child sexual abuse and for complementing rape laws. At a press conference called in response to the government's stand by the NGO Voices Against Section 377, representatives of gay rights, women's groups, child rights, health and human rights organisations said the section criminalised homosexual sex while failing to protect children from abuse. Enakshi Ganguly Thukral of the National Campaign against Child Abuse said the government had justified the retention of the section on the grounds that it was necessary to prosecute child abusers. She said: "This was simply a

means to pit child rights against gay rights and to suggest that all paedophiles were homosexual men. This reflected the state's lack of any real concern for the child's search for justice. The government itself had acknowledged the need for a separate law to deal with child sexual abuse in its first periodic report to the United Nations Committee on the Rights of the Child."

Another argument of the government is that "law does not run separately from society" and that when Section 377 was brought under the statute, it "responded to the values and mores of the time in Indian society". Reacting to this, Vijay Nagraj, Director, Amnesty International-India, said that the government's response was a "deliberate and wilful violation" of international human rights law. He said it was trying to preserve a colonial law through the creation of sociological and legal fiction. He added that the law had to be based on human rights principles and "cannot blindly follow public opinion".

Women's rights groups have also come out strongly in favour of repealing Section 377. Reacting to the government's stand, Brinda Karat of the All India Democratic Women's Association (AIDWA), in an open letter to the Union Law Minister, said: "If we were to accept the government's standpoint then many of the legislations concerning women's rights and even Dalit rights would never have been enacted since even today there are many sections of society who consider wife-beating or dowry practices to be consistent with 'tradition and culture', just as they consider untouchability to be the 'natural order' of society." She added that even if one accepted the flawed argument that cultures and social attitudes have relevance for legal rights, then the government petition clearly has "a very narrow reading of culture and social acceptance, because Indian history is replete with examples of the accepted existence of homosexuality".

Those most affected by the threat of Section 377 are those who are the most vulnerable, like the Hijra sex worker population. Says Elavarthi Manohar, Programme Coordinator of Sangama, a Bangalore-based organisation working with sexual minority groups: "The Hijra sex worker population often faces violence from the police and local goons, because of Section 377 it is not possible to ask for redress. We are organising a rally soon to the Chief Minister's residence demanding that the law be repealed." Manohar adds: "Even if the court agrees to the current petition, it will not address the harassment that Hijra sex workers who are forced to use public spaces face, as it only asks for decriminalising 'private' consensual sex."

Whatever the final decision of the court, it is clear that the legal battle for the repeal of Section 377 is only the first step of a larger struggle for the recognition of the rights of sexual minorities in the country.

Uncircumcised Indian men

continued from page 27, col. 2

of education, marital status, living with family, multiple sex partners, sex worker partners, condom use, tattoos, and medical injections, was 0.12 ($p=0.003$).

However, the study did not find circumcision to be protective against other sexually transmitted diseases, including syphilis, genital herpes and gonorrhoea.

The findings suggest the benefit of circumcision may be biological rather than due to other factors, such as differences in behavior between circumcised and uncircumcised men, or the possibility that circumcision promotes the acquisition of sexually transmitted infections, said Dr. Reynolds. The inner surface of the foreskin is not as thickly "keratinised" as the outside or other surfaces of the penis, meaning it has less of a protective layer and may be more easily penetrated by HIV, he said. It also has higher numbers of the cells that HIV infects, possibly contributing to the reduced risk of HIV infection observed when the foreskin is removed.

There are other potential methods uncircumcised men may be able

to use to protect themselves against HIV, said Dr. Reynolds. In the future, a topical microbicide product might be applied to the foreskin before sex to protect against HIV. Such products are currently in development.

Circumcision isn't totally protective and may not be culturally acceptable or safe in some settings, so regular condom use is still the best way of protecting against HIV and other sexually transmitted diseases, said Dr. Reynolds. Condom promotion remains a key strategy in the current fight against the spread of AIDS, he said.

"Circumcision as a potential prevention strategy requires confirmation by randomised clinical trials, which are the gold standard in evaluating medical interventions," he said. There currently are clinical trials underway in Uganda, Kenya and South Africa.

Reference: Reynolds SJ et al. Male circumcision is protective against HIV-1 but not other common sexually transmitted infections in India. 41st Annual Conference of the Infectious Diseases Society of America, San Diego, 2003.

<http://www.aidsmap.com/news/newsdisplay2.asp?newsId=2350>,
Posted AIDS-India, 15/10/03