August 2006

SPECIAL REPORT

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TREATASIA

MSM and HIV/AIDS Risk in Asia:

What Is Fueling the Epidemic Among MSM and How Can It Be Stopped?

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Acknowledgments

TREAT Asia gratefully acknowledges the invaluable contributions of numerous organizations and individuals without whose help and support this report would not have been possible.

We are deeply indebted to those who have written about men who have sex with men (MSM) and HIV/AIDS in Asia, and to the organizations that have supported and produced these articles and publications in order to call attention to the problem. Although too numerous to mention here, some of the excellent reports that framed this analysis include an overview of global HIV prevention activities and gaps by the Global HIV Prevention Working Group[5] and a 2003 review of MSM networks and MSM research in four Asian countries by the Australian Research Centre in Sex, Health, and Society.[58] Carol Jenkins has done invaluable work on the sociology of MSM and how it affects HIV programming.[85] The situation in South Asia has been highlighted by Shivananda Khan[99] (founder of Naz Foundation International) and others.[9] Finally, the MAP Network used its enormous collective knowledge and experience to identify the urgent need for MSM prevention in Asia.[127] A complete list of sources, including many valuable country-specific reports, is included in the Bibliography/Endnotes beginning on page 76.

To help identify key factors fueling the spread of local epidemics in the region, our research included interviews with front-line service providers, researchers, and activists working with MSM in Asia and the Pacific. These individuals—more than 40 representatives in 19 countries—generously gave of their time, participating in lengthy interviews two to three hours in duration. Their in-depth knowledge of MSM issues and their insights into MSM and HIV/AIDS programming needs in their countries provided vital information and added immeasurable value to our work. We appreciate their time, candor, and enduring commitment to MSM and other vulnerable populations at risk for HIV and AIDS. A list of interviewees and their affiliations is included in Appendix 1.

Among the earliest to recognize the need and commit significant resources to address HIV/AIDS among MSM in Asia has been the U.S. Agency for International Development (USAID) and the U.S. Centers for Disease Control and Prevention (CDC).

Many nongovernmental organizations (NGOs) both large and small have labored to reach MSM despite widespread indifference or hostility from governments. Several of these organizations are described in Appendix 2, but two in particular deserve to be highlighted:

- Family Health International has attacked the problem on two fronts, supporting sociological and quantitative research to document the scope of the problem and guiding local NGOs to implement peer-based initiatives. Its MSM initiatives started in 2000 in Bangladesh, Cambodia, and India, and expanded in 2001 to East Timor, Indonesia, Nepal, Pakistan, Papua New Guinea, the Philippines, Thailand, and Vietnam.
- Naz Foundation International was described by one NGO staffer as a "real lighthouse in the darkness."[72] Along with Humsafar Trust and others in India, Naz has helped define the MSM landscape in South Asia and has worked tirelessly to publicize and reduce the plight of the South Asian MSM population.

Last, we want to acknowledge and thank our five contributors. Nick Bartlett, Dr. Supriya Bezbaruah, and Paul Causey conducted detailed interviews and provided invaluable regional context; Dr. Paul Galatowitsch designed and directed the research strategy; and Dr. William Wells synthesized the research and wrote the main text. These extremely talented and dedicated individuals performed an extraordinary amount of work under enormous pressure in a remarkably short time.

We hope this report will serve as a catalyst for much needed change, and help those working on the ground to make their case for the vital importance of their work.

Executive Summary

As the worldwide AIDS epidemic enters its second quarter-century, HIV prevalence among men who have sex with men (MSM) is a growing concern, especially in Asia. In recent years, MSM in Asia have experienced an extraordinary rise in HIV prevalence. Various studies report infection rates as high as 14% in Phnom Penh, Cambodia; 16% in Andhra Pradesh, India; and 28% in Bangkok, Thailand. Unless dedicated resources and political will can be mustered in support of innovative and creative ways to stem rising infection rates, MSM in Asia will face a crisis more devastating than that experienced by gay men in the West during the epidemic's earliest years.

In this report, TREAT Asia attempts to present a comprehensive picture of MSM communities in Asia as well as their diverse religious, cultural, and socioeconomic backgrounds. The report summarizes the latest epidemiological and operational findings on HIV infection among groups whose behavior is difficult to monitor. Finally, it argues for several policy and donor-led strategies to slow this rapidly expanding epidemic.

MSM in Asia defy stereotypes established during the first 25 years of HIV/AIDS. Among the first to be affected by the disease, gay men in the West mounted a robust response to the epidemic through community-based prevention and education, behavioral change, and resource mobilization. In many ways, the gay community's pioneering advocacy defined how the battle against HIV/AIDS has been fought globally. But the political will and capacity of the gay community to mobilize in cities like San Francisco, New York, and Amsterdam appear to have few corollaries in the developing world.

MSM in Asia are particularly vulnerable. The nature of MSM activity across the continent is so diverse that it forces us to rethink the basic strategies of fighting AIDS: awareness, outreach, education, testing. In fact, the challenges of even identifying MSM, which include stigma, discrimination, denial, and ignorance, aggravate an already difficult situation. Limited numbers of MSM in Asian nations identify themselves as such, ruling out the possibility of peer- and community-based outreach—a key lesson learned in the West. Those infected with HIV, as well as those at risk of infection, share few social and cultural practices. Many are married; many conduct covert sex lives that often involve commercial sex. Still others have accepted the marginal status of MSM—often perpetuated by governments through either active discrimination or passive neglect. Yet the physiological and social factors that increase risk of infection among MSM still hold true. This report demonstrates that while addressing HIV infection among MSM in Asia has been ignored for many reasons, it is critical to alleviating Asia's escalating epidemic.

Prevalence of Male-Male Sexual Activity

Although male-male sex is widespread in Asia, relatively few men adopt a Western gay identity in which sexuality defines identity. Instead many Asian MSM define themselves based on adopted gender roles, which allow many men to participate in male-male sex while retaining their sense of masculinity. This behavior is particularly prevalent in South Asian cultures where other sexual outlets may be unavailable. Fluid and situational, male-male sex is believed to occur among one quarter to one half of men in certain populations (e.g., rickshaw pullers in Bangladesh and truck drivers in India).

The nature of MSM activity across the continent is so diverse that it forces us to rethink the basic strategies of fighting AIDS.

Diverse MSM Identities

The most prominent feature of MSM identities in Asia is their diversity. MSM identities include transgender individuals, feminine-acting MSM, their masculine-acting partners, gay-identified men, and men who have situational sex with each other. All of this diversity is in theory covered by the term MSM, which focuses on behavior rather than identity, but unfortunately in some locations even this broad term has become associated with single groups—often those that are most visible (e.g., feminine-acting MSM) or most politically active (e.g., gay-identified MSM).

Within these broad categories of MSM there is still more diversity. In each country, MSM have their own set of behaviors and interactions with other MSM groups. These may include differences in any or all of the following: prevention behaviors; frequency of transactional sex; relative social position of different MSM groups; characteristic

meeting places; behavioral norms when meeting other MSM; methods of self-identification; and fluidity among MSM identities. Prevention programs must be built upon a firm understanding of these behavioral and social norms.

High Risk Behaviors Leading to High HIV/AIDS Prevalence

Ignorance about the extent of male-male sex results in a relative lack of MSM programming, which in turn leads to high levels of risk behaviors. In the past, HIV/AIDS prevention programming in Asia has often concentrated on heterosexual sex or injection drug users (IDUs). Therefore, many men see sex with women as being an HIV/AIDS risk and male-male sex as a safer option. MSM often show much higher condom use when having sex with women than with men.

The prevalence of consistent condom use among MSM is as low as 12%, and up to half of all MSM in some regions have never used a condom. Yet a majority of these men believe that they are at low risk. In several countries less than 20% have been tested for HIV. Finally, up to half or more of these MSM also have sex with women—the result of a combination of situational sex and the social pressure to marry—and can thus serve as a bridge population for HIV/AIDS infection.

The unsurprising outcome of a situation characterized by lack of programming, lack of knowledge, and high prevalence of unsafe sex is rising rates of HIV infection. Even in countries with low overall HIV/AIDS prevalence, cases among MSM contribute disproportionately to the total. Other sexually transmitted infections (STIs) are both a marker of unsafe sex and a contributing factor to the transmission of HIV. In some areas more than half of all MSM have an STI. Few doctors in the region have the knowledge or cultural sensitivity needed to diagnose the many cases of rectal STIs.

Challenges to MSM Programming

The challenges in developing MSM programming are significant. First, many MSM do not identify themselves as such, and so are hidden from MSM-specific programming. This group includes most masculine-acting MSM, who may view sexual encounters with transgender individuals as heterosexual. Male sex workers are another group of individuals that often fail to identify as MSM. Even defining a particular group as male sex workers is problematic since exchange of money is common among many MSM who would not characterize themselves as sex workers.

MSM programming is inhibited by stigma associated with male-male sex. Discrimination can result in the absence of condoms and lubricant in places where male-male sex takes place, such as in saunas and parks. Campaigns aimed at MSM may be prohibited or denied funding, so that appropriate prevention messages are not available.

Stigma is present at many levels. Male-male sex is illegal in 11 of the 23 countries surveyed, and in many of the other 12 countries MSM are subject to arbitrary persecution, often by police. Those providing or accessing HIV/AIDS prevention programming are often harassed, so MSM may avoid getting involved in providing or accessing this programming. When MSM venues are marginalized, the only remaining possibility is furtive encounters, which are far more likely to involve unsafe behaviors. The marginalization of MSM relationships results in higher numbers of sexual partners and lower self-esteem, again leading to unsafe behaviors.

Finally, the absence of a vocal, self-identifying MSM population prevents the application of Western models of HIV prevention and behavior change, which are based on establishing behavior norms in a self-reinforcing community. Some successes have been achieved, however, in building Asian MSM communities that emphasize a collective rather than individualized MSM identity.

Up to half of all men in some regions have never used a condom. Yet a majority of these men believe that they are at low risk.

The Required Response

Swift action is needed to address this increasingly dire situation. In this report, TREAT Asia articulates several key recommendations to slow the epidemic among MSM in Asia, including improving prevention and education programs for all throughout the region:

- More vigorous political leadership that recognizes the problem, encourages groups to provide services for MSM, and adequately supports these services;

- Inclusion of MSM in all efforts to address the epidemic, including all partnerships between government and civil society;
- Inclusion of MSM in routine HIV/AIDS surveillance so that all parties can assess needs, plan a response, and evaluate outcomes. The unique nature of MSM communities and the social rules by which they live must be investigated so that appropriate interventions can be designed;
- Recognition of male-male sex in all education, prevention, and clinical efforts to stem the epidemic, i.e., accurate education about the risk factors associated with anal sex; prevention messages that address male-male sex without supporting stigma; condoms and lubricant made more readily available at sites where MSM have sex; clinics for HIV testing and STI and HIV/AIDS treatment made accessible to MSM.

The best programs are built around a participatory approach in which peers help each other overcome barriers to adopting safe behaviors. Early successes are emerging that incorporate many of these recommendations: one program in Indonesia has reported a threefold rise in consistent condom use among MSM and a fourfold rise in lubricant use. Such peer-led programs are often run by nongovernmental organizations. But the need remains to bring government into the equation so that those in power realize the extent of the MSM epidemic and contribute to the response. Real partnerships between government and civil society are the only way that both large-scale and community-based responses can be effectively marshaled.

Background

The Asian HIV/AIDS Epidemic Has Targeted Vulnerable Communities

Vulnerable communities dominate the story of the HIV/AIDS epidemic in Asia.[7] In many Asian countries the bulk of infections still take place among members of vulnerable communities, and so to prevent a generalized epidemic it is essential that these countries be pragmatic when dealing with vulnerable groups. Men who have sex with men (MSM)—the topic of this report—are a crucial part of this picture.

HIV/AIDS took root in Asia first and most dangerously within several marginalized communities—among them, intravenous drug users (IDUs), sex workers, and men who have sex with men—and from there moved out into the general population. Initially, HIV/AIDS developed slowly across the region and was seen only sporadically until 1988, but it then began to expand explosively among injection drug users (IDUs) in the Golden Triangle (the region around the Thai, Myanmar, and Lao borders). From there it spread on epidemic levels to sex workers. First Thailand and then Cambodia began to experience generalized epidemics (defined as an HIV prevalence of 1% or more[3]), with Myanmar joining their ranks more recently.[160]

The trajectory of HIV in these areas shows just how quickly low prevalence countries can transition into full-scale HIV/AIDS epidemics. Other Asian nations—including China (both Mainland and Hong Kong), East Timor, India, Indonesia, Japan, Malaysia, Nepal, Pakistan, Papua New Guinea, Singapore, and Vietnam—have also accumulated a high prevalence of HIV among at least some sub-populations. Although they have not registered generalized epidemics yet, they face the possibility of large-scale outbreaks. Bangladesh, Bhutan, Brunei, Laos, North Korea, Philippines, South Korea, Sri Lanka, and Taiwan have not yet seen extensive spread of HIV.

The Asian HIV/AIDS epidemic has not progressed so far that it cannot be stopped. Thailand and Cambodia have been strikingly successful in reducing HIV prevalence, using campaigns based on government commitment, multisectoral responses, community participation, and the involvement of civil society.[55] Targeting groups at high risk has proven to be a powerful strategy, but a rapid response is crucial.

HIV/AIDS and MSM in Asia: A Smoldering Fire

Despite the vulnerability of MSM to HIV/AIDS, little attention has been focused on these communities in Asia. Stigma and discrimination have marginalized MSM and rendered them invisible, and the result is that the unique prevention and treatment needs of MSM have been largely ignored. As the data presented in this report indicate, although many Asian countries have thrown themselves into the fight against AIDS on many fronts, their failure to grapple with the epidemic among MSM has now left them with the possibility of a public health disaster.

Asian MSM are particularly vulnerable to the epidemic. Denial of male-male sexual activity is high, yet male-male sex is widespread, diverse, and hidden from many standard prevention programs. Unprotected anal intercourse is extremely common.

For the purposes of this report, MSM are defined as biological males engaging in sexual activities with other biological males. It is important to point out, however, that sexual behavior among MSM can, and often does, encompass a vast, diverse, and fluid range of choices.

Sexual identity among Asian MSM is a complex issue that calls for a nuanced understanding of these communities.

Although many Asian countries have thrown themselves into the fight against AIDS on many fronts, their failure to grapple with the epidemic among MSM has now left them with the possibility of a public health disaster.

A number of researchers and nongovernmental organizations (NGOs) have been sounding the alarm on MSM and HIV in Asia. With grateful acknowledgment of this work and of an excellent report on the subject published last year,[127] this TREAT Asia report seeks to raise the profile of HIV/AIDS and MSM needs in Asia so that existing country epidemics can be halted and future ones avoided. China, India, and Indonesia combined contain almost half of the world's population, so even relatively low prevalence rates in these countries will mean an alarming number of infections. Increased attention to MSM and HIV/AIDS will be essential if the current epidemics are to be contained.

What is the Target Population?

Diverse Populations; Diverse Terms

All HIV prevention work—from epidemiology and behavioral surveillance to planning, outreach, and prevention programming—relies on an understanding of the target population. Who are these individuals, and how do they live their lives? Before we examine the key findings of this report—such as the prevalence of male-male sex, HIV/AIDS among MSM, and risk behavior among MSM—we must first describe the groups of people covered by the term MSM.

Gender roles and sexual behaviors among Asian MSM (as in populations in many parts of the world) have been poorly understood, and as a result it has been difficult to design effective interventions that will reach the appropriate populations. Even MSM itself is a problematic term, within which lies a wealth of geographic, social, sexual, and gender diversity.

MSM as a Problematic Categorization

> ***"It is not the existence of same-sex sexual relations that is new but their association with essentialist sexual identities rather than hierarchies of age, class or status."***
> **— Carol Jenkins[85]**

A "gay" or "homosexual" identity rarely applies in Asia. Instead, many Asian MSM define themselves based on their adopted gender roles, with feminine and masculine roles shaping both sexual behavior and personal relationships. The term "MSM" has thus been adopted in an attempt to focus on behavior rather than identity, and to include all men who have sex with men, regardless of how they see themselves. It encompasses males who define themselves either by their sexual behaviors (e.g., gay men) or by their feminine gender identities (*kothis, waria, katoey*), in addition to their masculine-identified sexual partners.[95]

Glossary

The term "men who have sex with men" or MSM is used in this report as a broad umbrella term for the extraordinarily varied communities found throughout Asia. Different nations, regions, and even communities may have MSM groups that defy conventional categorization. This glossary mentions only a few of the extant terms and groups, focusing on the ones that are most often mentioned in this report. Similar groups often exist under other names elsewhere in Asia.

In South Asia, in particular India, the most prominent groups include:

Hijras—A group of transgendered MSM sometimes considered to be a "third sex;" they are often castrated, and dress as women. After individuals are castrated they become part of a tight social group that is alternately feared and respected.[78]

Kothis—Effeminate men who nevertheless may be married. The *kothi* identity is a complex construction with no equivalent in the West. Similar to the *metis* of Nepal.

Panthis—Masculine men who have sex (usually in the insertive role) with *kothis*. They do not self-identify as *panthis* but are labeled as such by *kothis*. Similar to the *ta* of Nepal.

In Southeast Asia, some of the many groups include:

Katoey (Thailand and Laos), ***kteuy*** (Cambodia) and ***waria*** (Indonesia)—Transgendered MSM.

Sray sros (Cambodia; also called "long hairs" in English)—Men who identify as women; also, men who dress as women to attract men.

Pros saat (Cambodia; also called "short hairs" in English)—Non-transgender, masculine-acting MSM.

Unfortunately, a specific and singular identity often attaches itself to a label such as MSM. For example, in Cambodia the term "MSM" has radiated out from NGOs to the target population. Many of these men identify themselves as "an MSM,"[28] but they explain that some of the men they have sex with are "not MSM."[128] In contrast, in a study of 302 Bangladeshi males, no males having sex with males called themselves MSM, only 20% were aware of the term, and "most of them were annoyed and confused with this special taxonomy."[129]

The term also tends to become associated with those who are most easily identified (often transgendered or effeminate males), resulting in the exclusion of other men who have sex with men but blend into society.[96] This has consequences for both surveillance and programming strategies.

But even when several categories of MSM are detailed, this is not an adequate basis for understanding behaviors that can transmit HIV. Although "it is imperative to understand the language and classifications of local sexual cultures," this research can easily reinforce cultural stereotypes rather than explaining why the stereotypes exist. MSM behaviors "are often personally more fluid and variable than popular stereotypes convey."[23]

MSM in Asia Engage in a Wide Variety of Behaviors

Asia is a vast region of both industrialized and developing countries where both traditional and more modernized conceptions of MSM identity exist, often side by side. The balance between the two may shift as countries develop, but local variation is a persistent theme.

The MSM who are targeted by NGO interventions are usually those who congregate at known MSM meeting areas where they can encounter others for sex. Yet these areas attract only a particular subset of MSM—those who more strongly identify as seeking male-male sex and perhaps even as being "gay." This point was echoed again and again in the interviews conducted with front-line MSM service providers in the region.

But a "gay" identity is not dominant among Asian MSM—an identity based on gender is more common. Whatever population is identified or served by an NGO, it may be misleading to assume that this MSM population is the predominant one.[58] Similarly, external appearance and behavior (more feminine or more masculine) often do not map neatly or predictably onto sexual behaviors such as insertive versus receptive roles for anal sex.[58]

Behavioral heterogeneity is also common to transgender communities, which have a significant history in Asia. These groups adopt identities ranging from a "third gender" distinct from male or female (the *hijras* in India) to that of a heterosexual female or even an effeminate male.[85]

Detailed studies are needed to determine the nature of different sub-groups of MSM and their distinct beliefs and behaviors. Only then can sensible interventions be designed. A sample of two country-specific studies (many more of which are listed in Appendix 8) gives a sense of what can be uncovered by careful investigation:

1) A study of 1,306 MSM in Cambodia[128] determined that there were four times more *pros saat* (masculine-acting MSM who have sex with each other) than *sray sros* (transgendered MSM whose masculine sexual partners identify as neither *pros saat* nor *sray sros*). Their meeting spots overlapped only partially, and relations between the two groups were not always cordial. The *pros saat* were more likely to receive money for sex (20% regularly and 41% occasionally). These high levels of transactional sex led the investigators to hold focus groups, in which they found that exchange of money is a standard part of many MSM encounters for *pros saat*, and one way of establishing seniority in a relationship. A *sray sros* takes pride in attracting a paying customer, whereas a *pros saat* would rather be paying and thus displaying his ability to be in charge.[128]

2) Among MSM in Papua New Guinea, by contrast, selling sex is not driven by concerns of social hierarchy but used as a commonly reported income source (most are financially supporting children, other family members, and relatives). Most MSM do not self-identify as gay or homosexual. MSM have diverse sexual networks and many have had sex with multiple male and female partners, and have bought or sold sex with both men and women. In Papua New Guinea there do not appear to be any specific terms that refer to bisexual men or heterosexual men who have sex with other men, which suggests that the community may not really recognize non-gay identified or non-feminine MSM as a separate group. The community may not even recognize the fact that these men have sexual relationships with other men.[124]

In recognition of the great geographic diversity of MSM populations in Asia, the following is a brief sketch of how these populations are structured in different parts of Asia.

Detailed studies are needed to determine the nature of different sub-groups of MSM and their distinct beliefs and behaviors.

South Asia

Thanks to a few pioneering organizations, male-male sexual relations and MSM identity have been more closely studied in South Asia than they have in other areas of the continent, and as a result it is possible to draw a relatively nuanced picture of the region.

In addition to the *hijras, kothis,* and *panthis* described on page 5, MSM in South Asia include: gay-identified men; double-deckers, who have both insertive and receptive anal sex; and other MSM, who do not fit other categories but have situational sex with men because they are more sexually available than women. Studies in South Asia show that most relationships between MSM reflect the unequal power dynamics and gender antagonism present in the wider society.[85] Thus, a masculine or older partner will play a dominant role over a feminine or younger partner. More equal partnerships are possible between the few South Asian men who identify with the Western conception of a "gay" identity. These men are almost exclusively richer and fluent in English. But if MSM advocacy groups are based around these "gay-identified" men, they risk excluding the majority of MSM.

The effeminate *kothi* identity in South Asia is a more complex construction with no equivalent in the West. *Kothi* intend to get married and see this act as a "family compulsion."[101] Their understanding of their shifting roles is based on gender, not sexual preference, with the effeminate *kothi* still capable of temporarily taking on a masculine role when in the family situation.[78]

In public, however, the effeminate behavior of *kothis* makes them visible. They use this to attract a "real man" called a *panthi*, who is expected to be the insertive partner. In these gendered interactions, the receptive partner sees himself in a feminine role, but the insertive partner does not perceive himself as a victimized sexual minority.[95]

Only some of these interactions involve the exchange of money. Most male sex workers are *kothis*, but not all *kothis* are sex workers. If men resort to paying for sex, using a *kothi* for sexual release is seen by some Bangladeshi men as a less visible and less shameful activity than visiting a female sex worker.[99]

Beyond these categories is a vast universe of male-male sex conducted with no reference to sexual identity. This is the result largely of the sexual unavailability of women and the availability of men. Being seen with any woman is immediate grounds for suspicion, whereas close male companionship is an integral part of the culture. Crowded living conditions also present opportunities for furtive nighttime encounters between men, and responsibility for these behaviors can be displaced to spirits. For example, *Jiggery dosti* in Calcutta or *Jaani dosti* in Dhaka—terms meaning "close friends"—are boys or young men who may have sex with each other when their living situation results in them sleeping together. Meanwhile, since many married MSM see sex with their wives as a necessary chore, they often resort to same-sex encounters.

The levels of acceptance experienced by MSM often depend on class: upper-class MSM tend to be more independent; middle-class MSM are usually forced into marriages; and poorer MSM are generally tolerated only if they bring significant income to the family (a finding common to many countries).[126] Poorer MSM may access MSM-specific services more readily in some countries as they have less to lose (job, social status, etc.) if they are found out.[45]

Male-male sex can start early. The most common age of first sexual encounter is estimated at 11-14 years, often in these early years with relatives or older men.[100]

Southeast Asia

MSM in Southeast Asia consist of multiple populations that cannot be targeted with one approach. This region has a transgender tradition,[181] most famously in the *katoey* of Thailand and the *waria* of Indonesia. The Thai *katoey* are tolerated but not necessarily accepted.[198] Across the border in Cambodia, however, *kteuy* (the local transliteration of the Thai word) find less acceptance and the word can also be used as a pejorative term for any effeminate MSM.[28] Other groups of MSM remain distinct in Cambodia: Masculine-acting *pros saat* reportedly do not associate with more feminine *sray sros* because they want to avoid the stigma caused by the latter's effeminate behavior.[28]

The situational sex reported in South Asia is also seen in Southeast Asia. In Laos, for example, so-called "complete men" may have sex with other men when they are drunk and cannot find a woman, and most male sex workers identify as "complete men."[179]

MSM in Southeast Asia consist of multiple populations that cannot be targeted with one approach.

East Asia

In Chinese culture, sexuality is not generally a sufficient basis for defining an individual—instead, familial and hierarchical ties are far more important. Many Chinese MSM, as in much of the rest of Asia, therefore "find the identity of gay or homosexual alienating."[189] The open assertion of an MSM's sexual identity may be seen as an entirely inappropriate act of selfishness. Yet as long as this explicit declaration never takes place, the partner of the MSM may be integrated into a family through actions rather than words; much is left unsaid.

HIV prevention and community-building efforts among East Asian MSM work best when they are sympathetic to this sense of collective rather than individual identity. Taiwanese MSM groups devised several events in this mold. In the "Ten Great *Tongzhi* Dreamy Lovers Election," an anonymous MSM electorate voted on which mainstream celebrities would be the best gay lovers. The volume of votes testified to the strength of the community, but individuals did not have to confront society individually by exposing their own identity. In a second event, called "rainbow days," MSM were asked to wear red on one day, orange on the next, and so forth. Some non-MSM would by chance wear these colors also, so each individual had complete deniability, and the line between MSM and non-MSM was cleverly blurred.[189]

MSM Exist in Both Dense and Loose Networks

As can be seen from these brief sketches, MSM populations in Asia include an evolving mix of identities. This mixture creates additional threats for the spread of HIV/AIDS.

MSM in the West are particularly vulnerable to infection because the social networks in which they mingle are dense. If sexual contacts within this network are frequent, HIV can spread rapidly since a recently infected individual is up to 1,000 times more likely to transmit HIV than one who was infected some time ago.[84] But even without frequent sexual contact, dense networks present a great risk of a concentrated epidemic. Once a few individuals in this sort of community are infected, there are many pathways by which subsequent individuals may become infected. Dense networks create the conditions for rapid rises in prevalence rates.

The complexity of MSM populations in Asia means that there are both dense networks and overlapping looser networks made up of more widely dispersed individuals who have male-male sex more sporadically and opportunistically. The first group can provide the substrate for initial rapid rises in prevalence rates, and the second group can provide the conduit for spread to wider populations.

Lack of a Unified MSM Community

The diversity described above means that Asian male-male sexual activity cannot be represented by any single, uniform MSM community. The difficulty in forming a united MSM community presents a barrier to prevention because communities are an efficient means of establishing positive prevention norms. Safe sex practices are adopted and maintained only if they become normative behavior that is embraced by a community. But what if there is no MSM community to embrace them?[97]

MSM communities in the U.S. and Europe arose from the construction of a largely unified gay identity, which "contributed to a sense of belonging and of common cause."[9] The U.S. belief in individualism and the conviction that each person's actions can make a difference led to the mobilization of gay volunteer groups in response to the threat of HIV/AIDS. This model of peer-led intervention has dominated many of the international responses to HIV/AIDS prevention.

In Chinese culture, sexuality is not generally a sufficient basis for defining an individual—instead, familial and hierarchical ties are far more important.

Challenges in implementing this model are greater, however, where the "idea of constructing personal identities around sexual orientation is alien."[9] As in many parts of the world, the themes of family, marriage, and producing children are dominant throughout Asia. In India, if these requirements are met, a man may have sex with a man without compromising his masculinity. Male-male sexual activity can even strengthen patriarchy since men can fulfill their sexual needs while still repressing women's sexuality.

The lack of a unified MSM community is evident in the social division between masculine- and feminine-acting MSM. Of these groups, the hardest to reach are the *pan-thi*-like populations (partners and clients of feminine-acting MSM) who may have sex with other MSM quickly and furtively, with little or no socializing. (An exception are the panthi-like *ta* of Nepal, who do socialize with the *kothi*-like *metis*.[23])

Forming a community may drive away some potential members. There is an inherent tension between establishing a community, which tends to circumscribe who is allowed to belong, and the desire to include all MSM. But for those fighting HIV/AIDS among MSM in Asia, the group of "all MSM" needs to include all men who have sex with men, even those who are not committed to an exclusively gay identity.[85]

Key Findings

Many challenges exist for those responding to HIV/AIDS in Asia. It is not our intent to cover these general challenges in detail, as others have already done so. Rather, we seek to identify the gaps in recognition and response that have made MSM in Asia a population that is uniquely vulnerable to HIV infection. We start by demonstrating the existence of this huge problem before examining the reasons that it has arisen and the possible responses.

Asia Has Many MSM

Asia has more than enough male-male sex to fuel an epidemic. In industrialized countries, 5 to 10% of adults typically report a same-sex relationship at some point in their lives, and 1 to 5% report recent sex with a same-sex partner.[85] Population-based studies have suggested that the prevalence of male-male sexual activity in Asia is similar to or higher than that established for the West, and that large numbers of these MSM also have sex with women.

