

## Closely watched Pashtuns—a critique of western journalists' reporting bias about 'Gay Kandahar'

by Brian James Baer

*This article is reproduced in Pukaar as a warning about the media, many researchers, and those involved with HIV services who often re-formulate male-male sexualities within a western discourse on sexualities and identities.*

Soon after American troops entered Afghanistan following the events of 9/11/2001, reports began to appear in major press outlets documenting a phenomenon that had previously received scant attention: widespread homosexual activity among Afghan men, in particular among the Pashtun of the southern region of Kandahar. It seemed that Western forces sent into Afghanistan to liberate Afghan women had unwittingly liberated Afghan homosexuals, and Western journalists weren't sure what to make of that. The idea of homosexuality among rugged Afghan fighters was treated—often within the same article—both as a cultural curiosity and as an instance of abusive pedophilia. In the end, these Western press's accounts revealed at least as much about current Western fears and prejudices as about the local practices they concerned.

Shortly after the 9/11 attack, an article titled "Repressed Homosexuality?" appeared in *The Times* of London (October 5, 2001) suggesting a link between misogyny and homosexuality within the Taliban. A few months later a piece called "Kandahar Comes out of the Closet," also in the *Times* (January 12, 2002), offered anecdotal evidence of the re-emergence of visible homosexual activity in the Kandahar region following the defeat of the Taliban. This story was picked up in *The New York Post* under the title "A Gay Old Afghan Time Again." Two days later, *The New Yorker* published a lengthy report by Jon Lee Anderson on post-Taliban Kandahar in which he too broached the subject of homosexual activity. At last, *The New York Times* weighed in with a piece called "Shh, It's an Open Secret: Warlords and Pedophilia" (Feb. 21, 2002). A spate of articles followed with titles like "Kandahar's Lightly Veiled Homosexual Habits" (*Los Angeles Times*, April 3) and "The Royal Marines and a Gay Warlord" (*Sun Herald [Sydney]*, June 9). Even *USA Today* (June 3) got into the act with a piece that discussed the threat of AIDS in post-Taliban Afghanistan, a nation seen as particularly vulnerable because of "promiscuity and homosexuality without the use of condoms."

What makes these reports of open homosexual activity in Kandahar surprising is that they seem to contrast so markedly with the repressive policies of the Taliban—and Islamic societies in general. The official Taliban punishment for homosexual activity was to topple a stone wall upon the offender (most died from the experience but the occasional survivor was set free). Although this particular punishment was confined to Afghanistan, the persecution of homosexuals was and remains widespread throughout the Middle East. As Surina Kahn of the International Lesbian and Gay Human Rights Commission (ilghrc) has observed: "Homophobia runs through mainstream, conservative, and fundamentalist elements of Islam." Moreover, in recent years even some of the more progressive governments in the Middle East have been cracking down on homosexual activity in order to appease increasingly powerful and vocal fundamentalist groups. This was illustrated by the arrest of 52 suspected homosexuals in Egypt in May 2001 at a riverboat disco on the charge of "practicing debauchery with men."

Against this backdrop the open homosexuality of Pashtun men might seem the height of social tolerance. However, when read within the context of Western views of childhood sexuality, the love of youths (referred to as *ashnas* or *haluks*) among the Pashtun of Kandahar became a disturbing example of pedophilia. Several of these reports noted that the rape and kidnapping of youths had increased in the years preceding the Taliban takeover, and that the Taliban persecution of homosexual activity had been greeted by many Afghans with



enthusiasm. The tendency of Western observers to focus on instances of abuse was matched by a tendency to reduce same-sex relations to a Pashtun "obsession with sodomy." Despite the jocular tone of these exposés, their subtext was clearly aimed at discrediting the Pashtun tradition by equating it with the ultimate American taboo, adult sex with minors.

### A secret in plain view

Modern Western cultures, particularly Anglo-American ones, construct homosexuality as a secret—as the secret, according to Eve Kosofsky Sedgwick in *The Epistemology of the Closet* (1990); but this is not necessarily the way that other cultures have constructed it. Western journalists relentlessly projected onto Kandahar the two great secrets of contemporary American society: closeted homosexuality and child abuse. Viewing homosexuality as something that's kept secret, Western journalists found the patterns of silence and disclosure in Afghanistan to be rather baffling. They noted, on the one hand, a reluctance on the part of Kandaharis to discuss their homosexual liaisons. When asked about these relationships by one reporter (a female), a local contact replied: "These are hard questions you are asking. We don't usually talk about such things," Tim Reid of *The Times* of London noted the Kandaharis' reticence and accused local parents of "lying" when they, "who know in their hearts the nature of the relationship [between their son and an older man], say that their son is working for the man." Of course, what Reid calls a lie others might see as a tactful way of refusing to discuss a private matter.

But if Kandaharis seem unwilling to speak about their sex lives, as

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Naz Foundation International is a development agency specialising in providing technical, institutional and financial support for the promotion of the sexual health, welfare and human rights 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 services, where the beneficiaries of a service are also the providers of that service. We will always support such initiatives.

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

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

1. Promoting the reproductive and sexual health of males who have sex with males by encouraging sexual responsibility and safer sexual practices.
2. Encouraging males who have sex with males to access sexually transmitted infections 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 sexual responsibility of their male partners.
6. Encouraging communication of sexual health information between sexual partners and promoting partner notification of sexually transmitted infections and 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 services for infected female partners of males who have sex with males.

**Pukaar**

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

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

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

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**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)22 2205781/2205782  
Fax: +91 (0)22 2205783  
Email: lucknow@nfi.net

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

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## Closely watched Pashtuns

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Tim Reid noted, “there appears to be no shame or furtiveness” in the behavior of male-male couples. Michael Griffin, also of the Times, reflecting on the history of these relations, declared that “in Pashtun society, man-woman love was the one that dared not speak its name: boy courtesans conducted their affairs openly.” Reid wrote of pre-1994 Kandahar, where “the streets were filled with teenagers and their sugar daddies, flaunting their relationship.” It’s a bit ironic that Reid’s exposé was titled “Kandahar Comes out of the Closet,” for it promises an act of disclosure that the Pashtuns fail to deliver. At the same time, the Pashtuns’ behavior suggests a lack of shame that’s inconsistent with the Western view of “the closet.” Reid seems to be caught in the paradox of Western sexual discourse, which (as Foucault argued) is organized around the imperative to control sexual behavior by talking about it. In the end, Reid squares Kandahari behavior with Western expectations only by castigating the Pashtun for “lying” to avoid the subject and for “flaunting” their behavior in public.

The other Big Secret is that of pedophilia, the secret within the secret of homosexuality in the popular imagination, the ultimate taboo. Despite statistical evidence demonstrating that pedophilia in the West is more common among heterosexual men, the association of homosexuality and the sexual abuse of children remains prominent in Western anti-gay discourse, propelling “save our children” campaigns to restrict their contact with gay adults. By constructing age-stratified homosexual activity in Kandahar as pedophilia, Western journalists provided themselves a link to the ever-popular issue of child abuse—especially hot, what with the unfolding scandal in the Catholic Church. Needless to say, Western reports on age-stratified homosexuality in Kandahar typically stressed the “innocence” of the minors involved. For example, Reid wrote that Kandaharis preferred “naïve young boys,” while the Post described them as “fresh-faced.”

In their reporting Western journalists insisted on reducing relationships that are often long-term emotional bonds to a crude sexual bargain. The New York Times’ Craig Smith, for example, translated the term *haliq*, which crudely means “beautiful boy,” as “a boy for sex.” Michael Griffin, while noting the “rich tradition of homosexual passion” celebrated in Pashtun poetry and dance, nonetheless referred to it as “male prostitution.” Reid put forth that boys are “groomed for sex” with an older man, which is “usually a terrible fate for the boys concerned.” Without a shred of evidence, he described the courting of an *ashna*, which typically involves elaborate and expensive gift-giving. Smith’s contact provided the following description of this courtship: “If you want a *haliq*—‘a boy for sex’—you have to follow the boy for a long time before he will agree,” said Daud, smiling at Fareed in a hostel in Kandahar. ‘At first he was afraid, so I bought him some chocolate and gave him a lot of money,’ said Daud, laughing. ‘I went step by step, and after about six or seven months, he agreed.’”

The fact is that these relationships may last for many years; and, as one contact noted, “sometimes when the *halekon* [sic] grow up [and are no longer sexually desirable], the older men actually try to keep them in the family by marrying them off to their daughters” (LA Times, April 3, 2002). While Craig Smith reported that his contact, Mr. Fareed, “does not regret being lured into a relationship by his older friend,” his use of the word “lured” again portrayed the *ashna* as an unwilling victim.

Tim Reid pronounced solemnly that “once the boy falls into the man’s clutches, he is marked for life,” but added immediately that “the Kandaharis accept these relationships as part of their culture.” But if indeed they’re accepted, why would someone be “marked for life”? This non sequitur reveals that Reid merely assumed that psychic trauma and social stigma could be the only consequence of these relationships. In fact, evidence from Islamic cultures that have a tradition of age-stratified bonding suggests that the matter is forgotten when the minor comes of age. “[N]o one,” writes Stephen

O. Murray in *Homosexualities* (2000), “not even those who remember it from personal experience, will mention in his presence (or, probably, at all) his pre-adult sexual behavior. His male honor depends on his conduct as an adult.”

Another of Reid’s underlying assumptions about homosexuality is revealed in his statement that the Taliban leader, Mullah Omar, suppressed homosexual activity “despite the Taliban disdain for women, and the bizarre penchant of many for eyeliner.” The New York Post, which picked up Reid’s story, recapitulated his strange logic: “Despite the regime’s hatred of women and penchant for eyeliner, homosexuality was banned.” Like the association of homosexuality with misogyny, the attempt to equate the Taliban’s use of eyeliner with homosexual activity depends on a rusty Western stereotype that seems to have life in it yet. Jon Lee Anderson’s article in *The New Yorker* implied a connection between homosexuality and effeminacy by juxtaposing a report on the enduring tradition of pederasty among the Pashtun with a description of local practices that include the use of eyeliner and toe-nail polish and the wearing of colorful, high-heeled sandals a size or two too small—which “means that you mince and wobble as you walk.”

Maura Reynolds of *The LA Times* noted that “there is a strong streak of dandyism among Pashtun males. Many line their eyes with kohl, stain their fingernails with henna or walk about town in clumsy, high-heeled sandals.” But this equation makes sense only if we accept two Western assumptions: that homosexuality and effeminacy are automatically linked; and that the practices described are in fact “effeminate.” By that logic, turning to the West, what are we to conclude about 18th-century aristocrats in their wigs, face powder, tights, and high heels? Reynolds’ own research should caution against such simplifications. She quotes one local source as saying: “Hugging doesn’t mean sex, locals insist. Men who use kohl and henna are simply ‘uneducated.’” Moreover, her contact Daud, who’s unmarried and has sex only with men and boys, “does not consider himself homosexual, at least not in the Western sense.” And although he has never been physically intimate with a woman, he assures Reynolds: “I like boys, but I like girls better.”

### The Making of a Minority

Western views on homosexuality can be neatly divided into two overarching traditions: a Freudian school that sees all sexuality as “polymorphous” and homosexuality as one position on a fluid continuum; and a gay liberationist view that sees homosexuality as a distinct identity analogous to that of an ethnic minority. In Kandahar, there is clearly no sense in which homosexuality constitutes a minority identity—but this did not prevent Western journalists from constantly using the language of the Western gay rights movement to describe it. Thus, for example, faced with estimates from her informants that “between 18% and 45% of men [in Kandahar] engage in homosexual sex,” Maura Reynolds observed dryly that this is “significantly higher than the 3% to 7% of American men who, according to studies, identify themselves as homosexual.”

Journalists repeatedly used Western concepts such as “gay” and “the closet” to characterize the Kandahar situation, thus imposing their notion of homosexuality as a minority identity. The term “gay” is used in the title of the New York Post article—“A Gay Old Afghan Time Again”—as well as in the article itself: “Men accused of being gay were executed by having a wall toppled on them.” The word also appears in the headline of Smucker and Kili’s story, “The Royal Marines and a Gay Warlord,” even though the Afghan doctor quoted by Reynolds cautions that, among the Kandaharis, “homosexuality is what they do, not what they are.” The picture of homosexual behavior that emerges in even the shortest press accounts is complicated and, to the Western eye, contradictory. Smucker and Kili’s article profiles an Afghan warlord, Malim Jan, who has “two wives and ‘several boyfriends,’” and who has now taken a fancy to the Royal Marines visiting his camp.

Another way that journalists like Craig Smith and Maura Reynolds

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try to reconcile the evidence for polymorphous sexual desire with Western binarism is by interpreting the widespread homosexual activity as an aberration, a product of the extreme segregation of women in traditional Muslim cultures. This segregation presumably places women sexually out of bounds, forcing men to go elsewhere for gratification. And yet, as Tim Reid points out, the men who court adolescent boys are typically married with children, while the “gay warlord” profiled by Smucker and Kili has “two wives and ‘several boyfriends.’”

Michael Griffin appears initially to follow a similar line of argument, attributing the popularity of homosexual sex to the Taliban’s extreme misogyny or “gynæophobia.” Near the end of the article, however, he writes that the Taliban’s “gynæophobia appeared [to be] the product of a *repressed homosexuality*” (italics mine). Here he reverses the terms of his original argument, namely that homosexuality is the product of gynæophobia. Which is it, then? By arguing that homosexual activity is not an effect of misogyny but rather its cause, Griffin seems to be positing a primary homosexual desire, albeit a repressed one, that will not simply disappear with the eventual liberation of Afghan women.

Whatever the cause of homosexuality in Kandahar, the future of same-sex relations there is uncertain. While some predict an increase in tolerance of homosexual activity with the defeat of the Taliban, a recent law forbidding “beardless youths” in the army appears intended to restrict the practice of man-boy love—a possible reaction to the sudden Western interest in this subculture. This may signal a broader crackdown on homosexual activity throughout Afghan society. Moreover, the slow liberation of Afghan women and the opening of Afghanistan to the West promise to influence the construction of (homo)sexual behavior there in unpredictable ways, as a deeply traditional Islamic society, suddenly in the world spotlight, comes to terms with this sudden invasion of modernity.

Brian James Baer, associate professor of Russian Literature and Translation at Kent State University, is presently completing a book on the representation of homosexuality in post-Soviet culture.

*Gay and Lesbian Review: March-April 2003*

*(downloaded from <http://www.globalgayz.com/afghan-news02-04.html> on 8th March 2007)*

### Why we must work with male-to-male sex and HIV prevention, care and support

Because:

- It is the right thing to do on humanitarian grounds
- It is the right thing to do epidemiologically
- It is the right thing to do from a public health perspective

Males who have sex with males (MSM) whether their self-identity is linked to their same sex behaviour or not, have:

- The right to be free from violence and harassment
- The right to be treated with dignity and respect
- The right to be treated as full citizens in their country
- The right to be free from HIV/AIDS

MSM who are already infected with HIV, have the right to access appropriate care and treatment, equally with everyone else, regardless of how the virus was transmitted to them.

## Surveys show HIV continuing to rise in Vietnam, with significant risks among drug users, sex workers, and men who have sex with men

The Vietnam Administration for AIDS Control (VAAC) of the Ministry of Health announces the results of the HIV/STI Integrated biologic and behavioral surveillance (IBBS) that was conducted in seven provinces in 2005 and 2006. This set of surveys estimated the prevalence of HIV, other sexually transmitted infections (STI), risk behavior levels, and intervention exposure among injection drug users, female sex workers, and men who have sex with men.

Highlights of the surveys included the following:

- HIV prevalence among IDU averaged the highest of all population groups measured but varied across provinces. The highest rates were in Hai Phong (66%) and Quang Ninh (59%) and the lowest in Danang (2%) and An Giang (13%). The data showed evidence of rapid HIV transmission among a large new and young injecting population. For example, almost half of IDU in HCMC (48%) were under 25 years-old and about one-quarter (24%) had injected less than one year. However, HIV was quick to spread among both of these groups, with 33% and 28%, respectively, already HIV-infected.

- Over 10% of FSWs were HIV-infected in five out of seven provinces, with street-based sex workers (SSW) in most areas registering higher HIV prevalence than karaoke-based sex workers (KSW). The highest HIV prevalence was among SSW in Can Tho (29%) and Hanoi (23%). HIV infection among sex workers was highly correlated with injection drug use, with injecting sex workers from 3.5 to 31 times more likely to be HIV-infected than non-injectors.

- HIV prevalence among MSM was 5% in HCMC and 9% in Hanoi but these were not statistically significant differences. Other STI were also relatively high among MSM. For example, over one in 10 men in Hanoi (12%) were infected with rectal gonorrhoea and 8% had rectal chlamydia. In total, 22% of MSM in Hanoi and 16% in HCMC had at least one STI.

- The surveys showed that coverage of interventions programs is increasing but still needs to be improved. Use of voluntary counseling and testing (VCT) services was highest among IDU in Hai Phong (40%) and FSW and IDU in Hanoi, 35% and 34%, respectively. In HCMC, where a scale-up of VCT has occurred in recent years, approximately one in five of all high-risk groups reported that they have been HIV tested and know the results. However, over three-quarters of people living with HIV in the measured groups did not know that they are HIV-infected. For example, 90% of HIV+ MSM in Hanoi, 84% of HIV+ IDU in Can Tho, and 82% of HIV+ FSW in An Giang were unaware of their status.

The surveys will likely be repeated every two years to monitor trends in HIV, STI, risk behaviors, and intervention exposure. Results will be used for intervention planning, evaluation, and to assist in national HIV estimates and projections. A similar survey of clients of sex workers will likely be conducted over the next several months.

The surveys were conducted by the MOH National Institute for Hygiene and Epidemiology (NIHE) in collaboration with the VAAC, Provincial AIDS Centers and Committees, and Provincial Centers for Preventive Medicine. Technical assistance was provided by Family Health International (FHI), the US Centers for Disease Control (CDC), and the United States Agency for International Development (USAID), with funded provided by USAID through the President’s Emergency Plan for AIDS Relief (PEPFAR).

*MSM-Asia 28/2/07*

# Lubricants and microbicides

A vital part of preventing HIV transmission is the use of condoms for both vaginal and anal sex. Many people use personal lubricants as well, for enhancing pleasure and reducing dryness. Using lubricant may also reduce the risk of condoms breaking during sex.

