Advocacy, policy and support on male sexualities

Naz Foundation International

Rapid assessment of male vulnerabilities to HIV and sexual exploitation in Afghanistan

Final Report

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(Note Dr Carol Jenkins died on the 23rd January 2008, leaving an enormous gap in the lives of so many people in Asia and Pacific, particularly those who greatly benefited from her passion for her work, and her constant advocacy on the needs of highly vulnerable populations, including males who have sex with males.)

Contents

A word of caution

From *Practicing Desire – homosexual sex in the era of AIDS*, Gary Dowsett, Stanford University Press, Stanford, California, USA, 1996:

"It is probably not possible to know the extent of homosexual behaviour among males. What is clear from the research findings is that an incalculable number of …… men can and do have sex with other men, some frequently, some occasionally, in the right circumstances or at certain times in their lives, in certain sites or in certain institutional settings, with certain cultural overlays, or all the above." (p75)

"...a considerable diversity of contexts in which men pursue sex with other men." (p76)

"Many of the standard survey techniques may never obtain sufficiently accurate accounts of the extent of such activity. This is particularly true when such sexual matters are deemed unreportable for moral or legal reasons." (p76)

"Political/religious/cultural dynamics will always confound attempts to uncover just how sexually active [males] are...." (p76)

"The search for a definitive answer on the extent to which men have had and will have sex with other men is not going to offer a clue to the likely extent of this form of possible HIV transmission, and its geographical location. There is considerable doubt whether it is necessary to know the extent of homosexual practice among males in any country in order to develop public-health policy and to implement HIV and STD prevention strategies. More important is the consideration that no statistic on the extent of male-to-male sex, even of anal intercourse, should affect policy and budgetary decisions concerning prevention. This is so because it is not the *extent* of male homosexual behaviour that needs to be addressed, but the *diversity of the contexts* in which it is practiced." (p76)

Definition

The acronym MSM is usually taken for *Men Who Have Sex with Men*. However, the term *men* can be problematic within the context of different cultural definitions of Man, Manliness, and Manhood. In the context of NFI we use *MSM* to mean *Males Who Have Sex with Males*, where the term males is taken in its biological sense.

It should also be recognised that 'MSM' is a behavioural term and does not reflect a sexual identity. Within the use of the term 'MSM' and male-male sexual behaviours, there are many frameworks of 'MSM', from self-identified males with gender or sexual orientation, to those who anally penetrated other males as a masculine behaviour, to those who are situationally involved in male-to-male sex.

Within the framework of male-to-male sex, there is a range of masculinities, along with diverse sexual and gender identities, communities, networks, and collectivities, as well as just behaviours without any sense of affiliation to an identity or community. This statement addresses the concerns of all these diversities within the framework of *males who have sex with males*.

In this report, the author will be using the acronym MSM to mean males who have sex with males, or male-to-male sex, rather than the term men who have sex with men.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour, Change, Communication
CBO	Community-based organisation
CE	Christian Era
CRC	United Nations Convention on the Rights of the Child
CSA	Child sexual abuse
HIV	Human Immunodeficiency Virus
INGO	International non-governmental organisation
IRB	Institutional Review Board
JRC	Juvenile Rehabilitation Centre
KI	Key informant
KOR	Khatiz Organisation Rehabilitation
MOPH	Ministry of Public Health
MSM	Males who have sex with males
NACP	National AIDS Control Programme
NFI	Naz Foundation International
NGO	Non-government organisation
ORA	Orphans and Refugees in Afghanistan
PI	Principal Investigator
STI	Sexually transmitted infection
TOR	Terms of Reference
UNAIDS	United Nationals Joint Programme on AIDS
UNESCO	United Nations Educational, Scientific an Cultural Organisation
UNICEF	United Nations Children's Fund

Executive summary

Between October- November 2008, a small rapid assessment of male adolescent sexual exploitation and abuse, along with HIV risk and vulnerability among males who have sex with males, was conducted in Kabul, Kandahar and Maz-e-Sharif in Afghanistan. Preceding this, a scoping mission, a literature review, and a training workshop for the study teams were conducted.

In Kabul and Mazar-e-Sharif, 50 self-identified adult MSM were interviewed in each city. Along with these respondents, 19 street working adolescent males, 36 adolescents males in Juvenile Rehabilitation Centres, and 14 adults responsible for juvenile justice and care were interviewed as well.

Along with the data collected from these interviews, information from the Desk Review, and the Inception and Workshop reports produced by the Principal Investigator, were also used to develop the series of recommendations included in this report.

The findings clearly demonstrate that, as in many other societies, sexual exploitation and abuse of highly vulnerable adolescent males, as well as consensual male-to-male sex exists in Afghanistan at significant enough levels to require an immediate response to the requirements of social justice, health and well-being of these males, and to ensure that the country does not develop a range of concentrated HIV epidemics among males who have sex with males, and highly vulnerable adolescent males over the next few years, adding already to the economic burden that already exists.

Key findings

1. Male adolescent sexual exploitation and abuse

1.1 Gender construction and masculinities frame a significant proportion of adolescent male sexual exploitation and abuse:

Adolescent males with feminised behaviours sexually accessed at an early age by older boys and men. Most of these adolescent males grow up to follow a sexually active pattern as receptive males, self-identifying with their femininity and receptive role. The "dancing boy" syndrome would fall under this category.

- 61% of adult MSM reported sexual debut by the age of 15 and 91% of these respondents reported first sexual partners as being above the age of 19 years. Receptive anal sex was the primary sexual practice.
- While the majority of respondents (75%) stated that they were not forced into sex, only 37% stated that the primary emotion experienced was pleasure. Significant levels of guilt, shame, and anger were experienced by the remaining respondents. However 89% of the respondents stated that they received some sort of reward for this activity.
- All the MSM respondents had developed feminised self-identities such as *ezak* (males acting like women), or *khwaharak* (sister)
- At the same time, the historical tradition of *bachaboz* (boy lovers), continues to exist in differing part of Afghanistan. The culture of "dancing boys" is well known. Four (4/19) of the working street males interviewed had been to a party which had dancing boys. Several examples were provided in the Desk Review. Possessing a "beautiful boy" represents status to the older male.

Studies conducted in other countries in South Asia by Naz Foundation International[1] have shown that early sexual debut of feminised adolescent males appears to be very significant. This behaviour is framed within a psychosexual and social construction of masculinities within a patriarchal cultural setting, generating a framework of "handsome" or "feminised" adolescent boys being seen as "not-men", "a gender apart", a "third gender" so to speak. Thus, certain adolescent males, (along with feminised adult males), can therefore be seen as sexually accessible in a culture that has extremely low tolerance of sex between men, and where women are often perceived as asexual and inaccessible,

[1] See www.nfi.net knowledge section for the Lucknow, Dhaka, Delhi and Lahore assessment reports.

bound within a masculine honour system which sees women as a possession of the male; a father, brother, husband, or son.

1.2 Adult men and older male adolescents accessing young boys through sexual assault and exploitation.

As identified above, older males and men at times access younger feminised males for sex, primarily penetrative anal sex with a gendered framework of "men" and "not-men", whether this be through a "dancing boy" culture, or not.

While all the adolescent male adult gatekeepers had heard of, or knew of older men accessing adolescent males outside the framework of "dancing boys" and effeminate adolescents, 7/19 working street males had also heard of this from their friends, while 10/36 male adolescents in Juvenile Rehabilitation Centres had experienced such assaults, where 9/36 had either sexually assaulted or tried to sexual assault younger male adolescents. Only 3 out of the 36 respondents in the JRCs had experience both sexual assault by older males/men as well as committing sexual assault on younger adolescents. This means that 16/36 adolescent males in Juvenile Rehabilitation Centres had some engagement with male-on-male sexual assault. At the time only 2 such male adolescents were in the JRC for sexual assault on another male.

Reasons given for sexual assault on adolescent males, along with adolescent male-to-male sex behaviours included, poverty and the high costs of marriage, thus leading to sexual frustration, the lack of law enforcement making it easier for older men to sexually assault male adolescent, watching pornographic movies thus increasing sexual tension and no normative sexual outlets, a lack of religious knowledge, and poor parenting skills. Further, because of poverty, some adolescent boys engage in selling sex, while in a culture of gender segregation and the social policing of women, boys are often easier to sexually access than girls or women.

This does not imply that there are no other dynamics of male adolescent exploitation and abuse that relate to power, violence, self-hatred, and revenge, that relate to deeper psychological conflicts within the abuser, and which were also identified as possible further reasons for the sexual exploitation of adolescent males.

2. Adult males who have sex with males

As identified above, all of self-identified MSM perceived themselves as feminised males through their self-labelling, such as *ezaks* or *khwaharak*, indicating that, like other South Asian countries, the primary pattern of male-to-male sex is gendered between the masculine normative male who penetrates and the receptive partner as female-like, or "not a man", and where the primary sexual practice was anal sex.

Multiple partners was common among respondents, as was sex work, and there was a significant correlation between the numbers engaged with sex work as a source of income and the level of unemployment between the different cities. However, compared with other South Asia countries, the number of sex partners in the previous month, paid or unpaid, was low, ranging from 1 to 5 partners, although Kabul 26% of respondents did state that they had more than 6 partners the previous month.

While coercive sex was negligible in the previous month in both cities, when taken over the previous year, Kabul reported much higher rates of such coercive sex in this period than Mazar.

Meeting and sexual places tended to be private homes, shops and guesthouses, which would make it difficult to conduct outreach prevention activities, again quite different from the other South Asian countries. Respondents also reported that the majority of the sex partners were either paying clients, freely offered sex with strangers, as well as regular partners, and that these partners came from a range of occupational risks, where law enforcement and military personnel were a significant issue.

Consistent condom use was low (11%), where the usual lubrication was either saliva, or some oil-based product, and where it was usually the provider that suggested condom use. Condom use was higher in Kabul than in Mazar.

Intriguingly Mazar respondents reported much high rates of sex with females, both paid and unpaid, where the majority of respondents were unmarried. It also needs to be recognised that marital status in this study (23%) must not be taken as definitive of self-identified MSM. No condom usage was reported for sex with females.

While this study did not conduct any blood tests for sexually transmitted infections (or for that matter HIV), questions were asked regarding symptoms in the oral, genital and anal areas. While respondents in Mazar reported higher rates of symptoms than in Kabul (37 to 15 respondents respectively, this may be a consequence of the different sexual behaviour patterns between the two cities and the higher rates of receptive and penetrative anal sex activities in the former city compared with the latter, along with higher rates of female partners in Mazar. However the majority of respondents who reported some form of symptoms did not go for professional treatment.

Regarding feelings of depression or suicide, 26% reported experiencing these feelings over the past year.

The level of correct knowledge of HIV or AIDS was low, even though a majority of respondent had heard of AIDS, where the primary source of information was from friends or television. In terms of the adolescent males in Juvenile Rehabilitation Centres, doctors were the primary source of information on AIDS, but where, similarly, knowledge was also poor.

Personal risk perception in terms of infection with an STI was significantly higher in Kabul than in Mazar (13 respondents compared to 2 believed that they had a high risk of infection). And while knowledge of risk reduction was poor, more respondents in Kabul correctly identified the use of condoms in penetrative sex as a means of protection. However, with regard to partner notification should they ever be infection with an STI or HIV, the majority of respondents stated that they would not inform their partners because of the fear of "outing".

Conclusion

Adding to the cultural dynamic of the gendering of feminised males and "beautiful boys", and thus the perception of them as sexually available, is a culture of penetrative sexuality as part of masculine gender conformity, along with poverty and unemployment, a lack of socially entertainment spaces in a society that can readily access a global culture through satellite dishes, a society still conflict ridden and fearful of the past reappearing as the future, a lack of law enforcement, where at times it is the law enforcement personal who also engage in male coercive sex, then we have a scenario of significant levels of coercive male-to-male sex and consensual male-to-male sex that is based on a mutual gendered desire and felt need.

In a society that lacks sex education, normal socialising and sexual interactions between adult males and females, significant levels of shame, and a lack of knowledge about the body and about sex, there is bound to be an intense interest and curiosity about sex and sexuality, particularly with males in the throes of puberty and unmarried men. Ready accessibility to pornographic films, male only social spaces, the gendering of age, body pleasure, coercive sex, sexual and political economies, constructions of masculinities, along with male hierarchies in all male institutions, are usually ignored as possible drivers of male-to-male sex, including coercive sex.

Delay of marriage for many men because of affordability, along with relatively low access to sexually available women, has been one of the reasons given to explain why men have sex with adolescent males and feminised adult males, along with the fact that such males cannot get pregnant, that they are less problematic than females, less expensive than female sex workers, and are good for sexual fun.

Much of these coercive sexual interactions and male-to-male sex tend to be framed within a "body heat", "sexual need" and "semen discharge" framework.

Along with the low level of HIV and AIDS knowledge, poor public health infrastructure, a lack of strategic information, lack of access to any appropriate sexual health services and appropriate psychosexual counselling, along with a culture of shame and religious intolerance that generates significant levels of stigma, discrimination, violence and denial, as well as what appears to be a significant and growing injecting drug use culture, Afghanistan needs to prepare itself towards dealing with an emerging concentrated HIV epidemic amongst MSM. Its neighbour, Pakistan, is already experiencing such an emergence among MSM because of similar factors.

Key recommendations – a summary

1. Towards addressing male adolescent sexual exploitation and abuse

1.1 More research is urgently needed to the dynamics of male adolescent sexual exploitation that includes socio-cultural issues, cultural myths, gender, masculinities, sexual practices and social norms towards informing an appropriate health response should be addressed.
1.2 Further studies are also needed into the sexual networking of adolescent males who have sex with males, their early sexual debut, the construction of gender, identity and sexual practices, and their specific risks and vulnerabilities and sexual health needs.
1.3 Development of appropriate medical, psychological and psychosocial confidential child-centric services that include their HIV/STI and other sexual health concerns including capacity development of professionals engaged in these services.
1.4 Capacity development of professionals engaged in the juvenile justice system, including law enforcement agencies, lawyers, judiciary and staff at Juvenile Rehabilitation Centres.
1.5 Review of all policies and practices that impact on addressing male adolescent sexual exploitation and abuse in order to ensure a consistent approach to ensure that the physical, emotional, mental and social well-being of such males are being met.
1.6 A range of educational programmes should be provided in schools that address life skills, sex education, gender and masculinities, and the reducing early sexual debut.
1.7 More effective and appropriate law enforcement strategies need to be in place that can support the provision of services
1.8 Awareness programme developed for parents, teachers, and other professionals engaged with children regarding the issue of male adolescent sexual exploitation and abuse, and a referral system developed for access to appropriate services.

2. Towards addressing the sexual health needs of males who have sex with males

2.1 Increase strategic information in terms of MSM sexual networking, and the behavioural, social, gender, sexual, and epidemiological strategic information to inform service provision.
2.2 Improve the quality and efficacy of health sector providers to be able to appropriately address the sexual health and social inclusion concerns of MSM by the provision of training and skills development.
2.3 Support and encourage the development of MSM community based responses to sexual health issues amongst their constituents, while providing meaningful and consistent technical assistance, support and mentoring to achieve this.
2.4 MSM sexual health services provision should include
- Treatment and counselling on STIs (anal, oral and penile) and HIV
- Access to anti-retroviral treatment for those living with HIV
- Peer outreach and education
- Provision of safe spaces for social development and community building and mobilising
- Vocational training and skills building towards increasing economic opportunities and thus reduce sex work
- Psychosexual counselling

- Support and care for those living with HIV
- Distribution of condoms, water-based lubricant, and appropriate BCC materials

2.5 Include MSM in planning, designing and implementation of such interventions. This includes participation in problem identification, needs assessments, programme design, monitoring and evaluation.

2.6 Develop effective partnerships with local police in regard to the levels of harassment, sexual violence and blackmail that many MSM face, and also ensure that outreach and field workers from service providers would not be harassed by either police or local people.

2.7 BCC materials and resources designed and disseminated that are appropriate to the needs of MSM sub-populations, where such populations should be engaged in developing such materials and resources.

2.8 Recognise that the needs of various types of MSM will differ and may require differing responses. Thus, adolescent MSM who are sexually active will require appropriate services to their needs. Feminised MSM will require services appropriate to their needs and sense of identity, while the masculine partners of these MSM may not find such services appropriate to their self-image and needs, and therefore the health sector response will require strengthening to address their needs.

2.9 Promote an enabling environment that addresses stigma, discrimination, violence, abuse, and illegality that MSM face by developing and implementing policies and practices that respect the sexual health rights and social justice of MSM at national and local levels.

It has been clearly demonstrated in many countries that a moralistic and deterrent approach to HIV prevention does not work, that it only further drives the virus underground, that it increases levels of stigma, discrimination and violence against MSM increasing their risks and vulnerabilities and creates an environment for ever further increases in HIV prevalence and the numbers of people living with AIDS.

The above recommendations will provide a framework for addressing the psychosexual health needs of vulnerable and at risk male adolescents to sexual exploitation while also addressing the sexual health needs of males who have sex with males.

It is also understood that in the socio-political and religious context of Afghanistan, some of recommendations that are included in this report may well carry a high-cost burden, difficulties in implementation because of traditional and conservative resistance, and a range of legal impediments. It is recommended that for an effective response to male adolescent sexual exploitation and abuse, as well as males who have consensual sex with other males, a pragmatic approach needs to be undertaken to have any realistic impact.

Background

There is sufficient anecdotal evidence to indicate that male-male sexual behaviours, along with male child sexual exploitation and early sexual debut exist at significant levels in Afghanistan to cause concern, particularly with regard to child protection and terms of HIV risk and vulnerability.