Some of the **levels of male-male sex** reported by studies in Asia are:

- Self-identification as gay: 2% (China); or as homo- or bisexual: 7% (China).[203]
- Recent male-male sex (within past 3 or 6 months): 2% (Hong Kong[115]), 3-4% (Thailand[14,119], Philippines[194]), 6% (slums of Chennai, India[70]).
- Ever had male-male sex: 4.6% (Hong Kong[115]), 15% (truck drivers in India[98]), 18.5% (Laos[179]), 20% (China[203]), 22% (rickshaw pullers in Bangladesh[98]), 49% (truck drivers in Lahore, Pakistan[94]).
- Ever had unprotected anal sex with a man: 3% (of married men) and 10% (of single men; rural India[113]).
- Ever had sex with both men and women: 12.1% (Philippines[155]).

The high but variable South Asian statistics are consistent with male-male sex being tolerated as an acceptable outlet for men, especially when circumstances and cultural norms make women unavailable.

Many MSM in Asia Have HIV/AIDS

HIV prevalence has already reached high levels in many MSM populations. Due to gaps in surveillance, the speed with which these epidemics have arisen is in many cases unknown, although in several instances a rapid spread is suspected. Fueling these epidemics is the lack of MSM-targeted education, leading to unsafe behaviors and overly optimistic self-risk assessments (see the following "Risk Behaviors" section). In approximately ascending order, some of the **HIV prevalence figures reported for MSM** are:

- Over 1% in one study[89] and 3.1% in another[41] (China)
- 2.5% (Jakarta, Indonesia[151])
- 4% (Kathmandu, Nepal[145])
- 4.4% (2004) and 6.8% (2005; both in Tamil Nadu, India[176])
- 4.4% (Tokyo, Japan[134])
- 6.5% (Chennai, India[70])
- 5.8%[27] and 8%[149] (both in Ho Chi Minh City, Vietnam)
- 8% (Taiwanese bathhouses[109])
- 14.4% (Cambodia[68])
- 16% (2004) and 6.5% (2005; both in Andhra Pradesh, India[60])
- 16.8% (Maharashtra, India[123])
- 17.3% (2003)[188] and 28.3% (2005[185]; both in Bangkok, Thailand) and 15.3% (2005 in Chiang Mai, Thailand[185]).

HIV prevalence figures reported for male sex workers include:

- 3.6% (2002, Indonesia[151])
- 4% (Karachi, Pakistan[132])
- 5% (Kathmandu, Nepal[145])
- 15.4% (venue-based) and 22.6% (street-based; both in Bangkok, Thailand[185])

HIV prevalence figures reported for transgender populations include:

- 2% (*hijras* in Karachi, Pakistan[132])
- 11.5% (Bangkok) and 17.6% (Chiang Mai, Thailand[185])
- 22% (2003, *waria* sex workers, Indonesia[151])

Many countries in which overall HIV prevalence is low (less than 1%) nevertheless have high HIV prevalence among MSM—generally far higher than the rates for the general population, as can be seen from Table 1 on page 11. This is reflected in the disproportionately high MSM caseloads. Of reported HIV cases in the Philippines and Hong Kong, 23%[160] and 24%[115] respectively are attributed to MSM.

MSM in Asia Have a High Prevalence of Risk Behaviors

MSM in Asia show multiple risk factors that make them vulnerable to HIV/AIDS: misconceptions about risk factors; high levels of unprotected anal intercourse; high levels of transactional sex; high numbers of sex partners; and low perception of self-risk. Stigma contributes to these behaviors by reducing self-esteem, creating an antagonistic policy environment (blocking condom access; marginalizing MSM relationships and venues), and causing neglect by those who should be providing appropriate health messages.

With male-male sex often not legal or acknowledged, most MSM cannot gather in socially sanctioned venues. Instead, MSM congregate where sex is solicited or sold (although in some places even access to sex hotels is blocked for MSM[118]). This greatly increases the chances of greater promiscuity—in Bangladesh, for example, 26% of MSM respondents averaged over ten different sexual partners a month.[100] In Cambodia, focus groups stated that the more hidden MSM tended to have a greater number of partners, as they did not have long-term relationships.[128] And in India, the stigmatized and disempowered *kothi* are more fatalistic about HIV risk.[126]

Table 1: Population and HIV Seroprevalence Data by Country

Country	Total population[200]	Adult population HIV prevalence	People living with HIV/AIDS	MSM HIV prevalence
Bangladesh	147,365,352	0.3%[75]	2,400–15,000 (2003 est.)[1]	0.1% (0.2% of *hijras*)[75]
Bhutan	2,279,723	<0.1% (2001 est.)[200]	Less than 100 (1999 est.)[200]	Unknown
Brunei	379,444	<0.1% (2003 est.)[1]	<200 (2003 est.)[1]	Unknown
Cambodia	13,881,427	2.6%[1]	170,000[1]	14.4% (Phnom Penh)[68]
China (Mainland)	1,313,973,713	0.1%[1]	840,000[1]	3.1% (Beijing)[41]
China (Hong Kong)	6,940,432	0.1%[1]	2,600[1]	1.4%[115]
East Timor	1,062,777	Unknown	Unknown	1.0%[63]
India	1,095,351,995	0.4-1.3%[1]	2,200,000–7,600,000[1]	*Varies by region:* 6.5% (Andhra Pradesh 2005)[60] 6.8% (2004)(Tamil Nadu 2005)[176] 6.8% (Mumbai 2005)[93] 16.8% (Maharashtra 2003)[123] 4.4–18% (Chennai)[34]
Indonesia	245,452,739	0.1%[1]	110,000[1]	2.5% (Jakarta)[151]
Japan	127,463,611	<0.1%[1]	12,000[1]	4.4% (Tokyo), 1.3% (Osaka)[134]
Laos	6,368,481	0.1%[1]	1,700[1]	Unknown
Malaysia	24,385,858	0.4%[1]	52,000[1]	0.76%[46]
Myanmar	47,382,633	1.2%[1] or as high as 3.4%[16]	330,000[1]	Unknown
Nepal	28,287,147	0.5%[1]	61,000[1]	4.0% (Kathmandu) (5.0% male sex workers)[145]
North Korea	23,113,019	Unknown	Unknown	Unknown
Pakistan	165,803,560	0.1%[1]	74,000[1]	Unknown
Papua New Guinea	5,670,544	0.6%[1]	16,000[1]	Unknown
Philippines	89,468,677	<0.1%[1]	9,000[1]	<1.0%[125]
Singapore	4,492,150	0.2%[1]	4,100[1]	22% of new HIV cases are due to male-male sex (2004)[50]
South Korea	48,846,823	<0.1%[1]	2,962[201]–8,300[1]	35.8% of HIV cases are due to male-male sex (2005)[201]
Sri Lanka	20,222,240	<0.1%[1]	3,500[1]	13% of HIV cases are due to male-male sex[54]
Taiwan	23,036,087	>0.02%[182]	4,310[182]	8% (2006)[109]; also 48.2% of HIV cases are due to male-male sex[182]
Thailand	64,631,595	<1.5%[1]	570,000[1]	28.3% (Bangkok)[74]
Vietnam	84,402,966	0.4%[1]	220,000[1]	6.0-8.0%[185]

One way to understand unsafe behaviors is by comparing the risk of HIV infection to other risks in a person's life. MSM in Hong Kong who were asked to keep diaries referred to their concerns about losing (or not finding) a relationship, worries about loneliness, embarrassment, or not satisfying a partner, and the anxiety of being discovered having sex in a public place.[91] Diarists frequently cited the "courage" required for coming out and seeking partners, but this courage typically did not extend to safer-sex practices; instead, public sex, unsafe sex, and a general disregard for risk predominated.[91]

Unsafe sex was seen as a sign of commitment (for those in relationships) or of longing for love (for those not in a relationship). Informants from multiple countries stated that MSM did not use condoms so that they could "prove their love" to their partners. Negotiation over condom use failed because of accommodation (trying to please a partner by agreeing to his desires) and reciprocity (returning a favor). Overcoming these obstacles to safer sex requires strategies that focus on negotiation skills, self-esteem, and community building. "Effective prevention programs for MSM…must focus not on techniques of surveillance and intervention but on making safer sex a 'community practice'," noted a recent report from the Hong Kong AIDS Foundation.[91]

Similar problems with negotiating safe sex have also been seen in the evolution of a Western response to HIV/AIDS. These patterns are also evident in China, where the MSM community is exploring newfound freedoms. A lack of social ties following economic migration within China has provided opportunities for more frequent but still unprotected sex in saunas[167] and with a recently organized network of male sex workers or "money boys."[190] In several other countries, greater openness for MSM has, in the absence of sufficient MSM education, led initially to an increase in risky behavior.[37]

If Asian MSM communities can be liberated even further from the burden of stigma, some of this behavior may be reduced. But for this to happen, more research is needed to understand the underlying reasons for unsafe behavior. Then effective campaigns must be directed not just at MSM but at society at large, which creates the social framework currently constraining MSM action.

Low Condom Use

Low condom use can occur because of lack of knowledge, lack of availability, or failure to translate knowledge and availability into action. Although gaps in knowledge and availability do exist in Asia, there are bigger problems with barriers to condom use. In the surveys conducted for this report, condoms were described as being too expensive or insufficiently strong for anal sex. In several of the surveyed countries, police target individuals or MSM establishments that carry condoms, as the police consider the condoms to be evidence of commercial sex.[167,22] Most challenging of all, much of the male-male sex between masculine-identified MSM occurs quickly and furtively, with insufficient time or communication to establish condom usage.[9] For commercial sex, rates of condom use are routinely lower when comparing male-male to female-male sex.[127]

Unsafe sex was seen as a sign of commitment (for those in relationships) or of longing for love (for those not in a relationship).

MSM who were surveyed reported the following behaviors:

Condom used at last anal intercourse:

- 40% (Vietnam[44])
- 12.6% (India[131])
- 58.7% (*katoey* with casual partner, Laos[107])

Consistent condom use:

- 12% (*waria* in Indonesia[88])
- 14-17% (Cambodia, in the last month[28])
- 40% (Hong Kong[115])
- 12.6% (India, with male sex workers vs. 57% for clients of female sex workers[131])
- 34.8% (with male sex workers, Papua New Guinea[124])

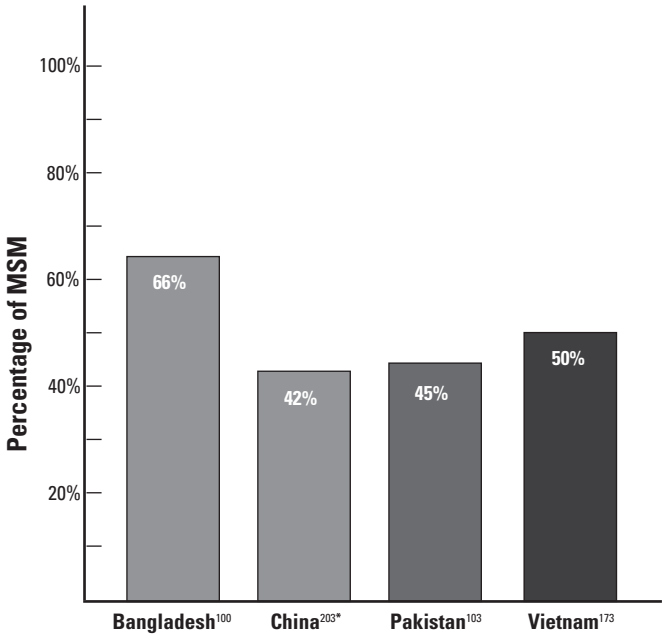
Use of a condom in the last incidence of sex with non-marital partner:

- 3-6% (truckers in Lahore, Pakistan[94])

Unprotected anal intercourse:

- 70% (in previous year, China[203])
- 49-50% (in past 6 months, China[41,40])
- 59.3% (recently, transgendered sex workers), 64.8% (male sex workers), and 53.1% (other MSM, all in Indonesia[151])
- 22% (during last bathhouse visit, Taiwan)

Table 2: MSM Who Have Never Used a Condom



*during insertion

Unprotected sex with a woman:

- 22% (during past 6 months; China[41])
- 84% (of the 50% of MSM who had sex with a woman in past 3 months; Andhra Pradesh, India[51])

Frequency of condom use:

- 45% (India[101])
- 17% (during anal intercourse in last month; Pakistan[103])
- 16% (when paying for anal sex; India[101])

Low Testing Rates

Compared to the HIV testing rates of 63–85% seen in Western MSM populations,[115] rates of HIV testing among MSM in Asia are low. Contributing factors include low risk awareness and testing sites that are too few in number or hostile to MSM. Examples of **HIV testing rates** include:

- 15.5%[117] and 20.6%[115] (both in Hong Kong)
- 18% (Beijing, China[42])

Low Lubricant Usage

Availability and usage of water-based lubricants are extremely low in Asia. One study found that only 48% of Lao *katoey* have ever used water-based lubricants for anal sex and only 19.5% of their partners have done so. Almost half of the partners had never heard of lubricant.[107]

High STI Prevalence

Prevalence of sexually transmitted infections (STIs) is high. This is both a marker confirming the high levels of unsafe sex and a contributing factor to the transmission of HIV, which can more easily be transmitted via the sores and inflammation caused by STIs. Typical figures for **STI prevalence** include:

- 55% (male sex workers) and 21% (MSM, both in Kathmandu, Nepal[145])
- 41% (had at least one symptomatic STI in the preceding 12 months, India[131])
- 93% (Pakistan[103])
- 60% (syphilis), 29% (rectal gonorrhea), and 18% (anal Chlamydia, *hijras* in Karachi, Pakistan[132])

Multiple Partners

A lack of sanctioned male-male relationships contributes to high **numbers of sexual partners**:

- 81% had at least one non-regular partner in the last year (Vietnam[44])
- MSM had 14.8 partners (on average) in the previous year (Ho Chi Minh City, Vietnam[44])

Incorrect Beliefs

Misinformation persists due to a shortage of explicit, MSM-specific messages. Of the MSM surveyed, many:

Believe they are not at risk of becoming HIV positive:

- 60% (Hong Kong[115])
- more than 80% (2004, China[39])
- 67% (not high risk, Papua New Guinea[124])
- 70% (homosexuals not at increased risk, or not sure, Ho Chi Minh City, Vietnam[44])

Believe someone who looks healthy cannot still transmit HIV:

- 53% (Ho Chi Minh City, Vietnam[44])
- "Many" of those interviewed (Yunnan, China[199])

Believe HIV/AIDS and STIs can be avoided by withdrawing before ejaculation:

- Greater than 50% (Lao *katoey* and their partners[107])

Thailand: Learning the Lesson a Second Time

Thailand's efforts in the early 1990s are a landmark example of the power of prevention. But Thailand also provides two graphic demonstrations of what happens when prevention is absent.

In the late 1980s prevention efforts in Thailand were almost non-existent. From 1984-89, the country's ministry of health had reported only 43 AIDS cases. But in the absence of prevention efforts, spectacular jumps in HIV prevalence took place across the country in two years or less. Prevalence rates of almost zero in 1987 rose to 18-52% in 1989 among various IDU populations; among new army conscripts, prevalence rose from 0.5% in 1989 to 3% in 1991; and among female sex workers in Chiang Mai, rates rose from zero in June 1988 to 43% in late 1989.

Thailand reacted to these figures by instituting significant prevention efforts. It is estimated that the 100 percent condom campaign in the early 1990s prevented up to 8 million new infections.[177] Extra-marital sex and visits to brothels were cut roughly in half, and condom use increased by 50-100%. Thailand recorded 143,000 new infections in 1991, but only 19,000 in 2003.

Unfortunately, messages from the 100 percent condom campaign were never targeted at Thai MSM, and almost no research or surveillance was conducted on the country's MSM population. The result has been a shocking recent rise in HIV among MSM. Research conducted by the Thai Ministry of Public Health and the U.S. Centers for Disease Control and Prevention Collaboration (TUC) showed HIV prevalence of 17.3% among Thai MSM in Bangkok in 2003.[188]

The picture has continued to deteriorate. When the study was expanded to three cities in 2005, prevalence had risen to 28.3% among MSM in Bangkok and 15.3% in Chiang Mai.[185] This 2005 figure for Bangkok MSM was actually higher than the corresponding figure for Bangkok male sex workers (which was 15.4% for venue-based and 22.6% for street-based male sex workers). Infection of Bangkok MSM was happening early: more than 20% were HIV-positive by age 22.[185,187] Remarkably, not one of the 491 men who tested positive in the 2003 study had reported that they were positive in an earlier questionnaire, probably because few had been tested and others were unwilling to disclose their status.

The slow development of prevention efforts and surveillance studies among Thai MSM has been attributed to a number of factors, including stigma (or perhaps a willful lack of attention).[31,32,178] But the evolving shift in emphasis from prevention to treatment in Thailand may have also undermined prevention work in communities such as MSM that were not reached when the condom campaign was first launched. Treatment is recognized as a powerful tool to strengthen prevention efforts, but an external review of the Thai effort has suggested that "the response to HIV has moved from a people-centered approach to a patient-centered approach, drifting away from the mobilization of forces within society for the prevention of the disease to a more clinical focus on infection after the disease has set in."[59]

Half of the MSM in a study in Beijing reported unprotected anal sex in the past six months, yet only 15% perceived themselves as being at risk for HIV infection.

Believe unprotected anal sex does not present a risk for HIV infection:

- 30.7% (Lao partners of *katoey*[107])

HIV Infection Among MSM Can Spread Quickly

HIV epidemics move from vulnerable groups to the general population when there are links between the two. One such link that is particularly strong in Asia is between MSM and women. Many MSM have sex with women, either within or outside of a marriage. Those **MSM who have had sex recently with female partners** include:

- 65% (MSM) and 45% (male sex workers) have regular sexual contact with females (Nepal[145])
- 97% (regular sexual contact with females, MSM military conscripts in Northern Thailand[15])
- 22% (last year, Ho Chi Minh City, Vietnam[44])
- 54.4% (last year, male sex workers) and 18.3% (last year, other MSM, Indonesia[151])
- 61.2% (last six months, Cambodia[69])
- 50% (last three months, Andhra Pradesh, India; 84% of these men did not use a condom[51])
- 48% (last month, with non-paying female partners, Papua New Guinea[124])

This translates into many MSM having sex with both men and women over a short period of time. In the following surveys MSM were asked if they had **sex with both men and women recently**. The following numbers of MSM answered in the affirmative:

- 28% (last six months, Beijing, China;[40] for almost half of these [11% of total] sex with both men and women in this period was unprotected[40])
- 42.6% (last six months, Cambodia[68])
- 25.9% (last three months, unprotected sex with both, Andhra Pradesh, India[51])
- 65% (last two months, India[112])

Many MSM are married, making it likely that they will have sex with at least their wives if not with other women as well. Marriage of self-acknowledged MSM is a growing trend in Singapore.[71] In other locations, the following proportion of **MSM are married**:

- 12.6% (China[39])
- 30% (of *kothis* in India[101]; 47% of these have sex with their wives, of whom 11% use condoms)
- 42% (Andhra Pradesh, India[51])
- 55% (India[112])
- 80% (have or will get married, urban China[203])

Prevention Messages Fail if They Are Not Specific to MSM

Large-scale HIV prevention campaigns are generally run by governments. These health educators in Asia, lacking data on MSM and confused by MSM diversity, have focused prevention strategies on the vulnerable groups defined early on in the epidemic—IDUs and female sex workers. This has led many MSM to conclude that their own behaviors are not risky.

In several countries, sex with women is seen as risky because bodily fluids are known to transmit HIV, but the relatively dry anus is thought to make anal sex "safe."[124] Based on the available prevention messages, this is a logical conclusion. Campaigns targeting female sex workers in India, for example, have resulted in women being seen as disease vectors who should be avoided in favor of *kothis*.[99]

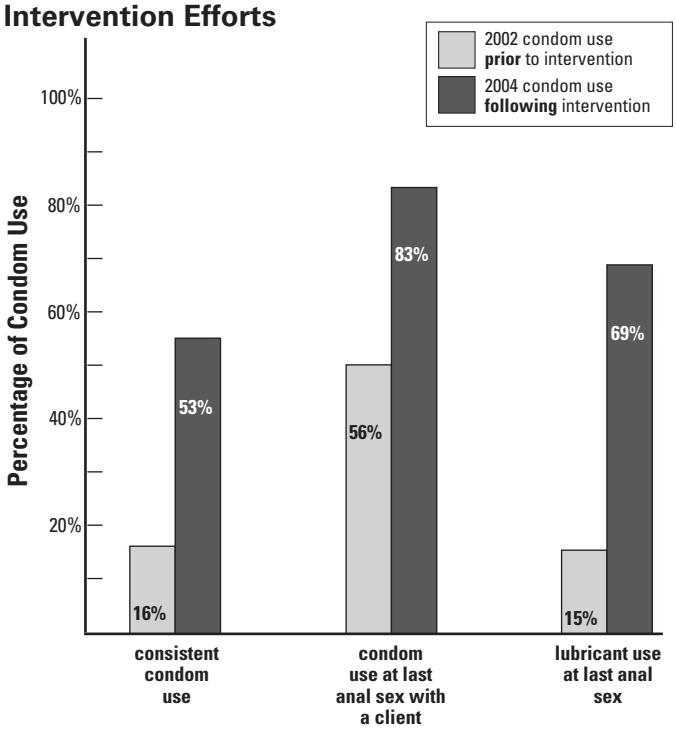
Without the correct information, MSM do not think of themselves as vulnerable. Whereas 78% of MSM used condoms consistently when buying sex from women in Phnom Penh, Cambodia, only 47% did so when buying sex from men.[68] Half of the MSM in a study in Beijing reported unprotected anal sex in the past six months, yet only 15% perceived themselves as being at risk for HIV infection.[40]

Interventions in Asia Have Worked

It is clear what happens to behavior patterns and HIV prevalence when no action is taken. MSM-based interventions are relatively young in Asia, but they can make a difference. Early results reported by Family Health International (FHI) are promising. Male sex workers were surveyed in Jakarta in 2002 and again in 2004 after the creation of an FHI-sponsored outreach program and condom use increased strikingly, as illustrated by Table 3. Similar results were seen for other MSM and for *waria*.[130]

Data can prompt action. The discovery of high HIV prevalence among Cambodian[68] and Thai[188] MSM prompted various prevention programs to be started in those countries. In other nations in Asia, high levels of unprotected sex and soaring STI levels should be ample evidence of the need to start MSM-targeted programs, with the aim of preventing all those infections before they take hold.

Table 3: Increase in Condom Use Among Male Sex Workers in Jakarta Following Intervention Efforts



Why Have MSM Been Neglected?

Worldwide, infection of MSM dominated the early story of HIV/AIDS. Male-male sex efficiently transmits HIV because anal sex causes small tears in the mucous membranes that allow HIV to infect the receptive partner. Yet in Asia the risks facing MSM have been neglected, as reflected in the high prevalence of HIV and risk behaviors described above. How has this come about?

Stigma and Violence Foster Invisibility

> ***"The generalized discomfort with male-male sex…has helped generate a familiar vicious circle: No data equals no problem; no problem equals no intervention; and no intervention equals no need to collect data."***
> **— MAP Report[127]**

Legal prohibitions against sex between men existed in 84 countries around the world in 2002[1], and exist in 11 of the 23 countries surveyed here (see Appendix 7). This latter group includes many of the former British colonies in Asia, which inherited discriminatory laws from England. (Ironically, England has now not only decriminalized male-male sex but allows same-sex couples to wed.) In addition, societies in many countries with no legal prohibitions still stigmatize and harass MSM, which drives their activities underground. The resulting invisibility makes it more difficult to help MSM protect themselves, and makes it easier to ignore the problem. Many countries that neglected MSM prevention efforts are now struggling to contain HIV everywhere.

Governments and other groups are often silent. In Cambodia, for example, the only mention of MSM in a 112-page report on HIV/AIDS is relegated to a single footnote. This fine print states that, in terms of the sexual spread of the virus, the heterosexual mode is "assumed," and explains that there is "little information available" about male-male sexual behavior.[26] Another supposedly comprehensive report on AIDS epidemiology in Vietnam[48] mentions MSM only in the list of acronyms, and a Cambodian report in 2004 doesn't even get that far.[164] On the policy level, both homosexuality (e.g., in Cambodia) and HIV/AIDS (e.g., in Japan[165]) have been dismissed as foreign imports. Without hard data, the problem of HIV/AIDS among MSM can be denied. In 2002, a senior health official in Vietnam was quoted as saying, "My guess is the number of homosexuals in Vietnam is only a few hundred."[180] The presence of a substantial MSM community in Cambodia was denied by many in the government until Family Health International (FHI) actually counted the community in Phnom Penh.[128]

Many countries that neglected MSM prevention efforts are now struggling to contain HIV everywhere.

Without the data, no interventions are carried out. In Nepal, no MSM-specific messages are allowed on TV, radio, or billboards.[144] In Pakistan, a single NGO is the only organization producing HIV educational materials for MSM.[103] Other messages focus on morality and condemnation or are so euphemistic that they are unclear.[103] As a result, many men believe that anal sex is risk-free. When governments do implement MSM education, they often use moralistic messages that drive MSM further underground.[104]

In 16 countries in the Asia-Pacific region, no more than 2% of MSM have access to HIV prevention programs.[166] Of 15 Asia-Pacific countries surveyed recently, only six had policies addressing MSM and HIV/AIDS, and only four had plans for how they would implement comprehensive outreach programs.[166] Early MSM projects were shut down by the governments of Vietnam[22] and China.[203] MSM themselves may be hesitant to get involved in anti-HIV efforts for fear of the double stigma attached to HIV/AIDS and MSM.[54]

Adding to neglect is harassment.[158] Blue Diamond Society, an NGO serving MSM in Nepal, has confronted a legal challenge to its existence[8] and battles persistent brutality against MSM, much of it by the police.[145] In August 2004, 39 members of Blue Diamond Society were arrested because of their sexual orientation and gender identities. In a press conference nine days into their 13-day imprisonment, one senior police officer reportedly said, "There are [a] maximum [of] 150 homosexuals in Nepal and we know what to do with them."[145]

In Nepal, recent findings also suggest that 37% of male sex workers have been raped, and that 57% of male sex workers and 8% of MSM have faced physical or mental violence.[145] *Kothis* in Bangladesh are perceived as always being available for sex, and this frequently leads to violence by police (suffered by 48%) and others (suffered by 65%).[158] In these situations, safe sex cannot be negotiated.[126] Violence against MSM is not restricted to large urban centers but is also prevalent (though usually invisible) in rural settings.[4]

If stigma is high, all MSM activities are compromised. Doctors in India have reportedly threatened to report MSM to the police,[93] police raids on saunas in Malaysia have caused owners to ban outreach workers,[174] medical staff in Sri Lanka have disclosed the HIV status of clients and mocked MSM,[54] and many MSM in China have been blackmailed.[190]

Whether the violence is physical or mental, the resulting stigma can help drive MSM to engage in unsafe sexual behavior.[56,202,196] Any approach to this problem requires not only working with MSM but with society itself so that the outcast status of MSM can be re-negotiated.

MSM Are Less Visible Than Other Vulnerable Groups

HIV/AIDS epidemics often develop under a veil of silence, unnoted except by their victims. One MSM focus group participant in rural Cambodia said, "I had a lot of friends, but my friends who have sex with the same gender in Poipet are all dead. Now it is only me here."[4] HIV/AIDS among MSM is under-counted because data are lacking or incomplete, and because there is confusion about MSM identities, including those of male sex workers.

Data Imperfections

In many countries, HIV surveillance efforts have ignored MSM. But even when MSM were included, the true extent of the MSM epidemic has often been obscured:

- Men who test positive for HIV often have multiple risk factors (e.g., unsafe homosexual and heterosexual sex). Either the men themselves or their governments may fail to mention the less socially acceptable risk factor.
- Many Asian MSM are married, making it much less likely that their MSM behavior will be reflected in HIV prevalence statistics.
- Marginalization of MSM populations may result in fewer MSM getting tested, whereas mandatory testing of IDUs in some countries risks overestimating the proportion of the epidemic that is based in this population.[77]

Visibility is further obscured by the multiple MSM identities in Asia. In most cultures, transgendered men and MSM who display more feminine behaviors are the more obvious manifestations of alternative sexualities. Yet the majority of MSM remain hidden from the general population.

As one researcher in South Asia noted, "After an initial couple of visits making friendships, it was easy enough to talk about their sexual encounters with local girls, or with 'female sex workers,' or with some of the foreign women. But it took two years of visiting these young males, aged between 14 and 25, before several of them would tell me of their sexual activities with other males, both local and foreign."[99]

Some MSM Identities Are Hidden

As we have discussed, MSM identities in Asia are often based on gender status (feminine vs. masculine).[85] MSM with more masculine identities are largely invisible to those outside the community, and they may not regard themselves as being part of a minority group. Even if these men contract HIV/AIDS from sex with another man, they will often continue to view themselves as heterosexual. Yet they have distinct patterns of behavior and outreach needs.

This is particularly true when the partner of the masculine MSM is a transgender individual. The Thai attitude towards *katoey* is that "maleness is defined not in terms of what anatomy you have, but in terms of what you do with that anatomy."[198] For example, in a study of 2,047 Thai military conscripts, 3.2% said they had experienced sex "with another man." When this question was posed as "with another man or with a *katoey*," the response rate doubled to 6.5%.[15] Even long-term relationships between non-transgendered men and *katoey* tend to be seen by the participants as heterosexual.[197] Similarly, men in Jakarta seeking transgender sex workers did not consider the encounters to be homosexual encounters.[151]

Despite this subtlety, or perhaps because of it, research has been lacking. A Medline search in early 2005 on the term "*katoey*" yielded no scientific publications, whereas a Google search yielded 25,600 results.[17]

HIV/AIDS epidemics often develop under a veil of silence, unnoted except by their victims.