Lubricants may also become important in another area—microbicides. These are prevention products that are being developed in the form of gels, creams, films, sponges and suppositories that contain anti-HIV compounds. Worldwide, most cases of HIV are spread through unprotected vaginal sex. Therefore, it makes sense that microbicides are being designed to work in that part of the body.

An advantage of microbicides is that they could allow women the opportunity to protect themselves before having sex, without the need to get permission or approval from men. This is necessary in many parts of the world, particularly where HIV is endemic. In these regions, women may not have a great deal of power over their lives, particularly when it comes to their sexuality. This makes them vulnerable to infection from HIV positive men.

Both men who have sex with women as well as men who have sex with men engage in anal intercourse, which can also place them at risk for HIV transmission. Because the focus with microbicides has largely been on the prevention of HIV transmission in the vagina, the effect and activity of these products in the rectum may be understudied. However, it is likely that once microbicides designed for vaginal use become widely available they may also be used for anal sex.

As a foundation for future work on microbicides and to better understand the impact of some commonly available personal lubricants and other substances on the rectum, researchers at the Johns Hopkins University School of Medicine in the United States have begun to engage in lab experiments and tests on volunteers. Their findings are intriguing and may give other research teams pause for thought as they develop potential microbicides.

## Study details

Researchers recruited 10 men for this study. At different points in time over a period of weeks, the men had different lubricants squirted into their rectums by the research team. These lubricants were:

ID Glide

a mixture of ID Glide and FemGlide

These substances were tagged with a tiny amount of radioactive material so that their passage through the rectum and colon could be monitored. Within 1½ hours after administering the lubricants, the study team began to probe the volunteers and removed tiny amounts of tissue from just inside the rectum to as deep as 40 cm (about 16 inches) from the anus into the colon. These tissue samples were observed under the microscope and analysed for changes and damage.

In parallel with this research on people, the research team also conducted lab experiments with the following lubricants and other substances:

Astroglide

FemGlide (also sold as Slippery Stuff)

Fleet enema

ID Glide

KY Jelly

PrePair

Specifically, they assessed the potential of these products to either pull water out of a cell or push water into a cell. If a cell loses water faster than it can be replaced, it becomes injured and can die. If it has absorbed too much water, the cell can also become damaged. Injured or damaged cells lining the rectum can, in theory, make HIV infection easier.

## Results

In testing these substances in the lab, the study team found that many of them were hyperosmolar—they tended to attract and absorb water from cells lining the rectum. This has the potential to damage these

cells. Indeed, the ability of the lubricants to pull water out of cells was between 4 and 14 times greater than the ability of rectal cells to retain water. The lubricant called FemGlide (Slippery Stuff) was the only product that did not have the potential to significantly pull water out of cells. The researchers classified it as hyposmolar, suggesting that it had the potential to push water into cells.

The other lubricants and substances, because they are hyperosmolar and attract and absorb water, have the potential to reduce the layer of mucus that coats the rectum.

Based on the analysis of tissue samples taken from volunteers, damage to cells lining the rectum occurred in less than two hours after lubrication was first applied. In theory, this damage may increase the risk of HIV transmission during sex. However, this study was not designed to assess such a risk and any conclusions drawn about that subject can only be theoretical possibilities.

Another finding from this study was that some lubricants, after being applied just past the anus, can migrate as far as 40 cm up the colon up to four hours after being applied. At such a distance, the lubricant becomes diluted and likely poses little threat to the health of colon cells. However, the potential for other issues (as noted below) arises.

## What's next?

The results from this study are intriguing and may stimulate other research teams to conduct studies to confirm and extend the initial findings of the Johns Hopkins team. The results from the present study also have implications for currently available lubricants and future rectal microbicides (which may or may not contain lubricants), including the following:

- Does exposure to certain commonly available lubricants in everyday use lead to rectal injury?

- How long after exposure to some lubricants will the rectum heal itself?

- How often can these products be safely applied to the rectum?

- As lubricants have the potential to migrate up the colon, will the concentration of microbicides still be active against HIV as they migrate and become diluted?

- Is it possible to create lubricants that do not migrate up the colon?

Overall, the results from the Johns Hopkins study show that much work remains to be done to study the potential safety of rectal microbicides and lubricants.

Sean R. Hosein

## References

- Steinbrook R. HIV in India—a complex epidemic. *N Engl J Med.* 2007 Mar 15;356(11):1089-93 .
  - Ramjee G, Morar NS, Alary M, et al. Challenges in the conduct of vaginal microbicide effectiveness trials in the developing world. *AIDS.* 2000 Nov 10;14(16):2553-7
  - Van Damme L, Ramjee G, Alary M, et al. Effectiveness of COL-1492, a nonoxynol-9 vaginal gel, on HIV-1 transmission in female sex workers: a randomised controlled trial. *Lancet.* 2002 Sep 28;360(9338):971-7
  - International Partnership for microbicides. About microbicides. Available at: [www.ipm-microbicides.org/about\\_microbicides/english/index.htm](http://www.ipm-microbicides.org/about_microbicides/english/index.htm)
  - Billich CO and Levitan R. Effects of sodium concentration and osmolality on water and electrolyte absorption from the intact human colon. *J Clin Invest.* 1969 Jul;48(7):1336-47
  - Fuchs EJ, Lee LA, Torbenonson MS, et al. Hyperosmolar sexual lubricant causes epithelial damage in the distal colon: potential implication for HIV transmission. *J Infect Dis.* 2007 Mar 1;195(5):703-10
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# The Asia-Pacific Coalition on Male Sexual Health

Shivananda Khan, Naz Foundation International

Despite evidence establishing male-to-male sex as one of the driving forces of HIV transmission in the Asia and Pacific region, only few HIV interventions strategically focus on prevention, treatment, care and support for males who have sex with males (MSM)<sup>1</sup> and transgenders,<sup>2</sup> where it is estimated by most experts, including UNAIDS, that targeted prevention programmes reach less than 8% of men who have sex with men, although at least 5% to 10% of all HIV cases in the world are as a result of sex between men.

In recognition of the need to build, strengthen and increase interventions addressing HIV-related vulnerabilities of males who have sex with males and transgenders in Asia and the Pacific, a Male Sexual Health and HIV in Asia and the Pacific International Consultation was held in New Delhi, India between 23<sup>rd</sup> and 26<sup>th</sup> September 2006 (see [www.risksandresponsibilities.org](http://www.risksandresponsibilities.org)).

This meeting brought together government officials, policy-makers, donors, researchers, grassroots activists, and community based organisations across Asia and the Pacific, to provide an opportunity for dialogue and learning, and to enable increased investment, strengthening and scaling up of strategies addressing male and transgender sexual health and related HIV risk factors. In addition, the consultation provided an opportunity to inform and develop strategic advocacy initiatives and deliberate on key policies related to the issues raised.

As an outcome of this meeting, it was agreed that a coalition, comprising of a regional alliance of civil society groups, HIV and AIDS organisations, MSM and transgender groups, in addition to international donors, development and government agencies, needs to be developed, to strongly advocate for increased investment, and scaling up of coverage of HIV prevention, care and support services for MSM and transgender populations across the region. This tripartite alliance is being called the Asia-Pacific Coalition on Male Sexual Health (APCOM), and advocate for increased and improved HIV and AIDS programming, will provide support to national and sub-regional networks, as well as work across the whole region, to facilitate the sharing of information on good practice in HIV prevention, treatment, care and support for MSM and transgenders. The coalition will be composed of organisations and agencies with a commitment to social justice and individual rights, along with those committed for improving the HIV and AIDS response to MSM and transgenders.

## Guiding Principles

The work of the Asia-Pacific Coalition on Male Sexual Health will be guided by the following principles, which have been adapted from the Guiding Principles of the Global Forum on MSM and HIV/AIDS:<sup>3</sup>

- **Individual rights and social justice.** The inter-related co-factors for HIV risk, vulnerability, and disparities, in access to care, treatment and prevention education, have a common basis in the significant social discrimination faced by MSM and transgenders. We believe that individual rights and social justice are key to the health and well being of MSM and transgenders.
- **Strength-based.** Solutions, programmatic, and policy responses often frame the HIV and AIDS problem in negative ways and demonise MSM and transgenders; we believe that effective responses to the HIV and AIDS epidemic directed at MSM and transgenders must acknowledge and build upon the strengths, competencies, and resources that such persons possess.
- **Sex positive approach.** All MSM and transgenders have the right to healthy and fulfilling sex lives, free from judgement and persecution. We believe that negative attitudes and narrow views about sex, sexuality, gender, and sexual expression are counter-productive and

have deleterious effects on the health and wellness of MSM and transgenders.

- **Empowerment.** Self-organising and open participation in the provision of appropriate HIV prevention, treatment, care and support services for MSM and transgenders is important in our work to end HIV and AIDS. We believe in supporting and respecting self-determination and self-initiated HIV and AIDS programmatic and policy responses.
- **Involvement.** There must be greater involvement of MSM and transgenders in programme planning and policy development arenas. We believe that HIV and AIDS programme and policy responses are strengthened by ensuring inclusion, parity, and representation.
- **Resources.** There is an urgent need to significantly increase investment, funding, and technical support for HIV programming directed at MSM and transgenders. At a minimum, we believe that funding should be at a level commensurate with the impact left by HIV and AIDS on MSM and transgenders.

## Mission

The Asia-Pacific Coalition on Male Sexual Health is a regional coalition of MSM and transgender community-based organisations, government, funding support agencies, and technical experts advocating for increasing investment and coverage of HIV services for these communities, along with promoting the Principles of Good Practice adopted at the Risks and Responsibilities Asia-Pacific International Consultation Meeting.

As an independent body, the *Asia and the Pacific Coalition on Male Sexual Health* in adherence to its guiding principles will also inform, augment and feed into activities, networks and advocacy initiatives supported under the umbrella of the Global Forum of MSM and HIV.

## Objectives

- Mobilise networks and communities of MSM and their organisations to participate in the response to HIV/AIDS prevention, treatment, care and support;
- Articulate and advocate for the needs and concerns of communities and networks of MSM and their organizations, involving in this process the various governments in the region, the body of technical expertise, and the various funding support and resource provider organisations, including, and when necessary, involving such governments, technical experts, and funding support organisations in the Governing Body;
- Ensure that community-based MSM organisations, particularly those with fewer resources and within affected communities, are strengthened in their work to prevent HIV infection, and to facilitate through such community-based MSM organisations, the provision of training and technical expertise on policy and rights, treatment, care and support, for all MSM, including those living with and/or affected by HIV and AIDS;
- Promote community involvement in participatory research to bridge knowledge gaps regarding MSM and their vulnerabilities;
- Promote the individual rights of MSM, in the development and implementation of policies and programs responding to all aspects of HIV and AIDS issues affecting MSM;
- Foster closer cooperation between government, community, technical experts, and funding support agencies to facilitate all of the above activities;
- Foster closer cooperation and collaboration with other affected communities infected and/or affected by HIV/AIDS and to mainstream MSM responses into the global fight against HIV and AIDS;
- Nurture and support transgender groups and organisations, and involve them in all activities as equal partners. It shall be the

endeavour of APCOM to help transgender groups form their own networks and coalitions to address their own issues and concerns.

#### Areas of emphasis

The coalition would devote itself to fostering, supporting and sharing information about:

- Country-level, sub-regional and regional action which raises awareness of MSM and transgender issues, and ensures that national, sub-regional and regional plans and strategies incorporate activities for MSM and transgenders, guarantees MSM and transgender representatives having a voice at policy setting forums, and mobilises expertise and financial resources;
- Evidence-based research and policy development to address critical knowledge gaps and to develop more responsive programme and policy recommendations;
- Advocacy through the establishment of effective partnerships with civil society organizations, government bodies, HIV and AIDS organisations, academia, and UN agencies.

#### Interim Structure of APCOM

The Interim Governing Board of APCOM shall be in place for at least the first year of its existence, until future Governing Board members can be chosen and put in place through due constitutional process of APCOM, and is constituted of 18 members, who are as follows:

Sector	Sub-region	Names
MSM groups	China	
	Developed Asia	Masao Kashiwazaki
	Greater Mekong	Siam Arayawongchai
	India	Ashok Row Kavi
	Pacific	to be announced
	South Asia (excluding India)	Sunil Pant
	South-East Asia (excluding GM)	Dede Oetomo
Transgender networks	2 representatives: nominated by transgender networks	
Government	2 representatives: nominated by UNAIDS	
Funding Support Agencies	2 representatives: nominated by UNAIDS	
Technical Experts	2 representatives nominated by UNAIDS and community	
Secretariat	Secretariat Coord.	Aditya Bondyopadhyay
Chair		Shivananda Khan
Observer Status	UNAIDS RST	

#### Future Structure of APCOM

- APCOM would be governed by a 19 member Governing Board which is constituted firstly of 7 elected members from the 7 sub-regions of the Asia-Pacific Region, elected by registered members from each grouping. In addition it will also have the following members:

- Two Transgender Representatives nominated by UNAIDS in consultation transgender groups in the region.
- Three Government Representatives from the Region, to be nominated by UNAIDS.
- Three funding support representatives from the region, to be nominated by UNAIDS.
- Three technical experts in the field of MSM and HIV, to be nominated by UNAIDS in consultation with the elected members of the governing board.
- The Executive Director of APCOM who shall be an Ex-Officio member of the Governing Board.

- APCOM shall have a permanent secretariat independent of its member organisations headed by the Executive Director.

#### Activities of APCOM secretariat and Outputs:

The main activities that the APCOM secretariat shall undertake in the 2 year period ending March 2009 shall include the following:

Component	Area of activity	Outputs
Coordination	With community groups	Network development nationally, sub-regionally and regionally
	With governments	Partnership meetings with donors and governments around key issues
	With donors	Partnership meetings with donors and governments around key issues
	With media	Increasing visibility and sensitisation
	With academia & research	Publications and research on strategic information and addressing knowledge gaps
Advocacy	Resource mobilisation	Increased commitment to fund MSM/TG services
	Governments	Inclusion of MSM/TG in national and sub-national plans, institution of sero-surveillance on MSM/TG transmission in country, research to fill knowledge gaps
	Media	Sensitised and greater coverage in addressing social justice concerns
	Civil society	Increased participation in achieving the above outputs
Strategic information	Epidemiological tracking	Evaluation of the direction of the epidemic
	Response tracking	Annual report jointly published with UNAIDS
Crisis interventions	With key actors in the crisis	Mitigations

*continued on page 8, col. 1*

You can access this and previous editions of Pukaar online at:

[www.nfi.net/pukaar-news.htm](http://www.nfi.net/pukaar-news.htm)

Other documents on related issues are available on the NFI website:

[www.nfi.net/publications.htm](http://www.nfi.net/publications.htm)

## Asia-Pacific Coalition on Male Sexual Health

continued from page 7, col.2

April - September 2007		
Component	Activity	Output
Coordination	<p>Development of Secretariat</p> <p>Interim Governing Body holds meeting in Bangkok, late May 2007: 20 participants. Review APCOM constitution and planning of activities at the 8th ICAAP</p> <p>APCOM website development with security features, including e-election procedures to Governing Body from Yr 2, information and data base</p>	<p>Secretariat functioning developed</p> <p>Interim Governing Body fully established, APCOM constitution accepted, and APCOM activities developed for 8th ICAAP</p> <p>APCOM website full developed and promoted election procedures developed enhanced networking across region achieved</p>
Advocacy  Organising	<p>Developing and implementing activities promoting APCOM at the 8<sup>th</sup> ICAAP in Colombo, Sri Lanka</p>	<ol style="list-style-type: none"> <li>1. Symposium on MSM and HIV in Asia and the Pacific</li> <li>2. Hosting a Satellite Meeting to officially launch APCOM in the region</li> <li>3. Conduct a Press Briefing with UNAIDS RST to promote APCOM</li> <li>4. Conduct a closed meeting matching donors with National AIDS Programmes in 4 to 6 countries around scaling up investment for sero-surveillance programmes for MSM and transgenders</li> <li>5. Meetings with donors, researchers, and community representatives regarding APCOM work for the future and gain support for these activities</li> <li>6. Conduct initial activities with the Local Committee representatives from the XVII International AIDS Conference to be held in Mexico City in 2008 for increased representation of MSM and HIV issues at all levels of the conference</li> </ol>
Strategic information	<p>Working with UNAIDS RST to develop in-country needs assessments regarding data on sero-prevalence and size estimations</p>	<p>Donors and countries identified for scaling up investment, particularly in regard to strategic information on sero-prevalence and increasing coverage. Four to six countries will initially be selected for donor matching</p>
Crisis intervention	<p>Developing principles and modalities for specific crisis intervention strategies. Crisis in this context relates to the following:</p> <ol style="list-style-type: none"> <li>1. Funding needs</li> <li>2. Individual rights abuse</li> </ol>	<p>Principles and modalities developed</p>

<sup>1</sup> While we use the term "men who have sex with men" here it is within the context of understanding that the word 'man'/'men' is socially constructed. Nor does it use imply that it is an identity term referring to an identifiable community that can be segregated and so labelled. Within the framework of male-to-male sex, there are a range of masculinities, along with diverse sexual and gender identities, communities, networks, and collectivities, as well as just behaviours without any sense of affiliation to an identity or community.

<sup>2</sup> Broadly speaking, transgender people are individuals whose gender expression and/or gender identity differs from conventional expectations based on the physical sex they were born into. The word transgender is an umbrella term which is often used to describe a wide range of identities and experiences, including: female-to-male and male-to-female sexual reassigned persons, cross-dressers, drag queens, drag kings, gender queers, and many more. In the Asia and Pacific region this would include *hijras*, *some kothis*, *zenanas and metis*, *kathoey*, *waria*, *bakla*, *fa'fa'finis*, etc. Because transgender is an umbrella term, it is often thought to be an imprecise term that does not adequately describe the particulars of specific identities and experiences. For example, the identity/experience of a post-operative female to male transsexual will probably be very different from that of a female-identified drag king who performs on weekends, but both are often lumped together under the term "transgender.")