The National AIDS Control Programme, MOPH, Afghanistan is implementing an HIV prevention, treatment, care and support programme, but lacks information on male-male sexual behaviours and the attendant risks and vulnerabilities.

NACP intends to conduct a rapid assessment of male-male sexual behaviours, exploitation, risks and vulnerabilities in order to understand the range of male-male sexualities and behaviours, the vulnerabilities of sexual exploitation, and risks of HIV and other sexually transmitted infections, through a range of methodologies which take into account the sensitivity of the issue in Afghan culture.

Funding for this assessment is provided by UNICEF under the 2008 AWP (annual workplan) for Item 0.7.5.16.2 MARA and EVA national prevention strategy developed.

Purpose/Objective

The objectives of this assessment include:

1. To describe the characteristics of MSM with particular attention to adolescent and young males within community, entertainment, and congregate settings in Kabul, Kandahar, and Mazar-e-sharif as it pertains to HIV prevention.

2. To assess the circumstances of child abuse/exploitation within the context of MSM within communities, entertainment, and congregate settings in Kabul, Kandahar, and Mazar.

3. To strengthen the knowledge base for the HIV national response for MSM and child abuse/exploitation among the government, donors, and NGOs.

4. To make recommendations for a stronger capacity among the government, donors, and NGOs for appropriate service delivery on HIV prevention, care and support for MSM and children at risk of child abuse/exploitation.

5. To review the development of MSM community-based self-help and other appropriate approaches to HIV prevention, to reduce stigma and discrimination, and to reduce violence against children.

Assessment sites

The assessment on male-to-male sex was conducted in Kandahar and Mazar-e-Sharif, while the assessment of juvenile male sexual exploitation was conducted in these cities along with Kandahar.

Map of Afghanistan

Socio-economic information on Afghanistan

Population	32,738,376			
Age structure	Age range	%	Male	Female
	0-14 years	44.6%	7,474,394	7,121,145
	15-64 years	53%	8,901,880	8,447,983
	65 years+	2.4%	383,830	409,144
Life expectancy	44 years			
Fertility	6.58 children born/woman			
Literacy	28.1%; male-43.1%			
Ethnic groups	Pashtun	42%		
	Tajik	27%		
	Hazara	9%		
	Uzbek	9%		
	Aimak	4%		
	Turkmen	3%		
	Baloch	2%		
	Other	4%		
Languages	Dari	50%		
	Pashto	35%		
	Others	15%		
Religion	Sunni Muslim	80%		
	Shia Muslim	19%		
	Other	1%		
Labour Force	Agriculture	80%		
	Industry	10%		
	Services	10%		
Unemployment	40%			
Below poverty line	53%			

Source: www.cia.gov/library/publications/the-world-factbook/geos/af.html
Downloaded, 2/9/08

Methodological approach

Issues	Methodology
Adult MSM, risks and vulnerability	With support from Dr. Farid Bazger of KOR and Dr. Abdul Rasheed, consultant, two study teams were developed that included 2 researchers and a key MSM informant to conduct the study in both Kabul and Mazar-e-Sharif, following a training programme conducted in Kabul between 6th – 9th October 2008. A questionnaire was developed in Dari, along with an appropriate consent form. Questionnaire interviews: S50 respondents in each city identified and interviewed: Socio-economic status Current sexual activity Commercial sex activity Sex with females Adolescent experiences and behaviours Health issues In addition, the Principal Investigator also held discussions with several self-identified MSM in both cities.
Male juvenile male-to male sex and exploitation	With the support of Aschiana, three questionnaires and consent forms were developed to discuss the issues of male juvenile sexual exploitation with male juveniles incarcerated in juvenile rehabilitation homes, along with staff at these homes, as well as working street males accessing Aschiana working street males centres. These studies were conducted in Kabul, Kandahar, and Mazar-e-Sharif
IRB	The Afghanistan IRB gave permission to conduct this study, in particular the male juvenile sexual exploitation, as an exception based on the nature of the study and the protection of respondents built into the questionnaires.

Study schedule

	Item	Comments	Time
Phase 1: Inception			
1	Develop Study Team and Review Panel	Through internet and direct discussions. Support sought from NACP Vulnerable Populations Working Group	
2	Initial desk review of current literature and discussions held and write report	Internet, documents already in hand, comments and information from key individuals in Afghanistan, primarily from study team members	2 weeks
2	Scoping mission to Kabul and Mazar followed by Kabul. No visit to Kandahar because of security situation – Mission report produced	For Mazar study, support from independent consultant For Kabul study support from KOR With regard to adolescent male child exploitation support from Aschiana	1.5 weeks
3	Design study instruments for Mazar based on site visit: Questionnaire Focus Group Discussion guide Interview guide Training guide for data collectors	Principal investigator to develop	2 weeks
4	Review Technical Review Team and amend where necessary	Disseminated to Technical Review team for comments and suggestions	1 week
5	Produce inception report		0.5 weeks
Total			**7 weeks**
All products delivered by end of September 2008			
Phase 2: Assessment			
6	Visit Kabul and provide training programme for all 3 assessment teams – will include PI and assistant from NFI	Sites for assessment will be Kabul, Kandahar and Mazar Also possibly conduct several interviews of respondents in Kabul as part of data collection	1 week
7	Data collection for Kabul, Kandahar and Mazar conducted in parallel	Planned supervision by Action AID With regard to male juvenile sexual exploitation issues seek assistance from Ashiana/CPAN for data collection	4 weeks
8	Review issues and concerns as they arise during data collection and respond to any queries from assessment teams as an on-going process	Principle investigator	1 week
Total			**6 weeks**
Phase 3: Reporting			
10	Data analysis period		3 weeks
11	Report writing period		3.5 weeks
12	Final visit to Kabul for report presentation		0.5 week
Total			**7 weeks**
Grand Total			**20 weeks**

The study

Male adolescent sexual exploitation and abuse

From: *Mapping of psychosocial support for girls and boys affected by child sexual abuse on four countries in South and Central Asia,* Save the Children, 2003.

Child sexual abuse (CSA) is known to occur in Afghanistan but is very hidden. Sexuality is [itself] a highly taboo subject, and it is [very] difficult to find information on child sex abuse and [exploitation]. No statistics on CSA are available, and most information is from anecdotal accounts….

Affection between men and women in public is not tolerated. Gender segregation and restrictions for women and girls is [the norm], [where publics spaces are male dominated]…

"Men are seen as needing 'sexual release' the lack of which can even result in poor health – [masturbation is seen as sinful]. On the other hand, the ideal construction of the female is asexual before marriage, and sexually passive after [see NFI Muslim studies]. There are traditional precedents for 'accepted ' child sexual abuse and exploitation. Reports of men using young boys for sexual gratification are well known and talked about. Traditionally, 'keeping' good-looking boys adds status and prestige to the man, and adds to his image (self or imposed) of virility. Under the Taliban, a [supposed] strict ban on homosexual [expression] made more overt aspects of practice go underground. However, the practice of boys under 18 [beardless boys] being brought to parties for entertainment is reported to still be taking place in some rural areas and in around Kandahar [as well as Kabul]."

"Culturally, Afghanistan does not share the same ideas of youth as the universalised western concept reflected in United Nations Convention on the Rights of the Child (CRC). Young people from 14 to 18 are considered adult, and are often expected to fulfil the same roles as adults in protecting the home, community, and family honour."

In keeping with the silence about sexuality, there is strong reluctance to acknowledge and raise the topic of CSA in Afghanistan. Teachers are afraid to bring up the subject with parents and parents are reluctant to solicit support from teachers.

From: *Desk review of current literature on HIV and male-male sexualities, behaviours and sexual exploitation in Afghanistan,* Shivananda Khan, 2008.

The concept of the beautiful boy, or the beardless [beautiful] boy, has strong historical roots that go back centuries across the Arab and Central Asia regions, expressed in Arabic poetry and Urdu ghazals.

In an essay written by Ingeborg Baldauf , *Bacabazlik: Boylove, Folksong and Literature in Central Asia,*[2] she states at the beginning of this essay:

> In Islamic tradition, Central Asia [and this includes Afghanistan] has had the reputation of being the region of boylove. Paederasty is said to have been introduced into Baghdad from Chorasan in the east, and even as early as the 9th and 10th century C.E. Afghanistan was regarded as the source of not only the loveliest boys, but of boylove itself (Adam Mez, *Die Renaissance des Islams* – Heidelberg: 1922)

[2] *Bacabozlik: Boylove, Folksong and Literature in Central Asia*, Ingeborg Baldauf, excerpt from Die Knavenliebe in Mittel-asien: Bacabozlik, Freie Universitat Berlin, Forschungsgebiedsschwerpunkt Ethnizitat and Gesellschaft, Occasional Papers, Nr. 17 (Berin: Verlag Das Arabische Buch, 1988. The translation has been done by Gerard Mooorman)

The whole essay is a description of this tradition and how it is expressed in Afghanisatn Uzbek culture (i.e. Northern Afghanistan), and the use of the term *bacabozlik* (in Persian *bacabozi*). *Bazaboz*, or 'boy gameplayer', is a male adult whose "hobby is the association with boys". While these relationships could be platonic and based on friendship, they often have sexual connotations, where the adult male will sexually penetrate the younger male. Usually the preference was for boys between the ages of 12 to 17 years, before the boy began to grow a beard. The boy was known as *baca*, or 'dancing boy'.

We know the historicity of this practice from a range of written texts that exists and were widely known amongst the literate Arabs in the early years centuries of Islam. Thus

> You know not how deep was the love in your eyes kindled within my soul, or how great was my suffering! Bless my beloved! He wised to visit me, but could not come near me because of his tear-drowned eyes; he feared the watchers, so he came to me quickly, taking all adornments off his neck, except his beauty. I offered cups of wine to him; the wine was put to shame by those honey-like lips, those pearly teeth! His eyelids were at last vanquished by slumber, wine made him obedient to all my wishes…
> Ibn al 'Abbar (d.1041 C.E.) [Source: A.R. Nykl, *Hispano-Arabic Poetry and its Relation with the Old Provencal Troubadours* – Baltimore: J.H.Furst, 1946, pp 110-1][3]

And such poetry was also popular in literary circles during late Mughal times, through the *ghazal*. A form of verse which originated in Persia and literally means "talking to the beloved"[4]

> O God, how lovely are these Turkish boys -
> To see them gladdens, as the coming of spring

While such accounts of history appear to celebrate the context of boy love in the pederastic sense of young adolescent males in the few years before the become adults (expressed in the sense that the Taliban demanded that all men must have beards!), which echoes the ancient Greek traditions expressed through the writings of Socrates, Plato and others, and where an old Afghan proverb that stated *women are for children, boys are for pleasure,* times have changed, whilst some of these practices and beliefs still linger substantively in Afghanistan (and elsewhere, such as in Pakistan, the Middle East, and North Africa to name a few regions).

But notice in the quote from Ibn al 'Abbar above where he states "…wine made him obedient to all my wishes."

And in the articles identified above, they speak of boys between 12 and 16, of "beardless boys", of "sodomy with young boys".

> "When a man sees a boy he likes -the age they like is 15 or 16 -they will approach him in the street and start talking to him, offering him tea," said Muhammad Shah, a shop owner. "Sometimes they go looking in the football stadium, or in the cinema (which has yet to reopen). *Kandahar comes out of the closet, The Times, 12/8/02*

> "I was only 14-years-old when a former Uzbek commander forced me to have sex with him," said Shir Mohammad in Sar-e Pol province. "Later, I quit my family and became his secretary. I have been with him for 10 years, I am now grown up, but he still loves me and I sleep with him." *Afghan boy dancers sexually abused by former warlords, Reuters, 18/11/07*

The idea of consent, adolescent sexualities as different from adult sexualities, the concept of the child evolving historical into its current incarnation, the concept of the rights of the child, the concepts of

[3] *The irresistible beauty of boys – Middle Eastern attitudes about boy love*, Maartin Schild, essay, (1980's date unknown), source unknown
[4] *Boy love in the Urdu Ghazal,* Tariq Rahman, Paidika, Summer 1989, Vol. 2, No.1

child abuse, whether physical or sexual, are all relatively new concepts primarily arising in the last 50 years, first in Western nations, and gradually spreading across the world, with the birth of the United Nations and its family of agencies, such as UNICEF, UNESCO, etc. Along with this a range of moral imperatives have evolved and new taboo subjects generated, particularly with the conflation of pederasty and paedophilia, which in their original meanings, were two very different constructs.

Ann Elizabeth Mayer in her book *Islam and Human Rights: Tradition and Politics*, compares Islamic law with international human rights laws and concludes that these two are not compatible. This she attributes to the belief that Islam is divinely commanded by Allah, and criticising it is considered blasphemous.[5]

The author goes onto state:

> "Islamic 'human rights' can offer no means for protecting the individual against state-approved Islamic laws and policies that violate international human rights laws."

Thus, Muslim theocratic states exist by asserting Islamic law over secular humanitarian law at the possible cost of freedoms of their citizens, female and male.

Culture, tradition, religious beliefs, terminology, orientalism, language, and law all clash on the boundaries of "illicit sex" in Afghanistan. So, in the cultural context of Afghanistan, who is defined as a "boy", and who is defined as an" adult"? For the Taliban, this was not so much around biological age, but in terms of the ability to grow a beard. But this definition has a long historical tradition, hence the term "beardless youth".

An interesting article appeared in the Gay and Lesbian Review in their March-April 2003 edition[6] following a number of articles in the Western media which explores the inappropriateness of the use of Western terminology (gay, homosexual, closet) in these articles, how they actually confuse the issues, and could make implementing strategies to address risk and vulnerability in terms of HIV (never mind address male sexual abuse and exploitation), extremely problematic. ORA's conflation of pederasty with homosexuality in its 2005 report is an example of this.

The articles and essays that the PSI has reviewed regarding this issue, describe a whole subterranean culture, visible, yet invisible, where often older men who access adolescent males are married with children, where "possessing" a "beautiful beardless boy" is a mark of status, power and money, where sometimes such boys are exchanged as favours and patronage with financial transactions engaged, expensive gifts and money given to favoured boys, where at times poverty drives such young adolescents to engage in such sexual encounters with older men, and where for some older men, apart from actual desire and longing for the "beautiful boy", sexual access to females is extremely circumscribed in a gender segregated society where women are socially policed, and where access to young males is so easy.

In an ORA study in Kabul of high-risk populations,[7] it had the following anecdote: *Asghari is a school student of class 7. When he was between 4 and 5 years old his father died and his mother remarried. Asghari went to live with his grandmother who asked him to begin collecting wood to sell to pay for his upkeep. Asghari found the job very difficult: "Some people were giving me money and started to sexually use me. I was happy with that because it was the easiest way to have money for my grandmother. Now it is my business, even if it is shameful. If there is an other alternative, I will stop it."*

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[5] *Gay Afghanistan, after the Taliban – homosexuality as tradition*, Richard Ammon, Maura Reynolds, Lou Chibbabaro, February 2002, http://www,globalgayz.com/g-afghanistan2.html

[6] *Kandahar: Closely Watched Pashtuns – a Critique of Western Journalists' Reporting Bias about 'Gay Kandahar'*, Brian James Baer, Gay and Lesbian Review, March-April 2003

[7] *Survey of groups at high risk of contracting sexually transmitted infections and HIV/AIDS in Kabul*, ORA International, April 2005

"I was only 14-years-old when a former Uzbek commander forced me to have sex with him," said Shir Mohammad in Sar-e Pol province. "Later, I quit my family and became his secretary. I have been with him for 10 years, I am now grown up, but he still loves me and I sleep with him."
Afghan boy dancers sexually abused by former warlords, Reuters, 18/11/07

A Pashtun tribesman [42] who fell in love with and "married" a 16-year-old boy faces summary execution in Pakistan after his "unholy union" provoked outrage among Islamic leaders.
Afghan tribesman faces death for wedding to teenage boy, Sydney Morning Herald, 7/10/2005

Another owner forced his 14-year-old boy to speak, although he would not give his name. "I was dancing last night," he said, looking exhausted. "I have been doing this for the past year. I have no choice -I'm poor. My father is dead, and this is the only source of income for me and my family. I try to dance well, especially at huge parties. The men throw money at me, and then I gather it up. Sometimes they take me to the market and buy me nice clothes."
Dancing boys of the north, Afghan Press Monitor, October, 2007

A 14-year old boy was arrested on a charge of pederasty, allegedly spending 6 months as a passive sodomite with a man in a nearby village. The boy claims that he was threatened by the man with a pistol and forced to go and stay with him. The man has been released on bail but the boy remains in the correction centre. The police and the attorney say that the case will be finalised according to law as soon as possible.
Justice for Children – the situation for children in conflict with the law in Afghanistan, Afghanistan Independent Human Rights Commission, working draft, January 2008

"…wine made him obedient to all my wishes…"
Ibn al 'Abbar (d.1041 C.E.) [Source: A.R. Nykl, Hispano-Arabic Poetry and its Relation with the Old Provencal Troubadours – Baltimore: J.H.Furst, 1946, pp 110-1][8]

Despite the proclamations of many *bachaboz* (boy lovers) that their man-boy relationships are based on desire and mutuality and are not abusive or exploitative, this does not stand up under scrutiny. In a culture of masculine power dynamics that define masculinity as penetrative, and thus is not lost if a man penetrates another male, especially a boy, where sexual access to women can be extremely limited, where poverty and unemployment is so extensive, where there is a strong phallic culture expressed through the gun, sexual exploitation and abuse of adolescent males will be relatively common, whether it is within a context of *bachabozlik* or not. How can a young male be said to choose to have receptive sex with man because of his poverty? How can such a male say no to a more powerful adult man who may carry a gun, or demonstrates local status and power?