Male Sex Workers Are a Diffuse Target for Prevention Activities

In some countries, such as China, fear of police raids makes male sex workers difficult to reach. But in others, it is the diffuseness of the population that makes it challenging to target.

Female sex workers present a classic example of a vulnerable group that can often be easily targeted, in their case via brothels. But male sex workers are rarely brothel-based and often it is difficult to determine who is and who is not a male sex worker.

Many MSM sell sex so infrequently that their classification as sex workers is ambiguous. In Cambodia, for example, exchange of money or favors is an accepted part of the MSM sexual environment—individuals may receive money for sex one day and pay for sex the next.[128] In one survey, 82.8% of Cambodian MSM reported having male partners who paid them to have sex.[69]

In India[101] and Pakistan,[103] the number of MSM receiving money for sex (40% and 57%) greatly exceeds the number who self-identify as sex workers (5% and 6%). In an additional complication, many male sex workers do not identify as MSM and thus require very different outreach activities.[192]

Migration Further Complicates Interventions

Migration from higher prevalence areas can transport HIV. Migrants are also more susceptible to high-risk behaviors because of isolation: from their partners; from their own culture; and from the social norms that would constrain their action if they were in their own town. Furthermore, migrants are often not reached by existing interventions if the local HIV prevention information is not available in their language or in a form consistent with their culture. In Singapore, as in many countries worldwide, migrants avoid getting tested for HIV as they will be deported if found to be positive.[71]

Much migration is driven by the search for work. Over a million Nepalese males migrate annually, one third of them to India.[65] In one survey 8% of Lao *katoey* reported unprotected sex with a male partner when the *katoey* were abroad, mainly in Thailand, in the preceding three months.[107] Risk behaviors were also more common for Hong Kong men who came to Mainland China for sex.[116]

The withdrawal of international funding makes sense when governments or the local population are willing to replace the lost revenue, but for MSM work this rarely happens.

MSM Prevention Is Conducted Almost Exclusively by NGOs

Governments concentrate on HIV prevention campaigns that are aimed at either the general public or more easily identifiable vulnerable groups such as female sex workers and IDUs. This leaves NGOs—often small, local NGOs with little capacity—to run prevention campaigns aimed at MSM. Although these NGOs have connections to the community, they often lack the resources or manpower to conduct a broad campaign.

Such NGOs usually rely on international funding for their survival. Bilateral international funding comes through the government, and thus is rarely assigned to NGOs that are focused on MSM.[138] Other funding sources may be unavailable, as several Asian countries are losing international support as they transition from "developing" to "developed" status.[174] The withdrawal of international funding makes sense when governments or the local population are willing to replace the lost revenue, but for MSM work this rarely happens. The resulting resource crunch comes just as the MSM communities in these countries are opening up and exposing their members to greater opportunities and risks. In Malaysia this has resulted in noticeably poorer HIV knowledge[174] and higher HIV incidence[137] among younger MSM.

What is Needed?

Far more activity is needed if HIV infections of MSM are to be reduced and contained. The barriers to this activity are many. As stated by UNAIDS, HIV prevention programs for MSM are hindered by the following:[6]

- Denial that sexual behavior between men takes place.
- Stigmatization or criminalization of men who engage in sex with other men.
- Inadequate or unreliable epidemiological information on HIV transmission through male-to-male sex.
- The difficulty of reaching many of the MSM.
- Inadequate or inappropriate health facilities, including STI clinics, and lack of awareness or sensitivity among STI clinic staff about the existence of anal, rectal, and oral STIs.
- Lack of interest among donor agencies in supporting and sustaining prevention programs among men who engage in same-sex behavior, and a lack of programs addressing male sex workers in particular.
- Lack of attention within national AIDS programs to the issue of MSM.

With these barriers in mind, the following four key activities need to be planned and implemented without delay.

1. Recognition of the Problem and of the Urgent Need for Political Leadership

Public sector officials at all levels need to acknowledge MSM as a significant vulnerable group requiring specific interventions. Political support and commitment of resources will be needed for these actions—both from national governments and from bilateral and multilateral agencies. A continuum of activities becomes possible as governments first recognize MSM as a category (a "groundbreaking" step in Papua New Guinea[72]), then allow groups to provide services for MSM, and finally provide those services themselves.

Economic self-interest is one of the most powerful motives that governments may have for committing resources to fighting HIV/AIDS among MSM. Many governments in the region are committed to economic growth but high rates of HIV infection can slow a country's economy.[122] In Hong Kong, a consultant recently demonstrated to the government that by 2020 the projected medical costs from an MSM HIV/AIDS epidemic would exceed $100 million a year.[120] Ignoring the MSM community is not an option, because one element that almost invariably goes along with urban development and globalization is a more active MSM community. If the development goals are desired, then HIV/AIDS and MSM become a pragmatic concern that must be addressed.[135]

The neglect of MSM must also be addressed as a matter of human rights. Human rights for MSM in the West are based on sexual identity. The right of individuals to adopt the gender of their choice is less important in the West, as Western gay men tend towards gender-normative behaviors (i.e., most biological males have male-oriented identities). Asia will require a greater emphasis on gendered human rights that protect the right of individuals to adopt the gender of their choice.[161]

China's Awakening

The China country profile in this document (see Appendix 3) highlights an opening up of the MSM community in China. A similar process has been occurring at the official level.

Early MSM-sensitive steps were not well received. In 1993, the director of China's National Institute of Health Education was dismissed for allegedly promoting gay civil rights by establishing China's first HIV/AIDS program for MSM. Up until 2000, Chinese academic journals were prohibited from publishing articles on MSM topics.

Then in 2001 things began to change. Several MSM formally attended and presented articles at China's Conference for Control and Prevention of AIDS/STIs.[203] A joint government/UNAIDS report[89] issued in December 2004 mentioned the term "MSM" 18 times compared to the three mentions in the same report a year earlier, and described MSM-specific trainings, self-help groups, and voluntary counseling and testing efforts (some in gay bars). In response, the state-controlled media released multiple articles highlighting the vulnerability of MSM to HIV/AIDS.[168] Finally, in 2005 the Chinese Ministry of Health demanded that its CDC institutions carry out health interventions with MSM.[203]

2. More Surveillance and Research to Understand Epidemics

MSM-specific studies have been conducted in Asia but, considering the vast size and diversity of the population, the coverage falls far short of what is necessary. Multiple countries in the region appear not to have conducted any epidemiological research among MSM groups at all. Even where there is evidence for concentrated reservoirs of HIV and a high prevalence of risk behaviors among MSM populations, countries generally expend few resources on either monitoring these populations or establishing prevention and education programs.

Existing research is also marred by multiple defects such as biased sampling, which may select groups that are at higher risk or otherwise non-representative.[58] Scale-up will require more research so that strategies can be better tailored for different populations.

Research is needed at multiple levels:

- MSM should be included as a risk category in national HIV surveillance surveys (as in Indonesia, Bangladesh, and the Philippines[130]) and in behavioral surveillance surveys.
- Quantitative research with MSM should evaluate knowledge, attitudes, beliefs, and practices (KABP).
- Sociological research is needed to determine the size, structure, and rules of MSM populations, how and where each MSM sub-group meets, and how different MSM sub-groups interact with each other. There is a need to "focus not just on what people 'know' and 'do' but also on the way sex and sexuality are *understood* and *lived*."[91] Once the power dynamics of MSM sub-groups are understood, those dynamics will determine whether different sub-groups must be targeted separately and with different messages.

Even where there is evidence for a high prevalence of risk behaviors among MSM populations, countries generally expend few resources on either monitoring these populations or establishing prevention and education programs.

Surveillance is needed to assess needs, plan a response, and evaluate outcomes. Surveillance that validates a successful program will encourage the continuation of that successful program.

Although there are reasons why certain groups may be more susceptible to risky behaviors, it takes behavioral surveillance surveys to determine whether this is the case. For example, the isolation of migrants from partners and local social mores often result in greater risky behavior. Yet in towns along the Thai-Cambodian border, the frequency of risky behaviors is the same for both migrant and local populations.[193]

These behavioral surveys are most useful when they identify the prevalence of the riskiest behaviors, such as unprotected anal intercourse with a casual partner. Counting all unprotected sex in one category—including unprotected oral sex, and unprotected anal intercourse with both casual partners and an exclusive, regular partner—can make it difficult to determine the real extent of HIV risk behavior. Research is also needed in each location to determine whether unprotected anal intercourse with a regular partner is a relatively more or less acceptable risk. Where most MSM are married (as in much of South Asia) or have multiple partners (as in Vietnam[44]), condom use is especially important for all anal and vaginal intercourse.

Investigative sociological research needs to be followed up with quantitative work. It is the job of the sociologist to dig out the buried truths, but this says nothing about whether these behaviors are present at a high enough frequency to be a significant risk factor for disease transmission. Existing preliminary MSM research in Asia has uncovered the broad outlines of behavior, but a significant gap remains in our understanding of which behaviors predominate.

Some of this research requires expensive population-based surveys, which are often the only way to overcome the sampling biases of so much research on MSM. Convenience and snowball sampling used in many studies have led to findings relevant to the more visible transgender and effeminate MSM populations, but perhaps not to less visible groups of MSM. Other work should focus on "particular 'communities of practice' [e.g., saunas, toilets] rather than attempting to study MSM 'in general'."[91]

Care must be taken so that NGOs do not create the reality that they then report upon.[58] An NGO that believes that *kothis* are the main MSM population will design a program that attracts mainly *kothi*. Researchers accessing the population through the NGO will come to the same conclusion and thus miss other MSM populations and behaviors.

As can be seen from the statistics cited in this report, many researchers choose indicators that do not match those used by others. There is a great need to define a few relevant indicators and to use them consistently. Otherwise different studies done at different places or different times cannot be compared.

Additional research is urgently needed on all aspects of male-male sex and HIV/AIDS, but especially on underexamined areas, including male-male sex and HIV risk among migrant laborers within Asia; sexual risk behaviors involving boys (common in some Asian countries, such as Sri Lanka[57]); and links between injection drug use and MSM. It appears that injection drug use is not common among MSM in Asia, but IDUs do use male-male sex to raise money for drugs. Researchers who study IDU populations should be encouraged to consider male-male sex in their behavioral surveys.

3. Greater Access to Prevention and Treatment Services

The almost complete lack of government services and programs for MSM in Asia must be addressed. Some of the areas that such programs should cover include:

Condoms and Lubricant

Condom use is low and lubricant use is lower still. This highlights the need for expanded prevention education to teach men that receptive anal intercourse without the use of lubricant vastly increases the likelihood of damaging the delicate lining of the anus, thus opening a pathway to HIV.

Condom breakage rates of 20-60% were reported in Bangladesh.[100] Causes included a lack of suitable lubricant (i.e., lubricant that is inexpensive and in a small pack), insufficiently strong condoms, and no training in correct condom use. Use of water-based lubricant was negligible in many countries, and it was not well known that oil-based lubricants actually promote condom breakage.

An all-in-one condom and lubricant package is the only practical product for most MSM. Lubricant in Asia is generally available only in bottles that are too large and too expensive for most MSM. Population Services International (PSI) makes one particularly suitable product called *Number One Deluxe Plus*—two condoms packaged with a sachet of water-based lubricant. The first launch site for this product in Asia was Laos, in late 2002.[152] Distribution to non-traditional outlets such as parks, toilets, clubs, and saunas is also needed. Condom vending machines, such as those available in Vietnam,[135] can help MSM avoid the embarrassment that prevents many from buying condoms.

An education barrier will remain for men who have sex with feminine MSM. Often the masculine partner maintains the pretense that he is having sex with a woman, and therefore does not acknowledge the need for lubricant.[128] Improving this situation will require education efforts so that both partners start to acknowledge that male-male sex, not vaginal sex, is taking place, and that appropriate protection should be used.

Education

Certain dangerous misconceptions appear in country after country across Asia and must be corrected. These include:

- Healthy-looking people cannot have HIV.
- Withdrawal is sufficient to prevent HIV infection during anal sex.
- Using lubricants can prevent HIV infection during anal sex.
- HIV is transmitted by bodily fluids and so cannot be transmitted via the dry anus.
- HIV affects only immoral people.[94]

Prevention messages cannot be targeted simply at the most visible MSM populations. As this report emphasizes, MSM are a diverse group and many hidden MSM can be reached only by broadcasting MSM-specific messages to the general public.[135] These messages should emphasize empowerment and avoid creating a sense of fatalism among the targeted group.

Clinics

If MSM can keep their identities hidden, their access to HIV testing and treatment may be equal to that of the general population. But often such subterfuge is not possible, especially at STI clinics. These clinics might present an excellent site for HIV/AIDS prevention and care, but healthcare workers usually lack knowledge of anal STIs and either fail to ask about male-male sex or overtly discriminate following disclosure of male-male sexual activity.[34,169] Few STI doctors are sensitized to the needs and realities of MSM. National guidelines on these topics are usually lacking, but are available from Naz Foundation International.[95] Additional guidelines on the treatment of STIs in MSM will be published soon in English by the International Union Against STIs–Asia Pacific branch.

MSM-specific clinics are rarely available[170] (there are only two in all of Indonesia[147]), and present their own dilemmas. MSM may fail to use these services because they do not want to be seen walking into a known MSM clinic.[135] (Singapore presents an extreme example in that any HIV testing clinic is associated with MSM and thus avoided by all men.[71]) Thus a multipurpose clinic that includes MSM-oriented services may be preferable.

The following steps, suggested for programs in Vietnam,[22] make sense for many countries:

- Sensitizing service providers to the health needs of MSM.
- Training service providers about the special needs of MSM for sexual health.
- Strengthening linkages and referral networks between the drop-in center and services available (e.g., STI clinics, voluntary counseling and testing sites) to meet the needs of MSM.
- Making MSM better informed about friendly STI clinics that are available to them.

Other Needs

Sensitivity trainings are needed for police, local authorities, and medical personnel. Police need to understand that raids will only drive behavior underground and make it more unsafe.

Advocacy networks are needed to coordinate the action of many small, often very young NGOs.[167]

Voluntary counseling and testing must be expanded[157] so that more MSM know their status and more can enter treatment programs. Knowledge of HIV-positive status has been shown to reduce risk-taking during sex, and treatment serves as a strong enemy of stigma. Some programs have successfully brought voluntary counseling and testing outreach to MSM venues such as saunas, and in a very few locations counseling and testing as well as medical services are available at MSM-targeted clinics.

4. Support for Peer-Driven Initiatives

Some activities are best conducted by NGOs and the peer networks that they can build and access. Funding for these NGOs needs to be increased significantly so that programming reaches more than a handful of MSM.

Outreach

There is too little MSM outreach[57,86,170] and the outcomes are rarely evaluated. MSM-specific outreach and services are available to only the most visible MSM populations; coverage of more hidden MSM populations is extremely poor. This was the common message across nearly all surveyed countries. MSM programming was often present only in a capital city and almost uniformly absent from rural areas. Strategies also rely too much on simple education initiatives, and too little on understanding why MSM are engaging in risky behaviors.[170]

MSM-specific outreach and services are available to only the most visible MSM populations; coverage of more hidden MSM populations is extremely poor.

MSM are difficult to reach because the populations are fragmented and marginalized. Transgender people, self-identified "gay" men, and men who blend into heterosexual society are all thrown into the single category of MSM. Older and younger MSM have very different needs in countries such as China where the MSM community is undergoing rapid change.

A failure to differentiate between these groups leads to problems. In Bangladesh, for example, a report identifying dire MSM service needs led to the formation of a single community organization.[100] Differing priorities necessitated a split, however, into the *kothi*-identified Bandhu Social Welfare Society and the gay-identified Association for Health and Social Development.

Participatory approaches are the mainstay of MSM prevention efforts. "The 'protection' approach, typically employed by public health policies and state-run programs, often does not suffice; instead, empowerment through involvement in decision-making is needed to ensure effective responses."[150] This calls for peer-driven programs. Sometimes, as in Laos, such community organizing is not permitted,[102] and in other cases the local NGO exists because of the largesse of an international NGO, so the local NGO's links to community may be tenuous. Some NGOs focus on education but fail to build the shared sense of community that makes education efforts effective.[167]

Many governments rely on NGOs to target minority populations. An over-reliance on these NGOs for outreach, however, can mean that programs may reach only those MSM populations that are most easily identified. For this reason, print and electronic media must also be used.[172] In some countries, hidden clients can be reached via hotline telephone services and the Internet,[147] especially in countries such as China where the Internet is becoming the primary means by which many MSM meet each other.[204]

Drop-In Centers

Drop-in centers can disseminate information and form the physical basis for building an MSM community. Such centers also can serve as portals through which other needs of these populations can be met, such as voluntary counseling and testing, treatment for STIs, and the provision of appropriate forms of psychosocial support.

Activities That Drive Change

NGO-led activities require a social environment that has at least a minimum level of tolerance for MSM outreach. But as long as there is even a hint of that tolerance, and MSM activities are funded and supported, those activities can then drive an evolution of community attitudes—a kind of positive feedback cycle. The argument sometimes heard in public health—that you must either change social attitudes first or implement programs first—is a false one. Programs planned for and with MSM can reduce the social stigmas that created the problems of marginalization in the first place. Activism must continue, but so must action.

Appendix 1: Methodology

As described in greater detail below, information used in this report was obtained from an in-depth literature review and through semi-structured interviews conducted with front-line service providers, researchers and activists working with MSM in Asia and the Pacific.

Literature review

Project staff queried the Ovid Medline, Psych Lit and Sociofile databases to identify all records pertaining to HIV or AIDS and MSM (men who have sex with men) in Asia since 1985.* In addition, staff conducted extensive Internet searches for each of the 23 countries examined to obtain reports, news articles and survey results related to MSM and HIV. In many cases, these documents were produced by NGOs or national and local governments, and were not available in the research databases. These included reports pertaining to HIV and male-male sex that were produced by international NGOs such as Family Health International (FHI) and Population Services International (PSI), by bilateral and multilateral agencies such as the World Bank and UNAIDS, and by health ministries. Searches were limited to materials written in or translated into English. Project staff also obtained and reviewed several unpublished reports, surveys and assessments of MSM and HIV risk provided by informants who were interviewed for this report, as well as newspaper accounts of male-male sex behavior and HIV where such accounts illuminated issues not addressed in published research literature.

From this literature, staff identified principal themes associated with the spread of HIV among MSM populations or via male-male sex in Asia. A number of excellent and comprehensive reports of male-male sex in Asia have been previously published, some fairly recently, and we relied on them heavily to guide our analysis.

Semi-structured interviews

TREAT Asia consultants in New Delhi, Bangkok, Los Angeles, and New York City conducted telephone interviews with front-line service providers, researchers and activists working with MSM in Asia and the Pacific. Using a semi-structured interview format, the interviewers asked respondents to discuss their organizations' MSM-related programming, as well as their knowledge of other programs addressing MSM populations or male-male sexual activity and HIV in their countries. Questions probed interviewees' general knowledge of MSM populations in their countries, as well as the characteristics of their MSM client populations. In some instances, interviewees provided investigators with unpublished behavioral surveys of their MSM clients. Additionally, interviewees were asked to provide their views on local needs at the city and country levels, as well as trends in risk behaviors, prevention and service challenges, and recommendations for additional HIV/AIDS prevention, treatment and surveillance programs related to HIV and male-male sexual activity. Interviews were conducted in English, or in local languages where interviewees did not speak English. To achieve consistency, project staff used the same standardized semi-structured schedule for each interview. However, interviewers often were required to adjust or re-word questions to ensure they were culturally and linguistically appropriate to respondents who did not speak English as a first language. Investigators were unable to secure interviews for Bhutan, Brunei, East Timor, and North Korea. In addition, due to scheduling difficulties and time constraints, some respondents asked that a blank copy of the interview questionnaire be sent to them so that they could type their responses and submit them electronically; follow up was conducted with these individuals by phone and email when needed.

A list of interviewees and organizations follows:

- Bangladesh
  - Md. Mamunur Rashid, Bandhu Social Welfare Society
- Cambodia
  - Choub Sok Chamreun, Khmes HIV/AIDS NGO Alliance
  - Kha Sovannara, KANHNHA
- China
  - Jia Ping, Ai Zhi Yuan Zhu Center for Health and Education
  - Damien Lu, GayChinese.net
  - Edmund Settle, UNDP
  - Wan Yanhai, Beijing Aixhizing Institute of Health Education
  - Wang Ruotao, Chinese Center for Disease Control
  - Wang Shuguang, Centre for International Program Development in HIV Social Study (CIPD); Sichuan Academy of Social Sciences; National Centre in HIV Social Research (Australia)
  - Zhen Li, volunteer, Beijing Gay Hotline
- Hong Kong
  - Barry Lee, Hong Kong AIDS Foundation
  - Paul Louey, AIDS Concern
- India
  - Venkatesan Chakrapani, Indian Network of Positive People (INP+); Social Welfare Association For Men (SWAM)
  - Ashok Row Kavi, Humsafar Trust
  - Sunil Menon, Sahodaran
  - Rahul Singh, Naz Foundation India
- Indonesia
  - Dédé Oetomo, GAYa Nusantara
  - Tono Permana Muhamad, Burnet Indonesia
- Japan
  - Masao Kashiwazaki, Japanese Foundation for AIDS Prevention; OCCUR
- Laos
  - Niramonh Chanlivong, Burnet Institute
- Malaysia
  - Nik Fahmee Nik Hussin, The Malaysian AIDS Council
  - Raymond Tai, PT Foundation (formerly Pink Triangle)
- Myanmar
  - Addy Chen, International HIV/AIDS Alliance—Myanmar Programme
  - Habibur Rahman, Population Services International

* Ovid is a powerful search engine that allows multiple and parsed searches. Search criteria included the following terms used separately and in combination with the names of each country: "HIV," "AIDS," "MSM," "males who have sex with males," "men who have sex with men," "homosexual," "gay," "IDU," "injection drug users," "transgender," "adolescent," "kothi," "kathoey," "waria," and "HIV testing."

- Nepal
  - Sunil Babu Pant, Blue Diamond Society
- Papua New Guinea
  - Christopher Hershey, Save the Children, Papua New Guinea
- Pakistan
  - Qadeer Baig, Pakistan National AIDS Consortium
  - Altaf Tariq, Homeopathic Medical Association of Pakistan
  - Obaid Mashoori, Ghazi Welfare Association
  - Tahir Khilji, Vision
  - Maimoona Noor, AWARD-Pakistan
  - Panjal Khan Sangi, Mehran Welfare Trust Larkana
  - Gul Mohammad Baloach, Consultant
  - Jam Jamali, Consultant
- Philippines
  - Joselito de Mesa, Library Foundation
  - Loreto Roquero, Jr., FHI Philippines
- Singapore
  - Abul Hamid Hassan, Action for AIDS Singapore (AFA)
  - George Bishop, National University of Singapore
- Sri Lanka
  - Sherman de Rose, Companions on a Journey
- Taiwan
  - Nai-Ying Ko, College of Medicine of National Cheng Kung University, Taiwan AIDS Society
  - Kang-Yen Lai, Taiwan Tong-Zhi Hotline Association
- Thailand
  - Paul Causey, Consultant
  - Dr. Frits Van Griensven, US CDC–Thailand
- Vietnam
  - Donn Colby, Vietnam-CDC-Harvard Medical School AIDS Partnership (VCHAP)
  - Asia Nguyen, The Population Council; PACT–Vietnam

Appendix 2: NGOs Leading the Way

Many NGOs have contributed to the HIV prevention effort among MSM in Asia and the Pacific, but several in particular stand out. Working with limited human and financial resources, these pioneering organizations have already begun to tackle the numerous daunting service needs and challenges confronting MSM populations in their communities. Each of these groups needs additional funding, supplies, and support to build upon the vital work they have already undertaken.

REGIONAL NGOs AND CROSS-CUTTING EFFORTS

Australian Federation of AIDS Organizations (AFAO)–International Program[13]

Since its inception in 1984, AFAO's primary focus has been on gay men and MSM, who comprise 80% of people living with HIV in Australia today.

Within the Asia-Pacific region, AFAO focuses on both strategic policy setting and advocacy, and on several identified priority areas—the two highest of which are MSM and HIV treatment literacy.

Within Australia, AFAO has undertaken a major national HIV education program for gay men/MSM and health promotion for positive people. It also hosts the National Aboriginal and Torres Strait Islander Gay, Sistergirl and Transgender HIV/AIDS Sexual Health Project.

Working with limited funds from private resources, AFAO targets one-time innovative but strategically placed projects within the Asia-Pacific region intended to "kick-start" MSM programs in areas of great need. The organization also provides guidance and support to MSM organizations to help them advocate for MSM programming. Over the last two years, AFAO's Asia-Pacific regional work has included:

- Commissioning a needs assessment for the creation and funding (by other donors) of a national network of Indonesian MSM HIV organizations.
- Providing strategic advice to Thai CBOs in responding to the dramatic increase in HIV infections among MSM over the last three years. AFAO support and activities included: funding for the first HIV awareness poster targeting Thai MSM; establishing a sauna owners network aimed at making condoms readily available in all MSM sex venues; initiating the establishment of a network of agencies involved in addressing HIV among Thai MSM; and securing significant funding to establish a unique twinning partnership between Rainbow Sky and its counterpart in Sydney, the AIDS Council of New South Wales.
- Co-funding (with Levi Strauss) the first Gay and Lesbian Health and HIV Conference in China, hosted by the AIZHIXING Institute in Beijing in June 2005, with more than 80 delegates attending from 15 major cities.
- Funding for Chengdu Gay Community Care, one of China's leading MSM groups.
- Support to Nguyen Friendship Society in Ho Chi Minh City for the development of an MSM outreach program to parks and public swimming pools, and to help stimulate the establishment of new MSM HIV groups in other regions.
- Organizing a 10-day study tour for four Papua New Guinea MSM (including two who are HIV-positive).
- Co-organizing a six-day study tour for the director of the MSM outreach program in Dili, East Timor.
- Conceiving and organizing MSM pre-conference satellites focused on MSM HIV programming prior to the 2004 International AIDS Conference in Bangkok.
- Sponsoring a satellite focused entirely on South and Southeast Asian MSM issues at the 2005 International Congress on AIDS in Asia and the Pacific (ICAAP) in Kobe, Japan.

AFAO, through its membership in APCASO, advocates for the initiation and scale-up of MSM programs at regional meetings such as the Pattaya Universal Access Scale-Up meeting in February 2006, along with international organizations, such as UNAIDS, and potential donor agencies (e.g., POLICY Project, FHI, and the International HIV/AIDS Alliance).

Family Health International (FHI)[62]

Formed in 1971, Family Health International (FHI) is among the largest and most well-established nonprofit organizations active in international public health. FHI works with a wide variety of partners, including governmental and nongovernmental organizations, research institutions, community groups, and the private sector to improve lives worldwide through research, education, and services in family health.

Headquartered in the US (North Carolina), FHI maintains offices in 37 countries and conducts research and field activities in more than 70 nations across the globe. FHI's Asia Regional Program, centered in Bangkok, provides technical, financial, administrative, and management support to FHI's country offices and their partners throughout Asia. FHI has programs in Bangladesh, Cambodia, China, East Timor, India, Indonesia, Laos, Nepal, Pakistan, the Philippines, Thailand, and Vietnam.

Across the globe, FHI works to: help countries and local communities prevent the spread of HIV/AIDS and sexually transmitted infections and care for those affected by them; increase access to quality reproductive health services, especially safe, effective, and affordable family planning methods; and improve the health of women and children, especially those who live in resource-constrained settings.

In Asia, FHI has targeted high-risk populations, including MSM and transgender communities, to reduce the spread of HIV/AIDS. Currently, FHI supports 24 organizations in Asia through which an average of 50,000 MSM/transgenders every quarter are reached regularly through interpersonal communication. For example, in India, the FHI India IMPACT Project has funded direct interventions with organizations working to reach MSM and trade unions.

FHI receives its funding primarily from US government agencies, principally USAID, the NIH, and the Centers for Disease Control and Prevention. Other major sponsors include the UK Department for International Development (DFID), and the Bill and Melinda Gates Foundation.

International HIV/AIDS Alliance[30,81]

Established in 1993, the International HIV/AIDS Alliance is the European Union's largest HIV/AIDS-focused development organization. Its mission is to prevent HIV infection; facilitate access to treatment, care and support; and lessen the impact of AIDS. The Alliance believes that local governments and NGOs and CBOs are the most qualified to match health and development efforts with the needs and capacities of poor people and resource-limited communities.

From its headquarters in Brighton, UK, and country offices in the Caribbean, China, Côte d'Ivoire, India, Madagascar, Mozambique, Myanmar, Ukraine, and Zambia, Alliance staff and consultants provide technical assistance, often together with financial support, to in-country intermediary organizations, which the Alliance calls 'linking organizations.' These in turn provide financial and/or technical support to NGOs and CBOs in their countries.

The Alliance works with "key populations"—groups that are likely to affect, or be affected by, the spread of HIV/AIDS. These include MSM, people who sell or buy sex, people living with HIV/AIDS, and injecting drug users. The Alliance helps these key populations to organize, manage, and sustain their own CBOs so that they can carry out HIV work in their communities.