Amended from [web.mit.edu/hudson/www/terminology.html](http://web.mit.edu/hudson/www/terminology.html), accessed 14/9/06

<sup>3</sup> [http://www.msm-aids2006.org/documents/conceptnote\\_18aug06.pdf](http://www.msm-aids2006.org/documents/conceptnote_18aug06.pdf)

October 2007 - March 2009		
Component	Activity	Output
Coordination	<ol style="list-style-type: none"> <li>1. On-going functioning of the Secretariat</li> <li>2. Website maintenance</li> <li>3. Community networking and mobilising</li> <li>4. Working with transgender communities, groups and networks to develop a transgender network for Asia-Pacific</li> <li>5. E-elections held for Governing Body in April 2008</li> </ol>	<ol style="list-style-type: none"> <li>1. Secretariat functioning</li> <li>2. Website maintained</li> <li>3. MSM and transgender groups and networks and inducted into the APCOM framework, becoming a part of national and sub-regional networks</li> <li>4. Asia-Pacific network of transgender groups and organisations developed and institutional support provided to sustain this network</li> <li>5. Technical assistance provided to support election procedures at sub-regional level for the governing body of APCOM, and elections held</li> </ol>
Advocacy	<ol style="list-style-type: none"> <li>1. Host 2 donors meetings in this 18 month period advocating for increasing investment</li> <li>2. Host a government policy meeting towards increasing investment, scaling up coverage and good practice</li> <li>3. Developing a range of media releases, working with regional and national media networks, and networking with a range of media</li> <li>4. Monitoring of responses to the HIV epidemic among MSM and transgenders in the region</li> </ol>	<ol style="list-style-type: none"> <li>1. 2 Donors meetings held, papers developed and disseminated</li> <li>2. Government policy meeting held, papers developed and disseminated</li> <li>3. Regular press releases disseminated, and APCOM media network developed</li> <li>4. In-country responses to HIV and MSM/transgender along with individual rights monitored and annual reports published</li> </ol>
Strategic information	Work with UNAIDS and a range of donors and researchers developing a range of papers on strategic information that also includes investment levels	A range of research papers published, including: sero-surveillance, social/behavioural studies, others as they arise
Crisis intervention	Activities determined as project progresses	Successful interventions as they occur

## Gonorrhoea ‘raises cancer risk’

*Men who have had gonorrhoea are twice as likely to develop bladder cancer, a study has found.*

Researchers analysed the histories of 286 bladder cancer cases and confirmed a link between the sexually transmitted infection and cancer.

In total, the Harvard School of Public Health team examined detailed health records on 51,529 US men.

Writing in the British Journal of Cancer, they said inflammation caused by gonorrhoea could be the key.

Dr Dominique Michaud, Assistant Professor of Epidemiology and lead author on the paper, said: “Two studies have previously suggested a link between gonorrhoea and bladder cancer in men.

“But these were retrospective studies - meaning information on gonorrhoea history was gathered after the cancer was diagnosed.

“These studies can sometimes give misleading results.”

This study was done prospectively - the cases chosen had full gonorrhoea histories available before the study started.

It is the first time such a prospective study has confirmed the link.

### Inflammation

Dr Michaud said: “Gonorrhoea is an infection that often recurs, causing local inflammation and symptoms such as incomplete emptying of the bladder.

“The inflammation itself or the associated symptoms could be contributing to the development of bladder cancer.”

Professor John Toy, medical director of Cancer Research UK said: “This study strengthens the suspected link between infection with the gonorrhoea bacterium and bladder cancer in men.

“The next step is to confirm whether the increased risk could be

caused directly by the gonorrhoea infection or its symptoms.

“Further research is also needed to exclude the possibility that gonorrhoea is acting as a marker for the real cancer-causing agent, such as a separate infection.

### STI danger

Although the number of new patients each year is falling, gonorrhoea is the second most commonly diagnosed bacterial sexually transmitted infection in the UK and the new study emphasises the importance of protecting against such infections.

Dr Gwenda Hughes, head of STI surveillance at Health Protection Agency said:

“According to our latest annual figures of all STIs, Gonorrhoea decreased by 13% (from 22,350 in 2004 to 19,495) in 2005.

“However, we should not be complacent and overall figures of STIs are increasing.

“Quick diagnosis is essential, so anyone who thinks they may have put themselves at risk of contracting an STI or has developed symptoms should seek advice from their GP or go to a GUM clinic as soon as possible.”

*Story from BBC News, 10/1/07*

Let me pass, I have to follow them. I am their leader  
Alexander August Kedru-Rollin, 1857

# Global Forum on MSM and HIV

## International Steering Committee Meeting: Meeting Report

Mexico City, February 4-6, 2007

The Global Forum on Men Who Have Sex with Men (MSM) and HIV was launched at the International AIDS Conference –AIDS 2006- in Toronto, Canada. This initiative grew out of a shared concern that existing HIV/AIDS strategies do not adequately address MSM needs. The Forum is integrated by a loose network of civil society groups, AIDS organizations, MSM groups and other agencies. It will work at global and national levels to advocate for improved AIDS programming for MSM, and to share information on best practice in HIV prevention, treatment and care and support for MSM.

During two and a half working days (February 4 to 6, 2007) the Interim Steering Committee met in Mexico City, at the Constella Futures/Mexico offices. The goal of this meeting was to develop an operational plan for 2007-2008 for the Global Forum on MSM and HIV.

The key objectives of the meeting were to increase understanding and clarity on:

1. Structure and governance of the Forum
2. Communication and representation
3. Key activities 2007-2008 (from present time to Mexico 2008)
4. Implementation plan and resource mobilization
5. Working with key populations and on transgender (TG) issues

The Interim International Steering Committee meeting included 12 key stakeholders from 4 continents, including Canada, Netherlands, Mexico, Cameroon, Colombia, USA, Thailand and India, as well as a guest from UNAIDS. Problems with visa arrangements hindered the participation of Samuel Matsikure from Zimbabwe. Robert Carr from Jamaica was unable to attend at the last minute.

The meeting was facilitated by Ken Morrison (Mexican Institute of Public Health, INSP/Health Policy Initiative HPI-USAID Project). The meeting's agenda focused on the following issues: a) Reports on MSM issues and networking initiatives from the regions; b) Evaluation of the Forum activities to date; c) Forum goals and objectives; d) Key activities; e) Governance and Structure; f) Funding; g) Follow-up; and h) Meeting evaluation.

### Reports from the regions

Each participant gave a brief description of the current situation in their respective region, sub region or country. A key aspect was the presentation of the summary report of the international consultation on Male Sexual Health and HIV in Asia and the Pacific: "Risks and Responsibilities" (New Delhi, India 23-26 September, 2006). The consultation brought together 380 delegates from governments, policy-makers, donors, researchers, grassroots and community based organization from 22 countries across the Asia-Pacific region. The consultation enhanced knowledge based on the technical, social and policy issues relevant to male-to-male and transgender sexual behaviors and HIV risk and vulnerability. Recommendations, key strategies, advocacy initiatives and policies were identified.

The following is a synthesis of common issues, concerns and needs from the regional reports and discussion:

#### 1. The need for greater coherence between the epidemic and corresponding policies and programs:

- a. Lack of data based on scientific evidence related to MSM and lack of related results-based on planning;
- b. Lack of knowledge and a research agenda based on real situations and needs;
- c. Insufficient community involvement and community-led initiatives;
- d. Prevalence of stigma and discrimination environment and lack of respect to the human rights of MSM.
- e. Lack of National AIDS Plans (NAPs) with MSM plan and corresponding budget;
- f. Absence of an MSM response within a public health agenda;

g. Lack of health and legal services to MSM;

h. Lack of knowledge and understanding among policy makers and donors regarding the situation, priorities and needs of MSM populations, as they relate to HIV/AIDS.

#### 2. The need for community mobilization and community development

- a. The development of products and initiatives should include a process of social mobilization;
- b. The building of social capital is a necessary on-going process in most of the regions;
- c. There is a common need for training on operations research, evaluation, project development and implementation;
- d. Most regions need a strong organizational/institutional development process for NGOs working on MSM issues;
- e. In most regions resource allocation for country-level responses on MSM needs is very limited;

f. Given the vast diversity of MSM communities there are specific necessities for specific populations and sub-populations.

#### 3. The need for greater collaboration and partnerships

- a. There is a need for an improved interface between the community and with donors and policy makers;
- b. In most regions the building of strategic alliances with other key actors around vulnerability, MSM issues and HIV is still weak;
- c. Lack of dialogue channels with national and regional key actors in most regions;
- d. Strengthening the voice and visibility of the MSM communities in some regions is a priority;
- e. Information exchange among the community (best practice, what works, what doesn't work) needs to be strengthened;
- f. There is a need to re-conceptualize MSM as a gender issue and address gaps in initiatives;
- g. Information about migration, prison and poverty issues among MSM is very limited;
- h. Complete inventories of existing resources and directories of key actors, organizations and networks working on MSM issues around the world are needed.

### Global Forum on MSM and HIV Goals

The participants did an exercise in which they designed a vision for the GF in the future, and then discussed this as a basis for the work plan. They agreed on the mission statement of the Global Forum on MSM and HIV: "To advocate for improved AIDS programming for MSM, and to share information on best practice in HIV prevention, treatment and care and support for MSM".

Participants described the vision of the GF as centred on three principal areas of work: a) knowledge management and information, b) advocacy, policy and programs and c) community mobilization and community development. The principles of empowerment, strength-based solutions, human rights & social justice, resources, sex positive approach and involvement underpin and support these areas of work. The areas of work and the principles, are designed to achieve the main aim of universal access to prevention and care services through National AIDS Programs (NAPs).

### Issues and activities

After the identifying these three principal areas of work, participants focused on developing a detailed list of components for each area: *Knowledge management and information exchange*

- 1) Literature searches on the issue, initiatives and research related to MSM and HIV, and establishment of an information clearinghouse;
- 2) Collection and analysis of information on MSM initiatives and corresponding resources allocated;
- 3) Develop inventories of MSM groups, strategic partners, and MSM-related research;

- 4) Web site development;
- 5) Identify sources of funding for implementation of MSM programs;
- 6) Knowledge transfer at international, regional and national AIDS conferences.

#### *Advocacy, policy and programs*

- 1) Focus the advocacy agenda on universal access;
- 2) Develop a position paper on global and regional MSM and HIV issues;
- 3) Initiate advocacy with donors
- 4) Develop partnerships with key actors
- 5) Ensure MSM representation at international, regional and national AIDS conferences.

#### *Community mobilization development*

- 1) Networking at community and global level;
- 2) Capacity building;
- 3) HIV competence;
- 4) Promotion of values to build legitimacy and recognition.

#### **Governance and structure**

The Steering Committee decided the administrative needs of the Global Forum should be undertaken by a small and flexible Secretariat to be hosted in a Global Forum partner organization and made up by a group of regional representatives with expertise and a few key international allies. Detailed Terms of Reference (TOR) will be developed in the following months in order for everyone to efficiently understand and carry out their corresponding responsibilities.

A location for an interim Secretariat will be defined in the next few months. The two organisations under considerations for the Secretariat location are AIDS Project Los Angeles (APLA) and Australian Federation of AIDS Organizations (AFAO) in Sydney.

The following is a list of people that will undertake the composition of the Steering Committee until a meeting in 2008 to appoint a new one:

#### **Regional Representatives**

Robert Carr – Caribbean  
 John Maxwell – North America (Canada)  
 George Ayala North America (USA)  
 Luis Fernando Leal Latin America  
 Siam Arayawongchai – Thailand – Greater Mekong  
 Joel Nana – Cameroon – Francophone Africa  
 Samuel Matsikire – Zimbabwe /English Africa  
 Aditya Bondyopadhyay – Asia & Pacific  
 Representative from Eastern Europe  
 Representative from Western Europe

#### **International Representatives**

Richard Burzynski, ICASO  
 Shivananda Khan, NFI  
 Don Baxter, AFAO (to be confirmed)

#### **Other Key Representatives**

Carlos Garcia de Leon - link with Mexico 2008  
 Representative from the International HIV/AIDS Alliance  
 Representative from UNAIDS

For the first 6 months, effective April 1<sup>st</sup>, 2007 George Ayala, Noel Nana and Richard Burzynski will serve as Co-chairs of the Global Forum. John Maxwell will assist in the transition process.

Participants also developed a list of key messages and tasks of the Global Forum:

- The Forum is planning to undertake a series of advocacy actions and technical support to strengthen national HIV/AIDS plans, so that they can reach/achieve Universal Access to prevention, treatment and care services targets. The committee will aim to connect MSM groups with technical assistance so that they can strengthen their community mobilization and programming response;
- All countries have agreed to specific key principles and frameworks to help them implement effective programs; but the risk of not achieving Universal Access is real, due to programs excluding those often most in need – those vulnerable and at risk. Among them are MSM. Programs that exclude reaching MSM, put at risk other

segments of the population, such as women married to a MSM. The Forum will focus more energy at country level to evaluate the status of NAPs and how they include or not interventions aimed to the health and well being of MSM.

- It is recognized that little scientific data has been gathered on the problems faced by MSM. The Forum will promote more research into the complexities of the MSM communities throughout the world, particularly focusing on those countries where there has been denial of MSM.

- Governments have agreed to strengthen their national plans with the Three Ones principle. The Forum will advocate with national governments and international bodies such as the UNAIDS and its cosponsoring agencies, to ensure the strengthening process.

- The Global Fund has been set up to help finance many of these programs, yet they support very few MSM programs. The Forum will promote studies on the amount of MSM programs that have been funded by the Global Fund at country level.

#### **Follow up Activities:**

##### Activities Deadline

- |  |  |
|--|--|
| 1. Secretariat location determined:      | March 1st, 2007                                      |
| 2. Develop terms of reference            | April 1 <sup>st</sup> 2007                           |
| 3. Develop work plan and budget          | April 1 <sup>st</sup> , 2007                         |
| 4. Website development.                  | April 1 <sup>st</sup> , 2008 (updating in June 2007) |
| 5. Mexico 2008 Conference plan developed | April 1 <sup>st</sup> , 2007                         |
| 6. Develop operative plan                | June 1 <sup>st</sup> , 2007                          |
| 7. Initiate fundraising                  | ongoing  |

#### **Other activities during the meeting**

During the final day of the meeting Hazel Davenport from CENSIDA (national AIDS program in Brasil) was invited to share a transgender point of view, and to explore ways of collaboration in order to strengthen the participation of transgender people at the International AIDS Conference, Mexico 2008. At the end of the session, participants expressed their commitment to Hazel, by supporting her work mobilizing the transgender community, and sharing information with key transgender stakeholders in all regions of the world.

After the meeting, a press conference was organized. At this advocacy event, Carlos Garcia de León, Juan Jacobo Hernández and Luis Felipe Leal were accompanied by Arturo Diaz, a Mexican activist on MSM issues. The achievements of the meeting were shared with the local media, highlighting related local MSM advocacy issues and their links with the goals of the Global Forum.

Mexico City Meeting: Full report now available:

As mentioned in the last email, The Interim Steering Committee of the Global Forum on MSM and HIV met in Mexico City February 4-6, 2007. The goal of the meeting was to develop an operational plan that included structure, governance, communications, areas of endeavour, implementation activities, budgets, and sources of funding. The committee consisted of twelve key stakeholders from five continents (Africa, Asia, Europe, North America and South America).

The PDF of the final report of the meeting is now available on the main page of the Global Forum website, in English, French and Spanish (<http://www.msmandhiv.org/index.html>).

#### *Updates to the "Latest News section" of the website:*

Find out more about how HIV/AIDS programming is failing same-sex practising people in Africa, and updates from the International rectal Microbicides Working Group regarding lubricant. (<http://www.msmandhiv.org/whatsnew/news.html>)

#### *Upcoming MSM and HIV-related events:*

Got an upcoming event you want to list? Send the Global Forum and email at [contact@msmandhiv.org](mailto:contact@msmandhiv.org)

Check out the web page for links to Foro Comunitario Latinoamericano y del Caribe en VIH/Sida e ITS (16-17 April, 2007), 4th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention (22-25 July, 2007) and 8th International Congress on AIDS in Asia and the Pacific (ICAAP) (19-23 August, 2007)  
 Upcoming Events: <http://www.msmandhiv.org/whatsnew/upcoming.html>

## MSM and best practice

It's an unfortunate reality that all too often, the people most at risk and most in need of HIV prevention, treatment and care programmes are those least likely to have access to these services. According to latest estimates, only one in ten people 'most at risk' has access to prevention services. In many cases, for injecting drug users, sex workers and men who have sex with men, AIDS poses a double burden—on the one hand, there are a very limited number of programmes specifically designed to reach them, and on the other hand, they are often faced with discrimination, stigma and in some cases even criminal prosecution by the societies they live in.

But evidence and experience shows that focusing AIDS programmes and services specifically on people who are most at risk leads to encouraging progress within the response and can help reduce stigma and discrimination.

This month's review of the UNAIDS Best Practice collection looks at the issue of men who have sex with men (MSM) in the Asia and the Pacific region and the focused programmes implemented in six countries that are showing progress.

In Asia, men who have sex with men are disproportionately affected by HIV. It is estimated that HIV prevalence is as high as 14% in Phnom Penh, Cambodia; 16% in Andhra Pradesh, India; and 28% in Bangkok, Thailand.

Men who have unprotected sex with men may also have unprotected sex with women and thus serve as an epidemiological bridge for the virus to the broader population. For example, a survey of over 800 men in China who have sex with men found that 59% reported having had unprotected vaginal sex with women in the previous year.

"It is a commonly held misperception that male-male sex happens only among men who self identify as 'gay'. Most men who have sex with men living outside the West are not identifiable as such, they live and work in their communities unremarked and are often heads of families with children," the Best Practice outlines

"HIV transmission prevention programmes addressing men who have sex with men are therefore vitally important. However, this population is often seriously neglected because of official denial by governments, the relative invisibility of men who have sex with men, stigmatization of male-to-male sex, ignorance or lack of adequate information," it says.

The MSM programmes, implemented in Bangladesh, India, Indonesia, the Philippines, China and New Zealand, were chosen to be part of the UNAIDS Best Practice collection due to their success in providing comprehensive interventions that engage all actors involved in the AIDS response.

Although different in their make-up, the programmes have common elements and activities that have proved to be effective in reaching and supporting men who have sex with men on AIDS issues in Asia.

Advocacy activities with governments, health services and mainstream communities are common to all programmes. In Bangladesh, successful advocacy from the Banhu Social Welfare Society, including networking and participation in governmental meetings, has ensured the inclusion of issues relating to men who have sex with men in the five-year National AIDS Strategic Plan. In Indonesia, the Aksi Stop AIDS and Family Health International programme have worked hard to engage the authorities in the AIDS response. The Indonesian Ministry of Health is now recognising the seriousness of the situation and communities of men who have sex with men have been invited to participate in consultations on AIDS-related issues.