Interview by Alixandra Fazzina – photojournalist, 2009 (respondent name changed)

Fluttering his eyelashes coated in thick mascara, Aresh is wearing blue coloured lens'. His jeans are skin-tight. Looking up and down his eyes dart around from under his black curly hair.

When he was just ten, a man kept hanging around the gates of his school. The twenty-nine year old Taliban fighter started buying Aresh gifts- books, pens and sweets at first. Then he started to give money and lifts to the young schoolboy in his car. Aresh was flattered with the attention, which he was told was because he was so handsome. One day though the older man took him to his house and brutally raped him. He was told if he uttered a word his family would be killed and he wouldn't be left alive.

A few weeks later was taken to a private Taliban party and made to dance for the guests. When he

[8] *The irresistible beauty of boys – Middle Eastern attitudes about boy love*, Maartin Schild, essay, (1980's date unknown), source unknown

wiggled his hips and moved like his sister, the guests were delighted. Two of the guests well connected to Taliban leaders later had sex with him.

There was no way Aresh could tell his family or friends. Apart from fearing for his life, the stigma would have been too great in conservative Afghanistan.

The contact lens' are something new but at first Aresh didn't wear make-up. Over a year, the Taliban soldier that continued to abuse him bought him lady's shalwar and blouses to wear and the routine of looking effeminate to try and please took hold. The sex however was still difficult to handle, "It was forceful, and I didn't like forceful".

Soon Aresh was working professionally, dancing Iranian style at weddings. With nowhere to turn, it wasn't long before paid sex with older men was becoming normal for him- five to eight clients a night brought him money and he could earn around $50 in one night.

"Nothing makes me happy and I blame the Taliban. If it wasn't for the rape, I wouldn't live like this". Working on the streets is a dangerous life for many young boys like Aresh. Risking arrest, robbery, rape and abuse they are outcasts among Afghan society.

As a part of this study, 100 adult self-identified MSM were interviewed, 50 in Kabul and 50 in Mazar-e-Sharif (see later in this report).

From this study, early sexual debut appears to be the pattern amongst self-identified feminised MSM in both cities, where 30/50 in Kabul and 31/50 in Mazar respondents reported first sexual contact with another male before the age of 15 with the majority of partners in both cities being above 25 years of age, and where receptive anal sex was the common sexual activity.

It was the older person asking the younger person for sex, while 20/50 respondents in Kabul and 5/50 respondents in Mazar stated that they were forced to have sex. At the same time 36/50 Kabul respondents and 27/50 in Mazar stated that they experienced negative feelings at the time such as anger, guilt and shame, with the remaining participants expressing a sense of pleasure arising from the event. Further 44/50 and 45/50 respondents from Kabul and Mazar respectively stated that they received either money or gift for this.

Self-labelling terms used by respondents in both cities reflect a process of gendering and feminisation. Thus in Kabul the majority of respondents used the term *ezak* to identify themselves, while on Mazar, the majority of respondents preferred to use the term *khwaharak*, meaning sister. These are equivalent to the terms *zenana* as used in Pakistan, *kothi* as used in India and Bangladesh, and *meti* in Nepal. These terms have no exact English translation, but carry significance in terms of gender/sexual orientation as a male who is feminine and takes on the receptive role in anal sex with another man, while perceiving himself as less than a man.

From *In their own words – the formulation of sexual and health related behaviours among young men in Bangladesh*, Shivananda Khan, Sharful Islam Khan, and Paula E Hollerbach, Catalyst Consortium, 2005:

Between the ages of 5-12, all *kothi*-identified respondents had experienced a conflict between what they felt and experienced while growing up, and what was socially expected of them as biological males. This was further exacerbated during puberty with the conflict between inner self-definition as female or female-like, in comparison to the physical changes they were experiencing. (See Table 18.)

Some young men, by the age of seven and as they mature, prefer to exhibit what are deemed to be feminine behaviours and practices that are demonstrated through mannerisms, dress styles, and other "girlish" behaviours.

Such males begin to define themselves as feminised males, that is, biologically male but psychologically female. The gendering of sex roles and the position taken by these feminised males then reaffirm their self-perception as "not-men." Sexual desires (both for individual males and for specific sexual acts) of *kothi*-identified males are also framed within this context; often through practice and experience, such feminised males are accessed for sex when young. By the age of 12 or 13 (although for many this was considerably younger), perceived differences are framed within the existing binary gendered framework of male/female…

…By that age, *kothis* had also begun socialising with other *kothis*, learning the *kothi* language, self-identifying as *kothis*, and adopting their sexual practices and behaviours, thereby accepting and reinforcing the *kothi* stereotype. Due to their sexual desires, practices, and their socially reinforced gendered roles and behaviours, *kothis* often perceive that they are females in male bodies and act out the desires, fantasies, and sexual roles that they believe females have.

Under usual circumstances, when they are with other *kothis*, feminised performance is the norm, and body language, physical expressions, language, dress, and mannerisms express what is perceived as being "female-like." However, *kothis* do not act (or perform) as women, nor do they dress up as women when the opportunity is provided. Rather, they try to imitate a romantic, cinematic version of the "vamp," the beautiful woman, the "sexy" woman, the ideal of a voluptuous, eroticised, decorative, and sexualised woman who seduces men.

In other studies conducted in Bangladesh and India by NFI into the impact of social, legal and judicial impediments to sexual health promotion, care and support for males who have sex with males, the link between feminisation, masculinity, patriarchal cultures, and sexual debut are clearly demonstrated, along with the gendering of male sexualities and practices.[9]

The component of this study exploring sexual exploitation and abuse of juvenile males was difficult because of the nature of the issue, the sense of deep shame and secrecy that pervades the whole subject, along with the physical, psychosocial and religious-political environment in which the study was being conducted, along with who was being accessed for information.

Great care had to be taken, not only on what questions would be permissible to ask, but also how they would be asked. And while the IRB had given a *waiver of consent* in regard to the male adolescents in this study, the study team were deeply concerned about any possible personal difficulties that may arise because of this study, so that the psychological and social safety of the child was paramount, and that the permission for the interviews would be granted by the relevant gate-keepers, as well as by the boys themselves. Many questions were therefore indirect to ensure that respondents (and their gatekeepers) felt comfortable in answering specific questions.

Because of these concerns, it was necessary to engage with a local NGO (Aschiana) who had considerable experience of the local environment and the nature of the potential respondents, and could conduct interviews in the local languages with sensitivity and due consideration. They thus were given the responsibility of developing appropriate questionnaires for the 3 sub-groups of respondents.

The central caveat is that this type of rapid assessment methodology is not really appropriate to gain any significant data on estimating the size of the affected population, but can only give a glimpse to the issues of concern. With the information gleaned from the literature review, and from the adult MSM study component, sufficient information, it was hoped, would be obtained to be able to make meaningful recommendations to address the issue of male juvenile sexual exploitation and abuse.

The male adolescent assessment component consisted of 3 sub-sets of respondents. These were:

1. Street working males (total 19 respondents)
   Migration camp, Baghe Daavod 5

[9] *Against the Odds*, Aditya Bondyopadhyay and Shivananda Khan, 2004, and *From the Frontline*, Shivananda Khan, 2006. Available on NFI website www.nfi.net/reports.htm

Qalla Hesamat Khan	4
Aschiana Centre, Mazar	10

2. Male adolescents in Juvenile Rehabilitation Centres (total 36 respondents)
   Kabul Juvenile Rehabilitation Centre: 26
   Mazar-e-Sharif Juvenile Rehabilitation Centre: 10

3. Staff at Juvenile Rehabilitation Centres (JRC), police officers responsible for juvenile cases, lawyers and others engaged with juvenile justice (total 14 respondents):
   Kabul (4):
   Children's Advisor
   Teacher
   Dormitory Manager
   Maintenance Officer

   Kandahar (6):
   Lawyer/Prosecutor
   Lawyer (Justice Department)
   2 Police Officers (Juvenile Dept)
   Administration Manager, JRC
   Managing Director, JRC

   Mazar (4):
   Police Officer, Juveniles
   Managing Director, JRC
   Child Rights Officer
   Social Worker, Juveniles

Working street males were accessed through Aschiana's work with such males, with the belief that their social and working environment made them potentially vulnerable to sexual exploitation and abuse by older juveniles and adult males. All were below 18 years of age, with the majority between 12 to 15 years of age.

Less than half attended school, and all came from very poor backgrounds, earning less than US$ 1 – 2 per day, and were in working environments that exposed them to potential sexual risks with daily interactions with male adults, i.e. their jobs included street work such as shoe polishers, car mechanics, street sellers, and car washing.

While 7/19 boys had heard of other boys who had been sexually assaulted, and 4/19 had been to "dancing parties" (see the section of *bacchabazi* in the Desk Review report which speaks of *dancing boys* and sexual liaisons with adult male patrons), the possibility of engagement in substance use (such as alcohol and illegal drugs) was a more significant issue, where 14/19 had witnessed such use, and 12/19 had a personal relationship with someone who was a user (7 of whom stated that it was one of their relatives).

However, gleaning any information on the prevalence of male adolescent sexual assault and abuse was just not possible, hindered by a variety of socio-cultural factors, although 2 respondents from the Baghe Daavod Migration Camp, and 2 from Qalla Hesmant Khan area stated that their areas had higher rates of male adolescent sexual exploitation by adults was higher than elsewhere, and 3 from the Aschiana centre in Mazar-e-Sharif stated that in their area, the issue was older children sexually exploiting younger children.

With regard to male adolescents incarcerated in Juvenile Rehabilitation Centres, the information obtained was somewhat more specific. While these boys were not asked why they were in the JRC in the first place, 4/36 stated that they were in these Centres because of sexually assaulting a younger boy. The majority of the boys accessed were between the ages of 15 to 17 (23/36)

11/36 of the boys stated that they know at least one adult male who had had sexual relations with male juveniles, while 6 stated that they had been at one time sexually assaulted, while 4 stated that an adult male had tried to sexually assault them. This means that 10/36 boys (28%) had had some form of experience a sexually assault by an adult male.

At the same time, 7 boys stated that they had sexually assaulted younger boys, and 2 stated that they had tried unsuccessfully, meaning that a total of 9 boys out of 36 had some experience of conducting a sexual assault on a younger male (25%), while 3 boys admitted that they had both been sexually assaulted by adult males and had assaulted younger boys. One case of such an assault was reported as being conducted in the JRC itself.

6 boys stated to having friends who have had sexual relations with an older man, while 6 boys stated that they had a friend who had who had sex with females. In 1 case the friend had sex with anal sex with both.

Adults involved in the juvenile justice and care believed that the reasons for sexual exploitation and assaults on juveniles arose from poverty and the high costs of marriage which is making it difficult for men to get married, leading to sexual frustration, the need of boys to have an income, and thus get engaged in selling sex, the lack of law enforcement making it easier for older men to sexually assault young boys, watching pornographic movies which would lead to sexual desire, a lack of religious knowledge, and parents leaving their sons unattended and free to roam, and absence of self-control. One adult stated that male same-sex behaviours arise because no marriage was involved and thus no family tensions, and that it was fun, while several stated that in a culture of gender segregation and social policing of women, boys are easier to access than females.

All the adults in this study component recognised the issue of sexual exploitation of male juveniles as a matter of concern, all had met boys who had sexually abused younger boys, and all stated that such exploitation was higher in their locality.

With regard to HIV risk and vulnerability, across this study component AIDS awareness was high, but specific knowledge was poor. At the same time, boys in the JRCs recognised their need to have more information on HIV and AIDS to "protect themselves and their families" (30/36), where what little information they had came from doctors in the JRCs themselves. In both the Kabul and Kandahar Centres, it was stated that it was possible to arrange HIV testing for boys, and that they had plans to educate the children on HIV and AIDS.

What the adult care-givers and those involved in the juvenile justice system would like to see implemented to address male juvenile sexual exploitation and abuse, along with HIV risk and vulnerability are educational programmes on HIV, stricter law enforcement against "illicit sex", increased religious education of youth, and educating boys to resist sexual assault.

What is clear from the above discussions is that sexual exploitation, assault and abuse of male adolescents is not uncommon in Afghanistan, falling into 3 primary patterns:

1. Adolescent males with feminised behaviours sexually accessed at an early age by older boys and men. Most of these adolescent males grow up to follow a sexually active pattern as receptive males, self-identifying with their femininity and receptive role. The "dancing boy" syndrome would fall under this category.
2. Adult men accessing young boys through sexual assault and exploitation.
3. Older male adolescents accessing young male juveniles through sexual assault and exploitation.

The level of such sexual exploitation and abuse is not clear. While 37% of working street males interviewed in this limited study (7/19) had heard of such experiences, 28% of those juvenile males accessed through the Juvenile Rehabilitation Centres had some experience of sexual assault by an older male (10/36) and 25% of these males (9/36) had committed a sexual assault on another male. At the same time, in the adult MSM component of this study, some 61% of those interviewed stated that

their sexual debut was before the age of 15, 25% stated that they were forced, and 63% stated that they had negative feelings about this experience.

The data from the JRCs, despite the small number of adolescent males surveyed, is alarming, as is the data from the equally small MSM study, both indicative of significant levels of male child sexual abuse and exploitation, made even more significant in a socio-cultural tolerance of the tradition of "dancing boys" as partners of older men, and where gender segregation is the norm.

In India, it is estimated that some 3 boys out of 10 are sexually abused.[10] In a study on the sexual abuse of street children brought to an Observation Home in New Delhi, India,[11] a total of 189 boys aged 6 to 18 years were assessed for sexual abuse. While the majority of boys were runaways, 38% has suffered sexual abuse, where strangers were the most common perpetrators. Similar levels of such abuse are found in Bangladesh and Pakistan, both Muslim countries.

It is not possible to make any informed estimate on the prevalence of male on male sexual exploitation and abuse in Afghanistan based on the above, but we can expect similar levels as that in the rest of South Asia. A more detailed and much larger study of juvenile males in schools and as street working males will be required to draw any specific conclusions.

Adult male-to-male sex

This study does not purport to provide a comprehensive review of male-male sexualities, behaviours and practices in Kabul and Mazar-e-Sharif. Rather it can only give a limited insight into the complexity, diversity, and range of the behavioural features of those males who have sex with males accessed by the study teams. By its very nature, the study is limited and biased, as respondents were accessed through the friendship networks of the study team members along with snowballing techniques.

Fifty respondents in each city were interviewed. Recruitment was through snowballing techniques via the initial input of the self-identified MSM who were a part of the study team.

Socio-economic status

70% of respondents from Kabul were in above 21 years age, while in Mazar this was 48%, with a significant proportion in the 18-21 years age bracket (30% and 52% respectively).

This study did not access those self-identified MSM younger than 18 years of age because of certain ethical and consent issues, but retrospective information in the study clearly indicate early sexual debut (see Question 201), while anecdotal information and documentation also indicate a significant proportion of self-identified MSM are sexually active before the age of 18 years (see previous report on a *Desk Review of current literature on HIV and male-male sexualities, behaviours and sexual exploitation in Afghanistan*, September 2008).

It needs to be noted here that such early sexual debut by self-identified MSM (primarily feminised males) is not uncommon across South Asian cultures (see NFI assessment reports of MSM in Dhaka, Lucknow, New Delhi and Lahore[12]).

In both Kabul and Mazar, the majority reported more than 6 years of education. However this should not be taken as definitive, as the study teams only accessed self-identified MSM through friendship

[10] India Today, 18 November 2008, *Innocence Violated*
[11] *Sexual Abuse of Street Children Brought to an Observation Home*, Departments of Community Medicine and Psychiatry, Maluana Azad Medical College, New Delhi 2004
[12] Available on the NFI website, www.nfi.net

networks, and these are often determined by class and educational status. Thus, the study teams did not access those who had no formal education, or were less educated.

At the same time, the majority of respondents were unmarried (38/50 and 39/50 respectively). However, the level of married MSM should not be determined by this, because of who was being recruited for the study. In all likelihood a significant proportion of MSM will be married at a later date, based on evidence from the other countries in the south Asia region, due to socio-cultural factors of "socially compulsory marriage".

In Kabul, the majority of respondents had migrated from a district town, while in Mazar, respondents primarily originated from major urban areas. At the same time, less than one quarter of respondents were married, but this may well be a reflection of the age spread of the respondents, where marriage in Afghanistan is determined as much as by economic situation as the family.

Most of the respondents in both cities lived with the parents.

101. Age of respondents

	Kabul N=50	Mazar N=50
18-21	15	26
22-30	29	22
Above 30	6	2

102. School attendance

	Kabul N=50	Mazar N=50
Yes	43	49
No	7	1

103. Years of education

	Kabul N=50	Mazar N=50
1-5 years	17	16
6-8 years	17	13
More than 8 years	16	21

104. Origin

	Kabul N=50	Mazar N=50
Village	0	63
District	42	14
City	8	33

105. Marital status

	Kabul N=50	Mazar N=50
Unmarried	38	39
Married	12	11

106. Who do you live with?

	Kabul N=50	Mazar N=50
Alone	1	1
With wife	9	9
With parents	32	39
With a male friend	6	1
With a relative	2	0

Significantly more self-identified MSM reported being employed in Mazar (32/50 than in Kabul (14/50), while more respondents reported engagement in sex work as a source of income in Kabul (39) than in Mazar (18). This can most likely be interpreted as a consequence of a lack of employment opportunities. 13/50 respondents in Kabul reported a monthly income of above 5000 Afghani (US$100), while only 5/50 in Mazar did so. Kabul reported 10 respondents with a monthly income of above 10,000 Afghani ($US200)

107. Employment

	Kabul N=50	Mazar N=50
Yes	14	32
No	36	18

108. What employment: Kabul

	Kabul N=14
Cleaner	3
Dancer	3
Shop-keeper	3
Working in guest house	1
Private job	1
Tailor	1
Journalist	1
Note: 1 respondent's answer was not translated	
39 respondents stated sex work as their source of income	

108. What employment: Mazar

	Mazar N=32
Car painter	3
Clerk	1
Farmer	4
Welder	3
Government job	4
Hair dresser	2
Mechanic	4
Rug maker	2
Private job	1
Tailor	4

Metal worker	2
Bakery	1
Cosmetic shop	1
18 respondents stated sex work as their source of income	

109. Average monthly income (Afghani)

	Kabul N=50	Mazar N=50
Below 1000	0	0
1000-2000	4	2
2000-3000	17	10
3000-5000	16	33
5000-10000	3	4
Above 10000	10	1

Identities

Self-descriptive labelling was similar in the two cities in terms of words used, usually implying some form of feminisation.