Since its inception, the Alliance has provided approximately US$100 million in financial support to over 2,500 projects, which have been implemented by over 1,800 community and faith-based groups. It has also offered technical support, including practical assistance, skills building and organizational development, to another 5,000 groups whose project financing comes from other sources. Funding from Alliance 'linking organizations' enabled 70 per cent of these groups to take part in the local response to HIV/AIDS for the first time. In Asia, the Alliance currently works in Cambodia, Central Asia, China, India, Mongolia, Myanmar, the Philippines, and Thailand.

Founded by the governments of France, Sweden, the US, and the UK, as well as the European Union and the Rockefeller Foundation, the Alliance's donor support base has since been broadened to include 17 major trusts, foundations, and corporate partners, as well as 13 governments.

UNESCO[183,52]

The United Nations Educational, Scientific and Cultural Organization (UNESCO) was founded in 1945. For this specialized United Nations agency, it is not enough to build classrooms in devastated countries or to publish scientific breakthroughs. Education, social and natural science, culture and communication are the means to a far more ambitious goal: to build peace in the minds of men.

UNESCO is working to create the conditions for genuine dialogue based upon respect for shared values and the dignity of each civilization and culture. The world urgently requires global visions of sustainable development based upon observance of human rights, mutual respect, and the alleviation of poverty, all of which lie at the heart of UNESCO's mission and activities.

For several years, UNESCO also has been very active in supporting a broad range of projects related to MSM and HIV in the Asia-Pacific region:

- UNESCO established an Internet-based information network (msm-asia) in the region to share essential information and discuss trends; more than 250 members interested in MSM and HIV interventions in Asia and the Pacific now receive this useful information on a regular basis.
- UNESCO is currently organizing an exchange workshop to be held in September 2006 and hosted by the Laos Ministry of Health and the Burnet Institute for fieldworkers from MSM projects around the region. The focus is on bringing people together who work closely with MSM to discuss challenges and opportunities, as well as ways to diversify messages and strategies.
- In Chiang Mai, Thailand, UNESCO supported the establishment of a cyber peer education project for MSM using a local dating chatroom. Since 2005, UNESCO also has supported the establishment of an outreach project for male sex workers in Pattaya, implemented by SWING (see below); additional funding was secured for an ongoing drop-in center.
- Responding to shockingly high HIV prevalence rates found in Bangkok's saunas, UNESCO made funds available for emergency outreach interventions, implemented by Rainbow Sky (see below). The twelve-month project began in June 2006. UNESCO also supported the Thai Ministry of Health in conducting a number of coordination meetings of organizations working with MSM, culminating in the first national planning workshop for MSM and HIV/AIDS in Thailand in May 2004. The MSM National Committee continues to meet to plan and advocate for greater government response to HIV among MSM.
- In Phnom Penh, Cambodia, UNESCO trained Inthanou Telephone Counseling Hotline counselors to be more sensitive about MSM issues and developed materials to promote the hotline as a more MSM-friendly resource. The organization also worked with a Cambodian anthropologist who has been collecting historical and sociological data about life histories of older MSM in Cambodia for a report to be released soon.
- In Vientiane (Laos), UNESCO supported the Burnet Institute in setting up an ongoing peer education project among MSM.
- With the Provincial Health Department in Haiphong, Vietnam, UNESCO set up an outreach project for MSM, many of whom appeared to be drug users and/or involved in sex work (the project ended in 2005).

Fridae.com (Internet-based)[64]

As the gay media leader in Asia, Fridae provides unparalleled reach to the diverse and hard-to-reach gay and lesbian communities in the region. Inspired by "Friday" from Daniel Defoe's novel *Robinson Crusoe*, Fridae is a diversified media and services company implementing an integrated strategy that covers the Internet, publishing, and events.

Fridae's innovative online portal (www.fridae.com) harnesses the distribution power and reach of the Internet to provide products and services to more than 250,000 unique visitors each month and more than 200,000 registered members. Fridae events include parties held around Asia.

Through its innovative media channels and events, Fridae is helping to build Asia's largest gay and lesbian community, united in diversity and transcending geographical borders. Fridae empowers gay Asia to: come together, stay connected, be informed, overcome discrimination, nurture personal growth, and foster healthy relationships. Fridae seeks to be gay Asia's leading media and events group, the business community's primary conduit to the Asian gay community, and a respected voice in advocacy for equality and freedom of choice.

NATIONAL ORGANIZATIONS AND GROUPS

BANGLADESH

Bandhu Social Welfare Society (BSWS)[12]

The Bandhu Social Welfare Society (bandhu means friend in Bangla) was formally established as a national nongovernmental CBO in 1997 after surveys revealed substantial risk for HIV and STIs among networks of MSM and their sexual partners in Bangladesh. The aim was to develop, implement and manage a range of programs promoting sexual health among MSM, with special emphasis on those identifying as kothi, as well as those engaging in male sex work. The group's mission is to ensure that all males in Bangladesh have knowledge and awareness of their own sexual health needs and can access appropriate low-cost sexual health services. The organization works to reduce the risk of HIV and STI transmission and improve sexual health among low-income males, especially those who are socially excluded and stigmatized.

Since its creation a decade ago, BSWS has grown from a staff of two to more than 150. Now operating in five Bangladeshi cities, BSWS provides outreach, STI treatment and management, counseling, and drop-in services. The group also organizes MSM social groups to build support and awareness among MSM communities that are broadly stigmatized and hidden. Additionally, BSWS has established a robust research capacity, as well as effective partnerships with international donor organizations and the Bangladeshi Ministry of Health and Social Welfare to conduct cutting-edge research and HIV sentinel surveillance among vulnerable MSM groups.

The accomplishments of BSWS demonstrate that peer-based and peer-directed NGOs can play a crucial role as partners in HIV prevention and social welfare. Such organizations are able to gain substantial access to vulnerable populations and to build trust, which facilitates the delivery of effective sexual health programs and STI treatment.

BSWS has worked aggressively to curb HIV risk behaviors among MSM in Bangladesh and these efforts appear to be paying off. Bangladesh continues to maintain some of the lowest rates of HIV in the world. Despite such success, challenges remain. Since 2005, BSWS donors have focused the organization's services on male sex workers, substantially curtailing their activities with MSM not involved in sex work. BSWS reports that they are unable to supply enough condoms and water-based lubricant to those who need them.

CAMBODIA

Men's Health Cambodia (MHC)[106]

MHC was founded in 2002 to deal specifically with the health concerns of MSM. A grant from FHI provided funds for STI and HIV/AIDS outreach education, counseling and health service referrals in Phnom Penh. In 2003, through a grant from KHANA (see profile below), MHC opened a second office in Siem Reap to serve the MSM population in this tourist town.

MHC operates a drop-in center where MSM can access educational materials, receive face-to-face counseling, and attend group education sessions on a regular basis. The center also maintains a telephone hotline (092-940-409) enabling callers to speak with a trained counselor about HIV/AIDS, STIs, and sexuality issues. The drop-in center is also a social gathering place. MHC Siem Reap has since expanded its target clients to include female sex workers, and maintains a drop-in center for both male and female sex workers, with services similar to the one in Phnom Penh. Clients of sex workers who feel they are at risk for STIs and HIV are encouraged to undergo testing and treatment and are referred to public health facilities and NGO clinics. MHC funds transportation costs of clients to and from health facilities.

MHC conducts outreach activities in several public areas around Phnom Penh where MSM are known to gather, and in three operational districts in Siem Reap. In these areas, HIV/AIDS information is disseminated, educational materials and condoms are distributed, and MSM are counseled on various issues. Among female sex workers, outreach work is being done in one operational district, and peer outreach workers regularly visit sex work establishments during the day to provide STI and HIV/AIDS education, counseling, condoms, and referrals to clients.

MHC has developed information education and communication materials that are suitable for its MSM clients and is currently developing materials for female sex workers. MHC is also pioneering work with young MSM (11-17 years old) by providing a separate education package for boys that includes hygiene, HIV/AIDS information contextualized for children, and information on child rights.

MHC is also engaged in empowering the MSM and female sex worker communities to advocate for equal access to information and services, protection from stigma and discrimination, and community acceptance. MHC hosts regular meetings of the MSM and female sex worker networks, coordinates meetings with stakeholders and gatekeepers (establishment owners, local authorities, police) for consultation and information-sharing, and raises the profiles of MSM and female sex workers in their communities at large to promote understanding and eventually reduce stigma and discrimination.

MHC stresses development of its personnel; staff and volunteers are sent to training workshops where available. MHC hires staff from its pool of volunteers. A number of key positions have been filled by qualified volunteers, increasing morale and commitment. In the future, MHC plans to reach more MSM and female sex workers, and expand its range of services by assisting clients with income-generating activities, either as an alternative to sex work or to supplement earnings.

Khmer HIV/AIDS NGO Alliance (KHANA)[105]

KHANA is one of the key national players in Cambodia's response to HIV/AIDS, supporting over 60 NGOs and CBOs across 16 provinces, including the municipalities of Phnom Penh and Siem Reap. In 2004, KHANA supported 71 local NGOs and 11 CBOs that reached more than 95,000 people living with or affected by HIV/AIDS.

KHANA receives technical and financial support from a range of international donors and partners. It then establishes partnerships with local NGOs and CBOs to develop their skills and resources to address HIV/AIDS issues and to strengthen their organizational and financial management. KHANA also helps these local grassroots organizations strengthen their relationships with government and health centers to improve their provision of key medical services such as voluntary confidential HIV counseling and testing and antiretroviral and TB treatment.

The grassroots organizations supported by KHANA implement focused HIV prevention activities, provide care and support to people living with HIV/AIDS and their families, and carry out advocacy activities to challenge stigma and discrimination. Because HIV/AIDS in Cambodia is no longer confined to vulnerable groups, KHANA and its partners target both "key" populations (i.e., those most likely to get HIV and transmit it to others) and the wider community. The populations reached include people living with HIV/AIDS and their families, orphans and vulnerable children, sex workers, MSM, uniformed services, garment factory workers, and young people in and out of school.

KHANA was formed in 1996 and receives its funding primarily from USAID through the International HIV/AIDS Alliance. KHANA also receives direct funding from the Bill and Melinda Gates Foundation, the CORE Initiative, EC-UNFPA, Family Health International, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Food Program, and the New Zealand Agency for International Development.

CHINA

Ai Zhi Yuan Zhu Center for Education and Health (Shengyang, China)[87]

The Ai Zhi Yuan Zhu Center for Education and Health was established in 2002 to focus on HIV/AIDS education, behavior intervention, and voluntary counseling and testing in the gay, lesbian, bisexual, and transgender (GLBT) community. Since then the group has expanded to play a more active role in increasing access to HIV/AIDS education, prevention, treatment, and human rights protection for vulnerable population groups in northeast China, including male and female sex workers, GLBTs, unemployed people living in poverty, and people living with HIV/AIDS. Ai Zhi Yuan Zhu also lobbies the Chinese government and the public to promote tolerance and legally support equality for people especially vulnerable to HIV/AIDS.

Ai Zhi Yuan Zhu currently works in Shengyang, the largest city in northeast China, and its activities include condom distribution and health intervention for GLBT groups. The Center also is doing research on the lifestyle of GLBT groups in Liaoning Province, Shengyang, and surrounding cities. In addition, Ai Zhi Yuan Zhu has launched a series of training sessions on capacity building for other HIV/AIDS NGOs in China. It plans to expand its work into cities surrounding Shengyang to reach its goal of halting the spread of HIV/AIDS in northeast China.

Ai Zhi Yuan Zhu collaborates with governmental organizations, academic institutes, and the media in many of its projects and programs. Ai Zhi Yuan Zhu has received financial support from the Chinese Association of STD Prevention and Control, the Bela•Martin Fund in Britain, and Beijing Aizhixing Institute.

Chi Heng Foundation (Hong Kong)[38,43]

Founded in 1998 and based in Hong Kong, the Chi Heng Foundation is an AIDS NGO focusing on MSM and children orphaned by AIDS in China. The organization has a network of MSM outreach teams in eight Chinese cities, namely, Beijing, Shanghai, Dalian, Xian, Zhengzhou, Guangzhou, Shenzhen, and Hong Kong. Team members in each city include local MSM who conduct community-based outreach work distributing condoms, lubricants, and safer sex materials in MSM venues such as public parks, toilets, bars, and saunas. The organization also operates a website (www.chmsm.org) supported and funded by UNFPA that is specifically focused on improving the health of MSM. It also runs one of the first national toll-free hotlines for MSM in China, providing psychological, social, and legal support to MSM and their families in China, as well as support and treatment information to MSM who are HIV-positive.

In addition to HIV prevention targeting MSM, Chi Heng also is involved in anti-stigma campaigns and public education projects, such as sponsoring and co-organizing the first accredited course on homosexuality offered at Fudan University in Shanghai every year since 2003, and organizing the biannual Media Awards on Tongzhi Coverage since 2000.

The Chi Heng Foundation also works to prevent the spread of HIV/AIDS and cares for people living with and affected by the disease in China by comprehensively funding the education of AIDS orphans in the central region of the country. As the only private foundation focused on helping AIDS orphans in central China, Chi Heng provides psychological care, material assistance, and vocational training to help these orphans complete their education. Chi Heng currently has offices in Shanghai, Guangzhou, Hong Kong, and Henan, and employs over 20 paid staff. Funding sources are mainly private, but also include partial support from UNDP/ UNFPA, UNESCO, The Global Fund, and the Clinton Foundation.

INDIA

The Humsafar Trust[79]

The Humsafar Trust promotes the rights and health of sexual minorities in India, specifically self-identified gay men and other MSM. Beginning with its informal start in 1990 and formal registration as an NGO in 1994, the Trust has worked with government, public health authorities, the medical establishment, and various social groups involved in sexual health and social empowerment. The Trust's outreach services began in 1994 following an assessment of the needs of MSM in India. Soon after, condoms were obtained through the city and state governments and from private sources, and volunteers were recruited to distribute them every week in parks, on the beaches, and at other places where MSM meet. The Trust has distrib-

uted more than 100,000 condoms since the outreach service began in 1994. Telephone counseling also is available for individuals on a daily basis.

In 1994, the Humsafar Trust organized the first gay men's conference in the sub-continent after consulting with gay men's groups in India. The objective was to network with peer leaders from the emerging gay groups in South Asia and to develop an effective strategy to fight the HIV epidemic. Over 70 men from India, Sri Lanka, New Zealand, Great Britain, and the US attended.

The Humsafar Trust currently operates the Humsafar Center, one of India's only safe spaces for self-identified gay and bisexual men. The Center regularly sponsors lectures for gay men by prominent doctors, counselors, lawyers, and other professionals on topics concerning sexual health. A large, well-stocked library, archives, and a computerized database help patrons of the Center locate information on general physicians, labs, surgeons, and experts on sexual problems, as well as information about low-cost lodging for gay men in Mumbai.

The Humsafar Trust shares information and best practices with national and international GLBT organizations and HIV/AIDS groups. It is currently designing and printing its own information, education and communication materials on sexuality and HIV/AIDS for the GLBT communities in India.

Naz Foundation International (NFI)[133]

The Naz Foundation is an international NGO that exists to improve the sexual health, welfare, and human rights of MSM by developing effective policies on these issues and by providing technical, financial, and institutional support to MSM networks, groups, and organizations in developing countries.

Naz's strategy is to focus on the most vulnerable MSM—those who are socially excluded, stigmatized and marginalized because of their feminine behaviors and identities, and whose primary sexual partners are men from the general male population. These MSM are primarily from low-income networks and collectives.

Naz believes in the innate capacity of local people to develop their own appropriate sexual health services and to implement programs whose beneficiaries are also the service providers. Naz empowers low-income MSM collectives, groups, and networks to develop and deliver sexual health self-help programs targeted to their specific needs.

Naz directly supports the development of local programs in several ways. The MSM Self-Help Program provides training, resources, and institutional development to local MSM networks to develop their own sexual health services. The MSM Training and Resource Center provides a range of training programs on issues relevant to MSM sexual health concerns, as well as a growing library that includes materials on male sexuality and gender and sexual health issues. Networks of MSM trainers and consultants provide technical assistance and support to local MSM sexual health projects.

In addition to directly supporting the development of local grassroots organizations, Naz advances the rights of MSM in the developing world by conducting research on issues related to MSM, masculinity, and male sexuality. Naz works with donors, international, national and local governments and NGOs to advocate for human rights and sexual health of MSM, with a focus on the socially excluded and stigmatized. Working with its MSM partner agencies, Naz also facilitates networking, sharing of information and skills, as well as regional support to MSM sexual health projects through its Asian Region MSM AIDS Network (ARMAN). Finally, Naz regularly produces a range of resources, including behavior change communication materials, briefing papers, handbooks, and training manuals, along with its quarterly journal, *Pukaar*, all of which focus on MSM sexual behaviors, masculinity, and male sexuality.

Naz is unique in that it recognizes that an effective HIV/AIDS strategy for MSM also must address their sexual partners who are often heterosexual. Naz collaborates with NGOs that work with heterosexual youth and men to include information about anal sex and HIV/AIDS in their education materials.

Naz is headquartered in the UK and has regional offices in India. It receives funding from governmental organizations, NGOs, private individuals, and corporate sponsors, including DFID, the Elton John AIDS Foundation, FHI, the International HIV/AIDS Alliance, UNAIDS, USAID, and several other groups.

INDONESIA

GAYa Nusantara[67]

GAYa Nusantara's mission includes: supporting human rights for GLBT people and their right to gender and sexual expression; opposing violence (physical, psychological, social and cultural); and supporting democracy, independence, and openness. The group also works toward public and media awareness, and supports optimal sexual welfare, self-actualization, and freedom of expression.

GAYa Nusantara runs a community center, which serves as an information base for GLBT people. The center provides a variety of information, including sexual health (HIV/AIDS and STIs), community agendas, and resources for meeting people; this information is also available via telephone and on the organization's website. The center also produces a monthly publication and provides counseling services on topics such as sexuality and identity. Although the center is working at full capacity, it cannot meet all the needs of the GLBT community.

The group's website includes information on how GLBT terminology developed in Bahasa (the country's official language, a modified form of Malay), as well as a timeline of public recognition of GLBT people in the modern era in Indonesia and globally. The first gay organization in Indonesia (Lambda Indonesia) opened its doors in 1982, and other gay groups followed. In 1993, a lesbian and gay Indonesia conference was held, and in 1996, the Party of the Democratic People (PRD) became the first political party in Indonesian history to include gay and transsexual rights in its platform. The website also has an FAQ section, which includes questions such as "Why can't the majority of our community accept gay people?" and, "How many gay and lesbian Indonesians are there today?" There also is a description of a short course on gender and sexuality that GAYa Nusantara offered in 2005 with support from the Ford Foundation.

JAPAN

OCCUR[92,140]

OCCUR (Japan Association for the Lesbian and Gay Movement) is a grassroots, all-volunteer gay activist organization working to unite Japanese gays to oppose repression and discrimination. Established in 1986, OCCUR's mission is to promote networking among lesbians and gays, disseminate accurate knowledge and information about lesbians and gays, and eliminate stigma and discrimination. In 1990, OCCUR filed Japan's first homosexual discrimination suit against the Tokyo Metropolitan Government for its refusal to allow gays to stay at its youth center (OCCUR eventually won).

Located in Tokyo, OCCUR serves all areas of Japan and targets its services and activities to gay men/MSM and lesbians/WSW. The organization's primary services and activities for MSM include: LIFEGUARD, an HIV prevention workshop at gay bars in all sub-regions; a toll-free STI hotline; a legal support program for PLWHAs, regardless of their sexuality; an outreach program; and publications (flyers and leaflets distributed at gay bars, sex clubs, saunas, etc.). They also are a sponsor of the Tokyo Gay and Lesbian Film/Video Festival. Their primary sources of funding include donations, membership fees, grants from foundations, and contract program/research with the government.

MALAYSIA

PT Foundation[153]

The PT Foundation (previously known as Pink Triangle) is a voluntary, non-profit CBO providing HIV/AIDS and sexuality education, prevention services, and a care and support program for six communities that are difficult to reach due to societal discrimination: drug users, sex workers, transsexuals, homosexual men and women, and people living with HIV/AIDS. The PT Foundation aims to minimize the rates of HIV/AIDS in marginalized communities, improve the quality of life for people living with HIV/AIDS, and reduce discrimination based on ignorance and lack of information.

Since its formation in 1987, the PT Foundation has grown from providing telephone counseling on HIV/AIDS and sexuality to offering an extensive array of programs for various communities that are discriminated against because of sexuality and HIV/AIDS. One program works to prevent the transmission of HIV among female sex workers and transsexuals by providing information and counseling on HIV/AIDS and STDs, doctor referrals at a drop-in center, an outreach program, and weekly and monthly information sessions, counseling, and self-improvement workshops. A similar program for MSM seeks to reduce HIV infection rates among MSM in Kuala Lumpur, with a secondary objective of empowering MSM to feel confident in their sexuality. The program targets all levels of MSM in Kuala Lumpur, including the educated middle-class, "Anak Ikan" (teenage Malay males), and closeted MSM. Other programs target people living with HIV/AIDS, drug users, and lesbians.

The PT Foundation receives significant financial support from the Malaysian AIDS Council.

NEPAL

Blue Diamond Society (BDS)[21]

As Nepal's only organization for sexual minorities, BDS is working to transform the lives of sexual minorities, including the meta, dohori, ta, gay, bisexual, lesbian, hijra, singaru, fulumulu, kothi, kotha, strian, maugia, panthi, and many others. Since its inception in 2001, the organization's efforts have focused on HIV/AIDS/STI prevention and outreach education. BDS currently conducts the only HIV/AIDS/STI prevention program in Nepal that targets the MSM community. In addition to a weekly clinic that offers free HIV/AIDS/STI check-ups and treatment, BDS provides a weekly social support group, a weekly MSM-oriented/safe-sex film show, and a 24-hour drop-in center. BDS recently began a campaign to build a library of books and videos exploring sexuality, gender, and non-conforming lifestyles. Such literature is currently impossible to obtain in Nepal because sexual matters are not discussed.

BDS organized Nepal's first meta pride parade in Kathmandu. BDS members also have participated in Nepal's Red Cross/Thompson and FHI's Condom Day, distributing condoms, lubricant, and safe-sex literature in drag. Most recently, BDS held its 3D Extravaganza Party (Diwali, drag, dance) at the Hotel Vaishali in Thamel, Kathmandu, at which BDS members performed traditional Nepali cultural dances, paraded in drag, and hosted a dance party for Nepalese and foreigners. The event, which was held in honor of the festival of lights, Diwali, raised funds to support the development of Nepal's first video and book library for sexual minorities.

SOUTH KOREA

Ivan Stop HIV/AIDS Project (iSHAP)[83,162]

Ivan Stop HIV/AIDS Project (iSHAP) is funded by the Korean Federation for AIDS Prevention, a government body ("Ivan" is a local term for gay). The organization has six employees and is based in Seoul, with another office in the South. iSHAP has a website, but it is entirely in Korean. (Language was a major barrier in learning more about this and other MSM groups in South Korea.)

Korean Sexual-Minority Culture and Rights Center (KSCRC)[111]

The KSCRC is the first center for sexual minorities (lesbian, gay, bisexual, transgender, queer, iban, tongsungyaeja, and those who are questioning their sexuality), people living with HIV/AIDS, and those who support the rights of sexual minorities in South Korea.

KSCRC's mission is to provide a safe place for these minorities to explore and develop their sexuality. The KSCRC also seeks to empower sexual minorities through its cultural events, research, education, policy advocacy, counseling, and publications. Through its work both in and outside of these minority communities in South Korea, the KSCRC serves as a national champion of sexual minorities and sexual health related to HIV/AIDS in South Korea.

The KSCRC is currently designing a questionnaire to study attitudes and experiences of middle and high school teachers related to homosexuality and bisexuality, gender diversity, and GLBT individuals. Recognizing that accurate information about sexuality and HIV/AIDS is essential to successfully achieving its objectives, the KSCRC is also collaborating with academic institutions and nongovernmental public health organizations to publish a library of HIV/AIDS information in Korean.

SRI LANKA

Companions on a Journey (COJ)[61]

COJ was formed in 1995 with initial support from Alliance London, an international HIV/AIDS donor agency. The group's formation was met with considerable media coverage, both positive and negative. After a brief suspension of activities following the initial public outcry, COJ registered as an NGO with the Sri Lankan Ministry of Social Services in September 1995 with a mandate to support persons living with HIV/AIDS. With a seed grant from the Royal Netherlands Embassy, COJ rented a house in Colombo and created a drop-in center for gay men and other MSM.

In 1999, COJ received core funding from Hivos, a Dutch NGO whose basic commitment is to poor and marginalized people—and their organizations—in countries of the global South and East, and Eastern Europe. The promise of continued funding enabled COJ to promote its program of advocacy and support for the rights of Sri Lankan homosexuals, despite the virulent hostility they continued to face. By inserting itself into the public eye, COJ endorsed "sexual citizenship" and created a space where initially gay men and later lesbians were allowed to participate in the political and social life of the state. COJ's numerous civic activities include the establishment and coordination of a highly visible HIV support group (which also promotes the use of condoms), distribution of educational material, organization of media campaigns, and research into the needs of HIV-positive men and women. COJ holds an annual World AIDS Day event on December 1, and has constructed the Sri Lankan AIDS Quilt. It also has recently embarked on a more ambitious and contentious mission to decriminalize homosexuality in Sri Lanka.

TAIWAN

Taiwan Tongzhi Hotline Association (TTHA)[175]

The TTHA was formed in 1998 to provide members of the GLBT community with peer counseling, support networks, and a community resource center. The community resource center functions as a friendly space where marginalized members of the GLBT community can connect and find useful information to help make positive changes in their lives.

The TTHA trains peer counselors to use their personal life experiences to help other GLBT community members gain a better understanding of their sexuality. Finally, as a community resource center, the TTHA provides information about group meeting times, upcoming events, news, and social activities for the GLBT community. It also offers a number of public services including a sexual health hotline, twice monthly public lectures, coalition-building meetings, and lectures on lesbian-related events.

THAILAND

In Thailand, a handful of committed and concerned community leaders, often aided by individuals working in international development and health organizations, have formed a number of community-based groups to respond to the needs of their friends and loved ones. These men and women spurred the government, as well as established AIDS and international donor organizations (including FHI-APD and UNESCO), to convene the first-ever national meeting on MSM and HIV in late 2004, and secured a commitment to add MSM to the national HIV planning process for 2006–2010.

Rainbow Sky Association of Thailand (RSAT)[90,156]

In 2001, Thai gay and transgender men started the RSAT, which is today the only officially recognized, legally registered group structured to serve the needs of gay men and transgender people. (Legally registering an NGO in Thailand is a lengthy process that takes three to five years and involves first becoming "registered" and then becoming a "foundation" to obtain tax-deductible, non-profit status.) In 2005, RSAT refocused its emphasis on HIV prevention among MSM and on improving male sexual health. Utilizing a pool of over 200 volunteers, RSAT offers street outreach that includes distribution of condoms and lubricant in many of the places where MSM gather, such as parks, saunas, and discos. RSAT continues to be a key partner in the research work of the Thai Ministry of Public Health-US CDC Collaboration (TUC), which discovered alarming HIV prevalence rates among MSM in Bangkok in 2003 and 2005 (17.3% and 28.3%, respectively). RSAT's work reaches many provinces in Thailand and includes an office in the Patong Hospital in Phuket in the south, in addition to a drop-in center and hotline in Bangkok.

Bangkok Rainbow Organization (BRO)[10]

BRO was started shortly after RSAT and strives to increase acceptance of homosexuality in Thai society, while providing empowerment through social activities for Thai gay men, such as holiday parties, weekend retreats from the city, and a movie club that features showings of gay-interest films. BRO also supports the development, translation, and distribution of gay-positive books, such as the recent Rainbow Boys series. In 2005, in response to rising HIV rates, BRO used its relationships with MSM-related businesses to form the first-ever association of saunas for MSM and also assumed leadership roles in both the Pride Festival Organization and the MSM Community Advisory Board of the TUC.

Service Workers in Group (SWING)[30,102]

In 2004-2005, a new social services organization, SWING, became the first group to serve male sex workers—based largely upon the concept for female sex workers pioneered by the world-renowned Thai organization EMPOWER. SWING maintains drop-in centers in the heart of the commercial sex scene in Bangkok and the nearby beach resort, Pattaya.

MPlus+[33]

In Chiang Mai in the north of Thailand, MPlus+ started in 2004 as a collaborative effort of international donor agencies and RSAT. In 2006, MPlus+ will become Thailand's second officially recognized organization formed to improve the sexual health of MSM, including transgenders. The MPlus+ mission is to empower MSM in the greater Chiang Mai area to adopt safer behaviors to protect themselves and their partners against HIV. Services include a drop-in center, an onsite medical clinic—in association with the local Thai public health system—for testing and treatment of sexually transmitted illnesses, and community outreach and education, including Internet-based prevention.

"Community" has a unique meaning in Thailand, as evidenced by these groups. In addition to the above, there are now a growing number of community groups in existence or being started by and for Thai men and women, with some estimates counting over 20 such groups in hamlets and villages in every corner of the Kingdom. Through the leadership exhibited by all of these groups and the advocacy they generate with the Thai government and international donors, the HIV epidemic among MSM in Thailand can hopefully be curbed and eventually reversed.

VIETNAM

FHI conducts research on MSM in Vietnam and supports multiple MSM intervention sites to provide access to services. The two largest of these are **Blue Sky** in Ho Chi Minh City, and the **Light House Club** in Hanoi.