The Best Practice publication highlights a number of interesting outreach activities that some of the programmes are implementing. For example, in Hong Kong, the 'AIDS concern' organization set up a programme focusing on customers of saunas. Materials promoting safer sex such as leaflets, comic books and information brochures were produced and distributed across 13 saunas and outreach workers

met with owners and staff to foster relationships and assess the situation. Increasingly, condoms, and lubricant were also distributed. "Good relations between the outreach workers and the sauna owners continue and there have been increased opportunities for contact with clients as a result of testing services. As a result clients are less apprehensive," the publication states.

The programmes highlighted in the publication underline that activities implemented by people living with HIV have been proven to be more effective and help to further break down AIDS-related stigma and discrimination.

### Know your epidemic

As the Best Practice outlines, in many countries, prevention efforts are hindered by laws that criminalize male-male sex, making work with men who have sex with men difficult and hindering their contribution to the response to the epidemic. Where social, cultural and religious attitudes make the issue politically sensitive, politicians are generally reluctant to support policies and programmes that might result in public criticism from community leaders and groups.

HIV prevention programmes for men who have sex with men like those featured in the Best Practice are vitally important to stop HIV transmission. However, lack of research about men who have sex with men including their behaviours and attitudes, and criminalization and stigmatization of and legal discrimination against these men, are also significant barriers to implementing effective programmes. Research was an integral part to the success of the AIDS Concern sauna outreach activities in Hong Kong as part of the activity a research project was undertaken to determine the prevalence of high risk behaviours among sauna clients, levels of access to free condoms and lubricant, and the nature of information materials that would be best suited to sauna clients.

Through the examples of the six MSM programmes, the publication underlines that HIV programming for men who have sex with men needs to be carefully tailored to local cultures and conditions. Rather than relying on approaches based on patterns of male-male sexual behaviour observed in Western Europe and North America, local sexual minorities should be identified and engaged in developing programmes. In New Zealand, the New Zealand AIDS Foundation promotes the use of a community's cultural resources to make AIDS information materials relevant and attractive. Designs, images, colours, language and models are used which are instantly recognizable as belonging to either the Maori or Pacific Islander communities.

As the Best Practice underlines, UNAIDS supports a range of responses aimed at reducing the vulnerability of men who have sex with men to HIV and its impacts including the promotion of high-quality condoms and water-based lubricants, ensuring their continuing availability; safer-sex campaigns and skills training; peer education among men who have sex with men and female partners; and strengthening organizations of self-identified gay men, enabling them to promote and rapidly increase HIV prevention and care programmes for men who have sex with men.

"Twenty five years into this epidemic, the reality is that only one in ten men who have sex with men have access to HIV prevention services. This is a massive failure, and setting it right has to be among the highest priorities for the increasingly strong global AIDS response as we aim to achieve universal access to HIV prevention, treatment, care and support for all groups, including men who have sex with men and transgender people," said Purnima Mane, UNAIDS Director of Policy, Evidence and Partnerships.

*MSM-Asia 22/3/07*

*UNAIDS Press Release - March 21, 2007*

## Anti-gay discrimination fueling HIV-AIDS epidemic in Africa

Discrimination against gays in Africa is fueling the HIV/AIDS epidemic on that continent, according to a report released Thursday by a rights group that called for urgent action to address the issue. The International Gay and Lesbian Human Rights Commission (IGLHRC), a non-profit US-based organization, said that African governments as well as the Bush administration and European governments must break the wall of silence that surrounds AIDS and same sex practices in Africa or face responsibility for the spread of the disease.

"Despite increasing evidence of the need for HIV-related interventions for same-sex practicing people, there are scarcely more than a handful of formal HIV prevention, testing, treatment, or care programs targeting men who have sex with men in Africa and even fewer for same-sex practicing women," the report says.

"Without immediate attention to this human right crisis, efforts to effectively combat the AIDS epidemic in Africa may be seriously challenged," it added.

Cary Alan Johnson, senior specialist for Africa at the IGLHRC, said although some African countries, such as Senegal, Nigeria and Kenya, have made efforts to tackle the problem, these same countries maintain laws that target homosexuals and lesbians. "If anything is increasingly the vulnerability of gay men in Africa with HIV, it is sodomy laws that prevent people from speaking honestly about who

they are and that push people further away from HIV prevention services," Johnson told AFP.

He said the Bush administration was contributing to the stigmatization of gays in Africa as many of the organizations funded by the US government were faith-based and blatantly homophobic.

"Faith-based organizations have done some wonderful work in Africa but by definition a lot of their religious doctrine is homophobic," Johnson said. "So they can't be made to respond to the needs of gay and lesbian people in the field."

The 125-page report entitled "Off the Map" lists a number of examples in which African gays and lesbians have been denied treatment or ridiculed, sometimes by foreign-funded organizations, because of their sexual orientation.

It calls on African governments to repeal laws that discriminate against gays, to boost funding for programs specifically targeting homosexuals and to train health professionals so that gays and lesbians no longer face discrimination when seeking medical care. It also urges the United States in particular and foreign donors in general to help create programs aimed at assisting gays in Africa.

"We know that if these things don't happen, the entire effort to fight HIV in Africa is going to be sabotaged," Johnson said.

With slightly more than 10 percent of the world's population, Africa is home to 60 percent, or more than 25 million people, living with HIV/AIDS.

Though there are no firm statistics, it is estimated that gay people make up between three and 10 percent of the population in Africa, Johnson said.

*AMAG Network, 2/3/07*

## For the first time, a transgender person has been legally recognized in a Nepal's history as a transgender.

About 10 days ago, I was in Nepalgunj visiting Blue Diamond Society's (BDS) Branch office and met a number of metis (male person who dresses and identifies as a woman) including Chanda Rani. We discussed about many human rights issues and constitutional rights of transgenders, gays, lesbians and bisexual people. During the discussion, I told the metis that the Citizenship Team (the government team that is registering citizenship ID to Nepali citizens) was issuing citizenship IDs and that transgender should demand the citizenship that truly represents themselves, not as a man or a woman but as transgender, and to test the Interim Constitution that ensures equality for every citizen.

Inspired, Chanda applied for citizenship at Khas Karkandho VDC Ward No. 9 in Banke District, near Nepalgunj demanding the citizenship ID that identifies her as transgender. Today she has been issued with a citizenship ID that erased the "M/F" part under gender (to identify as male or female) and replaced with "Both".

The citizenship ID No. is 66302/9, and her name is written as Chanda Musalman. The citizenship was given on the basis of birth and her father's name is Faidher Musalman. This is a landmark victory for sexual and gender minorities in Nepal. We just hope that the other rights of sexual and gender minorities will be ensured as well.

Congratulation to Chanda Musalman and best wishes to all sexual and gender minorities in Nepal.

We express our hearty gratitude to the Citizenship Team and to the Nepal Government for this recognition.

*From Sunil Pant, President of Blue Diamond Society, Nepal  
3/2/07*

## New HIV/AIDS cases in Japan reach record high

The number of people newly diagnosed with HIV and those who developed AIDS in Japan in 2006 reached record highs of 914 and 390, respectively, according to preliminary data released Wednesday by the Japanese AIDS Surveillance Committee, the Kyodo/Yahoo! Asia News reports.

According to the committee's report, the most significant increase in new HIV cases occurred among men who have sex with men, and 15 times more men than women reported a new HIV-positive diagnosis in 2006.

In addition, an increasing number of people ages 30 and older became HIV-positive in 2006 compared with 2005, the report found.

It also shows a nearly 10% increase in new HIV cases from 2005 to 2006 and a 6.3% increase for those who developed AIDS during the same time period, the AP/Forbes reports.

Revised data from 2005 indicate that 832 new HIV cases and 385 AIDS cases were reported that year.

In addition, the report found that the number of people in Japan receiving no-cost HIV tests increased by 16.2% in 2006, suggesting that HIV/AIDS awareness in the country is increasing, according to AFP/Nation.

"While the number of people getting checks is growing, we believe infections themselves are on the increase," Aikichi Iwamoto, committee chair and a professor at the University of Tokyo's Institute of Medical Science, said, adding, "Given most were infected through sexual contacts, we hope people will understand that HIV is increasingly common, take preventive measures and get examined early if they are worried about anything."

This was the third consecutive year that HIV/AIDS cases in Japan totaled more than 1,000 and reached record highs, the Kyodo/Yahoo! Asia News reports.

*AIDS-Asia, 16/2/07*

## AIDS and public security: The other side of the coin

Joanne Csete

*The Lancet 2007; 369:720-721*

In December, 2006, the Joint UN Programme on HIV/AIDS (UNAIDS) submitted to its governing board a paper on HIV/AIDS and security—a culmination of wide ranging UN discussions on this subject that began with the historic consideration of AIDS in the Security Council in 2000. The paper reprises frequently raised concerns—ie, that high AIDS-related mortality in the military will compromise security in highly affected countries, or that high costs of AIDS will sap public resources needed to ensure security. UNAIDS notes that such destabilisation has not yet occurred, but that “does not mean that...such a threat will not emerge”.

In such analyses, the effect of AIDS on military strength and public security overshadows what may be a substantially more important link between AIDS and security—i.e., the effect of the unfettered pursuit of a public security agenda, including counterterrorism measures, on the lives of people who are most affected by, or vulnerable to, HIV/AIDS.

For example, the 2004 tragedy in which 32 armed attackers took 1200 hostages at a school in Beslan, Russia, resulted in more than 300 deaths, including many children. Anyone who was working on HIV/AIDS in Russia was unsurprised that a few weeks later, the Kremlin announced that autopsies showed, rather improbably, that all the Beslan attackers were heroin addicts. However, police in Beslan never saw any drug-using equipment, and witnesses reported no signs of drug use by the hostage-takers. The Kremlin's assertion, which could not be verified because the autopsy records were not made public, was consistent with the government's history of demonising people who use drugs as the worst kind of criminals.

In Russia, the extreme criminalisation of drug users impedes effective HIV/AIDS programmes because most HIV transmission is linked to drug injection. Furthermore, harsh criminalisation of drug use impedes programmes in Thailand, where a violent war on drugs in 2003, that resulted in more than 2500 deaths, was justified in the name of public security, and the USA praised Thailand as a partner in the “war on terror”. Thailand's successful reduction in HIV incidence and prevalence in sex workers, who are not criminalised, contrasts with that of continued high HIV prevalence in drug users.

Men who have sex with men have been caught up in the politics of antiterrorism in various settings. In Egypt, where there was previously some degree of quiet tolerance of homosexuality, the political need to assert traditional Islamic values since Sept 11, 2001, has led to increased repression of homosexual and bisexual men. Heightened security associated with the Maoist insurgency in Nepal has reportedly encouraged police to attack homosexual men with impunity. In India, men who have sex with men and street-based sex workers told Human Rights Watch that police abuse against them increased in the name of counterterrorism after the December, 2001, attack by five armed men on the parliament in New Delhi, India.

In other words, people who are particularly vulnerable to HIV are in many countries the first to be targeted by counterterrorism and security measures. All too often, such targeting is assisted by criminal sanctions against homosexuality, criminalisation of sex work, and severe criminal penalties for minor non-violent drug offences. Establishment of criminal penalties in these areas facilitates both official and social marginalisation of these people, who find it almost impossible to have police protection if their rights are violated.

UNAIDS and its cosponsor agencies rarely include criminalisation of people who are vulnerable to HIV in their analyses of national AIDS responses. They prefer to characterise AIDS-related human-rights problems as stigma and discrimination, which although certainly important, do not capture adequately the severe effect of criminalisation on people affected by HIV and on their ability to use AIDS programmes without fear. It is hardly an accident that the fastest-growing AIDS epidemics in the world are in countries of the former Soviet Union and of parts of Asia, where public-health approaches to address drug use are grossly underfunded compared with criminal-law approaches. Moreover, such criminalisation is reinforced easily when security and counterterrorism are high on the political agenda. UNAIDS' incomplete analysis of AIDS and security, and its failure to appreciate the effects of criminal law on those most affected by AIDS, impede its ability to advocate effectively for the interventions based on human rights that it always claims to pursue.

## Maoist cleanup drive hits Nepal gays

After being persecuted by King Gyanendra's regime and the new multi-party government, Nepal's homosexual community is now at the receiving end of a society clean-up drive launched by Maoist militants.

The communists, who now freely roam in the capital after they signed a peace accord with the new government of Prime Minister Girija Prasad Koirala and had the terrorist tag lifted, have now turned their attention to cleaning “social pollutants”, ranging from pornographic films to homosexuality, Kathmandu's gays, who had joined hands with the Maoists and political parties to oppose King Gyanendra's direct rule, felt the new communist crackdown last month after Maoist cadres went around ordering house owners not to let out rooms to homosexuals and lesbians.

Alarmed at the new diktat, members of the community met the former Maoist commander of Katmandu valley, known as Sagar, to persuade him to call off the drive.

“We don't want to evict anyone,” Sagar said. “So we have asked house owners to allow tenants. However, we are against any aberrant activity that could have a negative and vitiating effect on society.”

The insurgents, who have been campaigning against polygamy, polyandry, infidelity and drunkenness, have a zero tolerance policy

towards homosexuality. Blue Diamond Society, Nepal's only NGO fighting for gay rights met a Maoist leader, Dev Gurung, to try explain the rights of gays, lesbians and transgenders to him. The rebel leader reportedly said that homosexuality was a by-product of capitalism. “Under Soviet rule and when China was still very much a communist state, there were no homosexuals in the Soviet Union or China,” Gurung reportedly said. “Now they are moving towards capitalism, homosexuals may have arisen there as well. So homosexuality is a product of capitalism. Under socialism this kind of problem doesn't exist.”

When Blue Diamond Society met other Maoist leaders to point out that homosexuals were under attack from Maoist cadres, the reaction was “disheartening”, it says. Homosexuals were once the pet target of security personnel during King Gyanendra's regime.

At the Women Human Rights Defenders' third national consultation, Amrita Thapa, general secretary of Maoists' women's association, said homosexuals were “unnatural” and were “polluting society”.

*Asia Age, 5/1/07*

## Global AIDS epidemic continues to grow

*New data also show HIV prevention programmes getting better results if focused on reaching people most at risk and adapted to changing national epidemics*

The global AIDS epidemic continues to grow and there is concerning evidence that some countries are seeing a resurgence in new HIV infection rates which were previously stable or declining. However, declines in infection rates are also being observed in some countries, as well as positive trends in young people's sexual behaviours.

According to the latest figures published today in the UNAIDS/WHO 2006 *AIDS Epidemic Update*, an estimated 39.5 million people are living with HIV. There were 4.3 million new infections in 2006 with 2.8 million (65%) of these occurring in sub-Saharan Africa and important increases in Eastern Europe and Central Asia, where there are some indications that infection rates have risen by more than 50% since 2004. In 2006, 2.9 million people died of AIDS-related illnesses.

New data suggest that where HIV prevention programmes have not been sustained and/or adapted as epidemics have changed— infection rates in some countries are staying the same or going back up.

In North America and Western Europe, HIV prevention programmes have often not been sustained and the number of new infections has remained the same. Similarly in low- and middle-income countries, there are only a few examples of countries that have actually reduced new infections. And some countries that had showed earlier successes in reducing new infections, such as Uganda, have either slowed or are now experiencing increasing infection rates.

"This is worrying—as we know increased HIV prevention programmes in these countries have shown progress in the past—Uganda being a prime example. This means that countries are not moving at the same speed as their epidemics," said UNAIDS Executive Director Dr Peter Piot. "We need to greatly intensify life-saving prevention efforts while we expand HIV treatment programmes."

### **HIV prevention works but needs to be focused and sustained**

New data from the report show that increased HIV prevention programmes that are focused and adapted to reach those most at risk of HIV infection are making inroads.

Positive trends in young people's sexual behaviours - increased use of condoms, delay of sexual debut, and fewer sexual partners - have taken place over the past decade in many countries with generalized epidemics. Declines in HIV prevalence among young people between 2000 and 2005 are evident in Botswana, Burundi, Côte d'Ivoire, Kenya, Malawi, Rwanda, Tanzania and Zimbabwe.

In other countries, even limited resources are showing high returns when investments are focused on the needs of people most likely to be exposed to HIV. In China, there are some examples of focused programmes for sex workers that have seen marked increases in condom use and decreases in rates of sexually transmitted infections, and programmes with injecting drug users are also showing progress in some regions. And in Portugal, HIV diagnoses among drug injectors were almost one third (31%) lower in 2005, compared with 2001, following the implementation of special prevention programmes focused on HIV and drug use.

### **Addressing the challenges: Know your epidemic**

In many countries, HIV prevention programmes are not reaching the people most at risk of infection, such as young people, women and girls, men who have sex with men, sex workers and their clients, injecting drug users, and ethnic and cultural minorities. The report outlines how the issue of women and girls within the AIDS epidemic needs continued and increased attention. In sub-Saharan Africa for example, women continue to be more likely than men to be infected with HIV and in most countries in the region they are also more likely to be the ones caring for people infected with HIV.

According to the report, there is increasing evidence of HIV outbreaks among men who have sex with men in Cambodia, China, India, Nepal, Pakistan, Thailand and Viet Nam as well as across Latin

America but most national AIDS programmes fail to address the specific needs of these people. New data also show that HIV prevention programmes are failing to address the overlap between injecting drug use and sex work within the epidemics of Latin America, Eastern Europe and particularly Asia.

"It is imperative that we continue to increase investment in both HIV prevention and treatment services to reduce unnecessary deaths and illness from this disease," said WHO Acting Director-General, Dr Anders Nordström. "In sub-Saharan Africa, the worst affected region, life expectancy at birth is now just 47 years, which is 30 years less than most high-income countries."

The *AIDS Epidemic Update* underlines how weak HIV surveillance in several regions including Latin America, the Caribbean, the Middle East, and North Africa often means that people at highest risk - men who have sex with men, sex workers, and injecting drug users - are not adequately reached through HIV prevention and treatment strategies because not enough is known about their particular situations and realities.

The report also highlights that levels of knowledge of safe sex and HIV remain low in many countries, as well as perception of personal risk. Even in countries where the epidemic has a very high impact, such as Swaziland and South Africa, a large proportion of the population do not believe they are at risk of becoming infected.

"Knowing your epidemic and understanding the drivers of the epidemic such as inequality between men and women and homophobia is absolutely fundamental to the long-term response to AIDS. Action must not only be increased dramatically, but must also be strategic, focused and sustainable to ensure that the money reaches those who need it most," said Dr Piot.

*UNAIDS Press Release, 21/11/06*

## Tamil Nadu order to integrate transgenders as 'equals'

The Tamil Nadu government in India has issued an order ensuring equal opportunities to transgenders in society. The Government Order 'Rehabilitation of Aravanis' (hijras) was recently passed by the Social Welfare Department based on the recommendations of a sub-committee, comprising government officials from the Social Welfare, Health and Education departments along with social workers.