In Kabul the majority of respondents used the term *ezak*, to identify themselves. This is equivalent to the terms *zenana* as used in Pakistan, *kothi* as used in India and Bangladesh, and *meti* in Nepal. These terms have no exact English translation, but carry significance in terms of gender/sexual orientation as a male who is feminine and takes on the receptive role in anal sex with another man.

In Mazar, however, the majority of respondents preferred to use the term *khwaharak*, meaning sister. Equivalent terms also exist in the other countries of south Asia.

With the use of these terms, it appears that the significant framework of male-to-male sex in Afghanistan is based on gender roles and self-identities, as is the common pattern in the other countries of south Asia, where the receptive partner perceives himself as female-like, while the penetrating partner perceives himself as a masculine man.

110. Self-labelling - Kabul

	Kabul N=50
Ezak	32
Koni	6
Bazigar	4
Baccha Bareesh	2
Dojensa	1
Jensbas	1
Maragak	1
Rajhasa	1
Zenana	1
Kharab	1

110. Self-labelling - Mazar

	Mazar N=50
Ayash	7
Koni	14
Dokhter	3
Khwaharak	23
Kharab	1
Ghar	1
Baccha	1

Kabul

Ezak	Man acting like women or hermaphrodite
Koni	Receptive person in anal sex
Bazigar	Boy who dances at a party
Murat	People who act like women or (Zenana - used in Pakistan)
Baccha Baresh	The word meaning is Bboy without beard but they used it as expression for the boy usually kept by another man
Dojensa	Feminised male acting as a woman
Jensbas	Regular sex with mane or to Have sex with male or just looking for male sex
Maragak	Translation not possible
Rakhasa	Boy who dances at a party
Zenana	A self-identifying label for a feminised male who is the receptive partner of men – used in Pakistan
Kharab	Bad person- usually used for a boy who has been raped or is the receptive partner in anal sex with men

Mazar	
Ayash	Person who is looking for sex
Koni	Receptive person in anal sex
Dokhter	Girl
Khwaharak	Means sister – an expression that some self-identified feminised MSM for each other
Kharab	Bad person
Ghar	A hole – used for a boy who is receptive partner in anal sex
Baccha	Boy

Sexual activity

All respondents reported male-to-male sexual contact in the previous two months. Kabul respondents reported a higher level of coercive sex than in Mazar, mainly in the previous year (32/50 to 12/50 respectively). However, 20 respondents from Kabul did not specify a time frame, so all we can say is that coercive sex in Kabul is a part of the pattern of male-male sexual activities.

113. Were you ever forced to have sex with another male

	Kabul N=50	Mazar N=50
Yes	32	12
No	18	38

114. If yes, when was the last time?

	Kabul N=32	Mazar N=12
Last month	0	0
More than three months	0	1
Last year	1	2
More than one year ago	11	9
Yes but not specific	20	0

See Question 208 when this question was repeated more specifically, where in Kabul 14 respondents reported coercive sex in the previous year, whereas only 3 persons in Mazar reported this.

While Kabul MSM reported no sexual contact with a woman apart from those who stated they were married, in Mazar, 15 unmarried self-identified MSM reported sexual contact with a woman (see Question 105 for marital status). Why there appears to be a difference between Kabul and Mazar in terms of female partners is not clear, but one can speculate that social conditions in Mazar is different than Kabul where female contacts may well be easier. Observations by the PI seemed to bear this out.

115. Sexual contact with another woman

	Kabul N=50	Mazar N=50
Yes	12	26
No	38	24

In terms of substance use, there was little alcohol or drug use in either city, with approximately one-fifth of respondents reporting using hashish. Almost no injecting drug use was reported.

116. Have you taken alcohol in the last month?

	Kabul N=50	Mazar N=50
Every day	1	0
At least once a week	10	3
Once in two weeks	9	17
Did not drink	18	5
Never drink	12	25

117. Have you used any drugs other than alcohol in the last month?

	Kabul N=50	Mazar N=50
Yes	15	9
No	35	41
Hashish	10/15	9/9

118. Injecting drugs in the last month

	Kabul N=50	Mazar N=50
Yes	1	0
No	49	50

119. Have any of your sexual partners injected drugs in the last month

	Kabul N=50	Mazar N=50
Yes	2	1
No	24	46
Don't know	24	3

Sexual history

Early sexual debut seems to be the pattern amongst self-identified feminised MSM in both cities, where 30/50 in Kabul and 31/50 in Mazar respondents reported first sexual contact with another male by the age of 15 with the majority of partners in both cities being above 25 years of age, and where receptive anal sex was the common sexual activity. Similar patterns of such early sexual debut among feminised MSM have been reported in other countries of south Asia.[13] Part of the explanation for this lies in within the frameworks of masculinities in these countries, along with, often, strict gender segregation, male ownership of public spaces, and a lack of socialising between males and females.

While the majority of respondents stated they were not forced into this sexual activity (particularly in Mazar where only 5 respondents stated that they were coerced, while in Kabul 20 respondents reported being coerced), a significant majority of respondents experienced a range of negative feelings including anger, guilt and shame. Only 14/50 respondents in Kabul reported feeling pleasure, while in Mazar this figure was 23/50.

The majority of respondents (Kabul 44/50 and Mazar 45/50) received a reward for this activity (cash or gift).

However, respondents from Kabul reported significant levels of coercive sex in the past year compared to Mazar (14/50 to 3/50 respectively). This is a significant difference, which may well lie in the socio-political-religious contrasts between the two cities, where a much stronger gender segregation and military presence exists in Kabul compared to Mazar.

201. Sexual debut with another male/man?

	Kabul N=50	Mazar N=50
Below 10 years	4	1
11-15 years	26	30
16-18 years	17	19
Above 18 years	3	0

202. Age of male/man with whom first had sex with

	Kabul N=50	Mazar N=50
Below 10 years	0	0
11-15 years	0	1
16-18 years	3	2
19-21	18	5
Above 25 years	29	42

[13] See Dhaka, Lucknow, and New Delhi assessment reports and a range of papers produced by NFI on its website www.nfi.net

203. Type of sex on first sexual encounter

	Kabul N=50	Mazar N=50
Receptive anal sex	45	48
Penetrative anal sex	0	4
Thigh sex	5	1

Note: for Mazar there were multiple responses

204. Who asked for sex?

	Kabul N=50	Mazar N=50
Yourself	2	4
Other person	48	46

205. Were you forced to have sex?

	Kabul N=50	Mazar N=50
Yes	20	5
No	30	45

206. What were your feelings at this time?

	Kabul N=50	Mazar N=50
Angry	10	3
Guilty	5	0
Shame	21	24
Pleasure	14	23

207. Did you receive and gifts or money?

	Kabul N=50	Mazar N=50
Yes	44	45
No	6	5

208. How many times have you been forced to have sex with another male/man in the last year?

	Kabul N=50	Mazar N=50
1-5 times	12	3
6-10 times	1	0
More than 10	1	0
Never	36	47

Current sexual behaviour

Compared to other countries in the South Asia region, partner rates are very low with the majority of respondents in both cities reporting rates of one to five partners in the last month. However, 17/50 respondents reported more that 6 partners in month in Kabul, while in Mazar this was 9/50.

Possible reasons for this low rate of partners could well be the palpable sense of fear, of insecurity, of discovery, much of which had been generated during the Taliban era, but which still continues to be a dark shadow over the lives of MSM in both cities. Further, at the time of the study, a crackdown in Kabul on "dancing boys" was being enforced, driving many away from their specific sites and going underground. Along with this was a constant threat of violence that most MSM believe exists. Social networks were broken during the Taliban reign, and as yet have still not been rebuilt to the levels that existed prior to the Taliban take-over.

The primary sexual practice being reported was receptive anal sex, where coercive sex reported in the last month was negligible.

Consistent condom use was poor, with higher rates being reported in Kabul compared to Mazar, while saliva or an oil-based product are used as lubrication.

A range of primary meeting places where identified, where, unlike in other South Asia countries, these were personal homes, shops and guesthouses (this would certainly make outreach activities very difficult), and where, again unlike other South Asia countries, sexual activities primarily took place in such private spaces.

The majority of sex partners were identified as paying clients, strangers and regular partners, which indicates that the majority of respondents not only had a regular partner, but were also involved in sexual activities with other men.

The respondents in both cities with regard to their sex partners also identified a range of occupational groups. Apart from a range of civilian occupations, law enforcement and military personnel were significant, an issue of concern regarding the lack of attention to the issue of HIV amongst the unformed services.

301. Different partners in the last month

	Kabul N=50	Mazar N=50
1-5 partners	33	41
6-10 times	13	9
More than 10	4	0

302. How times did you do receptive anal sex in the last month?

	Kabul N=50	Mazar N=50
1-5	29	25
6-10 times	17	24
More than 10	4	1

303. How times did you do penetrative anal sex in the last month?

	Kabul N=50	Mazar N=50
1-5 times	6	37
6-10 times	0	1
More than 10	0	0
Non-penetrative	0	12

304. Forced sex in the last month

	Kabul N=50	Mazar N=50
1 time	2	0

305. Condom use for anal sex

	Kabul N=50	Mazar N=50
Every time	8	5
Sometimes	23	7
Never	19	40

306. Lubricant use for anal sex

	Kabul N=50	Mazar N=50
Every time	2	5
Sometimes	36	45
Never	12	0
No response	5	0

307. What type of lubricant

	Kabul N=50	Mazar N=50
Saliva	48	43
Oil	0	0
Cooking oil	3	4
Cream	2	41
Others	2	16
Others include: shampoo, Vaseline, machine oil		

Multiple responses

308. Where did you meet your sex partners?

	Kabul N=50	Mazar N=50
Personal home	5	10
Sex partner's home	49	48
Someone else's home	27	46
Park	0	8
Public toilet	2	2
Bus	1	0
Car	3	2
Shop	23	34
Guest house/hotel	44	39
Hammam	7	1
Cinema hall	1	0
Office	1	2

Multiple responses

309. Where did you do sex?

	Kabul N=50	Mazar N=50
Personal home	5	10
Sex partner's home	49	48
Someone else's home	27	46
Park	0	8
Public toilet	2	2
Bus	1	0
Car	3	2
Shop	23	34
Guest house/hotel	44	39
Hammam	7	1
Office	1	2
Cinema Hall	1	

Multiple responses

310. Who were these sex partners?

	Kabul N=50	Mazar N=50
Regular partner	36	45
Friend	13	28
Stranger	47	45
Neighbour	5	3
Male relative	3	2
Male sex worker	2	3
Paying client	46	47

Multiple responses

311. Which occupational group did your sex partners come from?

	Kabul N=50	Mazar N=50
Truck drivers	29	12
Law enforcement personnel	25	31
Taxi drivers	32	37
Shopkeepers	42	39
Military personnel	25	10
Mechanic	13	8
Businessmen	40	34
Others	14	19

Multiple responses

Paid male-to-male sex

All respondents in both Kabul and Mazar reported that they had received money for sex in the previous month, with the majority receiving between 100-500 Afghani (US$2-US$10), primarily for receptive anal sex. However, Mazar respondents reported significant levels of penetrative anal sex as well (27/50), while Kabul respondents reported a range of non-penetrative acts such as oral sex, masturbation and thigh sex (13/50/37/50, and 41/50 respectively).

In Kabul, paid sex appears to involve a significant level of different types of sexual activities compared with Mazar, however these reported activities do not include those that are provided for free with their regular partners, and others who are deemed "handsome" by the respondents (anecdotal information provided by a number of participants in pre-survey discussions).

Reported paid partner rates are relatively low compared with other south Asian countries with 33/50 and 25/50 respondents reporting between one and five paying clients in Kabul and Mazar respectively in the last month, while 17/50 and 24/50 reporting more than 6 paying clients in the previous month in these cities respectively.

Condom use was significantly higher in Kabul than Mazar for the last paid sex act (14/50, 4/50 respectively), but still low, and generally it was the provider that asked for condom use. In terms of consistent condom use, again Kabul was higher than Mazar with 8/50 (16%) reporting consistency compared to 3/50 (6%), much lower than the UNAIDS figure of 60% condom coverage required to ensure adequate risk reduction. Usually it was the sex provider who decided on condom in anal sex.

401. Have you received money for sex with another male?

	Kabul N=50	Mazar N=50
Yes	50	50
No	0	0

402. The last time you were paid, how much did you receive (Afghani)?

	Kabul N=50	Mazar N=50
100-500	33	38
500-1000	13	9
1000-1500	3	1
More than 1500	1	2

403. The last time you were paid for sex, what type of sex was this?

	Kabul N=50	Mazar N=50
Receptive anal sex	49	49
Penetrative anal sex	5	27
Oral sex	13	10
Masturbation	37	0
Thigh sex	41	2

Multiple responses

404. The last time you were paid for sex, was a condom used?

	Kabul N=50	Mazar N=50
Yes	14	4
No	36	46

405. If a condom was used, who decided this?

	Kabul N=14	Mazar N=4
Yourself	8	3

Your partner	4	1
Mutual	2	0

406. In the last month, how many times have you been paid for sex?

	Kabul N=50	Mazar N=50
1-5 times	33	25
6-10 times	12	23
11-15 times	5	2

407. In the last month, how many times were condoms used if you were paid for sex?

	Kabul N=50	Mazar N=50
Every time	8	3
Sometimes	14	3
Never	28	44

408. In the last month, if condoms were used for paid anal sex, who decided this?

	Kabul N=22	Mazar N=6
Yourself	12	4
Your partner	10	2

Only 3 respondents in each city reported paying for either receptive or penetrative anal sex, where no condoms were used.

409. Have you ever paid for sex with another male/man?

	Kabul N=50	Mazar N=50
Yes	3	3
No	47	47

410. How much money did you pay the last time you bought sex from another male/man (Afghani)?

	Kabul N=3	Mazar N=3
100-500	2	1
500-1000	1	1
1000-1500	0	1

411. What type of sex did you pay for?

	Kabul N=3	Mazar N=3
Receptive anal sex	2	1
Penetrative anal sex	1	2

412. In the last month how many times have you paid for sex with another male/man?

	Kabul N=3	Mazar N=3
1-5 times	3	3

413. In the last month how many times were condoms used for anal sex when you paid for sex?

	Kabul N=3	Mazar N=3
Every time	0	0
Sometimes	0	0
Never	3	3

414. In the last month when you paid for anal sex, how many times did the other person ask you to use a condom?

	Kabul N=50	Mazar N=50
Every time	0	0
Sometimes	0	0
Never	3	3

Sex with females (other than wife, if married)

Mazar reported significantly higher rates of sex with females (other than one's wife) than Kabul (35/50, 7/50), perhaps due to the comparatively more relaxed social environment in the former city (as experienced by the author) and the greater opportunities to socialise/meet with women. Since in Mazar only 11 respondents reported being married, a significant proportion of unmarried males who were self-identified MSM were also have sex with females. Again Mazar reported a higher number of paid sex with females (11/35) than Kabul, but this also indicates a significant level of unpaid sex with females in the former city. At the same time Mazar respondents report two paid acts of anal sex with females (2/11).

For those buying sex from females, it appears to be at least once a month, but with no condom usage.

501. Have you ever had sex with a female (other than your wife if married)?

	Kabul N=50	Mazar N=50
Yes	7	35
No	43	15

502. Have you ever paid for sex with a female?

	Kabul N=7	Mazar N=35
Yes	3	11
No	4	24

503. What type of sex did you pay for?

	Kabul N=3	Mazar N=11
Vaginal sex	3	9
Anal sex	0	2

504. How many different females did you pay for sex in the last month?

	Kabul N=3	Mazar N=11
1-5 times	3	11

505. In the last month how many times were condoms used when you have sex with females

	Kabul N=3	Mazar N=11
Every time	0	0
Sometimes	0	2
Never	3	9

Health

With a limited budget, this study did not conduct blood testing for STIs (or, for that matter, HIV), but tried to find out about symptomatic conditions and other issues by asking appropriate questions. This was quite difficult because terminology was difficult to address in meaningful ways, as it was understood that there would be a lack of knowledge on medical terms, and that colloquial terms may also not be available. Thus the questionnaire did not address specific symptoms, but does provide an indicator for more in-depth study at a future date on the issue.

Mazar respondents reported much higher symptomatic concerns than Kabul where 37/50 respondents stated that they currently had some type of symptom in the genital or anal area compared with Kabul's 15/50. This may have arisen because of the higher rates of both receptive and penetrative anal sex activities in Mazar compared with Kabul, along with higher rates with female partners other than one's wife.