Blue Sky[136]

Blue Sky began its partnership with the Ho Chi Minh City AIDS Committee and FHI in September 2003 and was one of the first MSM groups/support clubs established in Vietnam. It is currently the most visible and active group in the country due to support from the Provincial AIDS Committee. Blue Sky runs a comprehensive drop-in center with counseling, referrals, trainings on MSM issues, "edutainment" events, and an onsite cafe in the heart of Ho Chi Minh City, and has extended its service coverage to 17 of the 24 neighborhood districts at 35 outreach sites. Since its inception, Blue Sky has demonstrated a keen ability to work with the government, international donors, and international NGOs, while maintaining an active and vibrant membership. While not exactly a CBO in that it was started by international donors, Blue Sky has successfully engaged the MSM community in Ho Chi Minh City and it enjoys the community's strong support.

Light House Club[24]

At the Light House Club in Hanoi, an MSM support club that was founded with the support of the STDs/HIV/AIDS Prevention Center (SHAPC), major services include:

Community outreach activities: These activities are led by trained peer outreach workers (POWs), with supervision and support from health educators. The POWs do outreach at "hot spots"—places where MSM are most likely to gather (cafes, road-side bars, saunas, parks, streets, discotheques, cinemas, swimming pools, etc.). POWs build friendships with their peers in various networks to educate them and to communicate messages about HIV/AIDS and STIs. They also distribute materials, condoms, and water-based lubricant, and make referrals to the drop-in center and other supportive services, including sites for VCT, and STI and HIV/AIDS care and treatment.

Drop-in center services and activities: These include counseling (HIV/AIDS/STIs and psychosexual health); information (mini-library, topic talks, information education and communication materials, etc.); referrals to MSM-friendly services for VCT, STIs, opportunistic infections/antiretroviral therapy, home-based care and peer support groups; "edutainment" activities (music performances integrated with messages on HIV/AIDS/STIs, dramas, and HIV quizzes); and regular meetings with POWs.

Referrals to "MSM-friendly services" for STIs, VCT, and HIV care and treatment: This activity began with an inventory of STI clinics to identify MSM-friendly clinics with quality services. Next, the referral services network was set up within the project and STI doctors were trained on clinical management guidelines for sexual heath care of MSM/transgenders. Referral cards were developed and used by POWs and the drop-in center, and monthly meetings are held with referral services to retrieve referral cards, monitor utilization of services, and obtain feedback.

HIV/AIDS communication in community/entertainment establishments: Undertaken by members of the Light House Club, this activity aims to raise AIDS awareness among MSM in the community, increase awareness of MSM issues among community members, and build support for the project.

Appendix 3: Country Profiles

The following country profiles are based largely on the interviews conducted as part of this project. Thus, many of the statements are opinions from individuals or even a single individual, and are not necessarily verifiable facts. Nevertheless, we believe that the views of these front-line providers give a valuable insight into the MSM situation in the countries in Asia.

BANGLADESH

Population
147,365,352 (July 2006 est.)[200]

Languages
Bangla (official, also known as Bengali), English[200]

Religions
Muslim 83%, Hindu 16%, other 1% (1998)[200]

Ethnic groups
Bengali 98%, tribal groups, non-Bengali Muslims (1998)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 43.1%; Male: 53.9%; Female: 31.8% (2003 est.)[200]

Form of government
Parliamentary democracy[200]

Adult population HIV prevalence
In 2004, 0.3% among general population; 4% among IDUs; as high as 8.9% in one neighborhood studied[75]

People living with HIV/AIDS
2,400–15,000 (2003 est.)[1]

MSM HIV prevalence
0.1% among MSM; 0.2% of hijras[75]

Legal status of male-male sexual activity
Illegal: punishable with life in prison, or a shorter term plus a fine. To date, only one case is known to have been prosecuted under this section.[195]

MSM quantitative and qualitative findings[157]

Bangladesh has low HIV prevalence in both the general and MSM populations, but extremely high levels of unsafe behavior and low levels of MSM recognition and support, meaning that HIV poses a serious threat.

Social support
In Bangladesh, MSM are not socially exposed. Very few NGOs provide support to MSM. Many MSM also have sexual relationships with women, both inside and outside of marriage.

HIV/AIDS knowledge
Knowledge gaps exist in many areas of HIV/AIDS prevention, mainly concerning correct and consistent condom use. Myths and misconceptions abound, such as the idea that HIV can be transmitted by mosquitoes or only between MSM. Most HIV prevention programs are based in urban areas; rural areas are largely excluded. Written information on HIV and AIDS prevention is available in Bangla, but not in local dialects. The Bandhu Social Welfare Society (BSWS), the only significant NGO targeting MSM, has produced some pictorial leaflets for delivering HIV/AIDS information to MSM in areas with low literacy levels. It also provides HIV/AIDS prevention education services in the field and at a drop-in center. Recent USAID funding restrictions have forced the organization to target only male sex workers, creating a serious gap in services for other MSM.

HIV testing and treatment
HIV testing is available in hospitals and clinics, but not widely. It is only MSM-sensitive at one site. Only a handful of organizations working with MSM have MSM-sensitized physicians and counselors who routinely ask clients about male-male sexual activity. Treatment is often insurmountably costly.

Condom use
BSWS provides condoms to MSM, and is the only source of water-based lubricant, but cannot keep up with demand. Condoms also are available for purchase at grocery stores and pharmacies. BSWS estimates that 80%-90% of its clients know correct condom usage, but do not use them consistently.

There is no doubt that the law contributes to high-risk behavior among MSM. In the words of Mamunur Rashid: "Male-male sex is a desire that you can't avoid. When anyone likes this sexual practice and knows that it is illegal, definitely he wouldn't leave it. Rather he will hide himself and continue. More importantly, if he gets any sexually transmitted infections, he will never feel comfortable to speak about it, even to a physician. Not only this, as these sexual practices aren't allowed, people who are doing these activities out of their house … surely try to make it hurried. As a result, the possibility of condom use will be very poor. As the issue is very sensitive and officially not allowed, nobody will like to speak about this issue. And likely the harassment and violence rate will be increased."

Sex work
The scope of this issue is difficult to assess, as male sex workers are scared of being isolated after their identity has been disclosed. Only BSWS targets this population for services.

Next steps
BSWS identified increased, MSM-sensitive voluntary counseling and testing (VCT) as urgently needed to control the spread of HIV, as well as partner management and advocacy.

BHUTAN

Population
2,279,723 *Note:* other estimates range as low as 810,000 (July 2006 est.)[200]

Languages
Dzongkha (official), Bhotes speak various Tibetan dialects, Nepalese speak various Nepalese dialects[200]

Religions
Lamaistic Buddhist 75%, Indian- and Nepalese-influenced Hinduism 25%[200]

Ethnic groups
Bhote 50%, ethnic Nepalese 35% (includes Lhotsampas, one of several Nepalese ethnic groups), indigenous or migrant tribes 15%[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 47%; Male: 60%; Female: 34% (2003 est.)[200]

Form of government
Monarchy; special treaty relationship with India[200]

Adult population HIV prevalence
Less than 0.1% (2001 est.)[200]—UNAIDS does not provide any data on this

People living with HIV/AIDS
Less than 100 (1999 est.)[200]—UNAIDS does not provide any data on this

MSM HIV prevalence
Unknown

Legal status of male-male sexual activity
Illegal. Homosexuality is illegal between men, punishable by life in prison.[76] Bhutan's penal code is the same as that of India.

MSM quantitative and qualitative findings

AIDS epidemic
According to an announcement by its health minister on World AIDS Day, Bhutan had a total of 76 cases of HIV/AIDS in the country in 2005. There is a risk of greater spread in the future based on the widespread use of alcohol, a highly mobile population, a growing commercial sex trade, and the likelihood of having multiple partners.[73] However, this may be somewhat mitigated by the fact that healthcare and education are free to all.[19] According to the UNAIDS country report, all HIV cases so far are considered to be through heterosexual transmission.[18]

MSM in Bhutan
We could not identify any NGO working on either HIV/AIDS or MSM issues in Bhutan. In-country contacts, speaking anonymously, stated that they did not know of any such NGO. This was verified by WHO.[139] No data on MSM and HIV/AIDS are available for Bhutan.

BRUNEI

Population
379,444 (July 2006 est.)[200]

Languages
Malay (official), English, Chinese[200]

Religions
Muslim (official) 67%, Buddhist 13%, Christian 10%, indigenous beliefs and other 10%[200]

Number and names of ethnic groups
Malay 67%, Chinese 15%, indigenous 6%, other 12%[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 93.9%; Male: 96.3%; Female: 91.4% (2002)[200]

Form of government
Constitutional sultanate[200]

Adult population HIV prevalence
Less than 0.1% (2003 est.)[1]

People living with HIV/AIDS
Less than 200 (2003 est.)[1]

MSM HIV prevalence
Unknown

Legal status of *male-male sexual activity*
Illegal. Homosexuality is criminalized by Sections 292, 294 and 377 with a penalty of up to 10 years' imprisonment or a fine of up to BN$30,000 [approximately US$19,000].[195]

MSM quantitative and qualitative findings

We were unable to find any organizations working with MSM and HIV in Brunei. We were unable, despite repeated efforts, to contact the Brunei Ministry of Health. UNAIDS reports that virtually no information is available on who has contracted HIV or how; nor are other common health indicators available.[25] We found no documentation of MSM activity in Brunei pertaining to HIV or otherwise.

CAMBODIA

Population
13,881,427 (July 2006 est.)[200]

Languages
Khmer (official) 95%, French, English[200]

Religions
Theravada Buddhist 95%, other 5%[200]

Ethnic groups
Khmer 90%, Vietnamese 5%, Chinese 1%, other 4%[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 73.6%; Male: 84.7%; Female: 64.1% (2004 est.)[200]

Form of government
Multiparty democracy under a constitutional monarchy, established September 1993[200]

Adult population HIV prevalence
2.6% (2003 est.)[200]

People living with HIV/AIDS
170,000 (2003 est.).[1] The number of adults living with HIV/AIDS in Cambodia declined during the last years of the 20th century; this decline was attributed to both decreased risk behavior and increased deaths.[47]

MSM HIV prevalence
14.4% in Phnom Penh (est. 2003)[28]

Legal status of male-male sexual activity
Legal: same-sex relationships between women and between men are legal, as is sodomy.[28] However, police harass MSM and male sex workers in the street. Reports of male-male rape by police are common.[171]

MSM quantitative and qualitative findings[28,170,171]

The Cambodian government has succeeded in reducing HIV prevalence via a 100% condom campaign and bringing treatment to approximately 50% of those who currently need it. But prevention efforts targeting MSM have been largely left up to NGOs.

Gender identities
MSM in Cambodia fall into two main camps that do not mix significantly—*sray sros* and *pros saat*. The English term for *sray sros* is "long hair," or feminine/transgender MSM, and for *pros saat* it is "short hair," or masculine MSM; the latter are probably in the majority and may not identify as "gay."[68] Most heterosexual Cambodians are not aware of how many masculine-acting—and often married—men are sexually active with other men. Short hair MSM enjoy a degree of privacy that is not afforded to long hairs. For instance, short hairs sometimes meet for sexual encounters in each others' homes, while long hairs are most often forced to meet in parks; this is partly because long hairs are often kicked out of their homes and must either live on the streets or engage in sex work to earn a living. Few Cambodians will hire long hairs for conventional jobs.

Social support
On the other hand, long hairs' visibility affords them more access to MSM services. Many long hairs avail themselves of social support services from CBOs and NGOs; the government is tolerant, but not supportive, of either group. There are a few public places expressly designated for MSM, but fear of discovery keeps many MSM away from bars or drop-in centers. Short hairs sometimes socialize in public, but generally only with each other, in order to avoid being identified as MSM.

HIV/AIDS knowledge
MSM in Cambodia are often aware of HIV transmission and prevention, but are not always able to apply this knowledge to their own behaviors in order to avoid risk of infection. They have only limited access to condoms, which are imported and expensive except when offered through social marketing programs. Secrecy only exacerbates the situation, and some MSM base HIV risk assessments on whether a potential partner appears to have good personal hygiene or not. This is especially true for male sex workers. Although condom use among commercial sex workers is markedly improved from 15 years ago,[164] male sex workers are often unable to negotiate condom use and generally do not use lubricant because clients "would know for sure that they are non-female." However, long hairs' female gender identity does serve them well to a degree, as they are able to internalize prevention messages aimed at heterosexual women and thus understand the importance of using condoms. Short hairs, on the other hand, often misconstrue prevention messages aimed at heterosexuals to mean that they are safe when having sex with other men. There are some prevention materials targeted at MSM, but our informants emphasized that much more was needed. Communication vehicles that do not overtly identify their users as MSM—such as a now defunct radio show called "15 Minutes for Men," and an MSM hotline—have proven popular.

HIV testing and treatment
HIV testing and free treatment is available in the capital, Phnom Penh, and in about half of the operational districts. Only one clinic in Phnom Penh specifically accommodates MSM.

CHINA (MAINLAND)

Population
1,313,973,713 (July 2006 est.)[200]

Languages
Standard Chinese or Mandarin (Putonghua, based on the Beijing dialect), Yue (Cantonese), Wu (Shanghainese), Minbei (Fuzhou), Minnan (Hokkien-Taiwanese), Xiang, Gan, Hakka dialects, minority languages[200]

Religions
Daoist (Taoist), Buddhist, Muslim 1%-2%, Christian 3%-4%. Officially atheist (2002 est.)[200]

Number and names of ethnic groups
Han Chinese 91.9%, Zhuang, Uygur, Hui, Yi, Tibetan, Miao, Manchu, Mongol, Buyi, Korean, and other nationalities 8.1%[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 90.9%; Male: 95.1%; Female: 86.5% (2002)[200]

Form of government
Communist state[200]

Adult population HIV prevalence
0.1% (2003 est.)[1]

People living with HIV/AIDS
840,000 (2003 est.)[1]; recently revised by the Chinese government to 650,000[146]

MSM HIV prevalence
Beijing study - 3.1%[41]

Legal status of male-male sexual activity
Homosexuality was decriminalized in 1997, and the Chinese Psychiatric Association de-pathologized homosexuality in 2001. While gay sex itself today in China is not illegal, MSM may be arrested for public sex or for paid sex.[167] MSM may also be targeted for blackmail by both police and marginalized male sex workers looking to make extra money.

MSM quantitative and qualitative findings[86,121,167,190,191,192,204]

Social support
The past decade has seen vast changes in how MSM communities in China connect, and there continues to be a broad range of different behaviors among MSM in urban and rural locales. In the past, MSM almost never came out to family and friends, but instead often got

married and raised families. Sexual activity with other men through the early 1990s took place in a secretive and marginalized fashion in parks, restrooms, or other public places. In recent years, a gradual opening of legal policies and growing tolerance of homosexuality by the government and society at large have allowed a generation of younger MSM to be openly gay. The emergence of gay organizations, online chat rooms, and public meeting places, such as bars and saunas, has allowed MSM to meet and organize.

In smaller cities or the countryside, a large number of sexually active MSM continue to hide their identities. Public acceptance and gay-friendly venues are limited, and MSM activity is more likely to occur in parks, public restrooms, or similar places. Informants report that in general older MSM still tend to be much more secretive about their same-sex encounters and limit such meetings to only sex. Moreover, older MSM tend to have more partners and to be at higher risk of infection. One interviewee noted that this stems in part from disenchantment—younger men are reportedly idealistic and look for romantic, monogamous relationships when coming out. After spending time in the community and finding expectations are not met, men tend to increase their number of sexual partners.

MSM programming has increased substantially in popularity and funding in recent years. Most of the larger cities in China now have MSM organizations offering HIV prevention programming. Projects now employ peer workers who go to saunas and bars to distribute condoms, lubricant, and information education and communication (IEC) materials, and to host educational events.

HIV/AIDS knowledge
Most MSM have heard of HIV/AIDS, especially urban and younger populations. However, an awareness of HIV does not necessarily translate into reducing sexual risk behavior. Many MSM believe that they are not at risk for contracting HIV; others appear to take risks despite education efforts. STIs are common among MSM in China, and NGO workers reported increasing rates of HIV in testing their clients. One NGO worker in Shenyang estimates current prevalence among highly sexually active MSM in the community at 10% and rising quickly. Low condom use is particularly a problem in saunas where fear of police raids discourages owners from providing them. In addition, condom quality in China has been a problem in the past. Current social marketing and other efforts are designed to bring high-quality condoms to as many people as possible. Lubricant has become available in China in recent years, though many brands are reportedly of low quality and better brands may be expensive. Drug and alcohol use is generally low.

Sex work
A recent and worrisome trend in China has been the increase in the population of male sex workers, often referred to as "money boys" or "young brothers." These young men often come from poor backgrounds in the Northeast, and although some of them may become involved in the profession after moving to the cities and not being able to find work, others are reportedly recruited from their hometowns for this purpose. This group can be difficult to reach for a number of reasons: they do not identify with campaigns aimed at openly gay men; they can be difficult to locate due to widespread fear of police raids; they are frequently moved from one city to another; and obtaining government and community support for interventions targeting this population is more difficult because they are viewed as a public health danger and as criminals.

HIV testing
HIV tests are free, but many sites charge patients for associated costs. These costs can be a barrier for lower income MSM. Though testing is reportedly available at a number of locations in larger cities, many testing sites are located in settings that may not be MSM-friendly. MSM often avoid hospital-based testing locations, for example, because they worry about having their male-male sexual behavior identified by doctors or other staff. Some MSM-friendly approaches—such as using outreach workers to recruit patients from bars and saunas—have been tried recently, but such efforts are still in the early stages. There is extensive health-related HIV and STI knowledge available on the Internet, but limited gay-friendly healthcare exists in China.

HIV treatment
China began offering antiretroviral (ARV) treatment at no cost in 2004. However, fear of being identified as HIV-positive, as well as fear of having the mode of transmission disclosed, provides an enormous barrier to treatment for some MSM. In smaller cities and towns in particular, protecting the privacy of one's status may be especially difficult.

Funding for MSM work
Several foundations and the occasional bilateral funder support MSM activities in China. One organization did a review of funding available in China and found that there was a total of 8 million yuan (approximately US$1million) for all organizations working on HIV among MSM during 2005. The survey covered 39 organizations. Wan Yanhai, the author of this report, noted that most groups hadn't started work on care and support, and that these figures would be significantly higher if antiretrovirals and other care costs were included. Also, treatment for STIs and capacity building for NGOs were not included.

CHINA (HONG KONG)

Population
6,940,432 (July 2006 est.)[200]

Languages
Cantonese and English; both are official[200]

Religions
Eclectic mixture of local religions 90%, Christian 10%[200]

Number and names of ethnic groups
Chinese 95%, other 5%[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 93.5%; Male: 96.9%; Female: 89.6% (2002)[200]

Form of government
Limited democracy[200]

Adult population HIV prevalence
0.1% (2003 est.)[1]

People living with HIV/AIDS
2,600 (2003 est.)[1]; 32% of these are MSM[44]

MSM HIV prevalence
1.4%[115]

Legal status of male-male sexual activity
Legal. Private "consensual homosexual acts" were decriminalized in Hong Kong in 1991, although the age of consent is 21 for MSM.[118,120] Hong Kong's reabsorption into China has led to some ambiguity about statutory nuances, but homosexuality has been decriminalized in China also.[195]

MSM quantitative and qualitative findings[118,120]

Social support
MSM in Hong Kong commonly meet for social and sexual purposes in bars and, especially, saunas. Massage parlors—some legal, most offering illegal sexual services—have become popular in recent years. Because Hong Kong is quite small, the community is close-knit and MSM have a relatively easy time meeting others over the Internet or through friends. As most Hong Kong residents live with their parents until they marry, it is especially difficult to socialize with other MSM while keeping one's sexuality hidden. Families and heterosexual friends are uncomfortable accepting that their loved ones identify as gay, but rarely evict them or cause them physical harm.

HIV/AIDS knowledge
HIV/AIDS information is available in English, Mandarin, and Cantonese. Most MSM are aware that unprotected anal and oral sex are HIV risks. Condoms are easily accessed: they are given out for free at bars and in saunas, although lubricant is less widely available. Knowledge of proper use is spotty.

The transgender population remains quite separate from other MSM and requires its own outreach materials. Male sex workers are also targeted with their own safe sex information, but while they apply this knowledge rather diligently in situations involving commercial sex, they often fail to carry it into their personal relationships. Overall, people usually keep their HIV status a secret. Most MSM are unaware of knowing anyone who is HIV-positive, which makes unprotected sex seem less risky.

HIV testing and treatment
A couple of NGOs perform HIV-related outreach to the MSM community, and the Department of Health has begun collaborating with other organizations through its VCT programs. One NGO, AIDS Concern, rather aggressively offers MSM-sensitive VCT, having established offices in saunas and other places where MSM congregate, but by no means are they able to reach everyone. Still, testing rates among MSM are twice as high as among the general male population.[117] Treatment for HIV-positive people is subsidized and is provided anonymously; unlike most doctors, many HIV treatment providers are sensitive to MSM issues. AIDS Concern and others have provided sensitivity training.

Sex work
In the last few years, male sex workers have become increasingly public and available; their customers access them by phone or by Internet. This increase in commercial sex work owes a lot to sex tourism and migration: many male sex workers in Hong Kong are Thai or mainland Chinese, and some Hong Kong men travel to mainland China to patronize them there, where unsafe sex is more common.

EAST TIMOR (DEMOCRATIC REPUBLIC OF TIMOR-LESTE)

Population
1,062,777 *Note:* other estimates range as low as 800,000 (July 2006)[200]

Languages
Tetum (official), Portuguese (official), Indonesian, English. About 16 indigenous languages (including Tetum, Galole, Mambae, and Kemak) are spoken by significant numbers of people.[200]

Religions
Roman Catholic 90%, Muslim 4%, Protestant 3%, Hindu 0.5%, Buddhist, Animist (1992 est.)[200]

Ethnic groups
Austronesian (Malayo-Polynesian), Papuan, small Chinese minority[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 58.6%; Male: not available; Female: not available (2002)[200]

Form of government
Republic[200]

Adult population HIV prevalence
Unknown

People living with HIV/AIDS
Unknown

MSM HIV prevalence
1%[63]

Legal status of male-male sexual activity
Legal[143]

MSM quantitative and qualitative findings

HIV/AIDS epidemic
By 2002, East Timor reported only six known cases of HIV and a prevalence of 0.64%, although these figures are generally considered unreliable.[184] FHI opened an office in the country in May 2002, the same month that the country officially gained its independence. FHI then carried out surveillance and behavioral surveys among groups at risk, notably female sex workers and MSM.

MSM in East Timor[63]
FHI found HIV prevalence rates of 3% for female sex workers and 1% for MSM. Among both of these groups, 15% had curable sexual infections such as gonorrhea and chlamydia. Risky sex was found to be the norm among MSM, and 50% of MSM were also having sex with women including sex workers. According to Rui Carvalho, FHI Program Officer and spokesperson for the MSM community in Dili, "FHI has turned things around for MSM in East Timor. Before FHI arrived, MSM were a shunned, vulnerable community with little access to information." FHI supported the first-ever condom distribution campaign targeting MSM.

INDIA

Population
1,095,351,995 (July 2006 est.)[200]

Languages
Hindi is the national language and primary tongue of 30% of the people. English enjoys associate status and is the most important language for national, political, and commercial communication. There are 14 other official languages: Bengali, Telugu, Marathi, Tamil, Urdu, Gujarati, Malayalam, Kannada, Oriya, Punjabi, Assamese, Kashmiri, Sindhi, and Sanskrit. Hindustani is a popular variant of Hindi/Urdu spoken widely throughout northern India but is not an official language.[200]

Religions
Hindu 80.5%, Muslim 13.4%, Christian 2.3%, Sikh 1.9%, other 1.8%, unspecified 0.1% (2001 census)[200]

Ethnic groups
Indo-Aryan 72%, Dravidian 25%, Mongoloid and other 3% (2000)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 59.5%; Male: 70.2%; Female: 48.3% (2003 est.)[200]

Form of government
Federal republic[200]

Adult population HIV prevalence
0.4–1.3% (2003 est.)[1]

People living with HIV/AIDS
2.2 million–7.6 million (2003 est.)[1]

MSM HIV prevalence
Varies by region, sometimes considerably. In Andhra Pradesh, 6.5% in 2005[60]; in Tamil Nadu, 6.8% in 2004[176]; in Mumbai, 6.8% in 2005[93]; in Maharashtra, 16.8% in 2003[123]; and in Chennai, between 4.4–18%.[34]

Legal status of male-male sexual activity
Illegal[195]

MSM quantitative and qualitative findings[34,93,126,169]

Due to the immense size and geographic diversity of India's population, it is difficult to characterize MSM in India with both brevity and accuracy. Following are some general statements that apply to a plurality of MSM in India, but not by any means to the entire population.

Social support
MSM in India tend to find each other in public places. Parks, beaches, public toilets, and other cruising spots are especially popular with teenagers and younger men. There is a stronger sense of community among *hijras* (a specific group of transgendered MSM, sometimes considered to be a "third sex," who are often castrated) and *kothis*, but many other MSM remain hidden and isolated. As long as male-male sexual activity is not open it may be tolerated, especially if a man is fulfilling his obligation to marry and have children. MSM from poor families may be tolerated if their income is important to the family, but among the middle class, there is more likely to be pressure to marry regardless of sexual orientation. The penal code criminalizing homosexuality makes it difficult for community-based organizations (CBOs) and NGOs to publicly provide support, as such support—especially safer sex education for MSM—would be seen as abetting an illegal activity. MSM are not actually prosecuted for male-male sex; rather, the law is used for harassment and blackmail by some members of law enforcement and others.

Condom use
Condoms are widely available in India, although non-oil-based lubricant is not. MSM in India have sex with several partners a year, and sometimes several in a month, and condom use is sporadic. MSM are particularly unlikely to use condoms with boyfriends, as this would be seen as an indicator of distrust.

HIV/AIDS knowledge
HIV/AIDS education materials are distributed by CBOs in many of the local languages, but focus on modes of transmission other than male-male sex, in part due to the penal code mentioned above. The National AIDS Control Organization asserts that the main mode of transmission in India is heterosexual sex. As a result, many MSM develop the misconception that anal sex is safer than vaginal sex. *Hijras* and MSM in rural areas (where there are no CBOs) are sometimes not reached at all.

HIV testing and treatment
HIV testing is widely available in hospitals and through CBOs and NGOs, but is rarely targeted to MSM. Medical providers have been known to harass, threaten and expose men who admit to male-male sex, and fear of such retribution may prevent MSM from getting tested, or at least from discussing their sexual behavior. MSM-sensitive health care is also not widely available, due to prejudice and ignorance.

Progress
Despite all of these barriers, some headway is being made: in Mumbai, HIV seroprevalence rates among MSM were halved between 1999 and 2005, according to one of our informants, Ashok Row Kavi of the Humsafar Trust. All of the organizations we spoke with had managed to perform some sort of outreach to MSM, even in the face of the penal code, but all of them emphasized a dire need for more education, more funding, and steps toward decriminalization.

INDONESIA

Population
245,452,739 (July 2006 est.)[200]

Languages
Bahasa Indonesia (official, modified form of Malay), English, Dutch, local dialects, the most widely spoken of which is Javanese[200]

Religions
Muslim 88%, Protestant 5%, Roman Catholic 3%, Hindu 2%, Buddhist 1%, other 1% (1998)[200]

Ethnic groups
Javanese 45%, Sundanese 14%, Madurese 7.5%, coastal Malays 7.5%, other 26%[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 87.9%; Male: 92.5%; Female: 83.4% (2002 est.)[200]

Form of government
Republic[200]

Adult population HIV prevalence
0.1% (2003 est.)[1]

People living with HIV/AIDS
110,000 (2003 est.)[1]

MSM HIV prevalence
2.5% in Jakarta[151]

Legal status of male-male sexual activity
Legal[142]

MSM quantitative and qualitative findings[142,148]

Social support
Urban MSM in Indonesia meet at public pools and toilets, and sometimes in the cinema. These options are simply not available to rural MSM, who are consequently much more secretive and must find social opportunities wherever heterogeneous crowds gather, such as at food stalls or religious gatherings. A number of NGOs provide support for MSM. Transgender MSM also receive support from the government; they are much more visible than other MSM and an easier outreach target. Families disapprove of MSM, but express their disapproval verbally rather than through violence. If an MSM contributes to the household income it can soften the rejection considerably. Indonesia has several ancient traditions of alternative sexualities, such as the *warok* of Ponorogo, who take young boys as lovers—although the practice is highly institutionalized, and is seen as a social stepping-stone for the boys. Such traditions are dying out, but have still resulted in a society that is both accustomed to and, for the region, relatively tolerant of openly acknowledging male-male sexual activity.[141]

Condom use
According to our informants, unprotected anal sex has increased recently. Condoms are easy to buy, and lubricants are also available but often expensive and less familiar. Use of club drugs (ecstasy, crystal methamphetamine) has reportedly increased among both MSM and the general population, although injection drug use is quite low.

HIV testing
The Indonesian government is scaling up HIV testing rapidly—there were 25 hospital-based VCT sites in 2004, and there will be 100 by the end of 2006, including rural and mountain locations. Hospital counselors receive limited MSM sensitivity training.

HIV/AIDS knowledge
HIV/AIDS education materials are available throughout the country, especially on the Internet, and knowledge of condom use is quite good among the literate. FHI pioneered the use of materials that used MSM slang, but found them ineffective. Poor, "street" MSM are often missed by outreach, as are those who are extremely secretive about their sexuality, in both cases because they are not involved in MSM community institutions such as drop-in centers and hotlines. MSM in general lack knowledge about how to negotiate safer sex. One informant stated that seroprevalence rates among MSM continue to climb, and those who test positive are getting younger. Our informants rated availability of MSM prevention information and education as quite low, but steadily improving. They emphasized the need for community mobilization and capacity building.