The order states that the Social Welfare Department will look into legalising sex re-construction (SRC) surgery in Government hospitals for transgenders. These surgeries are not legal in the state and this has forced many transgenders to move to other states for surgery. The order says that the Social Welfare and Health Departments will soon come out with a separate plan to legalise the surgery.

The Health Department, in coordination with recognised and qualified counsellors, will also provide counselling for men who have sex with men (MSM) and transgender regarding the surgery. The Department will identify MSM at an early stage to prevent complications.

In an important move, the order has further stated that government offices should not discriminate against transgenders.

"Serious action will be taken against those who ill-treat or misbehave with the transgenders," said sources. Instead transgenders will be given priority in all government offices and hospitals on a humanitarian basis. "Government doctors should provide proper treatment and counselling to them without discrimination," sources said.

*The Indian Express, 8/3/07*

## New way of thinking about gay men and unprotected sex needed, says study

An Australian study published in the December edition of *Sexually Transmitted Infections* has found that the characteristics of a sexual encounter between gay men rather than gay men's individual characteristics predict whether or not unprotected anal will occur. The investigators suggest that this is a major finding and that health promotion workers need to stop thinking about certain individuals having a propensity to engage in unprotected sex, but rather recognise that "the occurrence of unprotected anal intercourse... is significantly shaped by characteristics and context of the specific sexual encounter."

In the past investigators have attempted to see if gay men's social and demographic characteristics could predict if they had a greater risk of engaging in unprotected anal sex. Other research has focused on the influence of social networks. Investigators have also looked at the characteristics of sexual encounters where unprotected anal sex took place.

Investigators from the Victorian Networks Study (Vines) in Melbourne, Australia wished to further explore the complexity of gay men's sexual activities by simultaneously considering the relationship between an individual's characteristics, their social networks, and the characteristics of their recent sexual encounters. By doing this they hoped to show which factors were associated with protected and unprotected anal sex.

They designed a cross-sectional study involving 202 men recruited from gay community venues in Melbourne in 2002. In interviews they provided detailed information on 733 sexual events.

Most of the men (91%) identified as gay, 79% were born in Australia, 70% were in employment, 60% had received a college education and the mean age was a little under 37.

Almost three-quarters of the men (73%) said they were HIV-negative, with 16% being HIV-positive and 11% reporting that they did not know their HIV infection status.

Only 17% of men reported ever having injected drugs, and over half of these said that they had not injected drugs in the last year.

Nearly half of the men reported social networks that consisted of a majority of men, but only 37% of networks were mostly gay, and a similar proportion of networks were entirely HIV-negative.

The investigators then looked at the men's reported sexual behaviour. The median number of sexual encounters per man was

four. The majority of these encounters (56%) did not involve any anal sex. Of the other encounters, 31% involved protected anal sex and 13% involved unprotected anal sex.

Most the sexual encounters were with casual or occasional partners (85%), with the remaining 15% of encounters being with a regular partner.

HIV status was only known for 31% of encounters.

Just over a third of encounters took place at the home of the other sexual partner, a quarter of encounters took place within the men's own home, 13% of encounters took place whilst cruising, 15% in saunas, and 6% in sex on the premises venues.

A total of 70 men (35%) reported at least one episode of unprotected anal sex. There was no relationship between age, education, country of birth, sexual identity, or employment with unprotected anal sex.

Significant predictors of unprotected anal sex were injecting drug use in the last year (adjusted odds ratio: 9.97), uncertainty of a partner's HIV infection status (adjusted odds ratio, 3.00), having sex at the partner's home (adjusted odds ratio, 1.99), having sex in a sauna (adjusted odds ratio, 1.91), and having sex in a sex on the premises venue (adjusted odds ratio, 17.99).

Of the 96 episodes of unprotected anal sex, eleven (2%) occurred between partners known or believed to be HIV serodiscordant.

"This paper substantially advances our understanding of the complexity of homosexual and bisexual men's sexual practice", comment the investigators. They stress that, for the first time, a study included the characteristics of individuals, their social networks, and details of their sexual encounters.

The investigators believe that their work has important implications for HIV prevention activities. First, health promotion workers should take into account the settings where sex take place. Second, their research found that men often engage in both protected anal sex and unprotected anal sex.

### Reference

Smith AMA et al. *Individual characteristics are less important than event characteristics in predicting protected and unprotected anal intercourse among homosexual and bisexual men in Melbourne, Australia*. *Sexually Transmitted Infections* 82: 474 – 477, 2007. *MSM-Asia*, 25/1/07

## HIV spreading rapidly in Malaysia

HIV infections in Malaysia could surge to 300,000 by 2015, senior health official says

The number of HIV infections in Malaysia could surge by more than fourfold to 300,000 by 2015 as the virus spreads rapidly from high-risk groups to the general public, a senior health official warned Sunday.

Other than drug addicts, official statistics indicate the HIV virus that causes AIDS is spreading quickly to women, fishermen, lorry drivers and factory workers, said Ramlee Rahmat, deputy director-general of public health.

Some 73,000 Malaysians have been infected with HIV, of which 75 percent are intravenous drug users and 7 percent are women, he said.

"Based on the trend that we are seeing, HIV infections can escalate to 300,000 cases by 2015 if we do not do anything," Ramlee said.

The government has taken aggressive steps to fight HIV transmission under a five-year national strategic plan launched in 2006, he said.

This includes drug substitution therapy and needle exchange

programs for drug addicts, and providing free antiretroviral drugs at government clinics especially for women and children.

"We have put up intervention measures. We are taking this very seriously. If we carry out our plans effectively and the public cooperates with us, we will be successful in curbing the spread of the disease," he added.

UNAIDS has last year said Malaysia was among several Asia-Pacific countries that risked an HIV epidemic among drug users unless the government took the problem more seriously.

Three people die from AIDS-related illness every day in Malaysia, the Health Ministry has said. It warned last year that the spread of AIDS could wipe out Malaysia's development made over the last 50 years and devastate the economy.

*AIDS Asia* 13/2/07

## Homosexual men are demanding a controversial “sex disease” vaccine designed to prevent a female cancer

Gardasil protects against the most common of sexually transmitted infections, human papillomavirus (HPV), which can cause cervical cancer. But HPV also causes genital warts and anal and penile cancer, and men argue the jab would guard against these. Many private clinics are offering it to men. One in London says it has immunised dozens in the last six weeks.

### Controversy

Gardasil has been causing controversy since it was launched in the UK late last year, mainly because it is designed to be given to children before they become sexually active and can catch HPV.

The motivation is to protect themselves and to prevent spreading HPV to their partners. Dr Sean Cummings, who has been supplying Gardasil to his male patients

The government is considering whether all girls, and possibly boys, aged 11 or 12 should get it routinely in schools, ultimately to cut cervical cancer rates. Gardasil is licensed for boys and girls aged nine to 15 and women aged 16 to 26. But doctors can opt to give it to other people “off licence” if they wish.

### Strong demand

Dr Sean Cummings at the Freedom Health clinic in Harley Street, where dozens of men have had the jab, said he was happy to recommend Gardasil to his adult men, at £450 for a three-dose course.

“We’ve had a strong demand for it. I had a man come in for the vaccine this morning. He was 24. Then I have one this afternoon who is 67 years old.

“The motivation is to protect themselves and to prevent spreading HPV to their partners.”

Opponents say there is no point in immunising people who are already sexually active.

### More proof

But Dr Paul Fox, a genito-urinary medicine expert at the Chelsea and Westminster and Ealing hospitals, believes it can be worthwhile. He argues that it is unlikely a person will have encountered all of the four strains of HPV found in Gardasil, including the two linked to cancers, even if they are leading a very promiscuous sex life.

“We should not just be looking at vaccinating people in their pre-

teen years. Other people would benefit as well.”

“We would not urge mass vaccination until we know it works,” said Roger Peabody of the Terrence Higgins Trust

Dr Jo Longstaff, of the Independent General Practice private clinic in Cardiff, which also offers the Gardasil vaccine, agrees.

“Our first enquiry about Gardasil was from a male patient. I think they should be considering it.”

Dr Anne Szarewski, clinical consultant for Cancer Research UK who has been involved in evaluating both Merck’s Gardasil and GSK’s rival jab Cervarix, says there may be a case for immunising men.

“Men who have sex with men are at a much higher risk than average of anal cancer and genital warts, particularly if they are HIV-positive.

“Clearly it would be very important if the vaccine could protect. The problem is we do need proof.”

### Trials in men

Merck is currently testing the vaccine’s efficacy in 4,000 men, including 500 men who have sex with men. And the US National Institute of Health is also carrying out trials to see what benefits it could have for people with HIV. Merck said its priority was to tackle cervical cancer, but has not ruled out giving the vaccine to other groups - including men who have sex with men.

Roger Peabody of the Terrence Higgins Trust said if the trials were successful, there would be a good case for vaccinating young boys, not only to stop the spread of HPV to women, but to protect men against HPV-related disease.

Dr Szarewski agreed, saying: “It is bad enough suggesting to people that their 12-year-old daughter might need a vaccine against a sexually transmitted infection.

“I would be interested to see the response of suggesting to parents that they should vaccinate their boys at 12 in case they become gay.”

She said heterosexual men and women also risked anal cancer. About 400 people are diagnosed with anal cancer each year in the UK. The disease is slightly more common in women than men.

*MSM-Asia, 23/2/07*

## Indonesia’s AIDS epidemic among the fastest growing in Asia

Indonesia’s AIDS epidemic is among the fastest growing in Asia, especially among intravenous drug users and commercial sex workers, and half of new infections have been found in the easternmost Papua province, the World Health Organization said.

“Indonesia is facing a huge threat,” Bjorn Melgaard, WHO’s senior health consultant, said Saturday after an independent review team spent nearly two weeks surveying efforts to fight the AIDS virus in several provinces across the sprawling archipelago.

The team found that the government has put in place good strategies and intervention programs to handle the epidemic, but more needs to be done on a local level to secure long-term funding to fight the spread of HIV, the virus that causes AIDS, and to improve access to condoms, testing and counselling.

Surveillance of sexually transmitted disease also needs to be stepped up, the team found.

There were 2,873 new AIDS cases in Indonesia in 2006, a 140 percent increase from 1,195 in 2004, with most cases found in

intravenous drug users and commercial sex workers, the team said.

Papua, the country’s most remote province geographically and politically, had by far the largest population of people living with the AIDS virus, accounting for 20 times the national average- around 50 percent of the country’s total number of cases.

“More than 2 percent of the population in Papua were infected with HIV/AIDS,” the report said, adding that health centres in the province must work especially hard to strengthen programs to prevent mothers from spreading the virus to their children.

WHO warned late last year that Indonesia showed a trend that its AIDS epidemic was still not under control, compared to neighbouring Thailand and Cambodia, where rates of infection appear to be stabilizing.

“Its HIV/AIDS epidemic is among the fastest growing in Asia,” Melgaard said.

HIV has infected an estimated 169,000 to 216,000 in the nation of 220 million.

*AIDS-Asia, 19/2/07*

# The World Medical Association statement on HIV and AIDS and the medical profession

*Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006*

## Introduction

1. HIV/AIDS is a global pandemic that has created unprecedented challenges for physicians and health infrastructures. In addition to representing a staggering public health crisis, HIV/AIDS is also fundamentally a human rights issue. Many factors drive the spread of the disease, such as poverty, homelessness, illiteracy, prostitution, human trafficking, stigma, discrimination and gender-based inequality. Efforts to tackle the disease are constrained by the lack of human and financial resources available in health care systems. These social, economic, legal and human rights factors affect not only the public health dimension of HIV/AIDS but also individual physicians/health workers and patients, their decisions and relationships.

## Discrimination

2. Unfair discrimination against HIV/AIDS patients by physicians must be eliminated completely from the practice of medicine.

a. All persons infected or affected by HIV/AIDS are entitled to adequate prevention, support, treatment and care with compassion and respect for human dignity.

b. A physician may not ethically refuse to treat a patient whose condition is within his or her current realm of competence, solely because the patient is seropositive.

c. National Medical Associations should work with governments, patient groups and relevant national and international organizations to ensure that national health policies clearly and explicitly prohibit discrimination against people infected with or affected by HIV/AIDS.

## Appropriate / Competent Medical Care

3. Patients with HIV/AIDS must be provided with competent and appropriate medical care at all stages of the disease.

4. A physician who is not able to provide the care and services required by patients with HIV/AIDS should make an appropriate referral to those physicians or facilities that are equipped to provide such services. Unless or until the referral can be accomplished, the physician must care for the patient to the best of his or her ability.

5. Physicians and other appropriate bodies should ensure that patients have accurate information regarding means of transmission of HIV/AIDS and strategies to protect themselves against infection. Proactive measures should be taken to ensure that all members of the population, and at-risk groups in particular, are educated to this effect.

6. With reference to those patients who are found to be seropositive, physicians must be able to effectively counsel them regarding: (a) responsible behaviour to prevent the spread of the disease; (b) strategies for their own health protection; and (c) the necessity of alerting sexual and needle-sharing contacts, past and present, as well as other relevant contacts (such as medical and dental personnel) regarding their possible infection.

7. Physicians must recognize that many people still believe HIV/AIDS to be an automatic and immediate death sentence and therefore will not seek testing. Physicians must ensure that patients have accurate information regarding the treatment options available to them. Patients should understand the potential of antiretroviral treatment (ART) to improve not only their medical condition but also the quality of their lives. Effective ART can greatly extend the period of time that patients are able to lead healthy productive lives, functioning socially and in the workplace and maintaining their independence. HIV/AIDS is increasingly looked upon as a manageable chronic condition.

8. While strongly advocating ART as the best course of action for HIV/AIDS patients, physicians must also ensure that their patients

are fully and accurately informed about all aspects of ART, including potential toxicity and side effects. Physicians must also counsel patients honestly about the possibility of failure of first line ART, and the subsequent options should failure occur. The importance of adhering to the regimens and thereby reducing the risk of failure should be emphasized.

9. Physicians should be aware that misinformation regarding the negative aspects of ART has created resistance toward treatment by patients in some areas. Where misinformation is being spread about ART, physicians and medical associations must make it an immediate priority to publicly challenge the source of the misinformation and to work with the HIV/AIDS community to counteract the negative effects of the misinformation.

10. Physicians should encourage the involvement of support networks to assist patients in adhering to ART regimens. With the patient's consent, counselling and training should be available to family members to assist them in providing family based care. Physicians must recognize families and other support networks as crucial partners in adherence strategies and, in many places, the only means to adequately expand the care system so that patients receive the required attention.

11. Physicians must be aware of the discriminatory attitudes toward HIV/AIDS that are prevalent in society and local culture. Because physicians are the first, and sometimes the only, people who are informed of their patients' HIV status, physicians should be able to counsel them about their basic social and legal rights and responsibilities or should refer them to counsellors who specialize in the rights of persons living with HIV/AIDS.

## Testing

12. Mandatory testing for HIV must be required of: donated blood and blood fractions collected for donation or to be used in the manufacture of blood products; organs and other tissues intended for transplantation; and semen or ova collected for assisted reproduction procedures.

13. Mandatory HIV testing of an individual against his or her will is a violation of medical ethics and human rights. Exceptions to this rule may be made only in the most extreme cases and should be subject to review by an ethics panel or to judicial review.

14. Physicians must clearly explain the purpose of an HIV test, the reasons it is recommended and the implications of a positive test result. Before a test is administered, the physician should have an action plan in place in case of a positive test result. Informed consent must be obtained from the patient prior to testing.

15. While certain groups are labelled "high risk", anyone who has had unprotected sex should be considered at some risk. Physicians must become increasingly proactive about recommending testing to patients, based on a mutual understanding of the level of risk and the potential to benefit from testing. Pregnant women should routinely be offered testing.

16. Counselling and voluntary anonymous testing for HIV should be available to all persons who request it, along with adequate post-testing support mechanisms.

## Protection from HIV in the Health Care Environment

17. Physicians and all health care workers have the right to a safe work environment. Especially in developing countries, the problem of occupational exposure to HIV has contributed to high attrition rates of the health labour force. In some cases, employees become infected with HIV, and in other cases fear of infection causes health care workers to leave their jobs voluntarily. Fear of infection among health workers can also lead to refusal to treat HIV/AIDS patients.

Likewise, patients have the right to be protected to the greatest degree possible from transmission of HIV from health professionals and in health care institutions.

a. Proper infection control procedures and universal precautions consistent with the most current national or international standards, as appropriate, should be implemented in all health care facilities. This includes procedures for the use of preventive ART for health professionals who have been exposed to HIV.

b. If the appropriate safeguards for protecting physicians or patients against infection are not in place, physicians and National Medical Associations should take action to correct the situation.

c. Physicians who are infected with HIV should not engage in any activity that creates a risk of transmission of the disease to others. In the context of possible exposure to HIV, the activity in which the physician wishes to engage will be the determining factor. Whether or not an activity is acceptable should be determined by a panel or committee of health care workers with specific expertise in infectious diseases.

d. In the provision of medical care, if a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease.

e. If no risk exists, disclosure of the physician's medical condition to his or her patients will serve no rational purpose.

#### **Protecting Patient Privacy and Issues Related to Notification**

18. Fear of stigma and discrimination is a driving force behind the spread of HIV/AIDS. The social and economic repercussions of being identified as infected can be devastating and can include violence, rejection by family and community members, loss of housing and loss of employment, to name only a few. Normalizing the presence of HIV/AIDS in society through public education is the only way to reduce discriminatory attitudes and practices. Until that can be universally achieved, or a cure is developed, potentially infected individuals will refuse testing to avoid these consequences. The result of individuals not knowing their HIV status is not only disastrous on a personal level in terms of not receiving treatment, but may also lead to high rates of avoidable transmission of the disease. Fear of unauthorized disclosure of information also provides a disincentive to participate in HIV/AIDS research and generally thwarts the efficacy of prevention programs. Lack of confidence in protection of personal medical information regarding HIV status is a threat to public health globally and a core factor in the continued spread of HIV/AIDS. At the same time, in certain circumstances, the right to privacy must be balanced with the right of partners (sexual and injection drug) of persons with HIV/AIDS to be informed of their potential infection. Failure to inform partners not only violates their rights but also leads to the same health problems of avoidable transmission and delay in treatment.