However, the majority of those respondents reporting some sort of anal or genital symptom did not go for professional treatment, where they either self-treated, visited a "street doctor", or did nothing. This was also true for those with previous symptoms. Only 4 respondents in Kabul and 1 respondent in Mazar reported ever visiting a clinic for sexually transmitted infections. From previously held discussions with MSM in Mazar, this low service take-up is primarily due to the fear of discovery.

3 respondents in Kabul and 1 in Mazar reported being tested for HIV (the term "AIDS test" was used in the questionnaire because of the concerns that respondents may not understand the difference between HIV and AIDS) at a private clinic, but it was not clear why they were motivated to have such a test. The results were reported as being negative, and they stated that they also had pre-test and post-test counselling, but the content and quality of this counselling was not evaluated.

In an attempt to capture any degree of depression or suicidal feelings that respondents may have experienced, as these can have a significant impact on risky sexual behaviours, respondents were also asked if they had ever experienced such feelings in the past year. 17/50 respondents in Kabul and 9/50 in Mazar reported such feelings.

601. In the last six months have you had any symptoms in the areas identified?

	Kabul N=50	Mazar N=50
Genital area	4	18
Anal area	11	22
Inside the mouth	0	3
None	35	13

Multiple responses

602. If you have these symptoms what are doing about them?

	Kabul N=15	Mazar N=37
Nothing	9	7
Self-treatment	1	11
Visit a government clinic	0	2
Visit a private clinic	4	5
See a "street" doctor	0	13
Ask a friend	1	1

Multiple responses from Mazar

603. If you do not have these symptoms now, have you ever had symptoms in the identified areas?

	Kabul N=35	Mazar N=13
Yes	15	6
No	20	7

604. The last time you had symptoms in these areas what did you do?

	Kabul N=15	Mazar N=38
Nothing	4	8
Self-treatment	4	13
Visit a government clinic	0	2
Visit a private clinic	3	4
See a "street" doctor	3	16
Ask a friend	1	1

Multiple responses from Mazar

605. Have you ever visited a clinic for any sexually transmitted infection?

	Kabul N=50	Mazar N=50
Yes	4	1
No	46	49

606. Have you ever been tested for "AIDS"?

	Kabul N=50	Mazar N=50
Yes	3	1
No	47	49

607. What was the result?

	Kabul N=3	Mazar N=1
Positive	0	0
Negative	3	1

608. Where was the test conducted?

	Kabul N=3	Mazar N=1
Private clinic	3	1

609. Were you counselled before the test?

	Kabul N=3	Mazar N=1
Yes	3	1

610. Were you counselled following the test?

	Kabul N=3	Mazar N=1
Yes	3	1

611. Have you ever felt suicidal in the past year?

	Kabul N=50	Mazar N=50
Yes	17	9
No	33	41

Knowledge

A majority of respondents had heard the term AIDS in both Kabul and Mazar, while much fewer had heard the term HIV. However, the level of correct knowledge and understanding of AIDS and/or HIV was considerably low based on the respondents' statements on what they had heard. Only one respondent correctly identified HIV as a virus. The primary sources of information were television, or friends.

Significantly more Kabul respondents believed that they did have a risk of being infected with an STI compared to those from Mazar (29/50, 8/50), where 13 of those in Kabul admitted that they had a high risk, while only 2 Mazar respondents stated this to be the case.

In Kabul, 20/50 respondents stated that they did not know how they could get infected with HIV ("AIDS"), while 15/50 respondents reported a similar lack of knowledge in Mazar. Significant minorities in both cities correctly cited 2 possible routes of infection, as well as reporting the sharing of barber's equipment as a possible route.

Knowledge of risk reduction was relatively poor with Kabul again showing better information where 18/50 in Kabul stated using condoms as a means of protection, while the proportion for Mazar was 10/50.

In terms of partner notification of an STI or HIV infection the majority of respondents stated that they would not inform their partners, perhaps arising from a deeply held sense of fear of discovery and "outing" with consequent difficulties that would rise from such notification.

701. Have you ever heard of AIDS?

	Kabul N=50	Mazar N=50
Yes	30	36
No	20	14

702. What have you heard?

	Kabul N=30
By having sex	4
Dangerous disease	11
Infection	2
Illness	1
Having sex with a foreigner	1
From bad things	1
From surgical equipment	1
Homosexual activities	1
Weak immune system	1
Sex without a condom	1
Sex with minimum partners	1
From other person	1
Everyone can get it	3
Don't know	1

702. What have you heard?

	Mazar N=36
Communicable disease	5
Dangerous disease	12
Disease	2
Deadly disease	2
Fatal disease	12
Infectious disease	5
Don't know	14

Multiple responses

703. Where did you get this information?

	Kabul N=30	Mazar N=36
TV	11	32
Radio	2	0
Friends	11	2
Doctors	1	1
BCC	1	0
Don't know	1	
From other people	4	0

Client	1	1
Outreach workers (ORA)	3	0

Multiple responses

704. Have you heard of HIV?

	Kabul N=50	Mazar N=50
Yes	8	19
No	42	31

705. What have you heard?

	Kabul N=8
Virus	1
Infectious disease	4
Illness	1
Only heard the term	2

705. What have you heard?

	Mazar N=19
Communicable disease	2
Dangerous disease	4
Fatal disease	4
Infectious disease	4
This means AIDS	3
Only heard the term	2

706. Where did you get this information?

	Kabul N=8	Mazar N=19
Doctor	0	1
Hospital	0	1
TV	7	12
Radio	2	0
Newspaper	0	5
Magazine	0	8
Friends	2	0

Multiple responses

707. Do you think you have a risk of getting an STI?

	Kabul N=50	Mazar N=50
Yes	29	8
No	21	42

708. If yes, can you grade your risk?

	Kabul N=29	Mazar N=8
Low	8	0
Medium	5	6
High	13	2
Don't know	3	0

709. Tell is 3 different ways of getting infected with HIV (used the word AIDS)

	Kabul N=50	Mazar N=50
Blood	15	20
Barbers' equipment	10	7
Sexual contact	24	11
Syringe	6	2
Using other people's spoon/toothbrush	3	5
Sex with a person with a positive person	1	2
By French kissing	1	
By drinking tea	1	
Don't know	20	15

710. Tell us 3 different ways of protecting yourself from "AIDS".

	Kabul N=50	Mazar N=50
Using condoms	18	10
Don't bath with anybody	7	5
Don't take blood from HIV positive person	1	
Only sex with healthy person	15	20
Hygiene	18	21
Ejaculate outside the body	6	10
Safe needle	1	2
Don't do receptive sex	1	1
Don't use barber's equipment	5	8

711. If you know you have an STI or "AIDS" will you tell your sexual partners?

	Kabul N=50	Mazar N=50
Yes	19	12
No	30	38
Maybe	1	0

Recruiting self-identified MSM in Kabul and Mazar for this study was not very difficult, once a key informant was recruited to be a member of the study teams, and with the snowballing techniques employed, a rapid assessment could be conducted. The numbers recruited for interviews could have been larger than the 50 in each city, but was limited by financial constraints. While it had been anticipated that fear of discovery would be a constraining factor, the two study teams were able to reassure respondents of confidentiality and security in order to access the information. This relative

ease of identification and recruitment could be a signifier of significant MSM sexual networks that are relatively readily accessible.

This limited assessment indicated significant levels of male sex work, the primary sexual practice of respondents being receptive anal sex, a gendered dynamic of male sexualities, significant rates of possible STI symptoms, poor knowledge of HIV and AIDS, low condom usage, as well as early sexual debut and coercive sex.

It is also clear that male-to-male sex exists in Afghanistan to a significant degree, and that there is a diversity of frameworks of sexualities and masculinities through which such behaviours are expressed. Much of the social and sexual lives of self-identified MSM are highly circumscribed by the possibility of violence, criminalisation, imprisonment, rape, and even death, all of which increases vulnerability and risk in the context of HIV, where access to condoms, water-based lubricant, and treatment services for sexually transmitted infections through oral and anal sex is problematic.

At the same time, to ensure that such services are developed, and made available, legal impediments will need to be addressed, where visibility could easily lead to arrest, trial and imprisonment, or to violence and abuse.

Desk review summary

(From the Principal Investigator's literature review of male-to-male sex and sexualities in Afghanistan: Everybody knows, but nobody knows – Desk review of current literature on HIV and male-male sexualities, behaviours and sexual exploitation in Afghanistan)

Afghanistan is emerging from 30 years of civil war, with significant issues of poverty, high fertility rates, low literacy, along with high levels of unemployment, low life expectancy, poor primary health care systems, and returning refugee populations.

While growing investment in development and infrastructure is occurring, Afghanistan is still being confronted by what is often called a "resurgent Taliban movement", with regular attacks against the Afghanistan authorities and Coalition forces that are leading to increasing insecurity, fear and concern for the future.[14]

Despite being a strongly conservative and traditional society, as well as defining itself as an "Islamic Republic", Afghanistan has begun to confront the possibility of an HIV epidemic with the recognition that all the behavioural and socioeconomic factors that produce high levels of risk and vulnerability exist within the country. This includes the acknowledgement of the existence of highly vulnerable populations such as injecting drug users, female sex workers, and males who have sex with males.

This acknowledgement is clearly articulated in the 2007 Project Implementation Plan of the Afghanistan HIV/AIDS Prevention Project (AHAPP) of the National AIDS Control Programme, Ministry of Public Health.[15]

At the same time, there is significant anecdotal evidence that sexual exploitation and/or abuse of adolescent males by older men exists in what appears to be significant levels, and can, in some parts of the country, be considered a social norm within certain segments of Afghanistan society, particularly among certain populations.[16]

In the context of HIV, while there is some data on HIV prevalence, particularly in the context of injecting drug use, there is almost none regarding male-to-male sexual behaviours, nor any ethnographic studies on MSM to understand the dynamics of male-to-male transmission and their possible risk and vulnerability to HIV and other sexually transmitted infections. What data does exist indicate a significant cross-over between injecting drugs users and male-to-male sexual behaviours.

This review synthesises what knowledge is available regarding male-to-male sexualities and behaviours in the context of Afghanistan, along with risks and vulnerabilities to HIV and other sexually transmitted infections, along with highlighting the issue of adolescent male sexual exploitation and abuse. Apart from accessing official reports and studies, due to the paucity of information, a range of media articles and essays from 1980s that speak of "dancing boys", "beardless youths" and pederastic customs in Muslim cultures and in Afghanistan. In addition, reports on MSM and HIV in a number of Muslim countries (such as Bangladesh, Indonesia, Pakistan, the Mahgreb), along with a range of books that speak of MSM in Muslim countries, and a range of reports, essays

[14] Personal communications with various public officials during the Scoping Mission

[15] Page 7, under Objectives and Description of Programme, Goals and Objectives, Figure 1 *Preventing HIV among most at risk and vulnerable groups within Afghanistan*, and under Component 3, which states that "…these groups can include IDUs, sex workers, MSM, their clients, their partners and others."

[16] See *Boys of the Taliban* by Jamie Glazov, January 1 2007, FrontPageMagazine.com http://www,.frontpagemagazine.com/Articles/ReadArticles.asp?ID=261990, downloaded May 15 2008, where he discuss a rule 19 of the Taliban instructing Taliban fighters that they must not take young boys without facial hair into their private quarters. Also see *Bacabozlik: Boylove, folksong and literature in Central Asia*, Ingeborg Baldauf, (date and source of essay unknown) which focuses on this subject in Afghanistan, hard copy of essay in NFI Resource Centre, Lucknow, India. Further, in a range of discussions in Kabul and Mazar during the Scoping Mission, almost every conversation on HIV and male-to-male sex raised the issue of what was called *baacha bazee* – dancing boys and possible pederastic encounters

and studies produced by NFI available on its website were also reviewed. A listing of all these resources is available as an annexe in this report, as well as identified in footnotes where appropriate.

While the majority of this literature does not specifically speak of the situation in Afghanistan, they do discuss the context of male- male sexualities and behaviours in both a historical and contemporary sense. These were contexualised in terms of Afghanistan as a Muslim country that borders Pakistan with historical links with India, and other Muslim countries.[17]

This review does not claim to be an exhaustive study of the issue of HIV, male-male sexualities, behaviours and sexual exploitation in Afghanistan. It does, however give a glimpse of the framework of male-male sexual practices in Afghanistan, and the complexities that this encompasses, along with a brief analysis of risks and vulnerabilities, and endeavours to come to an understanding on the nature and dynamic of male sexualities in the country that frames such sexualities along adolescent male sexualities and possible sexual exploitation.

Five key themes emerge from this review:

1. There is an enormous lack of data on male-male sexualities, practices, frameworks, population sizes, issues, needs and concerns, along with sexual networking and the extent of such behaviours
2. Male-to-male sexual behaviours do not form a monolithic oppositional binary with 'heterosexuality, but are expressed through a diversity of frameworks, where in Afghanistan these tend to be either age structured or based on gender performance within a structure of man/not-man. The partners of adolescent or feminised males do see themselves as being 'homosexual', but as masculine men who penetrate others.
3. There is a significant number of men in Afghanistan who are involved in the historical and traditional patterns of *bacha bazi,* the sexual involvement and exploitation of adolescent males.
4. There is a lack of appropriate services that address the needs of sexually exploited adolescent males, along with males who have sex with males, in an environment of significant risk and vulnerability, that could easily develop into a concentrated HIV epidemic unless addressed urgently
5. A sociocultural environment, along with religious and legal frameworks, that can be major impediments to developing appropriate services for sexually exploited adolescent males and MSM unless addressed sensitively.

Clearly, what the record shows, is that male-to-male sexual practices exist in Afghanistan, that they are possibly substantive within differing constructions of male-to-male sex, where they exist within high levels or risk and vulnerability in the context of HIV, other sexually transmitted infections, and a lack of human rights.

July 9, 2008: The Ministry of Public Health stated that "so far 435 HIV positive cases have been reported from different sources", adding that "there are an estimated 2,000 to 2,500 cases nationwide". The Ministry also stated that the potential risk factors for the spread of HIV include 30 years of war, high levels of poverty and illiteracy, displacement, poppy cultivation, drug trafficking and use, commercial and unsafe sex, and unsafe injection and blood transfusion practices (Source, sea-AIDS, 10/7/08)

A literature review by John Hopkins University[18] stated the following:
General population HIV prevalence: 0.01%
(source: POP, NACP, MOPH, 2007 and CSO, Islamic republic of Afghanistan, 2007)

[17] Zahiruddin Muhammad, the first Mughal ruler of India, was the son of Umar Sheikh Mirxza ruler of Farghana, a small principality of northern Afghanistan. He was known to have fallen in love with a boy called Baburi. Several Mughal rules and members of the court were also know to keep boy harems. See *Same-sex love in India – readings from literature and history*, edited by Ruth Vanita and Saleem Kidwai, MacMillan India Ltd, 2001

[18] *HIV in Afghanistan: a review of literature and evidence of disease burden among vulnerable populations*, Andrea Wilson, John Hopkins University, Draft, 2008

HIV prevalence among high risk groups:
Injecting Drug Users: 3.70%
(source: Todd C.S. et al. Prevalence of HIV, Hepatitis C, Hepatitis B, and Associated Risk Behaviours among Injecting Drug Users in Kabul, Afghanistan, 2006)

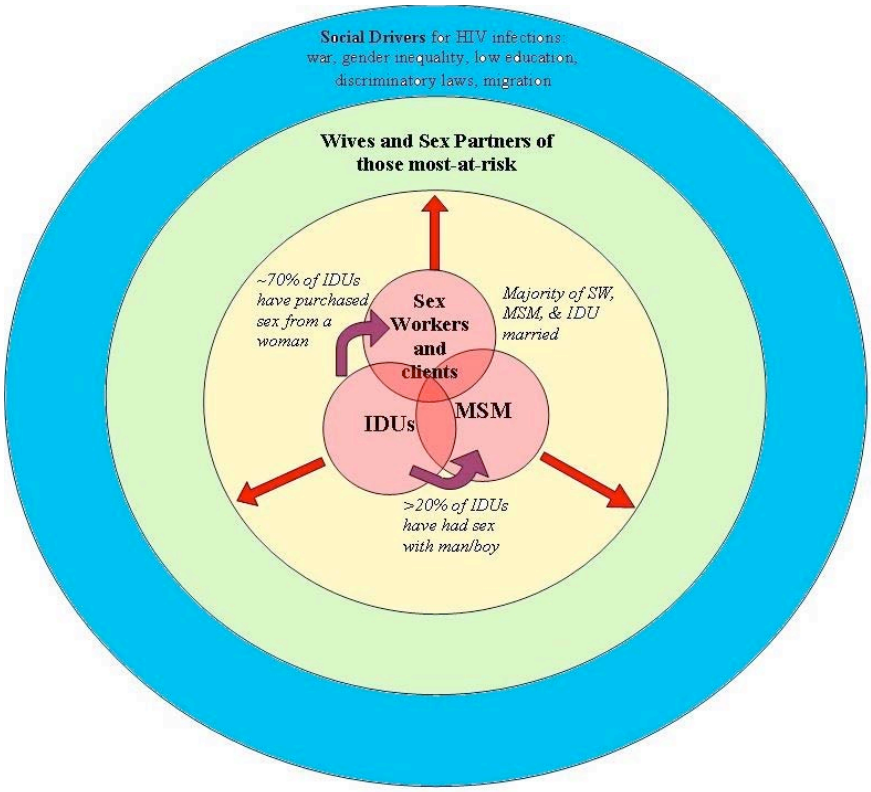
A mapping and situation assessment conducted by the University of Manitoba[19] stated that the existence of high risk IDU networks include relatively high prevalence levels of hepatitis C (36.6%), Hepatitis B (6.5%) and syphilis (2.2%) from the same source.