JAPAN

Population
127,463,611 (July 2006 est.)[200]

Languages
Japanese[200]

Religions
Observe both Shinto and Buddhist 84%, other 16% (including Christian 0.7%)[200]

Ethnic groups
Japanese 99%, others 1% (Korean 511,262; Chinese 244,241; Brazilian 182,232; Filipino 89,851; other 237,914)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 99%; Male: 99%; Female: 99% (2002)[200]

Form of government
Constitutional monarchy with a parliamentary government[200]

Adult population HIV prevalence
Less than 0.1% (2003 est.)[1]

People living with HIV/AIDS
12,000 (2003 est.)[1]

MSM HIV prevalence
In 2002, 4.4% in Tokyo and 1.3% in Osaka.[134] Our informant said he had seen a 64% increase in new HIV infections.[92]

Legal status of male-male sexual activity
Legal[195]

MSM quantitative and qualitative findings[92]

Social support
Many MSM in Japan identify themselves as gay or transgender, although those in rural areas are more likely to identify as heterosexual and have less support. Urban MSM have organizations and clubs, athletic groups and bathhouses. The government's only support for the community is in funding research.

HIV/AIDS knowledge
According to our informant, recent research has shown very high rates of understanding of HIV/AIDS transmission among MSM. There is more limited knowledge of STIs, but hotlines provide information. There is little outreach to the more hard-to-reach subgroups, such as youth; our informant identified a major increase among teenagers (14–15 and up) using the Internet to meet for sex. Because these youth do not have access to the most common gay venues, such as bars and clubs, they are often overlooked in HIV prevention efforts.

HIV testing and treatment
In urban areas, MSM-sensitive testing services are available, and healthcare providers are more likely to have been trained about male-male sexual behaviors; rural MSM are more lacking in access and sometimes risk exposure by using VCT services. On the other hand, healthcare workers in rural areas are more ignorant of male-male sex and less likely to ask. The approximately 1% of MSM in Japan that are foreigners often lack HIV prevention information because written materials are available only in Japanese.

Condom use
Condoms are widely available for sale in convenience stores and drug stores. In urban areas, some gay venues offer free condoms. Lubricant is more difficult to find; it is usually sold in sex shops, which are not easy to find and carry the risk of embarrassment and possibly being outed. Alcohol, poppers and crystal methamphetamine are also used by significant numbers of MSM and carry the risk of increasing unsafe sexual behaviors due to disinhibition.

LAOS

Population
6,368,481 (July 2006 est.)[200]

Languages
Lao (official), French, English, and various ethnic languages[200]

Religions
Buddhist 60%, animist and other 40% (including various Christian denominations 1.5%)[200]

Ethnic groups
Lao Loum (lowland) 68%, Lao Theung (upland) 22%, Lao Soung (highland) including the Hmong and the Yao 9%, ethnic Vietnamese/Chinese 1%[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 66.4%; Male: 77.4%; Female: 55.5% (2002)[200]

Form of government
Communist state[200]

Adult population HIV prevalence
0.1% (2003 est.)[1]

People living with HIV/AIDS
1,700 (2003 est.)[1]

MSM HIV prevalence
Unknown

Legal status of male-male sexual activity
Legal, although societal discrimination persists.[2]

MSM quantitative and qualitative findings[36]

Laos has low HIV prevalence but is surrounded by higher prevalence countries. The communist government restricts community organizing, making NGO programming more difficult.

Social support
Families are more accepting of MSM in Laos than in most other countries nearby and do not typically reject them. Some gay bars exist in the capital city of Vientiane. Our informant noted that male-male sex is increasing among young men.

HIV/AIDS knowledge
Sex education is poor throughout the country. In general, knowledge regarding HIV transmission is very low, even among those with some disease awareness. There is even less knowledge of STIs. Because literacy rates are so low, there are some audio-visual aids in tribal languages (Kumin and Hmong). There are a limited number of TV ads, posters and leaflets, but much more radio. PSI does outreach with peer educators, but mostly only for transgendered MSM. Some HIV/AIDS prevention information is becoming available for other MSM, but rollout is limited by resources, and availability overall is quite low.

HIV testing and treatment
VCT is only available at key hospitals in three cities; provincial hospitals are supposed to offer it but sometimes do not, and it is never MSM-sensitive. Risks of being "outed" are low, though, as confidentiality is strictly maintained. There is very little free or affordable access to ARV treatment.

Condom use
Condoms and non-oil-based lubricants are available, but there is a shortage in the country, causing even outreach programs to run out of supplies quite often. Condoms and lubricant are also sold in some pharmacies and beauty parlors in a social marketing campaign done by PSI. The level of knowledge among MSM about proper condom use is thought to be very low. Substance use among MSM is limited mostly to alcohol, although there have been recent reports of crystal methamphetamine use.

Male sex workers
There is very little organized sex work, male or female. Although commercial sex work is increasing, very few HIV prevention services target male sex workers.

Next steps
One of our informants, Dr. Niramonh Chanlivong, identified the most pressing needs as extending HIV/AIDS and STI education to rural areas, specifically via peer counselors. Dr. Chanlivong noted that VCT and STI clinics should be made more available for both MSM and the general population. She also felt more research would be needed to convince the public sector of the need for this outreach and to demonstrate that MSM are a "most at-risk population." She estimated that US$50,000 or less is currently being spent annually on MSM activities in Laos.

MALAYSIA

Population
24,385,858 (July 2006 est.)[200]

Languages
Bahasa Melayu (official), English, Chinese (Cantonese, Mandarin, Hokkien, Hakka, Hainan, Foochow), Tamil, Telugu, Malayalam, Panjabi, Thai. *Note:* in East Malaysia, several indigenous languages are spoken; the most common are Iban and Kadazan.[200]

Religions
Muslim, Buddhist, Daoist, Hindu, Christian, Sikh. *Note*: in addition, Shamanism is practiced in East Malaysia.[200]

Ethnic groups
Malay 50.4%, Chinese 23.7%, indigenous 11%, Indian 7.1%, others 7.8% (2004 est.)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 88.7%; Male: 92%; Female: 85.4% (2002)[200]

Form of government
Constitutional monarchy. Malaysia is nominally headed by a paramount ruler and a bicameral Parliament consisting of a nonelected upper house and an elected lower house; however, all but two peninsular Malaysian states have hereditary rulers.[200]

Adult population HIV prevalence
0.4% (2003 est.)[1]

People living with HIV/AIDS
52,000 (2003 est.)[1]

MSM HIV prevalence
0.76%.[46] Although mandatory HIV reporting includes information about method of transmission, considerable social pressures to be heterosexual probably result in major under-reporting of how many HIV-positive men are also MSM.[174]

Legal status of male-male sexual activity
Illegal.[195] Sodomy charges are usually only pursued in cases of underage sexual activity,[174] although they were used for what most perceived as a political persecution of deputy prime minister and PM heir apparent Anwar Ibrahim in 1999.[82]

MSM quantitative and qualitative findings[137,174]

Social support
As evidenced by the Ibrahim trial (see "Legal status"), male-male sexual activity is so taboo as to trump all other social considerations. There is considerable pressure to keep male-male sex hidden. A few NGOs work to provide support for this community, but many MSM are afraid to take advantage of established MSM services, and instead seek social support in private online "clubs." Families will not throw MSM out of their homes, but may threaten to do so or otherwise engage in emotional blackmail, pushing MSM to seek medical or religious intervention to change. Often, MSM will marry to escape or avoid these pressures.

HIV/AIDS knowledge
International funders pulled out of Malaysia in 2002–2003 because it was by then considered a "developed" country. But because MSM lack the developed social networks of Western countries, NGOs working with MSM have been forced to cut back their services considerably. While HIV/AIDS education for MSM was already quite limited, it has now become almost non-existent. Younger MSM who became sexually active after the funding cuts have exhibited the poorest use of condoms. More materials and outreach workers are needed. There are a few outreach programs in place for transgendered MSM, but these only target sex workers on the street.

Condom use
Condoms are readily available in pharmacies and supermarkets for about 45¢ apiece (which is not prohibitive). Men are often embarrassed to buy them, and condoms are not available in clubs and saunas—the places where MSM are having sex—because police will use them as evidence of illegal activity if they are found during raids. Condom use is relatively low, but higher among married men engaging in male-male sex. Lubricants are available but expensive and not widely used. Ecstasy and crystal methamphetamine use have reportedly increased in clubs.

Sex work
Male sex work in Malaysia is uncommon and mostly happens in male massage parlors.

HIV testing and treatment
HIV testing is widely available at low or no cost, but is not MSM-sensitive. Counselors do not ask about male-male sexual activity, but neither would most MSM reveal this information if asked. Overwhelmingly MSM-friendly doctors in the country work in private clinics, and thus treatment sensitive to MSM health issues is almost solely available to men of means. ARV treatment, however, is available and heavily subsidized through government programs.

Next steps
The PT Foundation (formerly PinkTriangle) has identified a rapid recent increase in STIs, including gonorrhea, syphilis, and HIV, as well as increases in recreational drug use and the number of saunas and massage parlors, but with no concurrent increase in educational efforts. Prevention efforts must be stepped up, although this is difficult to implement given the penal code. Educating MSM about sex is tantamount to abetting a crime. However, almost any effort would be an improvement: one of our informants estimated that the total funding currently available for MSM-related services is US$25,000 annually.

MYANMAR

Population
47,382,633 (July 2006 est.)[200]

Languages
Burmese; minority ethnic groups have their own languages[200]

Religions
Buddhist 89%, Christian 4% (Baptist 3%, Roman Catholic 1%), Muslim 4%, animist 1%, other 2%[200]

Ethnic groups
Burman 68%, Shan 9%, Karen 7%, Rakhine 4%, Chinese 3%, Indian 2%, Mon 2%, other 5%[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 85.3%; Male: 89.2%; Female: 81.4% (2002)[200]

Form of government
Military junta[200]

Adult population HIV prevalence
1.2% (2003 est.)[1]; other estimates range as high as 3.4%[16]

People living with HIV/AIDS
330,000 (2003 est.)[1] or approximately double that[16]

MSM HIV prevalence
Unknown

Legal status of male-male sexual activity
Illegal. Male homosexual relations are illegal per the penal code of 1882-1888.[195]

MSM quantitative and qualitative findings[37,154]

Government
Any evaluation of the rights of a minority group in Myanmar (formerly known as Burma, and still referred to as such by the US government and many expatriates) must be prefaced by the observation that it is ruled by an illegitimate military junta. Much of the country is extremely poor, and human rights are thought to be violated routinely. Many organizations doing MSM work insist on anonymity. Consequently little research has been done to date on MSM and HIV risk. Our informants pleaded for more attention from the international community.

Social support
MSM meet for sex in the usual public places, but rely heavily on beauty salons as social gathering places, and tend to congregate around *nagagodols*, or culturally accepted spiritual advisors, who are always MSM. Families are emotionally supportive only if the men support the household economically. NGOs are beginning to implement services for MSM, including PSI-run drop-in centers staffed entirely by MSM; there are no CBOs at present.

HIV/AIDS knowledge
Educational programs to date have focused on MSM in Yangon (formerly anglicized as Rangoon) and Mandalay, the two largest cities in Myanmar. As a result, MSM in these cities have fairly good knowledge about transmission and prevention, but MSM in other cities and rural areas are still in the dark; traditional spiritual and herbal beliefs—and misconceptions—abound. Bisexual men are particularly difficult to reach, as they routinely refuse offers of MSM services.

Condom use
PSI-Myanmar has done social marketing for condoms and lubricant throughout Myanmar, and recently added the female condom as an alternative for anal sex. Condoms are sold cheaply and widely; lubricant is available through PSI but the 10¢ per bottle price is not cheap for most Burmese. Rates of condom use are tied to education, and thus are much higher in the main cities than elsewhere. Many MSM are sexually active with women also, but are much more likely to use condoms with their male partners because anal sex is considered dirty. Drug use is quite low, but masculine MSM often drink strong alcohol, leading to disinhibited behavior; drinking is considered unladylike among more feminine MSM.

HIV testing and treatment
A national network of over 1,000 private doctors in Sun Quality Health Clinics have been trained by PSI in STI services, including MSM issues. HIV testing is available in the cities for free, but virtually inaccessible in rural areas. The Global Fund withdrew its funding this year, so VCT may cease to be available even in cities. ARVs are available for free only in a few places, and are otherwise prohibitively expensive for most Burmese.

Male sex workers
Most contractual sex in Myanmar is based around gifts of cash, food, or material goods, rather than formal sex work. Little is known about the habits of male sex workers other than that most are desperately poor.

NEPAL

Population
28,287,147 (July 2006 est.)[200]

Languages
Nepali 47.8%, Maithali 12.1%, Bhojpuri 7.4%, Tharu (Dagaura/Rana) 5.8%, Tamang 5.1%, Newar 3.6%, Magar 3.3%, Awadhi 2.4%, other 10%, unspecified 2.5% (2001 census)[200]

Religions
Hindu 80.6%, Buddhist 10.7%, Muslim 4.2%, Kirant 3.6%, other 0.9% (2001 census)[200]

Ethnic groups
Chhettri 15.5%, Brahman-Hill 12.5%, Magar 7%, Tharu 6.6%, Tamang 5.5%, Newar 5.4%, Muslim 4.2%, Kami 3.9%, Yadav 3.9%, other 32.7%, unspecified 2.8% (2001 census)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 48.6%; Male: 62.7%; Female: 34.9% (2000–2004 est.)[200]

Form of government
Parliamentary democracy and constitutional monarchy (CIA 2006)[200]

Adult population HIV prevalence
0.5% (2001 est.)[1]

People living with HIV/AIDS
61,000 (2001 est.)[1]

MSM HIV prevalence
In Kathmandu, 4% among MSM and 5% among male sex workers[145]

Legal status of male-male sexual activity
Illegal in Nepal,[195] although our informant reported, "The law is unclear regarding male-male sexual activity. The police and army typically arrest, blackmail, and charge MSM with public nuisance."

MSM quantitative and qualitative findings[144]

Social support
The Blue Diamond Society (BDS) is Nepal's only organization for sexual minorities. BDS was founded in 2001 and offers community-based sexual health, HIV/AIDS, and advocacy services for local networks of sexual minorities. Families typically reject members who are discovered to be MSM, especially if they are effeminate. MSM have been utilizing BDS's legal service very much as the violence against the more obvious (effeminate) MSM in Nepal is widespread. They also turn to BDS for emotional support.

HIV/AIDS knowledge
Many MSM turn to BDS for HIV-related training, education, condom distribution, care and support services, despite limited geographic coverage. However, BDS's HIV/AIDS prevention information is not available to diverse groups of MSM, nor is it tailored to sub-groups. With regard to HIV transmission, the knowledge gap is huge because of gaps in service coverage. HIV/AIDS prevention information is available in the local language, Nepali, but no MSM-specific prevention information (TV, radio, or graphics) is allowed. Information is especially limited for masculine MSM; they don't consider themselves a vulnerable group and so don't access HIV information.

Condom use
Condoms are available in pharmacies and many other shops, although many MSM don't use them. Water-based lubricant is generally not available: BDS distributed lubricant with support from PSI/Nepal, but only in Kathmandu, and the program was shut down in May 2006 by PSI. BDS also distributes condoms through peer and outreach educators at cruising sites. MSM report having sex with females very often, although there are higher levels of unprotected sex in these relationships because MSM find it difficult to explain condom use to their wives. MSM report high levels of alcohol use, especially a homemade brew called *raksi*, which is very strong; marijuana and hashish are also smoked. Injection drug use is not usually found among effeminate MSM but is not uncommon among masculine MSM. Harm reduction programs are very limited.

HIV testing and treatment
HIV testing is only available in a few city areas, and the services are usually not MSM-sensitive. Many masculine MSM and wealthy MSM do not access HIV-related services because they don't think they are at risk. No STI clinics for MSM exist in Nepal, but BDS is in the process of extending its existing program in Kathmandu to seven cities and will have STI clinical services in those areas. As a rule, MSM do not have access to MSM-sensitive health care services, which is especially problematic because STI rates are increasing sharply. Healthcare professionals typically do not ask clients/patients about male-male sex because it is a taboo subject; if MSM disclosed their sexual preference, their doctors would typically not treat them well. Effeminate MSM are the most discriminated against by healthcare providers and thus don't access healthcare services. ARV treatment is free only for a very limited number of people and very few MSM have access to such medications.

Sex work
Data are not available but it is believed that there are many male sex workers. Many effeminate MSM are engaged in sex work because of societal exclusion.

Next steps
Our informant, Mr. Sunil Babu Pant, Director of the Blue Diamond Society, identified the most pressing needs for MSM in Nepal as increased geographic coverage and expansion of current programs such as STI clinical services, increased distribution of free condoms and water-based lubricant, more care and support, VCT, ARVs, AIDS treatment and care, as well as addressing violence.

NORTH KOREA

Population
23,113,019 (July 2006 est.)[200]

Languages
Korean[200]

Religions
Traditionally Buddhist and Confucianist, some Christian and syncretic Chondogyo (Religion of the Heavenly Way). *Note:* autonomous religious activities are now almost nonexistent.[200]

Ethnic groups
Homogeneous; there is a small Chinese community and a few ethnic Japanese[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 99%; Male: 99%; Female: 99%[200]

Form of government
Communist state; dictatorship[200]

Adult population HIV prevalence
Unknown–government denies there are any HIV cases in North Korea[49]

People living with HIV/AIDS
Unknown

MSM HIV prevalence
Unknown

Legal status of male-male sexual activity
Unknown

MSM quantitative and qualitative findings

Because the government of North Korea does not allow information or people to flow in or out of the country, and because official data on most subjects are thought to be semi-accurate propaganda at best, virtually nothing is known about either MSM or HIV/AIDS in North Korea.

PAKISTAN

Population
165,803,560 (July 2006 est.)[200]

Languages
Punjabi 48%, Sindhi 12%, Siraiki (a Punjabi variant) 10%, Pashtu 8%, Urdu (official) 8%, Balochi 3%, Hindko 2%, Brahui 1%, English, Burushaski, and other 8%[200]

Religions
Muslim 97% (Sunni 77%, Shi'a 20%), Christian, Hindu, and other 3%[200]

Ethnic groups
Punjabi, Sindhi, Pashtun (Pathan), Baloch, Muhajir (immigrants from India at the time of partition and their descendants)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 48.7%; Male: 61.7%; Female: 35.2% (2004 est.)[200]

Form of government
Federal republic[200]

Adult population HIV prevalence
0.1% (2003 est.)[1]

People living with HIV/AIDS
74,000 (2003 est.)[1]

MSM HIV prevalence
Unknown

Legal status of male-male sexual activity
Illegal[195]

MSM quantitative and qualitative findings[11,104,138,163]

Social support
Families are sporadically supportive of MSM, often expecting them to marry despite their sexual orientation or at least to keep it hidden. Male-male sex is condemned by both civil and religious laws, but a few NGOs/CBOs exist that support MSM.

HIV/AIDS knowledge
MSM in Pakistan are quite ignorant of HIV transmission and prevention, and of other STIs. Some HIV/AIDS prevention materials are available for the general public, but only in Urdu and written in inaccessible language. The infrastructure needed to distribute these materials does not exist, and by government policy it is forbidden to discuss sexual transmission; in any case many MSM (like so many Pakistanis) are illiterate. This gap is only partially addressed by local NGOs through street theater performance.

Condom use
Many Pakistanis, including MSM, do not use condoms. Condoms are available as family planning tools, but are so unpopular that they are sometimes given to children to blow up as balloons. There is no discussion of their use for HIV/STI prevention. Many MSM are also sexually active with women, and are even less likely to use condoms with their female partners. This lack of use is especially true of male sex workers, whose clients will assume they are "sick" if they insist on condoms. Lubricants are simply not available, although some MSM make do with spit, oils, and soaps.

Drug use
Although Pakistan is a Muslim country, alcohol—as well as marijuana, hashish, and injection drugs—is used by some MSM. Also, in certain areas MSM inject steroids in their faces to develop more feminine cheeks and in their chests to develop breasts; sometimes they inject air for temporary inflation. There are very few harm reduction or needle exchange programs. MSM also share threads made of horse's tails (to clean anal warts), and water tubes (for anal douching).

HIV testing and treatment
HIV testing is available in Islamabad, and selectively in other places, but is underutilized. It is rarely MSM-sensitive, and is often offered without any counseling at all. Doctors do not ask their patients about male-male sex, because it is taboo: for instance, even though genital thrush (yeast infection) is common among MSM and uncommon among HIV-negative men, doctors will typically treat the disease and not inquire further. Free ARVs are available, but only in limited quantities. Patients identified as HIV-positive are often thrown out of hospitals, and consequently there is a widespread fear of becoming stigmatized as a result of seeking treatment.

Sex work
Male-male sex may start as young as age seven, and child abuse/exploitation is common. More often than not, some sort of fiscal transaction is involved, and pre-pubescent male sex workers are much sought after. One informant estimated that there are 50,000 male sex workers in Pakistan at present. They turn a brisk business, seeing anywhere from 5 to 25 clients a day, especially in their youngest working years. Very few HIV services exist for male sex workers.

PAPUA NEW GUINEA

Population
5,670,544 (July 2006 est.)[200]

Languages
Melanesian Pidgin is the lingua franca, English spoken by 1%–2%, Motu spoken in Papua region. *Note:* there are 715 indigenous languages—many unrelated.[200]

Religions
Indigenous beliefs 34%, Roman Catholic 22%, Lutheran 16%, Presbyterian/Methodist/London Missionary Society 8%, Anglican 5%, Evangelical Alliance 4%, Seventh-Day Adventist 1%, other Protestant 10%[200]

Ethnic groups
Melanesian, Papuan, Negrito, Micronesian, Polynesian[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 64.6%; Male: 71.1%; Female: 57.7% (2002)[200]

Form of government
Constitutional monarchy[200]

Adult population HIV prevalence
0.6% (2003 est.)[1]

People living with HIV/AIDS
16,000 (2003 est.)[1]

MSM HIV prevalence
Unknown

Legal status of male-male sexual activity
Illegal[195]

MSM quantitative and qualitative findings[72]

Social support
Most MSM in Papua New Guinea (PNG) do not identify as MSM or as gay, and those who wish to be openly gay struggle to define themselves in a positive light. According to our informant, "Over 800 languages and 3,000 dialects are spoken in PNG. There are almost as many distinct codes of sexual behavior and belief systems, so it's ridiculous to say there are no positive perceptions of homosexuality; this is not historically or currently true," although it is the popular perception. Several Melanesian cultures include ritualized homosexual practices, but male-male sex was criminalized when the country became an Australian colony and in many places has come to be seen as a foreign practice. Because of the tribal diversity in the country, especially in rural areas, it is difficult to generalize further about social perceptions. Save the Children (STC) and Hope Worldwide are both attempting to set up support services for MSM, but are forced to do much of this work underground because of social stigma surrounding identity politics. The sex act itself is of less concern to most PNGians. MSM are often rejected by their families, but stand a better chance of familial tolerance if they are already married (and plan to stay that way).

HIV/AIDS knowledge
There is very little knowledge of anal or oral sex as risk behaviors. Most HIV educational materials only refer to vaginal sex, and are only available in a few languages. Illiteracy is high, although some information is available via radio and a few graphic heterosexual posters. The broad variety of cultures in the country makes these easy to minsinterpret. Understanding of proper condom storage and use is quite low, and breakages are high. Only STC-PNG is working with MSM around HIV issues; many in-country NGOs providing HIV services are Christian and present material with a homophobic bias.

Condom use
STC distributes free condoms and lubricant, as do some other NGOs, but the quantity is quite low. Condoms are also available for sale in towns, but access is virtually nonexistent in rural areas. Most male-male sex is unprotected, and most MSM also have sex with women.

HIV testing and treatment
Sexuality and STIs are an area of shame, and until STIs are quite advanced, most PNGians try to ignore them hoping they will go away. HIV testing and ARVs are not widely available, and the only place to access MSM-sensitive testing is, again, STC. Many PNGians are afraid to access any HIV services as being infected with the virus carries social stigma.

Sex work
Exchange of goods and favors is an integral part of PNG culture, including in sexual relationships. "Payment" will often consist of a couple of drinks or something similar, but formal, income-producing sex work is uncommon.

PHILIPPINES

Population
89,468,677 (July 2006 est.)[200]

Languages
Filipino (based on Tagalog) and English are official; eight major dialects are Tagalog, Cebuano, Ilocano, Hiligaynon or Ilonggo, Bicol, Waray, Pampango, Pangasinan[200]

Religions
Roman Catholic 80.9%, Evangelical 2.8%, Iglesia ni Kristo 2.3%, Aglipayan 2%, other Christian 4.5%, Muslim 5%, other 1.8%, unspecified 0.6%, none 0.1% (2000 census)[200]

Ethnic groups
Tagalog 28.1%, Cebuano 13.1%, Ilocano 9%, Bisaya/Binisaya 7.6%, Hiligaynon Ilonggo 7.5%, Bikol 6%, Waray 3.4%, other 25.3% (2000 census)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 92.6%; Male: 92.5%; Female: 92.7% (2002)[200]

Form of government
Republic[200]

Adult population HIV prevalence
< 0.1% (2003 est.)[1]

People living with HIV/AIDS
9,000 (2003 est.)[1]

MSM HIV prevalence
<1% (2003 est.)[125]

Legal status of male-male sexual activity
Legal[195]

MSM quantitative and qualitative findings[53,159]

Social support
Although MSM in the Philipppines are as creative as those in other countries about finding venues to meet each other—they even utilize chat TV on cable—the Internet has opened up a new portal for encounters: 41% of MSM in the Philippines say they meet partners online. NGOs and CBOs provide support services for MSM, and local governments are beginning to open "safe spaces," although these are considered suspect and are underutilized. Other non-specific venues (such as hair dressers' associations) are known to be populated by and friendly to MSM. One informant noted a recent increase in group sex parties.

Transgenders and MSM who try to keep their sexuality well hidden are highly unlikely to use formal MSM services. Families tend to reject MSM unless they are economically dependent on them. Male-male sex sometimes starts as early as age 8 or 10, and the median age is steadily decreasing.

HIV/AIDS knowledge
Many Filipinos are confused about HIV transmission; for instance, they think the virus can be transmitted through saliva or through mosquito bites. There is even less understanding of transmission of STIs. There is some outreach to MSM through counseling, hotlines, and drop-in centers. Work groups (trade associations and unions) are ingrained in Filipino culture, and many men receive HIV prevention information through these venues. Rural and low-income MSM are the most difficult to reach.

Condom use
MSM are aware that they should use condoms, and can purchase them widely for 20¢ or more apiece; this is somewhat difficult for the poor. Alcohol and drug use are not uncommon and lead to increased risky behavior; some inject nubain, a narcotic, but harm reduction programs are limited and underground. Many MSM are also sexually active with females, and are more likely to use condoms with the committed partner, male or female. K-Y jelly is also available for sale but no other lubricant.

Sex work
There are currently no support programs for male sex workers (those that did exist have closed). Male sex workers are often harassed by the police on grounds of vagrancy, which drives them underground and makes outreach more difficult. Clients of male sex workers are both male and female.

HIV testing and treatment
VCT availability is limited to hospitals and a few clinics, and testing sites are found only through word of mouth or referrals. Services are costly and not MSM-sensitive, and a further deterrent is that MSM who keep their sexuality hidden risk exposure by getting tested; the result is that only 11% of MSM report having been tested for HIV. Healthcare workers do not receive any training about male-male sex, and do not ask about it because they simply don't know it exists. It is even more difficult for transgendered MSM to access healthcare due to stigma and discrimination.

SINGAPORE

Population
4,492,150 (July 2006 est.)[200]

Languages
Mandarin 35%, English 23%, Malay 14.1%, Hokkien 11.4%, Cantonese 5.7%, Teochew 4.9%, Tamil 3.2%, other Chinese dialects 1.8%, other 0.9% (2000 census)[200]

Religions
Buddhist 42.5%, Muslim 14.9%, Taoist 8.5%, Hindu 4%, Catholic 4.8%, other Christian 9.8%, other 0.7%, none 14.8% (2000 census)[200]

Ethnic groups
Chinese 76.8%, Malay 13.9%, Indian 7.9%, other 1.4% (2000 census)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 92.5%; Male: 96.6%; Female: 88.6% (2002)[200]

Form of government
Parliamentary republic[200]

Adult population HIV prevalence
0.2% (2003 est.)[1]

People living with HIV/AIDS
4,100 (2003 est.)[1]

MSM HIV prevalence
In the first half of 2004, 22% of new cases were reported to be caused by male-male sexual activity.[80] Cutter et al.[50] believe such numbers are underestimated, due to stigma and discrimination, which cause MSM to make false reports about modes of transmission.

Legal status of male-male sexual activity
Illegal, although the laws are generally used only to prosecute non-consensual acts or male-male sex in public places.[195]

MSM quantitative and qualitative findings[20,71]

Social support
Singapore is relatively ethnically diverse, but most groups are united in their disdain for MSM, especially for those who appear effeminate. Families tend not to reject MSM, but because often they are unable to accept their sexuality it becomes a taboo subject. Exposure of MSM on the front page of the national newspaper used to be common, but more recently the government has become more supportive of MSM. This is part of a push to retain and attract more creative talent in Singapore. As a result of this change, numerous gay clubs have opened and now flourish.