19. All standard ethical principles and duties related to confidentiality and protection of patients' health information, as articulated in the WMA Declaration of Lisbon on the Rights of the Patient, apply equally in the context of HIV/AIDS. In addition, National Medical Associations and physicians should take note of the special circumstances and obligations (outlined below) associated with the treatment of HIV/AIDS patients.

a. National Medical Associations and physicians must, as a matter of priority, ensure that HIV/AIDS public education, prevention and counselling programs contain explicit information related to protection of patient information as a matter not only of medical ethics but of their human right to privacy.

b. Special safeguards are required when HIV/AIDS care involves a physically dispersed care team that includes home-based service providers, family members, counsellors, case workers or others who require medical information to provide comprehensive care and assist in adherence to treatment regimens. In addition to implementing protection mechanisms regarding transfer of information, ethics

training regarding patient privacy should be given to all team members.

c. Physicians must make all efforts to convince HIV/AIDS patients to take action to notify all partners (sexual and/or injection drug) about their exposure and potential infection. Physicians must be competent to counsel patients about the options for notifying partners. These options should include:

1. notification of the partner(s) by the patient. In this case, the patient should receive counselling regarding the information that must be provided to the partner and strategies for delivering it with sensitivity and in a manner that is easily understood. A timetable for notification should be established and the physician should follow-up with the patient to ensure that notification has occurred.

2. notification of the partner(s) by a third party. In this case, the third party must make every effort to protect the identity of the patient.

d. When all strategies to convince the patient to take such action have been exhausted, and if the physician knows the identity of the patient's partner(s), the physician is compelled, either by law or by moral obligation, to take action to notify the partner(s) of their potential infection. Depending on the system in place, the physician will either notify directly the person at risk or report the information to a designated authority responsible for notification. In cases where a physician must disclose the information regarding exposure, the physician must:

1. inform the patient of his or her intentions,  
2. to the extent possible, ensure that the identity of the patient is protected,  
3. take the appropriate measures to protect the safety of the patient, especially in the case of a female patient vulnerable to domestic violence.

e. Regardless of whether it is the patient, the physician or a third party who undertakes notification, the person learning of his or her potential infection should be offered support and assistance in order to access testing and treatment.

f. National Medical Associations should develop guidelines to assist physicians in decision-making related to notification. These guidelines should help physicians understand the legal requirements and consequences of notification decisions as well as the medical, psychological, social and ethical considerations.

g. National Medical Associations should work with governments to ensure that physicians who carry out their ethical obligation to notify individuals at risk, and who take precautions to protect the identity of their patient, are afforded adequate legal protection.

#### **Medical Education**

20. National Medical Associations should assist in ensuring that there is training and education of physicians in the most current prevention strategies and medical treatments available for all stages of HIV/AIDS, including prevention and support.

21. National Medical Associations should insist upon, and assist with when possible, the education of physicians in the relevant psychological, legal, cultural and social dimensions of HIV/AIDS.

22. National Medical Associations should fully support the efforts of physicians wishing to concentrate their expertise in HIV/AIDS care, even where HIV/AIDS is not recognized as an official specialty or sub-specialty within the medical education system.

23. The WMA encourages its National Medical Associations to promote the inclusion of designated, comprehensive courses on HIV/AIDS in undergraduate and postgraduate medical education programs, as well as continuing medical education.

14.10.2006 <http://www.wma.net/e/policy/a25.htm>

Those who deny freedom to others, deserve it not for themselves  
Abraham Lincoln, 1859

## Focus on MSM and the spread of HIV/AIDS in Cambodia

As dusk falls along the banks of the Tonle Sap River, opposite the Royal Palace in Phnom Penh, the Cambodian capital, Noun, 35, a married engineer, stops at his favourite vantage point on his route home each evening, a popular cruising site for Cambodian gays, where last month alone he met seven different partners.

Noun's world is a complex one, riddled with deception and hypocrisy in this otherwise conservative Khmer society. "I'm not gay," he said. "I just like having sex with men."

Such an assertion is not unusual in many South East Asian nations, including Cambodia. In less than an hour's time he will return to his wife and two children about a kilometre away - none of whom are any the wiser about his activities.

Men who have sex with men (MSM) could well prove a pivotal part of Cambodia's bid to mitigate the spread of HIV/AIDS. "This is the hidden MSM population, who not only have sex with men, but also have sex with female partners," said Tony Lisle, Country Coordinator for the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Cambodia.

Penetrating Noun's world, and others like it, could be the most difficult challenge, but failing to do so could accelerate the spread of the pandemic among the country's 14.5 million people.

### Current prevalence rates

Cambodia has the highest HIV/AIDS prevalence in South East Asia, but has also made significant inroads against the disease since it first appeared in 1991. According to UNAIDS, the estimated level of infection among adults has dropped from a high of 3 percent in 1997 to 1.6 percent in 2006, which can be partly attributed to increasing HIV mortality as those infected during the period of peak HIV incidence move into AIDS.

Current surveillance data also suggest that the epidemic, largely driven by the continued patronage of commercial sex workers by Cambodian men, is changing: behavioural data now show consistently higher rates of condom usage in the sex industry, largely the result of enhanced public information campaigns and an assertive effort to promote 100 percent condom usage.

HIV incidence among sex workers and their clients appears to have been dramatically reduced, as corroborated by a reduction in the prevalence of other sexually transmitted infections (STIs) among them, but sexual networking continues to shift towards casual sex, making MSM as a risk group all the more important.

### MSM prevalence rates

Prevalence in the general population has also declined in recent years, but health workers warn there is little room for complacency. According to the latest survey by the Cambodian National Centre for HIV/AIDS Dermatology and STDs (sexually transmitted diseases), the HIV prevalence rate among MSM in Phnom Penh is 8.7 percent, and their networking behaviour has become a serious source of concern.

Of the 58 percent of men surveyed in three provinces - Phnom Penh, in the south, and Batdambang and Siem Riep in the northwest - who reported having sex with female partners in the past year, almost 25 percent also reported having sex with female sex workers, with 16.6 percent having had sex with casual female partners in the past month.

"When you have a very dense network, and when you have crossovers in the network between males and females, in the presence of high risk of STIs and in the presence of very low condom usage, then you have a potential for an explosive epidemic," Lisle warned.

"You're looking at multipartner behaviour," the UNAIDS official said, pointing out that not only were the men putting themselves at risk, but also the women they slept with.

### MSM - a global phenomenon

Male-to-male sex is found in every culture and society, and is often defined as a social and behavioural phenomenon rather than a

specific group of people. Although the description may include men who identify themselves as being homosexual or gay, bisexual or transgender, it can also include men who identify themselves as exclusively heterosexual and are often married, particularly where discriminatory laws or social stigma exist.

The manner in which Cambodian MSM define themselves blurs this distinction even more: according to a 2004 study of 1,306 MSM by Family Health International (FHI), 'Men Who Have Sex with Men in Phnom Penh, Cambodia: Population Size and Sex Trade', there are four times more of what are described locally as 'short-haired MSM' (masculine-acting MSM who have sex with each other) than 'long-haired MSM' (transgender MSM whose masculine sexual partners identify themselves as being from either group).

Relations between the two groups are not always cordial. Short-haired MSM enjoy a degree of privacy by being less visible than long-haired MSM, who tend to be more conspicuous, have a great deal of difficulty in securing employment and are often thrown out of their homes.

A recent report on 'MSM and HIV/AIDS Risk in Asia', by Therapeutics Research Education AIDS Training Asia (TREAT Asia), found that short-haired MSM were more likely to receive money for sex (20 percent regularly and 41 percent occasionally).

### Risk and awareness

In terms of HIV risk, male-to-male intercourse is significant in that it can involve anal sex, which, when unprotected, carries a risk 10 times greater than unprotected vaginal intercourse does for the receptive partner. At least 5 percent to 10 percent of HIV infections worldwide are estimated to occur via MSM but, according to UNAIDS, this figure varies considerably between countries and regions.

Many Cambodian men are unaware of these obvious risks. "It can be very difficult to reach MSM," Lisle said, particularly those who might be classified as short-haired MSM and therefore do not necessarily identify themselves as homosexual.

A government report, "Turning the Tide - Cambodia's Response to HIV/AIDS 1991-2005", identified the need to promote better understanding of risks and behaviour change, encourage consistent condom use among MSM, and to consider them not only a high-risk target group, but to involve them in the planning and implementation of prevention interventions.

A study of sexual behaviours, STIs and HIV among MSM in Phnom Penh, undertaken by FHI in 2000, documented an alarming HIV prevalence rate of 14.4 percent - approximately equivalent to the rate among informal sex workers at the time - aggravated by drug use among 24 percent of the sample population.

Although the government has begun to acknowledge MSM in its intervention efforts, the researchers found that NGOs and community-based organisations had only recently started implementing programmes to reach this group.

### Access to health care

Men's Health Cambodia (MHC) in Phnom Penh, established in 2002 and funded by FHI, was the first NGO dedicated to addressing the health needs of short-haired MSM in its drop-in centre and outreach programme.

According to UNAIDS, fewer than one in 20 MSM have access to the HIV prevention and care services they need - a figure largely in line with global indicators.

Of the 30 men visiting the MHC centre weekly, most are concerned about STIs and HIV testing, while others seek counselling to deal with their sexual identity in a country that frowns on homosexuality.

After successful awareness interventions, condom usage overall appears to be increasing, but the Executive Director of MHC, Mao Kimrun, 32, said much more needed to be done. "Not everyone understands the risks - there are still misconceptions that MSM are not at risk," he asserted. "Condom usage is still not widespread, and

many men cannot afford them.”

MHC runs a daily outreach programme in parks and other locations that MSM might frequent. “They usually ask me about HIV/AIDS or STIs, and they want to know about safe sex practices,” Thavro Dum, an MHC outreach member, told IRIN/PlusNews as he readied his motorcycle to make his evening rounds.

He said MSM were often aware of HIV transmission and prevention, but did not always know how to apply this knowledge to their own behaviour to avoid risking infection.

As confirmed by the TREAT Asia report, condoms are imported and expensive, which limits access, except when offered in social marketing programmes; secrecy exacerbated the situation - some MSM even based their HIV-risk assessment on whether a potential partner appeared to have good personal hygiene or not; male sex workers were often unable to negotiate condom use and generally did not use lubricant, because clients “would know for sure that they are non-female”.

“I’m afraid of HIV/AIDS,” said Eam Vandy, 27, a male sex worker who arrived in the capital three years ago in search of a job. He told IRIN/PlusNews his customers paid between \$5 and \$10, and he always used a condom. “Many of my friends are pretty boys [long-haired MSM]. Some use condoms; many do not.”

Such stories are not unusual in a country where poverty is rife and drives a growing number of people to work in the sex trade.

Sou Sothevy, 67, who has been a transgender sex worker since she was 14 and still works occasionally, commented, “Although MSM are aware of the risks, they don’t always use condoms with their partners. Some male sex workers forego the usage of the condom for more money.”

She spends most of her time as a local team leader in a network of some 5,000 sex workers - the Women’s Network for Unity - and also serves on the national steering committee as an elected representative. Sothevy, who has been living with HIV for over 10 years, believes most people have some awareness of the risk factors, but remain careless. “Many use drugs, including heroin,” she said.

“Cambodia is a very conservative country and there is discrimination towards MSM, not just from the family, but society as a whole,” she pointed out. As a team leader, she monitors members’ needs and keeps an eye out for new sex workers in her local area. Nationally, the network advocates for access to medicines and undertakes research for NGOs, United Nations agencies and the government by sex workers and the HIV-positive community.

Changing people’s perceptions would not be easy said Sear Young Tan, 39, of the recently established National MSM Network, which aims to eliminate stigma and discrimination against MSM, and promote equal access to HIV- and MSM-related information and services. “Discrimination against MSM is very much part of Cambodian life, both in the family and society at large,” the clothes-maker and makeup artist noted.

“This makes the fight against HIV/AIDS all the more difficult,” he said, reiterating the fact that many MSM do not think of themselves as MSM - even when they have sex with men. “It’s just for pleasure and means nothing.”

But with many short-haired MSM engaging in more sexual encounters than long-haired MSM - some having up to five different partners a week - he said, getting the message out to this group should be an integral part of the country’s intervention efforts.

Most Cambodians are unaware of how many masculine-acting - and often married - men are sexually active with other men, heightening the risk of spreading the virus among the general population.

One MSM focus group participant in rural Cambodia cited in the TREAT Asia report remarked: “I had a lot of friends, but my friends who have sex with the same gender ... are all dead. Now it is only me here.”

*AIDS - Asia, 23/2/07*

## Condom mishaps common among young men, study shows

Many young men could use a bit more instruction on proper condom use, according to lead author of a new study that found nearly one in three experienced recent condom breakage.

“We give condoms away all the time, and unfortunately that’s often all that we do,” Dr. R. A. Crosby of the University of Kentucky in Lexington, told Reuters Health. “I think it’s important to take me beyond consistent use when we make attempts to intervene, and promote the correct use as well.”

Crosby and his colleagues interviewed 278 men between the ages of 18 and 35 years old attending a public sexually transmitted infection clinic to understand how frequently and why condom breakage occurs. All of the men reported using a condom during intercourse at least three times in the previous three months.

Thirty-one percent reported at least one recent instance of condom breakage. Men who previously had a sexually transmitted infection were twice as likely to report condom breakage, while men who reported problems with condom slippage were nearly three times as likely to have problems with condom breakage. Those who said they didn’t feel confident with their ability to use condoms were also more likely to have experienced condom breakage.

Other risk factors were allowing condoms to contact a sharp object, having problems with the “fit and feel” of condoms, not squeezing air from the condom’s receptacle tip. Each of these three factors increased the risk of condom breakage by about two-fold.

The findings show that identifying men who need more information on how to use a condom could be as simple as asking them if they have problems with condom breakage or slippage, have had a sexually transmitted infection in the past, or don’t feel confident about using condoms, Crosby noted.

Men should also be instructed to avoid letting teeth, nails or other sharp objects to come in contact with a condom, he added, and should never use scissors to open a package.

He added that sexually transmitted disease clinics should ideally provide a range of sizes and brands of condoms to their clients, so men can find the best fit.

*Sexually Transmitted Infections, February 2007.*

### Sexual Health

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. WHO Draft Working Definition, October 2002

### Sexual rights

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence.

## Gay leader escapes St. Valentine's Day lynch mob

A St. Valentine's Day homophobic lynch mob of more than 200 in the Kingston, Jamaica suburb of St. Andrew's Parish chased and assaulted three men presumed to be gay and threatened to kill them - and the leader of the gay rights organization J-FLAG (Jamaican Forum for Lesbians, All-Sexuals, and Gays) was repeatedly and viciously assaulted by police when he went to the aid of the three alleged homosexuals targeted by the angry mob.

The February 14 anti-gay mob violence was sparked when a homophobic woman began screaming curses and anti-gay epithets at the three men, calling them "battymen" (Jamaican slang for "faggot") and hollering that they should be killed. The trio, who were described in various reports in the homophobic Jamaican press as "effeminate" and with "bleached-out faces, and dressed in tight jeans pants and skimpy shirts," took refuge in a pharmacy in the Tropical Plaza shopping centre, into which they were followed by their screaming accuser. The store management escorted the woman, who was still hollering threats and anti-gay insults, from the store, and telephoned local police.

This woman rapidly attracted the attention of passersby and other shoppers in the shopping centre, and in a matter of minutes the crowd grew to number some 200 people of all ages, and both men and women as well as teenagers and children joined in chanting threats and anti-gay epithets, shouting "kill them, kill the battymen," and demanding the three targeted men "come out to face our justice."

Gareth Williams, the 29-year-old leader of J-FLAG, said in a statement that, "I was already in the pharmacy purchasing items. I recognized the three men and went over and spoke to them, asking them to calm down."

"Because I had intervened to calm the situation, I was pointed at and referred to as a friend of the three guys," Gareth related, adding: "People said that I must be gay too. The crowd demanded that I come outside, so they could beat me. After hearing these threats, I decided to wait until the police arrived to escort the three guys out. I thought it would be safer for me to leave with them at the same time."

While waiting for police to arrive on the scene Gareth managed to get a phone call through to the New York offices of Human Rights Watch (HRW) as the hostile crowd continued to menace the men in the pharmacy. According to Scott Long, HRW's director of LGBT Rights, "Rebecca Schleifer of HRW's HIV/AIDS division, Jessica Stern, and I spent about two hours on the phone yesterday evening during this horrific incident, talking to the victims while the mob threatened them, to Jamaican activists, and to several different offices of the Jamaican police. What followed was a very tense episode of international action, with people mobilizing in New York, Geneva, and Kingston, and phoning both the Jamaican Commissioner of Police and the local police station to press the authorities to intervene immediately and provide protection."

When police finally arrived inside the pharmacy, "The three men were supported by the store staff but verbally abused by the police and by the store's private security personnel," said J-FLAG's Gareth. "I was violently abused by four members of the police team. They slapped me in the face, hit me on the head, and the handle of an M-16 rifle was used to strike me in the lower abdomen."

Gareth said that, "This assault happened because one of the police officers was being very aggressive and homophobic. I told him that he should not abuse us in that manner. The officers forcibly dragged me towards the door. When I told them not to treat me like that, they became even more hostile."

"I was the only one injured inside the pharmacy," Gareth noted, "but one of the three guys was hit on the head with an object when he went outside to get into the police car. The police refused to tell us how we were going to get safely outside amid the angry mob of approximately 200 people. This made us very anxious."

Once the men were finally put into a police car and whisked away,

the abuse continued. "While in the vehicle all the ways to the police station, the men were taunted by the police with anti-gay epithets," J-FLAG reported in a separate statement. "The insults continued even when the men arrived at the Half-Way Tree police station, where other police joined in the name-calling. The policemen at the station told them that they should be grateful and warned them never to return to Half-Way Tree."

J-FLAG's Gareth was later examined by a physician, and "my injuries are deemed serious by the doctor who examined me," he said. Those injuries, he explained, included: "soft tissue injuries to the right of the face (peri-orbital), right parietal scalp with minor soft hematoma, and blunt abdominal trauma and muscular spasm."

The St. Valentine's Day lynch mob incident is hardly the first time the Jamaican gay leader has been singled out by Jamaican police for abuse. When this reporter interviewed Gareth at length for Gay City News (New York) last October, he related how "I've had police officers turning up at my house, calling me 'battymen' and saying that I'll be murdered like Brian. In February, after a gay man was killed, there was a gang of police outside my house saying the same thing would happen to me."