HIV prevalence among other at-risk populations, specifically MSM, was classified as unknown in this report.

These reports recognises that HIV is an emerging issue of concern, and like other nations in Asia, has begun to rise amongst injecting drug users first.[20] As Pakistan has illustrated[21] it doesn't take long before HIV begins to spread out from an IDU base into other at-risk populations such as MSM and FSW. This is reiterated strongly in the Independent Commission on AIDS in Asia report, *Redefining AIDS in Asia: crafting an effective response*, released in March 2008.

A map demonstrating overlapping risk behaviours and links to the general population in an environment of multiple societal drivers if HIV transmission was used in a report *Understanding HIV in Afghanistan: the emerging epidemic and road ahead.*[22]

[19] *Mapping and Situation Assessment of High Risk Key Populations in Three Cities in Afghanistan, Final Report*, September 2007, University of Manitoba
[20] See the Independent Commission on AIDS in Asia, *Redefining AIDS in Asia: crafting an effective response*, 2008, www.unaids.org
[21] MSM in Pakistan – a review of existing literature, Dr Faran Emmanuel, Canada Pakistan HASP-PACP, national MSM consultation meeting, 2006 presentation
[22] p10, *Understanding HIV in Afghanistan: the emerging epidemic and road ahead*, The Islamic Republic of Afghanistan's National AIDS Programme, John Hopkins University/Indian Institute of Health Management Research, draft 2008 from qualitative source from 4 urban cities, Todd, C., Abed A., Strathdee, S., et al. Prevalence of HIV, viral hepatitis, syphilis and risk behaviors among Injection drug users in Kabul, Afghanistan. 2006; Todd, C et al. Seroprevelance and behavioral correlates of HIV, Syphilis, and Hepatitis B and C among High Risk Goups in three Afghan Cities. UCSD/IRC/Columbia University, 2008.



In the Manitoba report, MSM is mentioned, but with the caveat that information was very difficult to obtain. Thus it states that *key informants identified 12 – 21 men active in commercial sex in three districts (in Mazar-i-Sharif). However, since this activity is highly stigmatized in contemporary Afghan society, this likely reflects significant underreporting. In Mazar-i-Sharif, nine MSM primary key informants were interviewed, accessed through SM contacts. These informants confirmed that MSM activities are kept secretive amongst small networks. They indicated that risk seeking behaviour occurred mostly in the homes of clients with a frequency of about 3 clients /day. The primary KIs also reported that 100 or more MSM were selling sex in Mazar-i-Sharif, but the location and size of these networks was not confirmed."*

And in Table H.1.2 – *Selected drug using and sexual behaviours of IDUs in Mazār-i-Sharif and Jalalabad, Afghanistan* in their report, it highlights cross cutting issues relating to IDU and MSM

	Mazar-e-Sharif (n=45)	**Jalalabad (n=31)**	**Total (n=76)**
Ever had sex with a male	22%	21%	21%
Had sex with a male in past 6 months	7%	0%	3%

The Todd study quoted above also mentions such crosscutting issues where it states that *risky behaviours, including sharing syringes (35.4%), paying women for sex (76.2%), and sex with men or boys (28.3%), were common.*

This is also illustrated in table of injecting users profile developed in the draft report from John Hopkins mentioned above where data from a number of studies were combined:[23]\

[23] Page 14, Table 2. Injecting Drug Users Profile**.** Key descriptive indicators of injecting drug use in Afghanistan by four urban centers: Kabul, Heart, Mazar-i-Sharif, and Jalalabad.
*Data from *Todd, C & Scott P. UCSD/WRAIR/NAMRU Project, 2007*

Indicator	*Kabul*	*Herat*	*Mazar-e-Sharif*	*Jalalabad*
HIV Prevalence	3.0% (N=464); *2007**	3.1% (N=340); *2007**	No cases of HIV detected (N=187); *2007**	No cases of HIV detected (N=96); *2007**
Sex with men/boys: % of IDUs having had sex with men/boys	27% (N=464); *2007**	23.2% (N=623); *2007**		

In an ORA International survey of groups at high risk of contracting STIs and HIV in Kabul conducted in 2003-2004[24], while MSM are not mentioned as a specific risk group category[25] male-male sexual practices are mentioned several times in the report:

A number of cinemas in the area attract young boys who are often used for homosexual prostitution. The area also contains a number of police stations and many hotels with sleeping quarters for truck drivers and other transient people. The Mussafar Khana is a well-known place for truck drivers to sleep with many bus stations nearby. In addition District 1 has numerous musicians and male dancers, many of whom are known to provide commercial sex services.

ORA also surveyed government departments, such as the Department of Forensic Medicine, the Attorney General's Office, and also reviewed 2002 crime statistics. Unfortunately the ORA report conflates pederasty with homosexuality, so there was no breakdown between pederastic encounters where at least one of the partners involved was below 18 years,[26] and those encounters where both partners were 18 years and above.

Thus, from the Department of Forensic Medicine:

Type of cases	Number of cases
Illegal heterosexuality (Vaginal sex)	65
Illegal heterosexuality (Vaginal and anal sex)	22
Illegal homosexuality	85
Total	172

I am intrigued by ORA's use of the word "illegal" here. I am presuming that "illegal heterosexuality" means pre-marital and extra-marital vaginal sex. But what is the difference between the first and second figures other than the inclusion of anal sex? Interesting, this the only document where I have found any mention of anal sex with females! Again, unfortunately this key datum was not followed through.

[+] Data from *Action Aid KAP Study, 2006*

° Data from University of Manitoba Mapping Study, 2007

[24] *Survey of groups at high risk of contracting sexually transmitted infections and HIV/AIDS in Kabul*, ORA International, April 2005

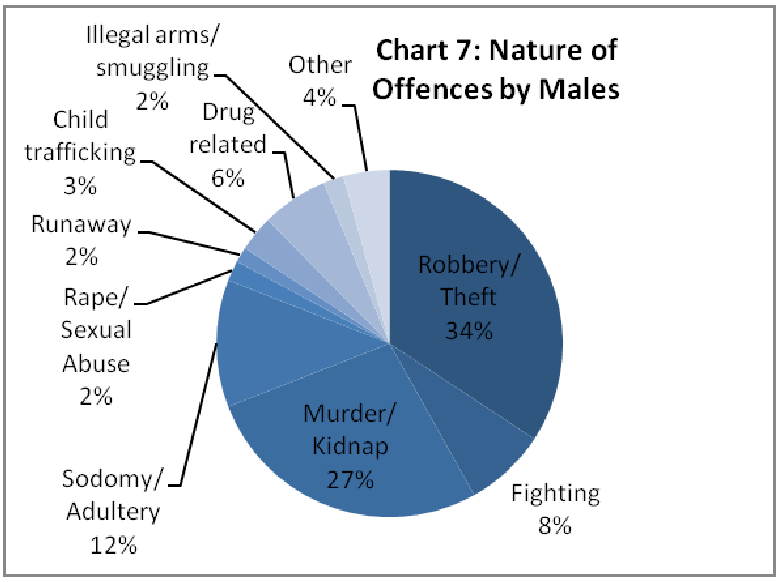
[25] At Risk Groups: Commercial sex workers (CSW's), Police officers, truck drivers and street children, including boot polishers, hotel workers and beggars, are at an increased risk of contracting HIV, ORA report, p4, Major Findings

[26] The UNICEF definition of a child is someone below the age of 18 years of age. However, in many countries, the legal age of consensual sex whether between males and females, or between males and between females, varies considerably. In the UK, this age is 16 years.

"Illegal homosexuality" – what does this mean? According to the Afghanistan Penal Code, male-male sexual behaviours are illegal, punishable by imprisonment, and if the *Sharia* is brought into play, death (see below for a discussion on the law). Also the use of the term "homosexuality" is also problematic, as it describes a "condition" or "orientation" and not a behaviour.

ORA's report goes on to state that the Attorney General's Office had recorded some 57 cases of pederasty in Afghanistan in the previous year (2202), while the United Report on Criminal Cases registered with the Attorney General of Kabul Province and related branches for the time period of 1/11/1381 to 12/12/1381 recorded …15 cases of pederasty within Kabul province's districts. Unfortunately, the conflation of the terms pederasty and homosexuality means that this particular datum, while interesting to point out, doesn't say that much.

In a study conducted by the Afghanistan Independent Human Rights Commission on the situation for children in conflict with the law in Afghanistan,[27] with 247 respondents, they reported:



For males, 34% of cases were related to robbery/theft while 27% of cases were related to murder or kidnap. However, in many of these cases the juvenile may not have been the sole or even the primary defendant. *12% of cases were related to sodomy or adultery* while only 2% of cases were related to rape or sexual abuse. 8% of male respondents had been charged in relation to fighting while a further 2% of cases were of boys who had run away from home.

[27] *Justice for Children – the situation for children in conflict with the law in Afghanistan*, Afghanistan Independent Human Rights Commission, working draft, January 2008

Some general observations

(From the Principal Investigator's Inception Report, September 2008)

It is only a few years ago that the Taliban controlled Afghanistan, bringing with them their own framework of moral codes and Islamic justice, which to a central extent, was shaped by their understanding of *sharia* law and the Qu'ran. Strict adherence was enforced, including the demand that all men should have beards, the banning of music and other forms of entertainment, the attacks on girl education schemes, enforced segregation of men and women, and many other areas which were perceived to fall under the *sharia*. In several cases, it was reported that MSM were imprisoned, whipped, or even executed. For the majority of MSM, particularly those whose gender performance was feminine, the risk of discovery leading to whippings, if not imprisonment, or death was an immediate experience, generating very high levels of fear. That fear continues to be experienced, exacerbated by the recent resurgence of the Taliban in the eastern and southern regions of the country, and impacts on all the lives of those whom the PI was able to meet during this visit while shaping what was possible to achieve during the actual study. Its psychological impact is incalculable, heightening the sense of extreme vulnerability and risk in day-to-day lives, increasing the sense of insecurity, while producing a negative impact on future hopes and aspirations.

With this level of insecurity and fear of the future, the significant levels of visible poverty, along with the known levels of male unemployment, and low levels of income, creates a social environment in which perceived deprivation motivates a demand for payment of any sort of perceived service, rather than voluntary action. This means that it is expected that all respondents for this assessment will demand some sort of recompense for the time spent in interviews, travelling to and from such interviews, and any other service being provided. This would have an impact on the budgeting process for the assessment, along with perhaps reducing access to potential respondents.

The PI, during his time in Kabul and Mazar, noticed very high levels of children below the age of 14 years of age either working on the streets or in a variety of small enterprises (tea-shops, repair shops, etc), indicating possible migration to the cities from rural areas, poverty and unemployment, along with a lack of adherence to compulsory primary education, and large families. This exposure in a highly gender segregated culture leaves many such children highly vulnerable to various degrees of exploitation, not the least being that of reduced income and early working lives, as well as potential sexual abuse, and a population growing up illiterate and lacking knowledge to build sustainable lives in a complex world.

The psychology of enclosure seems also to be pervasive. Architecturally, geographically, as well as appearance, indicated an inner sense of protectiveness to the "outsider". Thus homes are constructed with high walls that are inward looking rather that outward, the hills and mountains of Afghanistan surrounding villages, towns and cities, the concept of the bearded and beardless males, the beard hiding the face, the *hijab* and the *burqa* that hides the female, all create a sensibility of invisibility while strengthening a duality in the lives of so many Afghans – a distinct separation between the public and private domains, separated by walls of what could be perceived as deception and denial.

Afghan culture is socially controlled by a shame-based culture, based on male honour and privilege, very different from Western cultures, which are based on guilt. Shame is produced when community perception of an individual's behaviour is invoked through observation and knowledge, whether such knowledge is true of false (based on gossip). Such shame-based cultures reinforce denial and invisibilising of behaviours and practices that do not have social sanction. These frameworks could make it difficult to access information that relates to sexual practices that are *haram* (or illicit, illegal, or against the *sharia*)

Patterns of male-male sex observed by the PI or revealed through discussions include:

- Gender performance[28] – i.e. feminised males as receptive partners, who may or may not cross dress – in the current context socio-political context, public performance may well be highly circumscribed
- Pederastic frameworks – the concept of *baacha bareesh* (beardless boys) seems to be ubiquitous across Afghanistan, although it was interesting to hear people speak of such frameworks as being more common in "Kandahar", or "Mazar", or perhaps "Heart", or maybe "Jalalabad", always elsewhere then where we were.
- Commercial male sex work, although the number of sex partners were reportedly much lower than in Bangladesh, India or Pakistan
- Selling sex implies that there are buyers of male sex, and these buyers sought either penetrative or receptive sex
- Oral sex appears to be common, and less denied than in Bangladesh or Pakistan (less stigma attached to this practice than in those countries?)

Access to appropriate STI treatment services appears to be problematic, not only because of the high stigmatisation of receptive anal sex, but also because of feminisation of some males. Along with this could well be the lack of knowledge of anal STIs.

Gender segregation and the social policing of girls and women, with the relative freedom of male sociability, along with a culture that is highly homosexual and homoaffectionalist[29] creates an environment that can be socially tolerant of male-male sex for those who are the penetrating partners. This behaviour is not seen as homosexual, but as masculine. At the same time, only penile-vaginal sex is perceived as sex. All else is not. But being anally penetrated will be seen as highly stigmatising because of its perceived feminisation of the male body.

In such an environment, patriarchal and male dominated, where social spaces are male only, and gender segregation is the norm, early sexual debut of males, along with abusive and coercive sex is very likely.

There was some anecdotal evidence that anal sex between males and females also exist to a significant degree.

Marriage is socially compulsory, which means that most MSM would be married or eventually get married.

The strong Islamic influence, the low levels of education and literacy, along with the dependency upon *madrassa* education, means that often a strict, traditional and conservative understanding of the *sharia* and the *hadith* plays a significant role in terms of MSM, along with the personal psychological impact that many MSM will be dealing with.

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[28] Gendered framework - the word *gender* is a classifying noun and but often when the term gender is used, it is focused on women, where men are absent as a gender in themselves. The author has used the term *gendered* as an adjective to describe a state. In South Asia where there is often fairly strict social policing of gender(ed) boundaries, and where the primary (and visible) framework of male-to-male sexual behaviours is constructed not around sexual orientation, but around gender(ed) identities, the term *gendered framework* is used as a short-hand description of this state of affairs, i.e. males/men who identified as *kothi*s do not perceive themselves as males, but as "not-males" or feminised males.

[29] In South Asian countries, gender segregation of social spaces is a strong form of social policing of gender relationships. Primary relations are between the same gender (homosocial). Homoaffectionalism in the sense that the term is used in this text means social acceptance of the public display of male-to-male or female-to-female affection. For example, it is common in Bangladesh to see two males holding hands or arms wrapped around each other as they walk. Often male friends will also share beds when sleeping, wrapping themselves around each other. (See Hardman: 1993; Also Khan: 1996, where he points out that the boundary between homoaffectionalism and homosexual behaviours is very "thin" particularly in shared spaces and "under the blanket..")

It appears that there is a revival of traditional values and practices regarding *bacha bareesh,* which existed in Afghanistan (particularly in Pashtun and Uzbek regions) pre-Taliban days.

Size estimations[30]

"…The problem is so widespread that the government has issued a directive barring "beardless boys"- a euphemism for under-age sex partners - from police stations, military bases and commanders' compounds."
Shh, it's an open secret: warlords and pedophilia, New York Times, 21 February 2002

"Ninety percent of men have the desire to commit this sin," the mullah says. "But most are right with God and exercise control. Only 20 to 50% of those who want to do this actually do it."
Kandahar's lightly veiled homosexual habits, Los Angeles Times, 3 April 2002

It's not only religious authorities who describe homosexual sex as common among the Pushtun. Dr. Mohammed Nasem Zafar, a professor at Kandahar Medical College, estimates that about 50% of the city's male residents have sex with men or boys at some point in their lives. He says the prime age at which boys are attractive to men is from 12 to 16 - before their beards grow in. The adolescents sometimes develop medical problems, which he sees in his practice, such as sexually transmitted diseases and sphincter incontinence…

Zafar, the doctor, says that in the community at large the Taliban frightened many men into abstinence. "Under the Taliban, no more than 10% practiced homosexual sex," he says. "But now the government isn't paying attention, so it may go back up to 50%."
Kandahar's lightly veiled homosexual habits, Los Angeles Times, 3 April 2002

"This practice has such a long history in this province that local people treat it as a respected custom…"
Dancing boys of the north, Afghan Press Monitor, October 2007

While these quotes do not purport to give any size estimation are indicative of what appears to be a significant number of males/men involved in male-to-male. Nor did the current study provide any significant clues as to the prevalence of male-male sexual behaviours, nor the level of risk and vulnerability.

As discussed above male-to-male sex as a category is highly complex, diverse, and for many significantly gendered which makes it extremely difficult to make any effective size estimations. Simplifying this complex scenario, it is composed of two or more populations; those that may be relatively visible and those invisiblised because such males are a part of the normative male population.

At the same time, the issue of who is being defined as MSM is extremely pertinent. Should two males who only mutually masturbate each other be defined as MSM? Does a single male-to-male sexual encounter define the participants as MSM? Indeed, how frequently does a male have to sex with another male to be defined as MSM? Should risk to HIV infection be taken into account?

Behavioral surveillance studies are often problematic, inadequate and poorly designed. These studies are plagued by procedural and ethical issues such as where inappropriate questioning is the norm, poor formatting of studies, lack of confidentiality, stigmatization by researchers, or no mention of same-sex relations. This paucity in information and knowledge is further compounded by a lack of understanding of the dynamics and frameworks of same-sex behaviors in an Afghanistan context, particularly in the light of the socio-religious context of Islam as it is practiced in the country, and the recent Taliban past, along with the increasing potential for a Taliban resurgence.