HIV/AIDS knowledge
Action for AIDS (AFA) provides educational materials in Chinese, Malay, and, mostly, English (an almost universal second language). It performs outreach in saunas, which are popular sexual meeting places, and more formal venues; for those who seek privacy, these materials are also available over the Internet. AFA has found that individuals with more overall education are more open to learning about HIV/AIDS; the younger generation is also more accessible to

outreach work. MSM who identify as heterosexual are often unwilling to accept that they are at risk or to learn about the risks of male-male sex. The sub-population most lacking information is migrants, many of whom are uneducated laborers, usually Chinese, Bangladeshis, and Malaysians. Their communities tend to be insular, especially the construction workers, and while some of them are MSM they do not usually identify as gay.

Condom use
Condoms and lubricants are widely available for sale, and are provided free in some bathhouses and saunas. MSM report high levels of condom use, especially outside of committed relationships. Lubricants are also widely used, although some make do instead with saliva or shower gel. More than three quarters of MSM have never had sex with women; those who have are often closeted, sometimes married, and rarely use condoms with their wives. Drug use, while uncommon, is deep underground due to particularly harsh anti-drug laws (punishment can be as extreme as execution).

HIV testing and treatment
VCT is widely available, anonymous or confidential—although this confidentiality is sometimes not respected, particularly in reference to partner notification. There is a name reporting system in place, and aliens who test positive are asked to leave the country. Some of the anonymous test sites are run by MSM-sensitive NGOs, but at other sites doctors will not ask about male-male sexual activity. Many men are concerned that testing positive for HIV will label them MSM, and thus do not seek services.

ARVs are widely available, but most Singaporeans have to pay, and the drugs are expensive; AFA raises funds to provide some subsidized drugs. Some PLWHAs will seek ARVs in Thailand, where they are considerably cheaper.

Sex work
Sex work is common in massage parlors, but less so in other contexts (female sex workers are found in licensed brothels, and have very high rates of condom use). Little outreach has been done for male sex workers, except limited efforts to reach street-based transgendered sex workers.

Next steps
Our informants identified the most pressing needs in Singapore as outreach to migrant and transgendered MSM, and continuing emphasis on condom use among all MSM.

SOUTH KOREA

Population
48,846,823 (July 2006 est.)[200]

Languages
Korean, English widely taught in junior high and high school[200]

Religions
No affiliation 46%, Christian 26%, Buddhist 26%, Confucianist 1%, other 1%[200]

Ethnic groups
Homogeneous (except for about 20,000 Chinese)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 97.9%; Male: 99.2%; Female: 96.6% (2002)[200]

Form of government
Republic[200]

Adult population HIV prevalence
< 0.1% (2003 est.)[1]

People living with HIV/AIDS
Estimates vary, from 2,962 in 2005[201] to 8,300 in 2003.[1]

MSM HIV prevalence
As of 2005, 35.8% of HIV cases were due to male-male sex[201]

Legal status of male-male sexual activity
Legal[195]

MSM quantitative and qualitative findings

We are aware of one relevant organization, Ivan Stop HIV/AIDS Project ("Ivan" meaning gay men), which is funded by the Ministry of Health, but could not secure an interview with anyone there, due in part to language barriers. In fact, we were unable to secure an interview with anyone appropriate in South Korea, although we did receive some information on the MSM community from an expatriate South Korean gay activist and PLWHA researcher. Several Korean language websites exist.

Social support
The few GLBT organizations in South Korea are relatively new. Sexuality in general has been a taboo subject until quite recently, but paradoxically, this has allowed many gay and lesbian couples to live together as unquestioned "roommates."[66] South Korea is, to date, the only Asian country to pass a law forbidding discrimination on the grounds of sexual orientation.[201]

Condom use
A 2003 survey of the general population found that only 12% use condoms. The Korean CDC has launched efforts to encourage condom use, and seroprevalence rates remain among the lowest globally. Legal aliens are required to be tested for HIV, and those who test positive must either leave the country voluntarily or face deportation.[3]

HIV/AIDS knowledge
Students are taught about safer sex, starting in middle school, and are encouraged to be abstinent.[35]

SRI LANKA

Population
20,222,240 (July 2006 est.)[200]

Languages
Sinhala (official and national language) 74%, Tamil (national language) 18%, other 8%. Note: English is commonly used in government and is spoken competently by about 10% of the population[200]

Religions
Buddhist 69.1%, Muslim 7.6%, Hindu 7.1%, Christian 6.2%, unspecified 10% (2001 census provisional data)[200]

Ethnic groups
Sinhalese 73.8%, Sri Lankan Moors 7.2%, Indian Tamil 4.6%, Sri Lankan Tamil 3.9%, other 0.5%, unspecified 10% (2001 census provisional data)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 92.3%; Male: 94.8%; Female: 90% (2003 est.)[200]

Form of government
Republic[200]

Adult population HIV prevalence
< 0.1% (2003 est.)[1]

People living with HIV/AIDS
3,500 (2003 est.)[1]

MSM HIV prevalence
The Ministry of Health has made inquiries about MSM but country-wide surveys have not been done and statistics are not available. 13% of known HIV cases are attributed to male-male sex, but calculations used to arrive at this figure are unknown.[54]

Legal status of male-male sexual activity
Illegal. The Sri Lankan gay group Companions on a Journey (COJ) has pushed for repeal of laws banning gay sex and for sensitivity training for police. According to COJ founder Sherman De Rose, "The Companions' office is routinely searched and group members are verbally and physically harassed by cops."[195]

MSM quantitative and qualitative findings[54]

Social support
MSM are struggling with the issue of their identity. Sri Lanka has a very homo-social environment: sleeping in the same bed with another man is not considered an issue. However, families very rarely support men identified as MSM, because the religion condemns homosexuality and the law considers it a criminal offense. MSM are often thrown out of their homes and disowned, and the response is even worse for women. Violence is more common from the general public than families. Sri Lanka has one of the highest levels of suicide in the world, and a large number of these are gay people.[54] Our informant stated, "On World AIDS Day, the Minister said that homosexuality is an 'unnatural thing.' We ask that the MSM community be recognized." COJ currently provides support on issues of sexual identity and low self-esteem, and is also concerned about HIV/AIDS issues. The group runs three drop-in centers/safe spaces, has an outreach and condom promotion program, and does work on legal issues.

HIV/AIDS knowledge
In 2002, UNAIDS surveyed 1,000 Sri Lankans and 79% of them had no knowledge of or information on STIs, let alone HIV/AIDS. MSM are uncomfortable being linked with HIV, fearing double discrimination (for being MSM and potentially HIV-positive); thus, they are reluctant to discuss the issue. As a result, sexual health among MSM has not gotten the attention it deserves.

There is very little written information on HIV/AIDS prevention for MSM. Providing any kind of social support for MSM is very difficult, as male-male sex is illegal. Overall availability of MSM prevention information, supplies, and education services in Sri Lanka is very limited. The National AIDS Control Organization receives considerable funding to combat HIV and AIDS, but has not targeted MSM as an important vulnerable group.

Condom use
Men report engaging in unprotected anal sex with high numbers of partners, but most are reluctant to speak about their sexual behavior and are ignorant of proper condom usage. There are high levels of unprotected anal sex in prisons because condom distribution is not allowed. The Ministry of Health distributes 15,000 condoms to NGOs, including COJ, every three months, but condoms are expensive and are not available in many public venues where MSM meet for sex. Lubricants are not available at all. Many MSM report using very high levels of alcohol (Arrack, a local drink), as parties and bars are common meeting places.

HIV testing and treatment
HIV testing is available on a limited basis. Twenty-two government hospitals provide free VCT, but they are generally not MSM-sensitive and many Sri Lankans lack confidence in their services. Free ARVs have been available under the UNAIDS program since December 2005.

Sometimes medical staff divulge information on HIV status and, in some cases, those patients' houses have been burned. Patients being treated for AIDS and opportunistic infections are discriminated against by hospital staff and, sometimes, by doctors. Our informant said, "When gay people go to doctors for treatment, they are singled out; and if not the doctors, then the junior staff will ask them to sing, walk differently, etc., because that is how the public views gays. … The elite gays go to private hospitals where they are well taken care of due to their social status. There is a huge class and language issue."

In general, MSM do not have access to MSM-sensitive healthcare because the healthcare system does not officially recognize them. Our informant said, "MSM are reluctant to report STIs. Research shows that they do not tell the truth in healthcare centers due to harassment. Some healthcare professionals do ask clients/patients about male-male sexual activity. Female doctors tend to be more sympathetic. Some doctors were given training in a 1998 program, but there is widespread stigma and harassment in hospitals due to ignorance and lack of training. For example, in 1997, an HIV-positive person was beaten to death in a hospital by a drunken hospital attendant. Forensic people did not want to perform an autopsy for fear of HIV. Then the verdict was AIDS, though there were signs of injury in the chest."

Sex work
Commercial sex workers in Sri Lanka have high rates of STIs, which increase vulnerability to HIV. Many male sex workers are "beach boys," male children and adolescents who provide commercial sex services to mainly foreign, but increasingly local, pedophiles on Sri Lanka's beaches and in the main tourist areas. Beach boys often are not gay, but very poor, and they view sex work as the only way to get money to feed their families. They typically earn US$2-3 a day and rarely use condoms. No specific HIV/AIDS prevention or other related services targeting male sex workers can be found in Sri Lanka.

Next steps
According to our informant, the most pressing need is to increase knowledge and awareness of HIV/AIDS among MSM. He explained that family and religious pressures mean most MSM are afraid of coming out and being openly associated with an organization like COJ, which virtually eliminates their ability to access needed services.

TAIWAN

Population
23,036,087 (July 2006 est.)[200]

Languages
Mandarin Chinese (official), Taiwanese (Min), Hakka dialects[200]

Religions
Mixture of Buddhist, Confucian, and Taoist 93%, Christian 4.5%, other 2.5%[200]

Ethnic groups
Taiwanese (including Hakka) 84%, mainland Chinese 14%, aborigine 2%[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 96.1% (2003)[200]

Form of government
Multiparty democracy[200]

Adult population HIV prevalence
Greater than 0.02% (2003)[182]

People living with HIV/AIDS
4,310 (2003)[182]

MSM HIV prevalence
10% among MSM patronizing one gay bar in 1996,[108] and 8% in a 2004 survey of 8 gay bathhouses in 3 cities.[109] Also, 48.2% of HIV cases are due to male-male sex.[182]

Legal status of male-male sexual activity
Legal[195]

MSM quantitative and qualitative findings[110,114]

Social support
Gay people in their 30s or 40s generally don't disclose their sexual preference and most get married (and later divorced). Young people disclose to friends and then sometimes to members of their families, although only a minority come out to their parents. Parents pressure their sons to marry and have children.

Today, there are not a lot of gay bars in Taiwan; they became less popular due to the rise of home parties and exercise gyms, especially among older gay men who go to the gym to work out and cruise. MSM sex parties have been on the increase for the past 6-12 months. There are more than 30 gay bathhouses throughout Taiwan. There is also the "park culture": many gay men and MSM who do not identify as gay go to parks at night for both sex and socialization. There are a growing number of underground gay peer support groups that organize activities, such as basketball or swimming.

HIV/AIDS knowledge
Several NGOs currently provide specific services for people at risk for HIV. Some NGOs also provide care for PLWHAs. There are a handful of NGOs (reported to be only three) that provide services specifically for MSM. NGOs and gay activists distribute written information on HIV/AIDS prevention to gay communities through community outreach and the Taiwan Tongzhi Hotline. The hotline and its counterparts work with peer models to provide education, information, condoms, and HIV tests. Those who do not spend time in "gay" venues, including closeted MSM, seniors and youth, are more difficult to reach and often lack HIV prevention information. MSM who are involved in the gay community are well schooled in HIV prevention and condom use.

Condom use
Condoms are sometimes available at bathhouse entrances but not inside where people have sex. Many men also report using oil-based lubricants, which increase the risk of condom breakage, despite the fact that water-based lubricants are widely available.

Ecstasy and Ketamine are the most popular drugs, although some men also use amphetamines. Very few men report heavy alcohol use, but there is some substance use in gay bathhouses. Men report having lots of sex while on these drugs and do understand (or admit) that this behavior puts them at risk. Also, many MSM learn about sex from U.S. gay pornographic videos. Some gay videos from the U.S. now feature "bareback" sex (without condoms) and some men in Taiwan copy this behavior.

HIV testing
The Taiwan government has many anonymous and inexpensive HIV testing sites, although the emphasis is on testing rather than counseling. NGOs also provide these tests for free. Government test sites are located in hospitals, which some MSM don't like. There is also one city hospital in Taipei whose primary services are HIV testing and treatment for STIs. This is considered an open and welcoming setting for MSM, and many men are comfortable going there. Some testing sites also provide outreach in gay bars, and in Taipei they have provided anonymous HIV testing in gay saunas as well.

Sex work
Sex work is illegal, and thus generally underground. One of our informants reported that male sex workers may be educated men, university students, or soldiers. Men in these groups do sex work part-time to make extra money. Taiwan is very small so there isn't a country/urban dynamic such as in mainland China; country people

are not engaged in commercial sex work. Our other informant reported that she has male patients who are on call to have sex for money. They work at hotels or are called to visit clients. Many men, especially younger MSM, also use gay websites to find people online and then meet to have sex; some use these Internet sites to exchange sex for money. Our informant knew of no HIV prevention services in Taiwan targeting male sex workers.

HIV treatment
Taiwan does not have special healthcare services for MSM. More attention has been focused on IDUs recently, making MSM an even lower priority. The hospital system and NGO efforts are still very small. There are a limited number of doctors in Taiwan with expertise in HIV/AIDS care and they are generally very busy with many patients. There also are physicians who are themselves MSM or MSM-friendly. ARV therapy is free and accessible in Taiwan and confidentiality is respected, including respecting the mode of transmission. Medical personnel sometimes try to keep the diagnosis from the family, especially if negative repercussions are likely for the patient. Healthcare workers will sometimes do an assessment to see if the family is accepting of MSM. If not, they discuss this with patients and use alternate ways to disclose a diagnosis when necessary. Most MSM patients with HIV/AIDS ultimately decide to disclose their diagnosis but not their sexual orientation. One of our informants who does research on MSM and HIV/AIDS reported seeing more hepatitis B and C recently among MSM. She also said that the prevalence of drug resistance, especially to the NNRTI class of drugs, is much higher among MSM than other populations with HIV.

Next steps
According to our informants, high-risk behavior has moved into homes with the increase in sex parties, which have emerged as a major problem, especially when drugs are used. These activities are usually underground and the MSM who participate in them are harder to find and target with services. Other hard-to-reach MSM—including MSM of low socioeconomic status, male sex workers, and people who only use the Internet to find sexual partners—are very much in need of outreach and services. One of our informants said that advocacy is needed for greater acceptance of MSM, as well as untangling the association between HIV and MSM.

According to one informant, the Taiwan government is very conservative. It is aware that AIDS is a danger and that the epidemic will likely get worse but is unwilling to tell people what they need to know. The government says HIV is a worry only for people who are "high risk," but it won't tell MSM about constructive ways to reduce their risk, and it promotes abstinence strategies that don't work, sometimes overlooking condoms. Despite the country's wealth, the NGOs in Taiwan are poor and struggling. The Taiwan government gives little support and private donations aren't enough to meet the growing need.

THAILAND

Population
64,631,595 (July 2006 est.)[200]

Languages
Thai, English (secondary language of the elite), ethnic and regional dialects[200]

Religions
Buddhist 94.6%, Muslim 4.6%, Christian 0.7%, other 0.1% (2000 census)[200]

Ethnic groups
Thai 75%, Chinese 14%, other 11%[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 92.6%; Male: 94.9%; Female: 90.5% (2002)[200]

Form of government
Constitutional monarchy[200]

Adult population HIV prevalence
Less than 1.5% (2003 est.)[1]

People living with HIV/AIDS
570,000 (2003 est.)[1]

MSM HIV prevalence
28.3% (Bangkok)[74]

Legal status of male-male sexual activity
Legal,[195] although police may arrest MSM for being in a park with a condom or raid saunas that provide condoms.

MSM quantitative and qualitative findings[29,186]

Social support
In urban areas, MSM typically meet for social and sexual purposes at MSM businesses such as clubs/discos, karaoke bars and saunas. MSM also commonly meet in public toilets and public parks, although they will go elsewhere to have sex. One 2005 study identified more than 300 places in metropolitan Bangkok alone where MSM meet to look for or engage in sex. Some social support is available for MSM, but only in Bangkok and Chiang Mai—both have MSM drop-in centers operated by local CBOs. There are now drop-in centers for male sex workers and transgendered sex workers in Bangkok and Pattaya, respectively. In general, utilization of support services by MSM is very, very low and usually limited only to circles of friends who know someone who already attends or works there. Friends are important sources of support. Families are also important and for most MSM, family always comes first. Because families are so important, they generally do not completely reject MSM, except in non-urban or very poor families where they will be thrown out if they are not contributing financially. This is especially true for transgendered MSM who can't find regular work.

HIV/AIDS knowledge
HIV transmission is well understood but personal risk is not. MSM know about HIV prevention practices and tools (condoms and non-oil based lubricants), but still do not use them consistently. There is poor knowledge regarding other STIs and prevention practices. A lot of written information on HIV/AIDS prevention is available, including for MSM. Mass media campaigns were more common 5-10 years ago; there is one current MSM HIV campaign ("Sex Alert") underway targeted to MSM venues and websites, but it is very subtle.

Access to HIV prevention services for MSM is largely by word of mouth, although there is some advertising and limited promotion during outreach efforts. Information is available to diverse groups of

MSM and is tailored to subgroups. However, the hidden MSM population—which is thought to be much, much larger than any other group—is not being reached at all and has no access, since these men have no contact with these resources. Transgendered MSM have limited access to HIV/AIDS prevention information because of general reluctance to support or understand their issues.

HIV testing and treatment
HIV testing is widely available, including anonymous testing, although this is much more difficult to assure in small, village-based clinics and hospitals. Some HIV testing services are MSM-sensitive, but only in urban areas. Some MSM fear being exposed, which deters them from using such services.

Universal healthcare services are not well utilized by MSM, and there is little access to MSM-sensitive services outside of urban settings. One informant thought it unlikely that health care professionals would ask clients/patients about male-male sexual activity because both the patient and the healthcare worker would be embarrassed to discuss it and it would be very rude to ask something so personal. ARVs are provided for free to eligible patients. Transgenders have problems finding appropriate care—often they are ridiculed and told to just "stop it."

Condom use
Men report engaging in unprotected anal sex at high levels, although condoms and lubricant are readily available in convenience stores; condoms are inexpensive, but lubricant is not. Many MSM businesses have condom vending machines, and most saunas have condoms and lubricant available for free (at least one of each), either in the locker or at the front desk. In rural areas there are no condoms and lubricant available. MSM mostly know how to use condoms but are less aware of the importance of lubricant. MSM often have sex with females as well, and condom use depends on who the partner is: committed partner, less use; Western foreigner, more use; other Asia foreigner, less use; Thai partner of the same age, much less use. There have been reports of increased unprotected sex and dramatic increases in HIV seropre valence rates among MSM (from 17.3% to 28.3% in only two years). Almost all substance use among MSM is limited to alcohol. There also may be some underground drug use that is missed by prevention workers because it is highly illegal and considered "unacceptable" by ordinary people.

Sex work
Only a small percentage of commercial sex workers are male. There are many commercial sex establishments throughout Thailand, with male sex workers available for MSM. Most male sex workers are from "up country" (rural areas). Male sex workers tend to be very mobile, constantly in and out of sex work, usually traveling to urban areas to work and then going back home to their villages. There are specific HIV prevention and other HIV-related services targeting male sex workers available through SWING, a sex workers' advocacy group. Many male sex workers are go-go boys (in this context, a "boy" is any Thai man aged from 20 to 30 or 35).

VIETNAM

Population
84,402,966 (July 2006 est.)[200]

Languages
Vietnamese (official), English (increasingly favored as a second language), some French, Chinese, and Khmer; mountain area languages (Mon-Khmer and Malayo-Polynesian)[200]

Religions
Buddhist 9.3%, Catholic 6.7%, Hoa Hao 1.5%, Cao Dai 1.1%, Protestant 0.5%, Muslim 0.1%, none 80.8% (1999 census)[200]

Ethnic groups
Kinh (Viet) 86.2%, Tay 1.9%, Thai 1.7%, Muong 1.5%, Khome 1.4%, Hoa 1.1%, Nun 1.1%, Hmong 1%, others 4.1% (1999 census)[200]

Country-wide literacy rates (age 15 and over can read and write)
Total population: 90.3%; Male: 93.9%; Female: 86.9% (2002)[200]

Form of government
Communist state[200]

Adult population HIV prevalence
0.4% (2003 est.)[1]

People living with HIV/AIDS
220,000 (2003 est.)[1]

MSM HIV prevalence
6–8%[185]

Legal status of male-male sexual activity
Legal[195]

MSM quantitative and qualitative findings[45,135]

Social support
Most MSM in Vietnam do not see male-male sex as a defining part of their social identity. Feminine and transgender MSM are often unable to avoid being identified as such, but masculine MSM are referred to colloquially not by their gender but as "hidden" or "in shadow." Most MSM never "come out" to their families, but if they do—intentionally or inadvertently—it is not a problem as long as they keep it hidden. Urban MSM find support from international NGOs; rural MSM do not. Most of these interventions are pilot projects and results are not yet known. Rural MSM often move to urban areas to find employment opportunities. For many, this means sex work, but transgendered MSM have additional opportunities in beauty parlors and as performers. Their economic contributions to their families raise their status in the family and in turn mean that they are less likely to be rejected.

HIV/AIDS knowledge

MSM are aware of HIV as a problem but are not clear on the specifics of transmission, and perceive themselves as low risk. Younger MSM are more aware of the risks of unprotected anal sex. The Vietnamese government tends to blame HIV-positive people for their infection because male-male sex and intravenous drug use (the main HIV transmission route) are considered "social evils." Written HIV educational materials are available, and education is also conducted via radio, TV, and printed signage, although one of our informants characterized this as "not really effective." Educational efforts are sometimes directed at MSM, often through peer outreach and sometimes specifically at transgendered MSM. Hidden and rural MSM are difficult to reach.

HIV testing and treatment

VCT is widely available in urban and some rural areas. MSM-sensitive services are only provided in a few places in major cities. Most MSM do not discuss their sexual behavior when getting tested. Free ARVs are theoretically available, but vulnerable populations—MSM, IDUs, and transgendered people—have difficulty accessing them due to fear of being exposed and because healthcare workers do not receive any sensitivity training on male-male sexual behaviors. Vietnam's HIV epidemic has been driven by its spread within and from the IDU community.

Condom use

Condoms can be bought at vending machines and pharmacies at government-subsidized prices (about 5¢ each) and are handed out at VCT sites and through outreach. They are generally not available at night or at places where MSM gather for sex. Most MSM are not aware of proper condom use and often do not use them. Many MSM are also sexually active with women and are more likely to use condoms with their female partners. Non-oil-based lubricants have quite limited availability, mainly through prevention programs.

Sex work

Only a small percentage of commercial sex workers in Vietnam are male, and they see few clients—less than one per day—utilizing condoms about half the time. There are no designated places to meet male sex workers, and such work is quite casual.

Appendix 4: Contributors

Nick Bartlett

Nick Bartlett is a consultant based in Los Angeles, California. He has worked on a variety of research studies and HIV-related interventions in the Asia region, with a particular focus on China. Specific past assignments have included program development of social marketing activities in Southwest China, a study on HIV+ API in New York City, research on heroin use along the China-Vietnam border, and assessments to support the implementation of harm reduction activities in Southeast Asia.

Supriya Bezbaruah, PhD

Supriya Bezbaruah is a health communications professional based in New Delhi, India. She has worked on a number of public health communication and advocacy issues, such as HIV/AIDS, avian influenza, and the tsunami of 2004, with organizations such as the World Health Organization (WHO) South-East Asia Regional Office and the Johns Hopkins University Health Communication Program in India. She was formerly the health and science editor of *India Today*, South Asia's largest circulating newsmagazine. Supriya trained as a molecular cell biologist, with an undergraduate degree from King's College and a PhD from University College, University of London. She has also worked with the pharmaceutical company GlaxoSmithKline in the UK.

Paul Causey

Paul Causey has been an HIV program consultant based in Bangkok, Thailand, since 2001. His recent work includes coordination of the US government partners-led initiative to develop strategies and coordination of the scale-up of HIV interventions for MSM in the Greater Mekong Sub-region of Southeast Asia. During his 14 years in San Francisco as a community and HIV activist, he served on the boards of the AIDS Emergency Fund, Deaf Communities Together, and the Rainbow Deaf Society, helped create and hosted the long-running SF Cable TV program "AIDS Update," and was executive director of the Tenderloin AIDS Resource Center and AIDS Benefits Counselors/ Positive Resource Center.

Paul Galatowitsch, PhD

Paul Galatowitsch received his academic and professional training in the substance use and HIV field as well as in institutional and organizational sociology. He has significant experience in qualitative research methods, especially ethnography, survey research, and instrument design. He has written extensively on organizational and institutional responses to HIV/AIDS with a particular emphasis on MSM issues.

William Wells, MIA, PhD

William Wells is a writer and international public health consultant based in New York City. His recent work in Cambodia has included an assessment for the WHO of the government's HIV treatment efforts, and additional projects for CARE and FHI. In Sudan he helped assess the reproductive health programming of the United Nations Population Fund. His background is in molecular cell biology, with ten years of science journalism writing for clients including *New Scientist* and the U.S. National Academy of Sciences.