Gareth's last name, Williams, is a pseudonym he must use for his safety. His predecessor at J-FLAG's helm, Brian Williamson, 59 whom Gareth told me "was the only out gay person in Jamaica who had the courage to put his face on television" - was brutally murdered in his home in 2004 by anti-gay thugs, who mutilated his body with multiple stab wounds. An HRW researcher witnessed a joyous crowd that gathered outside Williamson's house to celebrate the murder. A smiling man called out, "Batty man," using the Jamaican patois for faggot, "he get killed!" Others joined the celebration; laughing and calling out, "let's get them one at a time," "that's what you get for sin," "let's kill all of them." Some sang "Boom bye bye," a line from a Jamaican song about killing and burning gay men that was made a hit by reggae singer Buju Banton.

Metropolitan Community Church, a gay denomination which recently opened a branch in Jamaica, reported: "Since the Valentines Day attack, the tragedy and violence have continued to grow. Over the last few days, other gay people reportedly have been attacked in Ocho Rios and Montego Bay, and at least one gay person in Montego Bay has been murdered. And on Sunday, there was an unconfirmed report that one of the three men attacked on Valentines Day had attempted suicide in the aftermath of the attack."

J-FLAG has issued a statement saying, "We applaud the actions of the staff at the store who showed a fundamental humanity and respect for their fellow Jamaicans, and who called for the assistance of the police. The response of the police, however, shows that citizens perceived to be gay remain vulnerable to attacks both from violent members of the public as well as from the security forces themselves sworn to defend against the violation of their rights. We call upon the Commissioner of Police, the Office of Professional Responsibility and the Public Defender to ensure that the policemen involved in this assault are brought to justice."

*MSM-Asia 26/2/07*

When I deny the integrity and self worth of another, I deny my own. When I deny another person social justice, I deny my own. When I violate another person's freedom to be, I deny my own. I commit violence against the other person so denied, and I also commit violence against myself.  
*Shivananda Khan*

## Breaking social taboos in Pakistan

On Pakistani television, Ali Saleem, 28, portrays Begum Nawazish Ali, a flirty, teasing widow, to achieve both political and personal goals.

In Pakistan, where publicly talking about sex is off limits, it takes a cross-dressing television host to take on the most sensitive subjects.

The talk is of delicate issues, including sex. "Maybe, yes, I am a diva," he says.

In a country where publicly talking about sex is strictly off limits, Mr. Saleem has managed not only to bring up the subject on his prime-time television talk show — but to do so without stirring a backlash from fundamentalist Islamic clerics.

And he has done so as a woman.

When Mr. Saleem takes to the airwaves, he is Begum Nawazish Ali, a coquettish widow who interviews Pakistan's glitterati and some of its top politicians.

A real woman could not possibly do what Mr. Saleem does. In the unlikely event a station would broadcast such a show, the hostess would be shunned. And taking on the guise of a married woman - whose virtue is crucial to her whole family - would be equally impossible.

But apparently a cross-dressing man pretending to be a widow is another matter entirely.

It is something of a mystery why a man who openly acknowledges he is bisexual is a sensation here. Traditional Islamic teaching rejects bisexuals and gays, and gay Pakistanis have few outlets for a social life. The gay party scenes in Lahore and Karachi are deep underground.

Mr. Saleem has his own theory for his popularity: he thinks Pakistan has always been more open than outsiders believed.

It is true that Pakistan is, in a sense, two countries. There is urban, and urbane, Pakistan, where Western mores are more accepted, although nudity would never be seen on television or scantily clad women on billboards. And then there is rural Pakistan, where Islam is generally practiced with more fervor.

It is also true that the Pakistani president, General Pervez Musharraf, is relatively tolerant about what the media can show and cover, including politics. Although General Musharraf came to power in a bloodless coup by the military in 1999, he has been more open to political criticism in the press than some of his democratic predecessors.

Mr. Saleem, 28, is thrilled with his success for reasons that are both political (he is proud to be breaking ground in bringing up tough subjects) and profoundly personal. "My biggest high is to see myself gorgeous in the mirror" he said recently while reclining in a makeup-room chair. As a beautician outlined his eyes, adding glitter and eye shadow, he said, "Maybe, yes, I am a diva."

It is hard to judge how successful Mr. Saleem's show is — there is no form of Nielsen ratings here. And there are clearly people who find the show revolting.

But by many measures, it is a success. Television critics have been generally supportive, and the show, which has been on a year and a half, has a prime-time slot despite its name, "Late Night Show With Begum Nawazish Ali." Mr. Saleem said it was named for its racy content, usually shown late, but he said the network scheduled it earlier hoping for a hit that would bring in more advertising revenue.

Urbanites, meanwhile, seem not to be able to get enough of the once-a-week show, which is rerun twice each week. They have showered praise on Mr. Saleem's portrayal of a middle-aged widow who, in glamorous saris and glittery diamonds, invites to her drawing room politicians, movie stars and rights advocates from Pakistan and India.

With fluttering eyelids and glossy lips, Begum Nawazish Ali (Begum means Lady or Mrs. in Urdu) flirts with male guests using suggestive banter and sexual innuendo. With female guests, she is something of a tease, challenging them about who looks better.

Questions are pointed and piercing. Politics, democracy and saucy gossip are enmeshed in her conversation.

Mr. Saleem sees the show's acceptance and commercial success as a testimony to the tolerance and moderation of Pakistan, a country often seen by the outside world as teetering on the edges of militancy and extremism.

Colorful and witty, Mr. Saleem is open about his own sexuality and sprinkles his conversation with gender-bending phrases. "My life fluctuates between two extremes," he says. "I always say this: I am a man and I am a woman. It is two gender extremes, and I am constantly trying to balance it."

He is unabashed at the criticism that his show often borders on raunchiness. "Sitting senators have sent requests to be on the show," he says.

Mr. Saleem has also been willing to take on tough political subjects. He is openly critical of the army's role in ruling Pakistan, for instance.

His show is not the only one pushing the envelope on that and other touchy subjects.

In another network television program, "Aalim Online," religious scholars from Shiite and Sunni sects sat side by side and responded to viewers' queries on different issues from their respective viewpoints.

Television talk shows and news programs have also openly criticized the policies of previous governments on their support for the Taliban and on their policies in Kashmir, which both India and Pakistan claim.

President Musharraf's policies and the role of the powerful Inter-Services Intelligence, or ISI, have come under fire on talk shows and analysis programs, something unimaginable some years ago.

That is not to say that anything goes. The restrictions on print media are generally tougher than for broadcast journalists, and some subjects are considered clearly off limits.

Owais Aslam Ali, secretary general of Pakistan Press Foundation, an independent media research center in Karachi, said that "on things of consequence, restrictions remain." He said that included reporting on the tribal areas bordering Afghanistan, where the Taliban and Al Qaeda are taking refuge.

Mr. Ali said there also were unstated restrictions on reporting about Baluchistan, the southwestern province where a low-level civil insurgency has long simmered. "This is a big black hole as far as media is concerned," he said. "Parameters have been set. You cross those parameters at your own peril."

Mr. Saleem, who in the guise of Begum Nawazish Ali often gets away with questions to politicians that print journalists might be wary of, said his show would not have been a possibility earlier. "I owe Begum Nawazish Ali's existence, in a certain way, to General Musharraf," he said.

But he appears to know his own limits. He shrugged when asked if he should not invite the general himself on the show, appearing to indicate that he knew that was one taboo he could not break. But it did not stop him from flirting with the idea, especially after General Musharraf made himself so open to the media during his book tour of the United States last year.

"I would love it if Musharraf would come on the show," he said. "If he can go on Jon Stewart's show, then why not?"

*MSM - Asia, 5/1/07*

Nothing in the world is more dangerous than sincere ignorance and conscientious stupidity  
*Martin Luther King, 1963*

## Over a third of gay men with anal infections reported no unprotected anal sex

Sexual practices other than unprotected anal sex appear to be risk factors for anal infection with gonorrhoea and chlamydia, according to an Australian study published in the online edition of *Sexually Transmitted Infections*. Investigators from the HIM study in Sydney found that over a third of gay men with anal gonorrhoea or chlamydia infections reported no unprotected anal sex, but had engaged in other sexual practices involving the anus, such as rimming, fingering, fisting, or the use of sex toys.

The investigators suggest that their findings have important implications for sexual health screens for gay men, and that all gay men should have swabs for anal infections regardless of whether they report unprotected anal sex.

In countries like the United Kingdom, United States, and Australia there was a marked and rapid fall in the incidence of gonorrhoea amongst gay men after the onset of the HIV epidemic. In recent years, however, there has been a steady increase in the number of new diagnoses of sexually transmitted infections (STIs), including gonorrhoea and chlamydia, involving gay men across the industrialised world.

Some sexually transmitted infections are thought to increase the risk of HIV transmission and infection, and this is one of the reasons why sexually active gay men are encouraged to attend for regular sexual health screens so they can receive appropriate treatment for infections and thereby reduce the risk of HIV transmission or infection.

Between June 2001 and late 2004, investigators from the HIM study in Sydney, Australia, conducted a prospective study to determine the incidence of and risk factors for anal and urethral infection with gonorrhoea and chlamydia.

A total of 1,427 gay men were included in the study. All were HIV-negative on entry to the study. Every year, they had a face-to-face interview about their sexual activity and underwent a sexual health screen which included both anal and urethral swabs for gonorrhoea and chlamydia. Every six months, they had a telephone interview where they provided details about their sexual activities and any diagnoses with anal or urethral gonorrhoea or chlamydia since the last study visit. The men had a median age of 35 years, and 95% identified as gay.

At baseline, 6% of men reported a diagnosis of urethral gonorrhoea in the previous twelve months, with 2% reporting anal gonorrhoea in the previous year. The baseline sexual health screen revealed that 0.33% of men had undiagnosed and untreated urethral gonorrhoea and 1% of men had undiagnosed and untreated anal gonorrhoea. The prevalence of urethral chlamydia at baseline was 1%, and the prevalence of anal chlamydia was 4%.

During the study, the overall incidence of gonorrhoea was 5.9 cases per 100 patient years. The incidence of chlamydia was 11.55 cases per 100 person years. A third of the cases of anal gonorrhoea and over 50% of the incidence cases of anal chlamydia were diagnosed at the annual study visits.

### Risk factors

Significant risk factors for urethral gonorrhoea were younger age ( $p = 0.04$ ), sexual contact with somebody known to have gonorrhoea ( $p = 0.001$ ), increasing number of casual sexual contacts in the previous six months ( $p = 0.016$ ), and unprotected insertive anal sex with a partner known to be HIV-positive ( $p = 0.032$ ).

The risk factors for urethral chlamydia were broadly similar, and

included younger age ( $p = 0.01$ ), sex with an individual known to have chlamydia ( $p = 0.001$ ), increasing number of casual sexual partners in the previous six months ( $p = 0.010$ ), unprotected insertive anal sex ( $p = 0.029$ ), and insertive oral sex to ejaculation ( $p = 0.007$ ).

Attention then shifted to the risk factors for anal infections. Anal gonorrhoea was significantly associated with younger age ( $p = 0.001$ ), sex with a person known to have gonorrhoea ( $p = 0.001$ ), receptive unprotected anal sex ( $p = 0.001$ ), and frequent receptive fingering with a casual partner ( $p = 0.001$ ).

The risk factors for anal chlamydia were similar including sexual contact with an individual known to have chlamydia ( $p = 0.001$ ), increasing number of casual sexual partners in the previous six months ( $p = 0.019$ ), receptive unprotected sex ( $p = 0.001$ ), and receptive rimming ( $p = 0.004$ ).

### Anal infections but no reported unprotected anal sex

Finally, the investigators looked for risk factors for anal infections in patients who received this diagnosis but who did not report unprotected anal sex. The investigators emphasised that 34% of diagnoses of anal gonorrhoea and 36% of diagnoses of anal chlamydia occurred in men who said that they had had not receptive unprotected anal sex. Fingering, fisting, and rimming were associated with anal gonorrhoea and fingering and the use of sex toys were associated with anal chlamydia.

"We have demonstrated for the first time in a prospective epidemiological study that sexual activities other than penile-anal intercourse were associated with infections in each site", comment the investigators. They add, "the independent association of anal infections with non-intercourse anal sexual practices suggests that comprehensive sexual health screening, particularly anal screening, should occur in all sexually active gay men, not just those who report unprotected anal sex."

### Reference

Jin F et al. *Incidence and risk factors for urethral and anal gonorrhoea and chlamydia in a cohort of HIV-negative homosexual men: the HIM study*. *Sexually Transmitted Infections* (online edition), 2007. *MSM-Asia*, 26/1/07

## Gay lobbyists for rules on heterosexual tieups

Stung by the state Supreme Court's ruling upholding a ban on same-sex marriages, proponents of gay marriages in Washington have introduced an initiative that would require heterosexual couples to have a child within three years of wedding or have their union annulled.

The Washington Defence of Marriage Alliance (WA-DOMA) hoped it would prompt "discussions about the many misguided assumptions" underlying the state Supreme Court ruling. The proposal would require couples to prove they can have children to get a marriage licence. Couples who do not have children within three years could have their marriages annulled.

"For many years, social conservatives have claimed that marriage exists solely for the purpose of procreation," says WA-DOMA organiser Gregory Gadow in a statement.

"The Washington Supreme Court echoed that claim in their lead ruling. The time has come for these conservatives to be dosed with their own medicine," Mr Gadow said.

If same-sex couples should be barred from marriage because they cannot have children together, all couples who cannot have children or will not have children together should equally be barred from marriage. And this is what the Defence of Marriage Initiative will do, he added.

The DOMA announced that their proposed initiative has been accepted by the secretary of state and assigned the serial number 957. *Asian Age*, 8/2/07

# Alarm as new HIV cases surge in Hong Kong

In what health experts see as a worrying trend, Hong Kong last year saw the highest rise in the number of HIV cases, it was reported Tuesday.

Equally worrying is the fact that between October and December last year, 40 percent of the new HIV cases were non-residents, forcing several legislators to urge the government to rethink its pricing strategy at social hygiene clinics.

According to the Health Department, 373 new cases of HIV were reported last year, a rise of 19 percent on 2005, with 98 cases being reported in the fourth quarter alone.

Centre for Health Protection consultant Wong Ka-hing said health officials would need to rethink their prevention strategy, but warned the gradually decreasing alert levels among Hong Kong is becoming a problem.

Wong also said the Department of Health's scientific committee had made recommendations that were still awaiting a response from the policy bureau.

Professor Lau Yu-lung, who chairs the Committee on AIDS and Sexually Transmitted Infections, said his committee was especially concerned at the spread of HIV infection among men having sex with men since polls suggested only 60 percent of them used condoms consistently.

Among the recommendations made by the scientific committee was that the government set up specialized sexual health clinics for men only, he said.

Billy Ho Chi-on from the City University's social studies division said while the rise in HIV cases was alarming, the incidence of HIV infections in Hong Kong was relatively low on a global scale and, therefore, a targeted preventional strategy would be sufficient.

Lawmakers and AIDS-concern groups pointed to the charging system at health clinics as one of the reasons for the increasing number of non-Chinese being infected.

Non-permanent residents are charged HK\$700 for each visit to a social hygiene clinic or HK\$1,910 at an HIV clinic.

Lau, who is also a Hong Kong University professor, said his scientific committee had previously recommended that charges for seeking HIV/AIDS tests be waived as a major preventional strategy

to safeguard public health.

"I understand the importance of maintaining a fair policy but the government needs to change its conservative policy and mentality towards sex workers," Lau said.

Frontier lawmaker Emily Lau Wai-hing said it was important to put public health over money with regard to social hygiene clinics.

Medical sector lawmaker Kwok Ka-ki said it was important to remove the barrier between those who could and could not receive free sex health treatment.

"You can differentiate between which sex workers get free treatment but, at the end of the day, it's the public who suffers," Kwok said. Kwok said he will bring the issue to the attention of the Legislative Council's health services panel before July.

A spokeswoman for the Health, Welfare and Food Bureau, in a written response to any inquiry by The Standard, said the government will consider reviewing the relevant charges at health clinics as appropriate.

Commenting on the infection figures announced Tuesday, Wong said: "In the past, there would be a new case every second day. But now we are seeing at least one new case a day."

Of the new 98 HIV cases reported in the fourth quarter of 2006, 83 were men. Twenty-three of the 98 were infected via heterosexual contact, 30 via homosexual or bisexual contact, 16 through drug injections and two via prenatal transmission.

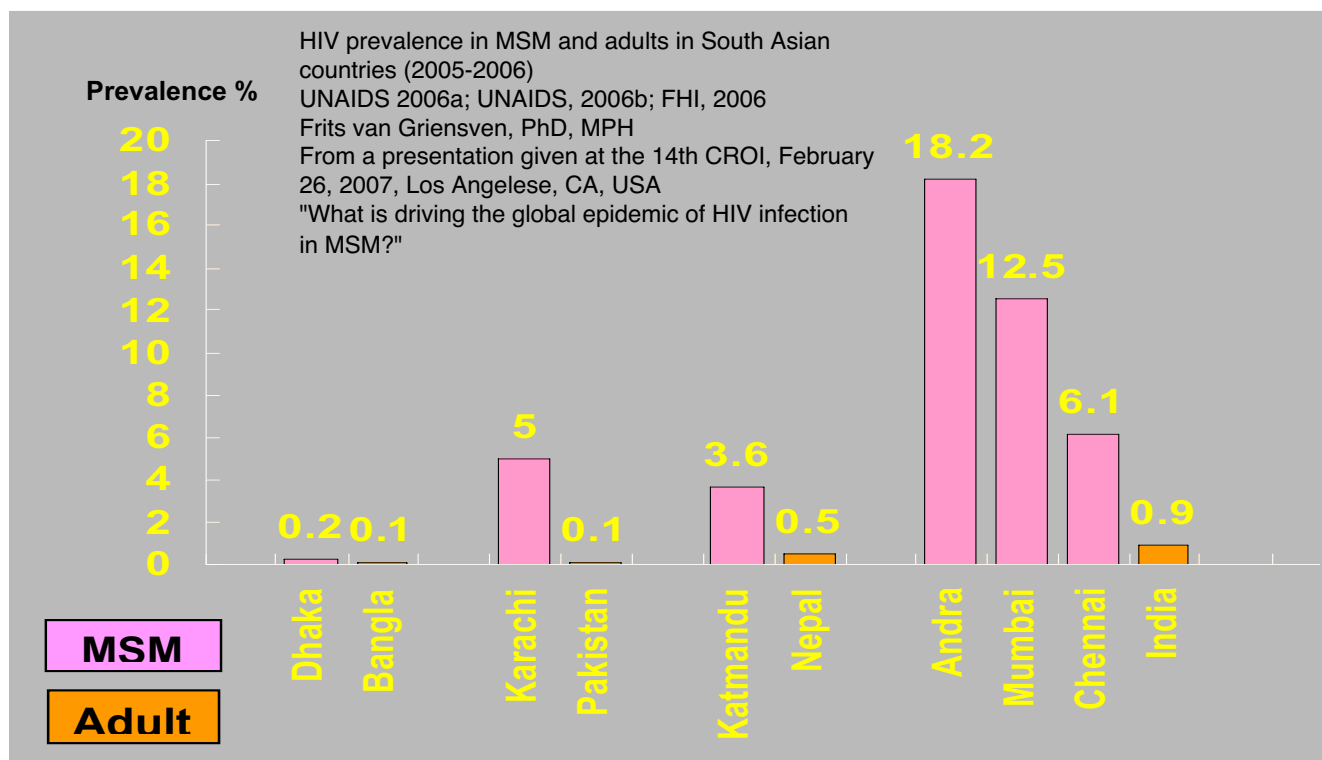
The other 27 cases remained undetermined due to insufficient data.