[30] Extracts from the literature review report, *Everybody knows, but nobody knows – desk review of current literature on HIV and male-male sexualities, behaviours and sexual exploitation in Afghanistan*, September 2008, produced as a part of this assessment.

This leads to a lack of sensitivity to the realities of male-to-male sex which can often further exclude many MSM from service provision, treatment and care, as well as significantly underestimate the number of at-risk MSM in any given population along with a lack of resources to support HIV intervention programmes.

The qualitative and quantitative studies regarding MSM in any given population depends very much on the sensitivity of the methodology used, who conducts such studies, how they are conducted, and the groups of males being accessed.

In Pakistan, AIDS Analysis Asia, reported in July 1996[31] that:
20% of men in one rural area have male-to-male sex
40% of men living in a Karachi squatter settlement had male-to-male sex
72% of truck drivers in central Karachi had sex with other males, while 76% had sex with female sex workers

In Bangladesh (another Muslim country, like Pakistan), in an NFI situational assessment in Syhlet in 2000[32] where 200 feminised MSM were interviewed, that they reported an average of 11 different sexual partners a week.

Similar levels were reported in other cities, where most of these sexual partners are so-called normative males. While respondents in the studies may well to some extent exaggerate these figures, there is a clear indication of considerable male-male sexual activity, even in countries with significant Muslim beliefs and traditions.

It has been estimated that between 3% to 20% of all men are estimated to have sex with other men at least once in their lives in parts of Asia (*Caceres CF et al. 2005: Estimating the number of men who have sex with men in low and middle countries. Sexual Transmission Infection Journal 82 -Suppl III*). In a north India study conducted by Dr Ravi Verma of Population Council (*AIDS 2004: 18. 1845-1856*), findings indicated that 10% of single men, and 3% of married men had unprotected anal sex with another male in the past year, while in the same study it was reported that MSM often had more female partners than other men, and they practice anal sex in 11% of their heterosexual contacts.

National or other representative samples of males throughout the world usually find between 5 and 20 percent have had sex with another male some time in their lives, although in certain countries proportions were higher. However, the proportion of males who report recent male-to-male sex within the past year or past 6 months is always considerably lower, ranging from 2 to 10 percent, or approximately half. Certainly, the manner in which these surveys are conducted and the degree of stigma associated with male-to-male sex varies region by region and can be expected to influence survey results, most likely towards under-reporting. Men who report being exclusively interested in male-to-male sex rarely exceed 5 percent in any population. A recent review attempting to examine surveys from around the world suggested that lifetime prevalence of male-to-male sex was 3-5 percent for East Asia and 6-12 percent for South and Southeast Asia (*Cáceres, C., Konda, K., Pecheny, M. Chatterjee, A. and Lyerla, R. Estimating the number of men who have sex with men in low and middle income countries.* ***Sexually Transmitted Infections*** *82(Suppl. III): iii3-iii9, 2006. doi.10.1136/sti.2005.019489*). This same study also estimated that the prevalence of male-to-male sex during the past year was approximately half of the lifetime figures but that the prevalence of unprotected sex was around 40-60 percent in East and Southeast Asia but 70 to 90 percent in South Asia (*Dr Carol Jenkins: Male sexuality and HIV – the case of male-to-male sex; paper developed for UNAIDS and Risks and Responsibilities: Male sexual health and HIV in Asia and the Pacific, an international consultation meeting; 23rd-26th September, 2006, New Delhi, India*).

Based on figures quoted by Caceres above, the male population between 15-64 years of age of

[31] Reported in *AIDS Analysis, Asia*, July 1996, Focus on Pakistan, page 6.
[32] *Situational assessment of sexual health among males who have sex with males and their sexual partners in Sylhet, Bangladesh*, NFI, 2000

8,901,880 identified in the section on socio-economic information above, and taking a conservative estimate of 4% of this figure, would give a possible size estimation of MSM in Afghanistan of some 356,075.

Concluding remarks

Male juvenile sexual exploitation and abuse exists in all societies at varying levels of degree and intensity. In Afghanistan this is also true, where significant levels of such exploitation and abuse exist among vulnerable males, whether such adolescent males have emergent same-sex desires or not, or whether they are feminised or not.

The commonly accepted understanding of male CSA as is understood in the West does not necessarily "fit", where there are historical patterns of sexual relationships with "beardless boys" that are a part of an adult male's social standing, along with strict gender segregation and social policing of females, making sexual access to woman extremely limited. At the same socio-cultural dynamics of the construction of masculinities within a patriarchal cultural framework, generates a framework of boys being seen as "not-men", and therefore sexually accessible in a culture that has extremely low tolerance of sex between men.[33]

This does not imply that there are not other dynamics of male juvenile abuse that relate to power, violence, self-hatred, and revenge that relate to deeper psychological conflicts within the abuser

At the same time this gendered framework of sex between males also configures adult male-to-male sexual encounters and relationships in Afghanistan, where the primary pattern is between those deemed not to be men - *ezaks* as self-defined in Kabul – and their more masculine and manly sexual partners. Often boys and feminised males are seen as a substitute for women as sexualised objects.

The lack of affordability of marriage for many men of marital age has been one of the excuses to explain why young men have sex with adolescent males, along with the fact that such boys cannot get pregnant, that they are less problematic than females, less expensive than female sex workers, and are good for sexual fun. Such men do not see themselves as homosexuals, or even as men who have sex with men. They have sex with "not-men", where much of these coercive sexual interactions tend to be framed within a "body heat", "sexual need" and "semen discharge" framework.

At the same time other rationalisations are provided to explain the existence of adolescent male sexual exploitation and abuse and consensual same-sex behaviours such as the lack of law enforcement and religious education, poverty, unemployment, and "bad" families and poor parenting.

In a society that lacks sex education, normal socialising between males and females, significant levels of shame, and a lack of knowledge about the body and about sex, will generate intense interest and curiosity about these sex and sexuality. Ready accessibility to pornographic films, male only social spaces, the gendering of age, body pleasure, coercive sex, sexual and political economies, constructions of masculinities, along with male hierarchies in all male institutions, are usually ignored as possible drivers of male-to-male sex, including coercive sex.

Thus juvenile male sexual exploitation and male-to-male sex based on gendered desire and orientation are inextricably linked within the construction of masculinity and gender in Afghanistan, where adolescent boys and feminised males are usually perceived as a "gender apart", a "third gender" so to speak. Add to this potent mixture a culture of penetrative sexuality as part of masculine gender conformity, poverty and unemployment, a lack of socially entertaining spaces in a society that can readily access a global culture, a society still conflict ridden and fearful of the past reappearing as the future, a lack of law enforcement, where often it is the law enforcement personal who also engaged in male coercive sex (see the data from the Kabul and Mazar studies), then we have a scenario of significant levels of coercive and abusive male-to-male sex, as well as consensual male-to-male sex that based on a mutual gendered desire and felt need.

[33] Several of the rules of the Taliban era related to all adult males having to grow beards, that soldiers could not take beardless boys into their barracks, and similar other barriers to any possible sexual encounter between adolescent males and older males, and between adult males themselves.

Along with the low level of HIV and AIDS knowledge, poor infrastructure, a lack of strategic information, lack of access to any sexual health services and appropriate psychosexual counselling, along with a culture of shame and religious intolerance that generates significant levels of stigma, discrimination and denial, as well as what appears to be a significant and growing injecting drug use culture, and the high level of male-to-male coercive sex that appears to exists, Afghanistan should be preparing itself towards dealing with an emerging concentrated HIV epidemic. Its neighbour, Pakistan, is already experiencing such an emergence.

Naz Foundation International has identified a number of key constraints and impediments to providing effective and appropriate HIV prevention programmes that can reach males who have sex with males, as well as address the issue of juvenile male sexual exploitation and abuse, which are relevant to Afghanistan. These are:

- Criminalisation, human rights abuse, social exclusion, stigma, and discrimination.
- Denial that sexual behaviours between males – including male-to-male sex work – exist (for a range of cultural, political, social, and religious reasons).
- Where at times male-to-male sex is accepted, the extent of such practices may be denied.[34]
- A lack of good knowledge and information (poor sociological/anthropological research, lack of epidemiological and behavioural data, a-prior assumptions, homophobia/gender-phobia).
- A lack of understanding of the complexity and diversity of male-to-male sexual behaviours, practices and identities.
- Invisibility of much of male-to-male sex.
- Cultural values of religious values, shame, dishonour, socially compulsory marriage, and masculinity.
- The unwillingness of government, donor and non-government organisations to recognise the issues and support appropriate studies.
- Inappropriate language and terminologies and constructions of sexualities and identities used in public discourses.
- Concepts of gender and masculinity that invisibilise gender variance and male-to-male sex.
- Strict gender segregation and denial of social mixing of males and females
- A strong patriarchal culture based on hierarchal obedience.

All this, and more, leads to a lack of effective and appropriate prevention programmes addressing male-to-male sexual behaviours and vulnerability and risk to HIV infection and transmission, and while currently, the data seems to indicate that Afghanistan is a low prevalence country as defined by UNAIDS, all the factors exist that may change this to a country with localised concentrated epidemics.

At the same time, with the significant levels of male sexual exploitation that appears to exist in the country that is confounded by continuing civil conflict and violence and the fear of a resurgent Taliban, processes, both legal and social, to address this concern become difficult to implement and carry through.

From a programmatic point of view in terms of providing HIV prevention, treatment, care and support services for MSM to reduce their risks and vulnerability, along with addressing adolescent male sexual exploitation and their social, medical, and psychological needs that this would generate, much more work needs to be done, as it is clear, from the evidence identified above, that there is an urgent need to develop appropriate services and methods of delivery which are readily accessible without hindrance.

However, in order for these to be achieved within a climate of illegality, religious conservatism, stigma and discrimination, a range of issues will need to be addressed, including:

- Lack of knowledge and expertise
- Lack of appropriate health and psychosexual counselling

[34] In a HIV intervention project in India conducted by an MSM CBO the government refused to accept the number of contacts being made by the project as "not realistic". Report to NFI from one of its partner projects, 2002.

- Afghanistan constructions of gender and masculinity
- Law enforcement in regard to male sexual abuse and violence
- Legal and social impediments to developing and accessing services
- Capacity of possible service providers

Needs and recommendations

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

Recommendations have arisen from taking the Rapid Assessment report, along with the Inception report, Literature Review, and the Workshop report as a whole.

There are several sub-populations within the dynamics of male adolescent sexual exploitation and abuse as well as males who have sex with males, taking note that the boundary lines between these affected populations can be extremely porous. These populations include:

- Male adolescents affected by coercive sex and abuse
- Perpetrators of such sexual exploitation and abuse, particularly older adolescent males
- Sexually active adolescent males who have sex with males (usually self-identified and primarily feminised males) and their partners
- Adult males who have sex with males (usually self-identified and primarily feminised males)
- Partners of these males

Based on the evidence submitted above, there is an urgent need to develop strategic and effective responses to the sexual exploitation and abuse of male adolescents, along with addressing the risks and vulnerabilities to HIV and other sexually transmitted infections of males who have sex with males in Afghanistan.

However, it is understood that in the socio-religious context of Afghanistan, some of these recommendations may well carry a high-cost burden, difficulties in implementation because of traditional and conservative resistance, and legal impediments. It is recommended that for an effective response to male adolescent sexual exploitation and abuse, as well as males who have consensual sex with other males, a pragmatic approach needs to be undertaken to have any realistic impact.

Addressing male adolescent sexual exploitation and abuse

1. Developing strategic knowledge and information

In order to effectively address the physical, emotional, mental, and social well-being needs of male adolescents who experience sexual exploitation and abuse, including their psychosocial and sexual vulnerability and increased risks of HIV and other sexually transmitted infections, there is a need to understand the roots causes of such abuse and exploitation in order that effective and appropriate intervention programmes can be designed that are child-centric.

Such research should include:

- Cultural based definitions of the child, adolescent male sexualities and sexual maturity, and sexual exploitation and abuse
- The need to understand the social and cultural contexts that involve family, community and religious structures, norms and values, such as the notions of shame and honour, and historical traditions of male sexualities, in order to develop appropriate psychosocial interventions.
- Male adolescents' own perceptions of sexual exploitation and abuse.
- Masculinities, sexualities and genders.
- Cultural myths on sexualities and sexual practices

- The impact of shame and honour on sexual practices
- The impact of sexual exploitation and abuse on adolescent males from different backgrounds and sexualities.
- Psychosocial needs of 'young perpetrators' in order to develop appropriate counselling
- Linkages between poverty and economic disempowerment, social networks and family structures, conflict situations, violence, tradition, substance use, access to pornographic materials, and gender relations and segregation to adolescent male sexual exploitation and abuse.
- Locational exploitation and abuse and differences (if any) between rural and urban settings.

2. Developing capacity

In order to affectively utilise this knowledge and to ensure appropriate service development and delivery professional development is an urgent concern.

This includes:

- A review of current curricula for the training of health, social work, law enforcement, judiciary and legal professions towards ensuring that appropriate information and resources are included in such curricula towards improving the knowledge, skills and capacity of students of colleges and universities who wish to be engaged in these professions. A significant amount of material is already available international that address this concern.
- Awareness and knowledge development within institutions and organisations involved in the care and support of vulnerable children on the nature and scope of adolescent male sexual exploitation and abuse.
- Appropriate training of professionals engaged in child protection and support, as well as those involved in the juvenile justice system, towards strengthening their knowledge and capacity to deliver sympathetic and child friendly services that address adolescent male sexual exploitation and abuse, such as medical doctors, psychologists, psychiatrists, law enforcement personnel, the judiciary, religious and community leaders, social workers, child rights specialists, and teachers, including staff of Juvenile Rehabilitation Centres. Such capacity development would include issues on gender and masculinities as they play out in Afghanistan culture and society and their impact on sexual beliefs and practices. Many such training packages already exist and are readily available.

3. Focused interventions

Programmes and services need to be designed and implemented to reduce the impact of the sexual exploitation and abuse that adolescent males experience, addressing their physical, mental, emotional and social well-being needs. Law enforcement strategies will also need to be developed in parallel that are sensitive to the needs of such sexually exploited and abused male adolescents, along with addressing the psychosexual issues of the perpetrators of such exploitation and abuse to reduce recidivism, while providing exemplary punishment. Therefore:

- Appropriate medical, psychological and psychosocial supportive services need to be developed that are confidential, child centric and friendly in nature, non-discriminatory, and are readily accessible and free. They should try to engage with the adolescent males family as a part of the supportive programme.
- An educational and awareness campaign needs to be conducted targeting parents, teachers, law enforcement agencies, and appropriate decision-makers engaged with children, highlighting the issue and providing age and socially contextualised specific materials and resources, along with a referral system that engages with appropriately trained professionals and psychosocial support to provide a backstop to such campaigns.
- Involvement of adolescent males in developing and designing such materials and resources, and as a part of the educational outreach, is essential component in any such strategy.
- Review of policies, law enforcement practices and conduct, along with the juvenile justice system and Juvenile Rehabilitation Centres towards ensuring the development of appropriate and

sensitive services that can support adolescent males who have experienced sexual exploitation and abuse.

- While effective and appropriate law enforcement of the laws dealing with child sexual exploitation and abuse is also required, such enforcement needs to be sensitively implemented with regard to those adolescents who experience sexual exploitation and abuse. At the same time adolescent males who perpetrate such exploitation and abuse on other adolescents will need counselling towards stopping any future occurrences.
- Appropriate confidential and non-discriminatory sexual health services will need to developed for adolescent males who have experienced (and may continue to experience) sexual exploitation and abuse that include testing and treatment for STIs as well as for HIV, psychosexual counselling, addressing shame, guilt and other negative psychological impacts, and any physical damage that may ensure following such abuse, such as rectal damage.
- The issue of adolescent male sexualities and those adolescents who are beginning to experience same-sex desires and act out on them is very sensitive and difficult to engage with. While the evidence indicates that many of such males experience sexual exploitation and early sexual debuts, their fundamental sexual nature is that of being sexually and emotional attracted to other males. In the Afghan cultural context such males often develop a feminised personality as part of the gender construction of male-to-male sexualities and practices. Specialised counselling and support programmes will need to be developed to address their specific psychosexual issues of concern, including self-acceptance, while addressing internalised stigma.
- Early sexual debut amongst such adolescent males can be addressed through appropriate sex education (as the Netherlands experience indicates), while at the same, effective risk reduction strategies need to be provided.
- Awareness and education on life-skills (such as negotiation skills, assertion skills, etc.), sexualities, sex education, gender roles, masculinities, and responsible sexual behaviour needs to be developed an implemented as a part of the schools' curriculum, along with such educational opportunities in Juvenile Rehabilitation Centres and a referral system to appropriate services.

Addressing the sexual health needs of males who have sex with males and reducing their risks and vulnerabilities to HIV and other sexually transmitted infections

It is clearly recognised that because of denial, invisibility, stigmatisation and illegality (both religious and secular), males who have sex with males already face considerable risks of harassment, violence, and perhaps imprisonment. HIV and AIDS create another framework for further victimisation. It was therefore perceived to be incumbent upon the National AIDS Programme and AIDS service organisations to work towards preventing stigmatisation and victimisation of males who have sex with males, as a part of a larger strategy on reducing risk and vulnerability to HIV and other sexually transmitted infections.