Appendix 5: Directory of Organizations Working With MSM in Asia

REGIONAL

Analysis & Advocacy
East West Center
1873 Volunteer Building
Thai Red Cross, Ratchdamri Road
Pratumwam, Bangkok 10330
Thailand
Tel +66-2-252-4904/+66-2-252-4906
Fax +66-2-252-4904
www.policyproject.com

Australian Federation of AIDS Organizations
PO Box 51
Newtown NSW 2042
Australia
Tel +61-2-9557-9399
Fax +61-2-9557-9867
www.afao.org.au

CDC-GAP/ARP
DDC 7 Building, 5th Floor
Ministry of Public Health, Soi 4
Nonthaburi 11000
Thailand
www.tuc.or.th

Family Health International (FHI)
Asia Regional Office
19th Floor, Tower 3, Sindhorn Building
130-132, Wireless Road
Kwaeng Lumpini, Khet Phatumwan
Bangkok 10330
Thailand
Tel +66-2-263-2300
Fax +66-2-263-2114
www.fhi.org/en/HIVAIDS/country/asia

International Federation of Red Cross and Red Crescent Societies (IFRC)
Regional Delegation Bangkok
Ocean Tower 2, 18th Floor
75/26 Sukhumvit 19
Wattana, Bangkok 10110
Thailand
Tel +66-2-661-6933
Fax +66-2-661-6937
www.ifrc.org/where/asiapac.asp

Population Services International (PSI)/Asia
Wave Place, 18th Floor
55 Wireless Road
Pathumwan, Bangkok 10330
Thailand
Tel +66-2-655-4001
Fax +66-2-655-4665
www.psi.org/where_we_work/innovaids.html

TREAT Asia
Exchange Tower
21st Floor, Unit 2104
388 Sukhumvit Road
Klongtoey, Bangkok 10110
Thailand
Tel +66-2-663-7561
Fax +66-2-663-7562
www.treatasia.org

UNAIDS Regional Support Team Asia Pacific
Office of the UN Resident Coordinator
c/o UNDP, 12th Floor, UN Building
Rajdamnern-nok Avenue
Phra Nakorn, Bangkok 10200
Thailand
Tel +66-2-288-2612/+66-2-288-1203
Fax +66-2-280-2701
www.un.or.th/unagencies/index.html#unaids

United Nations Educational, Scientific and Cultural Organization (UNESCO)
920 Sukhumvit Road
Bangkok 10110
Thailand
Tel +66-2-391-0577
Fax +66-2-391-0866
www.unescobkk.org

US Agency for International Development (USAID)
Diethelm Towers A
Suite 303
93/1, Bangkok
Thailand
Tel +66-2-205-5301
Fax +66-2-254-2838
www1.usaid.gov/locations/asia_near_east

AUSTRALIA

South Australian Sex Industry Network (SIN)
P.O. Box 7072
Hutt Street
Adelaide SA 5000
Australia
Tel +61-8-8334-1666
Fax +61-8-8363-1046
www.sin.org.au

BANGLADESH

Bandhu Social Welfare Society
99 Kakrail, GPO Box-539
Dhaka 1000
Bangladesh
Tel +880-2-933-9898/+880-2-935-6868
Fax +880-2-933-0148
www.bandhu.org

Chinnamul MSM-O-Nari Shangha
Khulna, Bagerhat
Bangladesh

Community Concern
Khulna, Jessore
Bangladesh

ICCDR,B (Centre for Health and Population Research)
GPO Box 128
Dhaka 1000
Bangladesh
Tel +880-2-886-0523-32
Fax +880-2-882-3116/882-6050/881-2530/881-1568
202.136.7.26

Let There Be Light
Dhaka
Bangladesh

Light House
Rajshahi
Bangladesh

Organization of Development Program for the Underprivileged (ODPUP)
House # 121, Road # 01 Banobithi R/A
East Azampur
Utter Dhaka 1230
Bangladesh
Tel +880-02-896-3630
Fax +880-02-895-2701

Social Advancement Society (SAS)
Vedvedi, Rangapani Road
Rangamati-4500
Post Box 47
Rangamati Hill Tracts
Bangladesh
Tel +88-00-0351-62517
Fax +88-351-61109

BHUTAN

Youth Development Fund
Youth Centre
Motithang
Thimphu
Bhutan
Tel +97-52-327-483/+97-52-322-250
Fax +97-52-326-730
www.youthdevfund.gov.bt

BRUNEI

Brunei Darussalam AIDS Council
c/o D'Anggerek Service Apartment
Lot 11044
Kg. Luagan Pulaie, Bandar Seri Begawan
Negara Brunei Darussalam
BC 2915
Brunei
Tel +673-234-5573
Fax +673-234-5380
www.freewebs.com/bdac_penyinar

CAMBODIA

AIDS Projects Management Group
Level 2, 50 York St
Sydney 2000
Australia
Tel +612-8231-6625
Fax +612-8231-6624
www.aidsprojects.com

CARE Project/Poipet
52, Street 352, Quarter
Boeung Keng
Cambodia
Tel +855-23-215-267/8/9
Fax +855-23-426-233
www.careinternational.org.uk/?lid=3509

Center for Disease Control and Prevention Global AIDS Program (CDC-GAP)/ Cambodia
1600 Clifton Road, NE
Atlanta, GA 30333
USA
Tel +1-800-CDC-INFO/+404-639-3311
www.cdc.gov/nchstp/od/gap/countries/cambodia.htm

Family Health International (FHI) Cambodia
P.O. Box 2586
Post Boeng Pralit
Phnom Penh III
Cambodia
Tel +855-23-211-914/+855-23-212-565
Fax +855-23-211-913
www.fhi.org/en/HIVAIDS/country/Cambodia

KANHNHA
PO Box 1285
Phnom Penh
Cambodia
Tel +855-12-695-503
www.kanhnha.bravehost.com

Khmer HIV/AIDS NGO Alliance (KHANA)
#33, Street 71
Tonle Basac, Phnom Penh
Cambodia
Tel +855-23-211-505
Fax +855-23-214-049
www.khana.org.kh

Médecins de L'Espoir Cambodge (MEC)
2AB, Street 118
Phsar Thmei I, Daun Penh
Phnom Penh
Cambodia
Tel +855-23-986-715

Men's Health Cambodia
Cambodia
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www.psi.org/where_we_work/cambodia.html

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www.usaid.gov/pubs/cbj2002/ane/kh

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Tel +81-3-3383-5556
Fax +81-3-3229-7880
www.occur.or.jp

University of Tokoyo Faculty of Medicine
7-3-1 Hongo, Bunkyou-ku
Tokyo 113
Japan
Tel +81-3-3812-2111 x3675
Fax +81-3-3813-1314

LAOS

Australian Red Cross
P.O. Box 2948
Vientiane
Laos
Tel +856-021-215763/+856-021-251585
www.redcross.org.au/howyoucanhelp_campaigns_HIVAIDS_arcprograms.htm

Centre for International Health, Burnet Institute
Building 06, 2A/04, Ban Sihom
Luang Prabang Road
Vientiane
Laos
Tel +856-21-250-853
Fax +856-21-250-854
www.burnet.internationalhealth.edu.au/home

Lao Youth AIDS Prev. Program (LYAP)
PO Box 53T
That Luangneua
Vientiane
Laos
Tel/Fax +856-21-414166
www.lyap.org

NCCAB
Km3, Thadeua Road
Vientiane
Laos
Tel/Fax +856-21-315500/+856-21-315127

PSI Laos
P.O. Box 8723
Vientiane
Laos
Tel +856-21-35-0740
Fax +856-21-315-334
www.psi.org/where_we_work/laos.html

Savannakhet Provincial Health Dept.
Laos
Tel +856-41-21-2021
Fax +856-41-21-2107

UNDP Laos
P.O. Box 345
Phon Kheng Road
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Fax +856-21-214819/+856-21-212029

MALAYSIA

APCASO
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51000 Kuala Lumpur
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Tel +603-4043-9602
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www.apcaso.org

Malaysian AIDS Council
No. 12, Jalan 13/48A
The Boulevard Shop Office
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51000 Kuala Lumpur
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Tel +603-4043-8177/+603-4045-1033
Fax +603-4042-6133
www.mac.org.my

PT Foundation (formerly Pink Triangle)
No. 7C/1, Jalan Ipoh Kecil, Off Jalan Raja Laut
50350 Kuala Lumpur
Malaysia
Tel +03-4044-4611
Fax +03-4044-4622
www.ptfmalaysia.org

MYANMAR

Alliance Myanmar
Queensberry House
104-106 Queens Road
Brighton BN1 3XF
United Kingdom
Tel +44-1273-718900
Fax +44-1273-718901
www.aidsalliance.org/sw7226.asp

Artsen Zonder Grenzen (AZG)
(Doctors Without Borders - Holland)
Plantage Middenlaan 14
1018 DD Amsterdam
Nederland
Tel +0900-821-22-12
www.artsenzondergrenzen.nl

Médecins du Monde (MDM)
62 rue Marcadet
75018 Paris
France
Tel +33-1-44-92-14-15
Fax +33-1-44-92-14-55
www.mdm-international.org

PSI Myanmar
No. 124, Pyay Road, 8 miles
Mayangone Township
Yangon
Myanmar
Tel +95-1-667-091/+95-1-662-927
Fax +95-1-527-668
www.psi.org/where_we_work/myanmar.html

NEPAL

Blue Diamond Society
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Khursani Tar, Lazimpat
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Tel +977-1-4443350/+977-1-4445147
Fax +977-1-4438600
www.bds.org.np

PAKISTAN

AMAL Human Development Network
PO Box 1516H#7
Street 62, G-6/4
Islamabad
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Tel +92-51-282-4930/+92-51-282-7774
Fax +92-51-227-2491
www.amal-hdn.org

AWARD Pakistan
(All Women Advancement and Resource Development)
42-C (II) Sahibzada Abdul Qayyum Road
University Town
Peshawar - Nwfp
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Tel +92-91-844-2067

CONTECH International
2-G Model Town
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FHI Islamabad
H#9 9th Avenue
F-8/1
Islamabad 44000
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Fax +92-51-285-4528

Ghazi Social Welfare Association
H. No. 95
Latif Colony
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Larkana
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+074-4046460/+074-4041945/+0300-3419931

Infection Control Society
CITILAB A-10, Sector 11-H
Nagan Chowrangi
Karachi
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Mehran Welfare Trust Larkana
Bhurgari Colony Road
Lahori Mohalla
Larkana
Pakistan
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National AIDS Control Program (NACP)
National Institute of Health
Chak Shahzad
Islamabad 44000
Pakistan
Tel +92-55096
Fax +92-55214

Nayyab Health Project
c/o **Vision** (see below)

ORA International
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Peshawar, NWFP
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Pakistan National AIDS Consortium
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+92-51-443-7019
www.pnac.net.pk

Rajarata Gami Pahana
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Sathi Foundation
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Muhallah Neewan
Chan Meeran
Lahore
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Vision
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Pakistan
Tel +92-425-853-740/+300-845-7696
Fax +92-42-630-528-9257

PAPUA NEW GUINEA

Hope Worldwide
353 West Lancaster Avenue, Suite 200
Wayne, Pennsylvania 19087
USA
Tel +1-610-254-8800
Fax +1-610-254-8989
www.hopeworldwide.org/index.htm

Save the Children PNG
Papua New Guinea
Tel +1-675-311-2354
www.savethechildren.net/alliance/index.html

World Vision
P.O. Box 9716
Federal Way, WA 98063-9716
USA
Tel +1-253-815-1000
www.worldvision.org/about_us.nsf/child/aboutus_papua

PHILIPPINES

Baguio Center for Young Adults
33 Assumption Road
Baguio City 2600
Philippines
Tel +63-74-442-8193

Family Health International (FHI) Philippines
Ground floor, Building 3
Department of Health
San Lazaro Compound
Santa Cruz, Manila 1003
Philippines
Tel +63-2-338-7464/+63-917-918-1070
Fax +743-512-7464
www.fhi.org/en/HIVAIDS/country/Philippines

Library Foundation
2580 A. Bonifacio St
Bangkal
1233 Makati City
Philippines
Tel +63-2-751-7047

ReachOut Foundation International
3A, 3/F, Miriam Bldg, Legaspi St.
Legaspi Village, Makati MM 1200
Philippines
+63-2-817-3743/+63-2-813-5702/+63-2-817- 0835/+63-2-813-5974
www.reachout-foundation.org/default2.asp

SINGAPORE

Action for AIDS (AFA) Singapore
21 Norris Road
Singapore 208263
Singapore
Tel +65-966-00-237
www.afa.org.sg

AIDS Society of the Asia and Pacific
c/o Coalition of Asia Pacific Regional Networks on HIV/AIDS
(7 Sisters)
12 Jalan 13/48A
The Boulevard Shop Office
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Malaysia
Singapore
Tel +603-4045-1033
Fax +603-4044-9615
www.7sisters.org/coalition/html/background/asap_1.html

Fridae.com
Fridae Limited
29th Floor, Wing On Centre
111 Connaught Road
Central
Singapore
www.fridae.com

National University of Singapore
21 Lower Kent Ridge Road
Singapore 119077
Singapore
Tel +68746415
www.nus.edu.sg

SOUTH KOREA

Ivan Stop AIDS Project (iSHAP)
South Korea
www.ishap.org

Korean Sexual-Minority Culture and Rights Center
South Korea
kscrc.org/en/intro.shtml

SRI LANKA

AIDS Coalition for Care, Education and Support Services (ACCESS)
Sri Lanka
Tel +074-516496

Companions on a Journey
40/16 Park Road
Colombo 5
Sri Lanka
Tel +94-11-251-4680

Rajarata Gami Pahana
(MSM project in Anuradharpura)
Sri Lanka

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Fax +886-2-2553-5236

Gender and Sexuality Rights Association of Taiwan
4F-4, No.430, Wen-Hua Rd. Sec. 2
Ban-Chiao 22044, Taipei County
Taiwan
Tel +886-2-2228-9598
Fax +886-2-2228-9599
www.gsrat.net

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Center for the Study of Sexualities
Dept. of English, National Central University
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Taoyuan, Taiwan 320
Taiwan
Tel +886-3-426-2926
Fax +886-3-426-2927
sex.ncu.edu.tw

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National Cheng-Kung University
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Tainan 701
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Section 2 Shih-Pai
Taipei 11221
Taiwan
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Fax +886-2-2827-0576

Persons with HIV/AIDS Rights Advocacy Association (PRAA)
Taiwan
Tel +886-2-2312-2859
Fax +886-2-2375-9150
www.praatw.org
enews.url.com/tw/praa.shtml

Taiwan Tongzhi Hotline Association
Taiwan
Tel +886-2-2392-1969/+886-922-568-570
Fax +886-2-2392-1994
www.hotline.org.tw/

THAILAND

Alternate Visions (consulting firm)
Alternate Visions, Krystal Court, apt. 10-2
23 Sukhumvit Soi 7
North Klongtoey, Wattana
Bangkok 10110
Thailand
Tel +66-02-655-0732
Fax +66-02-655-7495
www.alternatevisions.org

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Sukhumvit 16, Ratchadapisek Road
Klongtoey, Bangkok 10110
Thailand
Tel +66-2-259-1908/+66-2-259-1909
Fax +66-2-259-1910
www.apnplus.org/home/index1.html

Bangkok Rainbow
49/29 Phadipat Rd
Samsaenai, Phayathai
Bangkok 10400
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Tel +02-618-3221
Fax +09-039-1918
www.bangkokrainbow.org

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Department of Communicable Diseases
Ministry of Public Health
Nonthaburi 11000
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Tel +66-2-590-3200-1
eng.moph.go.th

McCann Erickson Thailand
McCann Erickson Worldwide
622 3rd Ave
New York, NY 10017
USA
Tel +1-646-865-2000
mccann.com

MOPH–US CDC Collaboration
DDC 7 Building, 4th Floor
Ministry of Public Health
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www.tuc.or.th

Mplus+
Thailand
Tel +053-404342
www.mplusthailand.com

MSF Belgium (Thailand)
94 rue Dupré
1090 Bruxelles
Belgium
Tel +33-2-474-7474
www.msf.be

Pact
1200 18th St, NW, Suite 350
Washington, DC 20036
USA
Tel +1-202-466-5666
Fax +1-202-466-5669
www.pactworld.org

Patong Hospital, Phuket
57 Sainamyen Rd
Tambol Patong, Ampur Kathu
Phuket 83150
Thailand
Tel +66-7634-2633/+66-7634-2634
Fax +66-7634-0617
www.patonghospital.com/eng

PSI Thailand
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Pathumwan, Bangkok 10330
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Tel +66-2-655-4001
Fax +66-2-655-4665
www.psi.org/where_we_work/thailand.html

Rainbow Sky Association of Thailand
Panjaphat Building, 5th Floor, No. 1
Patpong Rd., Suriyawong
Bangrak, Bangkok 10500
Thailand
Tel +66-2-632-6957; 632-6958
Fax +66-2-632 6956
(English assistance 01-341 4591)
www.fasiroong.org

The Royal Netherlands Embassy
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Bangkok 10330
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Tel +66-2-254-7701
Fax +66-2-254-5579
www.netherlandsembassy.in.th

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Bangkok 10500
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Pacific and Asian History Division
Research School of Pacific and Asian Studies
Building 9,HC Coombs Building
The Australian National University
ACT 0200 Australia
Tel +61-2-6125-3142
http://rspas.anu.edu.au/pah

USA

National Endowment for Democracy
1101 Fifteenth Street, NW, Suite 700
Washington, DC 20005
USA
Tel +1-202-293-9072
Fax +1-202-223-6042
www.ned.org

San Francisco Department of Public Health
25 Van Ness Ave
San Francisco, CA 94102-6033
USA
Tel +1-415-554-9000
www.dph.sf.ca.us/PHP/HIVHlthSvc.htm

USAID
RRB 5.10-090
US Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523-5100
USA
Tel +1-202-712-0775
www.usaid.gov

USAID Office of HIV/AIDS
1300 Pennsylvania Ave
G/PHN/HN/HIV-AIDS, 3rd Floor
Washington, DC 20523
USA
Tel +1-202-712-0676
Fax +1-202-216-3046
www.usaid.gov/our_work/global_health/aids/index.html#

VIETNAM

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23B Nguyen Du St.
V. Tau
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CDC-GAP/Vietnam
SA-29, 2nd Floor
2201 C Street, NW
Washington, DC 20522-2920
USA
Tel +1-202-647-3132
www.cdc.gov/nchstp/od/gap/countries/vietnam.htm

Center for Health Education and Communication Khanh Hoa
146 Nguyen Trai Street
Nhatrang City, Nhatrang
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Consultation of Investment in Health Promotion (CIHP)
108 A12 Alley
4/15 Phuong Mai Str.
Dong Da—Hanoi
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Fax +84-4-5770260
www.cihp.org/Desktop.aspx/English

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Columbia University
722 W 168th St
New York, NY 10032
USA
Tel +1-212-568-2291
www.mailman.hs.columbia.edu/index.html

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Da Nang
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Fax +051-897218

FHI
30 Nguyen Du Street, Suite 301
Hanoi
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Tel +1-844-943-1828
Fax +1-844-943-1829
www.fhi.org/en/HIVAIDS/country/Vietnam

Hai Dang (Light House)
Hanoi
Vietnam
Tel +04-736-6653

Haiphong Project
23 Cao Ba Quat
Hanoi
Vietnam
Tel +84-4-747-0275/+84-4-747-0276
Fax +84 4-747-0274
portal.unesco.org/geography/en/ev.php-URL_ID=2435&URL_DO=DO_TOPIC&URL_SECTION=201.html

Health Education Center of Khanh Hoa province
146 Nguyen Trai Street
Nhatrang City, Nhatrang
Vietnam
Tel +84-0515459

Ministry of Labor, Invalids and Social Affairs
2 Dinh Le Street
Hoan Kiem District
Hanoi
Vietnam
www.molisa.gov.vn

National Assembly Committee for Social Affairs
Vietnam
www.na.gov.vn/english/index.html

PACT Vietnam
6 Phan Chu Trinh
Hanoi
Vietnam

The Population Council
No 2 Dang Dung Street
Ba Dinh District
Hanoi
Vietnam
Tel +84-4-716-1716 x13
Fax +84-4-716-1707
www.popcouncil.org/asia/vietnam.html

STI/HIV/AIDS Prevention Center (Hanoi)
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Giang Van Minh Str., Ba Dinh District
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UNAIDS Vietnam
4th Floor, Room 405
44B Ly Thoung Kiet St
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Tel +84-4-9343417
Fax +84-4-9343418
www.unaids.org.vn

UNESCO Vietnam
23 Cao Ba Quat Street
Hanoi
Vietnam
Tel +84-4-7470275
Fax +84-4-7470274
www.unesco.org.vn

UNICEF Vietnam
72 Ly Thuong Kiet St
Hanoi
Vietnam
Tel +84-4-8261170
Fax +84-4-8262641
www.unicef.org.vn

Viet Nam-CDC-Harvard Medical School AIDS Partnership
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Provincial AIDS Committee/ HCMC
59 Nguyen Thi
Minh Khai, District 1
Ho Chi Minh City
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Fax +84-8-930-9152

INTERNATIONAL

Collaborative Fund
PO Box 51
Newtown NSW 2042
Australia
Tel +9557-9399
Fax +9557-9867
www.hivcollaborativefund.org

DKT
DKT International-Vietnam
Unit 504, 5th floor
30 Nguyen Du
Hai Ba Trung District
Hanoi
Tel +84-4-943-7363
Fax +84-4-943-7370
www.dktinternational.org

Elton John AIDS Foundation
P.O. Box 17139
Beverly Hills, CA 90209-3139
USA
www.ejaf.org

Ford Foundation
320 East 43rd Street
New York, NY 10017
USA
Tel +1-212-573-5000
Fax +1-212-351-3677
www.fordfound.org

Global Fund to Fight AIDS, Tuberculosis and Malaria
Geneva Secretariat
Chemin de Blandonnet 8
1214 Vernier
Geneva
Switzerland
Tel +41-22-791-17-00
Fax +41-22-791-17-01
www.theglobalfund.org/en

International HIV/AIDS Alliance
Tel +44-0-1273-718-941
www.aidsalliance.org

International Lesbian and Gay Association (ILGA)
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www.ilga.org

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Fax +1-416-599-6311
www.macaidsfund.org

Network of Sex Worker Projects
www.nswp.org

OSI
400 West 59th Street
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Tel +1-212-548-0600
www.soros.org

Sidaction
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75010 Paris
France
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Fax +33-0-1-53-26-45-75
www.sidaction.org

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www.unaids.org/en

Appendix 6: TREAT Asia and amfAR

TREAT Asia—An Unprecedented Regional Collaboration

TREAT Asia (Therapeutics Research, Education, and AIDS Training in Asia) is an initiative of amfAR, The Foundation for AIDS Research. It is designed to strengthen regional capacity for the safe and effective delivery of HIV/AIDS treatments across Asia, develop a research agenda responsive to the needs of local patient populations, encourage policies that enhance the quality of HIV treatment and care, and increase the capacity of civil society to advocate for patients' rights. TREAT Asia seeks to accomplish these objectives by:

- Training and supporting a core group of physicians, healthcare workers, and academics with expertise in HIV treatment;
- Building capacity around the necessary expertise and infrastructure for the safe and effective delivery of HIV treatments;
- Providing support for regional centers that can administer training with a modest investment;
- Establishing communication and consultation systems to facilitate sharing of expertise;
- Building mechanisms for increased government support and community awareness of HIV/AIDS research, treatment, and training programs;
- Developing a comprehensive understanding of the needs of the region for therapeutics research;
- Initiating therapeutic studies that are relevant to regional patient populations (including studies of new therapies, salvage therapy, HIV/TB co-infection, adherence, and pediatric HIV/AIDS in Asia).

TREAT Asia is governed by a steering committee comprised of medical and clinical research experts and representatives from the HIV/AIDS community participating in the network. The steering committee, in consultation with subcommittees for research, education and training, public policy and advocacy, and fund raising and communications, determines program priorities.

TREAT Asia Program Accomplishments

Since 2001 the TREAT Asia network has grown to include 22 sites in a dozen countries throughout the region, with each site providing clinical care to populations ranging from 200 to 4,000 HIV/AIDS patients. The network has made significant progress in four primary areas.

Research

- The network's first undertaking, the TREAT Asia HIV Observational Database (TAHOD), is the first regional database for HIV/AIDS in Asia. TAHOD will generate an ongoing analysis of transmission and treatment patterns across the region. As of July 2006, TAHOD has recruited over 3,000 patients at 15 sites. The database is gathering anonymous patient data from sites throughout the region, including core variables such as sex, age, ethnicity, HIV exposure category, HIV subtype, AIDS-defining illnesses, immunology and virology, antiretroviral and prophylactic treatment, and reasons for treatment changes. *Response to triple combination antiretroviral treatment in patients from Asia-Pacific: An analysis of retrospective data from TAHOD* was presented at the International AIDS Conference in Bangkok, Thailand, in July 2004. More recent papers include: *Predicting short-term disease progression among HIV-infected patients in Asia and the Pacific region: Preliminary results from the TREAT Asia HIV Observational Database. HIV Med* 2005;2005(6):1-8, and *The TREAT Asia HIV Observational Database: Baseline and retrospective data. J Acquir Immune Defic Syndr* 2005;38(2):174-179. TAHOD will be expanded to include sites from China (Yunnan province), Laos, Myanmar, and Vietnam as soon as funding becomes available.
- In 2005 TREAT Asia organized the first regional pediatric HIV treatment meeting in Bangkok. The meeting brought together frontline pediatric doctors to discuss issues related to pediatric treatments and to create a regional pediatric HIV/AIDS network.
- In 2006 TREAT Asia will launch a new drug resistance initiative. This project aims to build capacity for HIV drug resistance surveillance and monitoring in Asia, helping to ensure the safety and efficacy of generic ARVs that are available in the region.

Professional Education and Training

- In the Cambodian province of Svay Rieng, TREAT Asia has partnered with the Cambodian Health Committee and the Svay Rieng Hospital to train healthcare workers to administer antiretroviral therapy in tandem with TB treatment.
- In Vietnam, TREAT Asia has organized a series of HIV treatment workshops for healthcare workers in Lao Cai and Hoa Binh provinces in partnership with the International Center for Equal Healthcare Access (ICEHA) and the Highlands Educational Development Organization (HEDO).
- TREAT Asia initiated an online physician training program in Pune, India. Participants completed a twelve-week online HIVeDUCATION course in March 2006. HIVeDUCATION has been in development since 2002 when TREAT Asia co-sponsored a training session for more than 300 physicians on state-of-the-art treatment practices.
- The National Center for HIV/AIDS, Dermatology, and STD (NCHADS), a component of the Cambodian Ministry of Health and a TREAT Asia site, launched a physician training program in March 2006. The program will provide hands-on, real-world experience in HIV care and management for doctors and healthcare workers. In addition to working with established HIV care units and clinics, the program includes on-site mentoring, regional workshops, and a national symposium for program graduates. TREAT Asia was instrumental in shaping the curriculum and will provide funding for the program.

Strengthening Civil Society

- With support from GlaxoSmithKline's Positive Action, TREAT Asia is working to strengthen understanding of HIV/AIDS treatment among vulnerable communities in Asia. As part of a pilot project, TREAT Asia has joined an international collaboration to support treatment education and treatment literacy programs, and peer support activities for people living with HIV/AIDS at four sites in the central provinces of China. TREAT Asia will take the lead on community treatment education/literacy and will help build capacity at the county and township levels for treatment education programs for people with HIV/AIDS.
- TREAT Asia has partnered with the Asia Pacific Network of People Living with HIV/AIDS (APN+) to develop and implement community education programs in Cambodia and Vietnam.
- TREAT Asia launched a civil society mentoring program in October 2004. The Asian Community for AIDS Treatment and Advocacy (ACATA) provides an opportunity for community advocates to come together and increase their knowledge and skills around issues related to treatment, enabling them to become more effective advocates for treatment access, care,

prevention, and policy issues. The ACATA is also helping to bridge the gap between community advocates and the medical/healthcare communities in their home countries.

- Through an agreement with Family Health International's Asia Regional Program (FHI/ARP), TREAT Asia serves as the Regional Coordinating Secretariat for a new network of HIV programs for men who have sex with men in the Greater Mekong Subregion. The Network consists of more than 80 governmental and nongovernmental organizations working to prevent and treat HIV among MSM in six countries: Cambodia, China (Yunnan and Guangxi provinces), Laos, Myanmar, Thailand and Vietnam.

Policy and Communications

- The *TREAT Asia Report* newsletter is distributed in print to 5,500 readers and electronically to 2,600 additional readers. Published four times a year, the Report provides updates on treatment access, policy, clinical practice, and PHA issues in the region, serving as a vital conduit for important information about the epidemic. In addition, TREAT Asia is working with participating network sites to create Internet linkages to facilitate communication and the rapid sharing of best practices and clinical data.
- A TREAT Asia special report entitled *Expanded Availability of HIV/AIDS Drugs in Asia Creates Urgent Need for Trained Doctors* was released at the 2004 International AIDS Conference in Bangkok, Thailand. Its findings were covered in prominent reports from major news organizations such as *The New York Times*, *The Asian Wall Street Journal*, *India Tribune*, and the *International Herald Tribune*.
- The TREAT Asia network meets for three days each fall to review the progress of all TREAT Asia initiatives, disseminate results from the TAHOD, and evaluate research, training, and clinical objectives for the coming year. Funded primarily by amfAR, this meeting is attended by the principal investigators, clinical researchers, and technology support staff from each site, as well as by community leaders, individuals living with HIV, and representatives from the host country, other governments, and industry.

amfAR's Historic Role in the AIDS Epidemic

amfAR, The Foundation for AIDS Research, is dedicated to ending the global AIDS epidemic through innovative research. Funded by voluntary contributions from individuals, foundations, and corporations, amfAR has invested nearly $250 million in support of its programs since its establishment in 1985 and has awarded grants to more than 2,000 research teams worldwide. Aside from its TREAT Asia network, amfAR has invested more than $10 million in international grants alone, and has supported prevention and education activities in 39 countries, such as Argentina, Ethiopia, Gambia, India, Indonesia, Nepal, Nigeria, and Tanzania.

Since its inception, amfAR has increased understanding of HIV and helped lay the groundwork for major advances in HIV/AIDS treatment. Previous grants have supported:

- early studies critical to the development of protease inhibitors;
- pioneering work that led to the use of AZT to block mother-to-infant HIV transmission;
- the first studies demonstrating the potential of DNA vaccines;
- identification of CCR5 as a critical co-receptor for HIV; and
- identification of the anti-HIV properties of the T-20 compound, the first fusion inhibitor to be approved for use by the FDA.

In the late 1980s, amfAR pioneered the concept of community-based clinical trials on AIDS. Between 1989 and 1996, amfAR invested over $30 million in its Community-Based Clinical Trials Network and helped expand access to experimental therapeutics to tens of thousands of patients, facilitated the "real-world" testing of the safety and efficacy of new drugs, and, by actively engaging the community in the process, helped revolutionize the conduct of clinical trials in the U.S.

One of the first advocates for people affected by HIV/AIDS, amfAR galvanized national leadership on HIV/AIDS. The Foundation was instrumental in securing passage of key federal legislation shaping the US response to the HIV/AIDS epidemic, including the Hope Act of 1988, the Ryan White Care Act of 1990, the Americans with Disabilities Act of 1990, and the NIH Revitalization Act of 1993.

Today, the Foundation's activities continue to focus on:

- the identification and funding of promising, innovative projects that have not yet attained sufficient preliminary data to secure grants from traditional funding resources, such as the US National Institutes of Health and the pharmaceutical industry;
- HIV/AIDS treatment education programs for the public and continuing medical education programs in HIV/AIDS for healthcare providers;
- public policy activities to protect the human rights of all people affected by the epidemic and to advocate for the allocation of increased federal resources for HIV/AIDS programs based on scientific fact and solid public health principles; and
- global initiatives, such as TREAT Asia, that help healthcare workers and AIDS organizations in developing countries to maximize local resources and facilitate the development and implementation of effective international research, treatment, prevention, and education strategies.

Appendix 7: Legality of Male-Male Sex

COUNTRY	IS MALE-MALE SEX LEGAL?	ENFORCEMENT OF LAWS	LEGAL PUNISHMENT
Bangladesh[195]	No	Only one known case	Life in prison, or shorter term plus fine
Bhutan[76]	No	Unknown	Life in prison
Brunei[195]	No	Unknown	Up to 10 years in prison or fine of up to US$19,000
Cambodia[28]	Yes		
China (Mainland[167]	Yes (1997)	MSM arrested for public or paid sex	
China (Hong Kong)[118,120]	Yes (1991)	MSM under 21 still subject to prosecution	
East Timor[143]	Yes		
India[195]	No	Rare	Life in prison, or up to 10 years plus fine
Indonesia[142]	Yes		
Japan[195]	Yes		
Laos[2]	Yes		
Malaysia[195]	No	Usually only in cases of underage sexual activity	Up to 20 years in prison, plus whipping
Myanmar[195]	No	Unknown	
Nepal[195]	No	MSM arrested on grounds of public nuisance	Life in prison, or up to 10 years plus fine
North Korea	Unknown		
Pakistan[195]	No	Unknown	Up to life in prison under penal code; death by stoning or up to 100 lashes under Islamic law
Papua New Guinea[195]	No	Unknown	Up to 14 years for anal intercourse between any 2 individuals; up to 5 years for other male-male sex
Philippines[195]	Yes		
Singapore[195]	No	Only used to prosecute nonconsensual acts	Life in prison, or up to 10 years plus fine
South Korea[195]	Yes		
Sri Lanka[195]	No	Not enforced	Up to 10 years in prison
Taiwan[195]	Yes		
Thailand[195]	Yes		
Vietnam[195]	Yes		

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