Since 2003, the number of same-sex HIV infections has been rising steadily, while heterosexual transmission has remained at a stable level, Wong said.

He said HIV is a treatable disease but without treatment about half of the infected people will progress into AIDS within 10 years. The department also reported 73 new cases of AIDS in 2006, bringing to 855 the total cases confirmed since 1985.

Tuberculosis is also becoming more significant in Hong Kong, taking up 43 percent of AIDS-defining illnesses, followed by pneumocystis pneumonia and fungal infections, Wong said.

*AIDS-Asia 28/2/07*



# The other side of the coin: male prostitution in Chiang Mai

The room was on the 14th floor of an expensive apartment block, facing on to a balcony suspended far above the miasma of the city centre. A gleaming combination of shiny black granite, polished teak wood and windows, it was visible before we reached it - the light shining through the open door and bouncing off the stark white walls of the corridor, was accompanied by the sing-song buzz of engaged voices.

It was a delightfully hedonistic affair: generously heaped platters of snacks laid out on sparkling surfaces, a perennial flow of fine wine and cocktails, and two luscious, attentive barmen clad only in jeans and their six-packs. One of them - dark, tall and muscled - caught my eye as I walked in and stared at me intently with a practiced gaze until I looked away. "Love the eye candy. Are they straight?" I asked our host, Pete, a little later. "Oh yes, absolutely", he answered emphatically. "There are so many women coming to my party that I thought I'd do something for the girls tonight."

A few hours and a substantial number of drinks later, things had begun to turn pleasantly pear-shaped. Tongues and ties were loosening as the horizon flashed with the approach of a tropical storm and glances at the naked torsos behind the bar were no longer quite as furtive. The boy who had greeted me at the door swaggered up to our balcony table, dispensing Cosmopolitan refills from a leftover songkran bazooka. It was then that I really noticed his companion for the first time, standing quietly behind the bar. Aung had a strong, refined beauty - square jaw, full mouth, alabaster skin. When I began speaking to him later that night he commented on the traditional patung I was wearing and pulled a laminated photograph out of his wallet. His father, mother and grandmother, he told me, both women wearing sarongs similar to mine. "I haven't seen them in four years."

"If your friend wants to take him home she's perfectly welcome," I was surprised at Pete's message when it was relayed to me. At that moment I realised the power of the human ability to repress what we know to be true. In the recesses of my consciousness I had known all along that Aung was for sale, but as a virgin to the sex trade, I was having some trouble getting my head around it.

Over the next four months I became close friends with Aung and the complexities of his story became clearer to me. Like more than half of Chiang Mai's male sex workers, he was of Shan (Thai Yai) origin. A shared border between Shan State in Burma and Chiang Mai makes our Northern Province one of the most accessible areas to Thai Yai men seeking work outside Burma. Aung was 19 years old when he arrived in Chiang Mai via the Taichilek-Mae Sai border, four years previously. His Shan father and Chinese mother were farmers and money was always in short supply during his childhood. "Burma is not like Thailand," he told me on one occasion. "In Burma, the government doesn't help you if you can't afford to go to school. My parents were poor and couldn't help me either, so I left school five years early."

When Aung was 6 years old, three of his four siblings - two brothers and a sister - died suddenly, leaving behind a devastated family. "When I turned 17 I left home to look for work," he says. I went everywhere in Burma to find a job that would give me good money, but I couldn't find one, so I came to Chiang Mai," Aung said during one interview. "My parents cried when I left, but it was the only way I could earn money to help them. When I got to Thailand I didn't know anybody, I didn't know where I was going, I didn't understand the language. Thai is similar to Shan so I have mastered it, and now I am studying to improve my English."

Aung's first job in Chiang Mai was in a restaurant kitchen, working seven days a week from 8 a.m. till midnight, for a salary of 2,000 baht a month. When his Thai improved he moved on, taking a day job at a restaurant and working evenings as a barman in Chiang Mai's Night

Bazaar. It was here that he was approached by his first customer, a Singaporean woman who offered him a thousand baht to spend the night with her. "I was excited," he responded when I asked him how he had felt. "At the bar I earned just 4,000 baht a month. What could I do? I needed to send my father and mother money to build a new house." It was not long before Aung extended his services to men, though he told me he restricted these encounters to a few times a month ("otherwise I don't have the power") and by the time I met him he was completely immersed in the sex trade - working days at a massage parlour and nights at one of Chiang Mai's most popular go-go clubs. With the money he earned there he was in the last stages of paying off his parents' new house.

My first visit to his bar shook me up, literally. There is nothing subtle about the city's go-go bars - though I never saw full sex performed on stage, the shows are explicit and are followed by a brief parade in which all 'waiters' strut their stuff. My hands were trembling when I left that first night, but it was not so much the naked bodies on stage that upset me as the sight of Aung's name placard emblazoning his tie. It was that small detail that made me acutely aware that he, too, was the potential object of a simple monetary transaction. But as I became familiar with the scene, the violence of my initial reaction soon subsided to subtle discomfort. I didn't mind going to visit Aung at his bar anymore - I felt comfortable as long as he was there and I enjoyed talking to some of the boys I met, who were friendly and polite. There was even something strangely thrilling about a world in which society's conventions did not apply - a cultural underbelly governed entirely by the human desire for money and sex - and I realised how easy it would be to become entirely de-sensitised to the environment.

"It's not difficult to understand how young boys from poor families get drawn into selling sex", says Pad Thepsai, drop-in manager of Mplus, a non-profit organisation that provides health and information services to men who have sex with men (MSM) - homosexuals, transgender people and male sex workers. "Many boys come here from their villages in the hope of being able to send money back home to their families. Some of them are hill tribe, others are from Isaan and many are from Burma, where people are treated like animals - especially the ethnic minorities like the Shan or Karen."

The issue of male prostitution, he explains, is closely tied to the problems faced by Burmese refugees who come to Thailand looking for a better life. "Because most are illegal immigrants, they are often exploited. Many start out working in the construction industry and are paid only a portion of their salaries because the companies they work for know that, without ID cards, they can do nothing about it. And to get ID cards they need cash. They speak to other boys who are already working in the bars, making good money and this is the way they start. Everybody wants more money, a better life. Education is the best way - but not all sex workers have access to education. Most of them start selling sex when they are very young and have no idea what they are getting into. They get lost in this world, they don't understand the impact of the work they are doing - they don't have anybody to tell them."

Mplus provides the north's only free MSM clinic, as well as a drop-in centre and information resource centre dealing with MSM issues and education. The organisation also does outreach work with male sex workers and youths, providing information and distributing free condoms with the aim of curbing the spread of STDs. While the incidence of AIDS and other STDs is lower in Thailand than in some other parts of Asia, a 2005 study revealed that approximately 11.4% of male sex workers in Chiang Mai are HIV positive.

Like all thriving industries, Chiang Mai's male sex trade is a well-organised web of working spaces, systems and protocol. "There are

so many places where sex is sold," says Thepsai. "Mplus works all over Chiang Mai - in gay bars, cabarets, saunas, spas, massage parlours, cruising parks, stadiums - even one public toilet." There are approximately 36 gay meeting points in Chiang Mai, he tells me, many of which are frequented by male sex workers - some as employees of the bars, others as freelancers.

The fact that much of the city's male sex trade is concentrated in gay-friendly venues does not mean that all visitors and/or paying customers are gay men - or even men, for that matter. Several of the boys I met at the bars said they sold sex to all kinds and during my visits to the clubs I was offered sex by both heterosexual and homosexual workers who said they sold sex across the gender barrier. Aung puts the division of customers at his go-go club around 80% gay men to 20% women. "But there are also others that come to the bars - bisexual men, or married men that are mostly straight but like something different. And twice I have been with couples who wanted me to have sex with both of them."

The go-go bars are overseen by one or more mama-san - a management individual or team that provides the channels of communication needed for transactions in the bars to be smoothly conducted, including the payment of a 'bar fine' should customers wish to take a boy home. Fluent Thai and a reasonable command of English are pre-requisites for this position in Chiang Mai: 'captains' - as one told me he preferred to be called - often need to negotiate on behalf of Shan, Burmese, Isaan and hill tribe sex workers who aren't proficient in the languages of their clients. "Not all the boys go with customers and not all of them will sell full sex," says Ae, who has worked as a captain in both Bangkok and Chiang Mai, "but for most its easy money. A good mama-san knows exactly what each of his boys will do - whether they sell full intercourse or oral sex or only hand jobs. He finds out from the customers what kind of boy they like and what services they are looking for and helps to make a good match."

Aung tells me that he usually requests between 1,000 and 5,000 baht from customers for full intercourse, 10,000 baht if they appear to have the money to spend. "Most Thai customers will only pay 1,000 baht, sometimes 2,000 baht, but farang will often pay more, so I ask for more." While some boys working the go-go scene prefer not to go home with customers, Aung tells me that almost all will do so for 1,000 baht or more. "But not all customers come to the bars to buy sex," he adds. "Some just come for the show or to talk to the boys and then go home."

Monthian Promlatthisorn, Mplus project manager, estimates that male sex workers in Chiang Mai can make between 15,000 and 40,000 a month, a financial bracket far beyond the average earning potential of most student-aged Thais, and one that many Burmese refugees may never have dared to dream of. Quite simply, the money can't be beaten. "Approximately 95% of sex workers in gay bars are heterosexual," says Promlatthisorn. "They don't want to have intercourse with other men, but sex is the bridge to the money they want." I asked Aung at one of our meetings how he felt when he was servicing male customers. "I don't feel," he replied. "It's work...I just close my eyes and do my job." During this conversation he was calm and composed, even detached, but at another interview a few months later he became visibly upset. "None of us who work at the bar likes to do it. We are all there for the money. I don't work for me - I work for my mother and father."

"The issue of prostitution in Thailand - both male and female - can't really be separated from the country's cultural framework," says Tey, an eloquent Thai man who spent time studying and living in Germany and the United States. "In Western countries individuals can be independent from their families, while here there is an enormous degree of dependence on the fact that children will take care of their parents. If you look at it in the light of these expectations it's easy to see why the sex industry here is so successful. It is part of Thailand's cultural fabric. And people looking in from the outside need to understand that if you break down this system you not only break

individuals, but whole families."

At the Night Bazaar one evening I talk to Tua, a bar owner. The area around this popular night market is worked by boys playing pool, massaging or drinking with customers. Things work slightly differently here than at the go-go bars - though sex is just as easily available for purchase, not everybody sells it and those that do work on a freelance basis. "Many of these boys first come here selling flowers," says Tua. "They earn hardly anything in a day, and when they are offered 500 baht to give some guy a hand-job, they see it as easy money. Some of them start working in the sex trade as young as 10 or 11."

It is at the Night Bazaar that I meet Zach, a gentle, soft spoken Canadian who has twice taken boys home from this bar strip. After many months of exploring the sex trade from the perspectives of its purveyors, my conversation with him offers insight into another angle of the issue - that of those supplying the industry's demand. "These boys provide a service," he says, "which they are willing to sell and others are willing to buy. They can always say no if they don't want to go home with a customer - the choice is there."

Two other paying customers I speak to have a very similar outlook on the situation. At the same bar a few nights later, Belgian Gerry introduces me to his 20-year old 'boyfriend'. "He likes girls," says Gerry, "but that's not a problem for me. He comes with me at night, but he does his own thing during the day, because we both need our freedom. It's a good arrangement - a relationship that works." Dave, 45, is a regular visitor to the gay bars and massage parlours of his adopted home. "I don't go to bed feeling guilty at night," he tells me. "The way I see it, every relationship is a contract. These boys come here from the villages looking for money - so they get what they want and I get what I want, which is no-strings-attached sex."

On the last night I see Aung at the go-go bar, he shows me an Mplus card declaring him HIV negative and tells me he has decided to stop selling sex. "It's not good," he tells me, "I don't want to do it anymore." "Some things are more important than money", I say to him. "Your health is more important, your happiness is more important." "My life is more important," he agrees. But I am not surprised when three weeks later he relocates to a bar at the night market. For a while he continues to tell me he is no longer involved in the sex trade and only works as a barman, but later admits that he still services customers occasionally. He wants to open a small shop one day, he says, and hasn't saved up enough money yet.

*MSM - Asia 2/10/06*



An NFI training programme for scaling up MSM and HIV services coverage in India. With 16 such programmes, 36 community-based projects were developed within 6 months, 4 state level MSM and HIV Forums established, and 4 state level technical support facilities organised. The states where this was achieved are Andhra Pradesh, Karnataka, Tamil Nadu and Uttar Pradesh. This project was supported by DFID India

## Blue Diamond Society, Nepal's only LGBT organization, receives international recognition for their LGBT human rights work

*International Gay and Lesbian Human Rights Commission*

The International Gay and Lesbian Human Rights Commission (IGLHRC) proudly announced today the selection of the Blue Diamond Society (BDS) as the recipient of its internationally recognized Felipa de Souza Award. BDS is a community-based organization working for sexual minorities in Nepal. The 2007 Felipa Award will be presented to Sunil Pant, the Founder and Director of BDS, at two awards ceremonies to be held on May 1, 2007 in New York and on May 3, 2007 in San Francisco.

Since 1994, the Felipa Award has acknowledged the courage and impact of grassroots groups and leaders dedicated to improving the human rights of lesbian, gay, bisexual, transgender (LGBT) and other individuals stigmatized and abused because of their sexuality or HIV status.

"Blue Diamond Society is one of the most effective human rights groups in the world. What Sunil and other members have been able to do in such a short time to build visibility and effective action around LGBT issues in Nepal and international renown among their global peers is nothing short of astounding," said Paula Ettelbrick, the Executive Director of IGLHRC. "It is truly our honor to continue to work with them and to honor all they have done to promote human rights for everyone, everywhere - not just in Nepal."

The Blue Diamond Society (BDS), Nepal's only organization for sexual minorities, was founded in 2001 in an effort to address the needs of sexual minorities. In June 2004, in response to increasing incidents of police brutality against LGBT people, BDS organized the first public demonstration to support human rights for sexual minorities. Two months later, in another incident, Nepalese police arrested and jailed 39 LGBT activists. Immediately afterward, BDS spearheaded a national and international campaign to secure the release of the detainees.

BDS' mission is to create an acceptance of sexual minorities in the society, reduce stigma and discrimination of sexual minorities, reduce high-risk sexual behaviors and increase Sexually Transmitted Infections (STI) service utilization among sexual minorities for prevention of STI/HIV infection in Nepal, and to provide care and support for those sexual minorities who are HIV positive.

In the past few years, BDS has played an active role in Nepal's politics by supporting the pro-democracy movement in the country. Since the gay community was systematically targeted and oppressed under the absolute reign of King Gyanendra, BDS joined other Nepalese people in opposing his regime. Following the King's agreement to hand over power to the Nepalese people in April 2006, BDS has been working with the new government to include sexual minorities' basic human rights and protections in the new constitution. In January 2007, Blue Diamond Society organized a forum on "Nepal's New Constitution and the Rights of Minorities" where Lena Sundh, Representative of the UN High Commissioner for Human Rights, and Justice Edwin Cameron, Supreme Court of Appeal, South Africa shared their thoughts and experiences with Nepalese legal and political experts.

"[Receiving] this [award] is such a great honor for Blue Diamond Society, all the Nepalese LGBTs and our families and friends who have been supporting of us," said Sunil Pant, director of the Blue Diamond Society in Kathmandu, Nepal. "This award means increased visibility of the Nepalese LGBT community and empowering us in a crucial moment for the country as well as for the LGBT community itself."

Nominations for the Felipa Award are solicited each year from activists around the world. Nominees go through a rigorous review by the staff, board and the International Advisory Committee of IGLHRC. The Award embodies the spirit and story of Felipa de Souza, who endured persecution and brutality after proudly declaring her intimacy



*Sunil Pant, President, Blue Diamond Society*

with a woman during a 16th Century inquisition trial in Brazil.

The Felipa Award carries with it a \$5,000 (USD) stipend to assist and strengthen the ability of grassroots human rights groups to do their work. The awardees will also have the opportunity to meet with U.S.-based LGBT activists and supporters during special award ceremonies and public education events in New York and San Francisco.

Previous Felipa Award winners include: Rauda Morcos, founder of ASWAT (Voices) the first group for Palestinian lesbians, Gays and Lesbians of Zimbabwe (GALZ), the first organization to push for the human rights of LGBT people in Zimbabwean society and to provide counseling services and HIV/AIDS prevention campaigns; Simon Tseko Nikoli, the famed LGBT/HIV activist from South Africa; Jamaica Forum for Lesbians, All-Sexuals and Gays, whose leader Brian Williamson was murdered in 2004; Lohana Berkins, a globally known transgender activist from Argentina; and Maher Sabry, the Egyptian activist who notified IGLHRC of the arrests of the Cairo 52, a group of 52 men who were arrested by the Egyptian police at a Cairo gay nightclub in 2001.

17/1/07, IGLHRC

*The International Gay and Lesbian Human Rights Commission (IGLHRC) is a leading human rights organization solely devoted to improving the rights of people around the world who are targeted for imprisonment, abuse or death because of their sexuality, gender identity or HIV/AIDS status. IGLHRC addresses human rights violations by partnering with and supporting activists in countries around the world, monitoring and documenting human rights abuses, engaging offending governments, and educating international human rights officials. A non-profit, non-governmental organization, IGLHRC is based in New York, with offices in San Francisco and Buenos Aires. Visit <http://www.iglhrc.org> for more information.*