But is also recognised that Afghanistan, as a highly religious and conservative country, with a strong focus on Muslim beliefs and traditions, could well be under considerable pressure to present a religious approach to HIV, that is to develop a strategy based upon deterrence and punishment. The government and the Afghanistan National AIDS Control Programme have courageously included males who have sex with males as a target "community in prevention strategies. It was recognised that a deterrent strategy for the prevention of HIV would only drive male-to-male sexual behaviours even further underground than they already are. This would effectively prevent effective education and awareness programmes, rather than prevent HIV.

It also needs to be clearly recognised that whilst many would prefer to promote sexual abstinence before marriage and faithfulness within marriage, an obedience to Muslim law and values and the promotion of Muslim ideals, there will be those for whom these are essentially public acts of obedience, whilst in private other behaviours may well come into play.

The corollary to this is to accept that the only effective and appropriate HIV education and prevention strategy would be to promote safer sex behaviours amongst males who have sex with males and ensure that appropriate and accessible sexual health services are available and accessible to them which respect their confidentiality and anonymity and build upon their trust and respect.

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

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

However it also understood that not all males who have sex with males will access services provided by sexual health agencies for a range of reasons. It would be more appropriate and effective if the beneficiaries of services acted as agents of change. This means that it is necessary to support the development of peer-led community-based AIDS service organisations working with males who have sex with males.

Following on from these principles and the evaluation of the risk and needs assessment conducted in Afghanistan, the following recommendations are being made.

1. Bridging the knowledge gap

There is a need to have a better understanding of the dynamics and cultural patterns of male-to-male sex. This includes conducting appropriate, well thought through, and adequately funded, anthropological, sociological, behavioural and epidemiological research in partnership with the affected populations, understanding the socio-cultural frameworks and their multiplicity of sexualities, gendered identities, masculinities, and behavioural practices within local and national contexts, towards clearly identifying the significant risks and vulnerabilities experienced by these populations.

In addition strategic information needs to be developed on:

- Male-to-male sexual networking, identify formation and gendering of males
- Adolescent males who have sex with males and sexual debut
- Partners of feminised MSM
- Issues and needs of differing types and frameworks of MSM towards reducing risks and vulnerabilities

Male-to-male sexual networks need to be directly participating in such research by identifying and engaging with key informants from such networks as an initial. At the same time, an understanding of the knowledge and capacity needs of professionals engaged in sexual health, such as medical doctors, psychologists, psychiatrists, social workers, and counsellors in regard to stigma and discrimination of MSM should be identified and acted on.

Further, more knowledge needs to be developed regarding the partners of feminised MSM, where men from a variety of occupational groups were engaged sexually, such as truck drivers, uniformed services, and so on, as well as male-to-male sexual behaviours and practices in all male institutions, such as prisons, will need to be investigated for HIV risks and vulnerabilities.

In conducting such studies, several significant questions also need to be addressed:

a. Who is going to conduct the research?
b. How is it going to be conducted?
c. How is information going to be collected and by whom?

d. What questions are going to be asked, how are they asked, and in what language?
e. What terminology will be used?
f. How will the information be analysed and who will do the analysis?
g. How will the data be used in developing appropriate STD/HIV prevention and sexual health services?
h. Who will develop such services and who will work in them?

Any research into male-to-male sexual behaviours, must answer these questions adequately.

Government and donors can and must play a pivotal role in undertaking and supporting such participatory assessments and research.

2. Focused participatory interventions

For any HIV prevention, treatment, care and support intervention to be effective within networks and communities of males who have sex with males, these marginalised sexualities should be actively and substantively involved in planning, designing and implementation of such interventions. This includes participation in problem identification, needs assessments, programme design, monitoring and evaluation. Participation is essential in areas related to the development of legal frameworks and laws, policy, advocacy, education and programme design and implementation. Participation must include and reflect the full cultural and sexual diversity of men who have sex with men.

This means providing technical assistance, support and mentoring for the development of community-based interventions which empower MSM themselves to act as agents of change amongst their sexual and social networks. NGOs can be engaged by providing such assistance and support to MSM to develop their capacity and ability to develop and deliver appropriate sexual health services.

The central components of such programmes would include:
- Treatment and counselling on STIs (anal, oral and penile) and HIV
- Peer outreach and education
- Provision of safe spaces for social development and community building and mobilising
- Vocational training and skills building towards increasing economic opportunities and thus reduce sex work
- Psychosexual counselling
- Support and care for those living with HIV
- Distribution of condoms, water-based lubricant, and BCC materials

Specific services will need to be developed that address the needs of adolescent MSM to reduce their specific risks and vulnerabilities.

Effective partnerships with local police will need to be developed in regard to the levels of harassment, sexual violence and blackmail that many may face in public sex environments, and also to ensure that outreach and field workers from service providers themselves would not be harassed by either police or local people.

BCC materials and resources need to be designed that are appropriate to the needs of MSM sub-populations, and such populations should be engaged in developing such resources.

At the same time, it should be recognised that the needs of different types of MSM will differ and may require differing responses. Thus, adolescent MSM who are sexually active will require appropriate services to their needs. Feminised MSM will require services appropriate to their needs and sense of identity, while the masculine partners of these MSM may not find such services appropriate to their self-image and needs, and therefore the health sector response will require strengthening to address their needs.

3. Promoting an enabling environment

Government can and must enhance efficacy of policy and programme interventions by ensuring that representative ownership is key in all legal policy and programme efforts aimed at stemming the spread of HIV among males who have sex with males networks, groups and communities. Supportive legal, policy and programme environments are instrumental in helping males who have sex with males acknowledge their own risk and responsibilities in stemming the spread of HIV. For building enabling environments, government must enact legal and policy guidelines and structures that respect and protect the right of all its citizens to good quality prevention, treatment, care and support services. To ensure moving towards universal access, actions should include the de-criminalisation of sexual acts between consenting adult males who have sex with males.

While it is recognised that the above is an ideal response to the vulnerabilities and risks of males who have sex with males in Afghanistan, legal and policy approaches must be sought that increase the sense of safety and dignity of such males in order that they feel able to access services, and actively participate in the provision of such services. This will mean working with law enforcement agencies, particularly local police, the judiciary and other key stakeholders to reduce levels of discrimination and violence targeting such males.

4. Organisation development and strengthening

To ensure that good quality HIV prevention, treatment, care and support services are provided and accessed, organisations that include and represent males who have sex with males networks, groups and communities should be developed,fostered and supported. This includes supporting the development of MSM representative service organisations. Where this is not possible because of legal/social constraints, other implementing NGOs/INGOs could act as 'shelter' agencies providing technical, operational, management and other capacity building support to these community-based sub-organisations. This process recognises the need for empowerment and personal decision-making, along with peer processes for promoting risk reduction practices. Safe-spaces (i.e. drop-in centres) where meetings, social gatherings and other community activities can be held should also be supported.

5. Access to appropriate and affordable STI diagnostic and treatment services

All health care providers providing STI prevention, diagnosis, treatment and care services must be professionally competent in addressing the specific sexual health needs of males who have sex with males. This includes providing STI prevention and management in regard to anal and oral STIs and other pathologies that could be a result of anal and/or oral sex. Such services, as all other medical services, must be confidential. This is not only in regard to STI management but also pertains to overall professional conduct and attitudes in providing comprehensive health care related to consenting adults' sexual and gender preferences and choices As much as possible these services should be provided to males who have sex with males within locally accepted MSM community-based project structures, i.e. as a part of drop-in services. Where this is not possible, local male sexual health clinics, private or government, will need skilling up to take on board the specific sexual health issues and needs of males who have sex with males, particularly around gender and sexualities.

Where such capacity does not exist, training and sensitisation programmes need to be provided.

At the same time however, sexual health clinics for the general male population must also address male-male sexual behaviours and possible related health issues.

6. Access to appropriate HIV voluntary testing and counselling

Many males who have sex with males living with HIV are not only stigmatised by their HIV positive

status, but also by the route of infection and issues related to their sexual and gender identities. Testing, treatment, care and support programmes need to be competent and appropriate to address them appropriately, particularly in regard to feminised MSM.

Government, and NGOs/CBOs need to provide and donors must support pre- and post-testing counselling services for HIV and other STI that are confidential, non-judgemental and empathic to the needs of males who have sex with males. As much as possible these services should be provided to males who have sex with males within locally accepted MSM community-based project structures, i.e. as a part of drop-in services. Post-test support services must include counselling on the meaning of an HIV diagnosis and referrals to MSM competent prevention, treatment, care and support programmes and services.

7. Access to affordable condoms (including "female condoms") and water-based lubricants

Reducing the primary risk of infection with HIV and other STIs must be central to all HIV prevention programmes. Government, NGOs/CBOs and donors must support population-specific, free or affordable distribution of condoms along with social marketing campaigns to promote consistent use of condoms, as an essential component of risk reduction strategies for males who have sex with males. Such condoms should also include "female condoms" as well.

In addition, government, NGOs/CBOs and donors must ensure ready access to appropriately packaged water-based lubricants that enhance the efficacy of condom use for protection in of males who have sex with males as a risk reduction strategy.

8. Access to specific information through appropriate communication

Research consistently shows that HIV prevention information that is communicated to the general population is insufficient to generate sustained protective behaviour among males who have sex with males because it lacks specificity and appropriateness. Government, NGOs/CBOs and donors must support the development and dissemination of appropriate information by and for males who have sex with males, addressing their concerns, in languages, terminology and imagery that is realistic, life-affirming, meaningful, understandable, acceptable and engaging. Males who have sex with males should not be passive recipients of such information but involved as the producers of their own information, education and methodologies of communication.

9. MSM and female partners

In the socio-cultural context of Afghanistan, a significant proportion of MSM will be married and/or have female sexual partners. For married women, who culturally in South Asia tend to be monogamous, there are significant risks of STI/HIV infection from their husbands who may be having sex with other males. While no specific strategies have evolved as best practice examples in the region, it is essential that work that includes female partners, whether this be educational and outreach to MSM, and the need to engage with female partners should STI/HIV infection be discovered in the male partner needs to be elaborated.

10. Long-term technical and financial support

Government, national and international donors, multilateral institutions and international NGOs must commit and provide sustained technical and financial support to build the capacity of individuals and service organisations by and for males who have sex with males working in the areas of HIV prevention, treatment, care and support. This is in order to enhance core capacities such as HIV competence and other technical HIV-related and sexual health knowledge and skills, as well as programmatic and managerial governance and monitoring expertise. It is crucial that skills and opportunities in networking, community-building, advocacy and policy development, and monitoring

are also supported. Successful pilots and programmes must be documented and taken to scale in a manner that ensures sustainability, quality, and community ownership.

11. Advocacy on legal, judicial and social impediments to effective HIV and other STI prevention and sexual health for males who have sex with males

Government, international donors, multilateral institutions and international NGOs should assist in developing the capacity of males who have sex with males for advocating and effecting change on legal, judicial and social impediments that hinder HIV and other STI prevention, treatment, care and support programmes for individuals or networks, groups and communities of these marginalised sexualities.

Laws that criminalise consensual sex between adult males along with inappropriate policies continue to drive the spread of HIV by impeding the development, implementation and access to essential prevention, treatment, care, and support programmes. Donors, multilateral institutions and international non-governmental organisations should therefore support the government to proactively develop policies and laws that aid and support reduction in risks and vulnerabilities to HIV for all marginalised and stigmatised populations including males who have sex with males.

At the same time the uniformed services, both military and law enforcement, need to be educated and sensitised in the issues of same-sex behaviours, risks and vulnerabilities and that by their actions do not increase their own risks, as well as that of MSM.

12. Broadening the education and awareness agenda

Unprotected anal sex is not as uncommon as many may assume, and is not restricted to self-identified males who have sex with males, but includes males in an array of different situations as well as between males and females. Community-based organisations and other NGOs working with males who have sex with males in the area of HIV may not be able to reach such non-identified males easily. By ensuring that all HIV and STI prevention materials, programmes, and services include information pertaining to the risks of unprotected anal sex as part of broader sexual and reproductive public health awareness efforts, government, academic institutions and international donors international NGOs and direct service providers should ensure that this life-saving information reaches and is understood by the general population; male and female alike.

Annexe 1

Naz Foundation International (NFI) experience

Naz Foundation International is an international MSM agency registered in the UK, but working in South Asia on policy, advocacy and support on male sexualities and provides technical, institutional and financial support to MSM networks in South Asia to develop their own self-help responses to their sexual health needs.

Since 1997 it has conducted some fifty-three situational assessments among MSM in the countries of Bangladesh, India and Pakistan, while providing assistance to those that were conducted in Nepal and Sri Lanka. These assessments have been support by Catalyst Consortium (USA), DFID, Ford Foundation, FHI Asia, and the World Bank.

The methodologies, instruments and processes developed to conduct these assessments have been demonstrated to be effective over the years, and was replicated, with local amendments, to conduct the assessment in Afghanistan.

Along with these assessments, NFI has also developed a range of tools and methods for developing HIV prevention, care and support interventions for MSM, having assisted in the development of some 70 such projects in the region.

Shivananda Khan is the Chief Executive and founder of Naz Foundation International and has been the key principle investigator and developer of these studies and tools.

For more information on NFI please see their website *www.nfi.net.*

Annexe 2: Skills building workshop

Facilitated by Shivananda Khan of Naz Foundation International, this workshop was designed to increase knowledge and understanding of the participants regarding male-male sex and adolescent male sexual exploitation in the context of Afghanistan, while developing skills towards conducting the rapid assessment planned to follow this workshop.

Held in Kabul, Afghanistan, between 6 – 9 October 2008, the four day workshop initially explored male-male masculinities, sexualities, genders, identities and behaviours, risks, vulnerabilities and needs, along with issues of concern in terms of health, including sexual and psychological health and the risks around adolescent vulnerabilities to sexual exploitation. Following this, the workshop focused on assessment tools and methodologies of data collection, while reviewing and refining current draft questionnaires and consent forms.

Methodologies used during the workshop included facilitator presentations, open discussions, and small group work with feedback sessions.

There were 10 participants in this workshop reflecting the three different assessment teams:
Kabul – adult MSM
Mazar – adult MSM
Kabul, Mazar and Kandahar – male adolescents

A representative from the National AIDS Control Programme, MOPH was also present throughout the workshop.

The workshop was conducted in English, while the Dari translation was provided by one of the participants (Dr. Rasheed).

Workshop content

Day 1	Assumptions and personal sensibilities Define terms Defining sex Exploring gender, sexualities, and masculinities in the context of Afghanistan Socio-cultural and religious expectations in Afghanistan The tradition of *bacha bazi* in Afghanistan, and male adolescent exploitation Who are MSM in Afghanistan Why do men/males have sex with men/males
Day 2	Frameworks of male-male sex Identities and behaviours Male sex work *Bacha bazi* Risks and vulnerability Sexual health – psychosexual and psychosocial issues and concerns Constraints in data collection Informed consent Ensuring confidentiality and safety
Day 3	Who and what we are assessing What do we want to know Review of planned methodologies and tools In-depth analysis of adult MSM questionnaire
Day 4	Interviewing practice for adult MSM In-depth review of questionnaires to be used for male adolescent assessment

Issues arising in the workshop

Part 1: Same-sex behaviours in Afghanistan

A central concern of the workshop was to dispel any myths regarding the construction of male-to-male sexual behaviours, practices, sexualities and identities. This required reviewing concepts of masculinities and femininities as they are understood in Afghanistan. This was within an understanding that the word 'man'/'men' is socially constructed. The use of the term MSM does not imply an identity referring to an identifiable group or community that can be segregated and so labelled. Within the framework of male-to-male sex there are a range of masculinities, along with diverse sexual and gender identities and networks, as well as sexual behaviours without any sense of affiliation to an identity or network.

Participants were able to identify three key frameworks of male-to-male sex in Afghanistan. These were:
Gender based (self-identified feminised males as receptive partners who have sex with "normative" males who are the penetrating partners)
Age structured (adult men who have sexual relations with adolescent males – the *bacha baz*[35] construct in Afghanistan is a part of this, but not exclusively so)
Situational based (male friends who are 'hot', prison populations, occupational groups where access to females is very limited)

It was clear that in terms of HIV and STI vulnerability, the sub-population most at risk would be those males whose primary sexual active is receptive anal sex with multiple partners, such as feminised MSM and male sex workers, along with those who may have crossover behaviours, such as injecting drug use and anal sex. Males in prison settings could thus play a significant role in HIV and STI transmission.

In regard to sexual exploitation, both adolescent males and feminised males are significantly vulnerable due to the constructions of masculinity in Afghanistan, along with the current power dynamics that this generates, particularly in an environment where girls and women are strictly socially policed. In particular, working street males were seen as highly vulnerable, along with young males who work with adult males where there is little or none supervision or perception by other adults, such as in truck-driving situations, restaurants and tea-shops, and other commercial activities. The possibilities of such sexual exploitation in detention homes and prisons were also explored, along with the closed environments of family homes.

In a possible mitigating situation that could act to reduce the levels of male-male sexual practices, participants believed that, even in urban cultures, there was considerable social policing of all people, which may preclude opportunities for what is seen as "illicit" behaviours.

While an attempt was made to explore Muslim cultures across Central and South Asia and same-sex behaviours, this was seen by most participants as problematic because of the framework of religious discourse that could readily enter into the discussions. The conflation between Islam and Muslim itself was problematic, but clearly raised several issues of concern and resistance for some participants.

Knowledge of HIV and AIDS was low for some participants, and confusion regarding risk and vulnerability was clearly evidenced. Because of time constraints, it was not possible to hold a full discussion on this, despite an evidenced need to clarify the knowledge and understanding that some participants had on HIV, AIDS, and the risks of various sexual practices.

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[35] See: *Bacabozlik: Boylove, Folksong and Literature in Central Asia*, Ingeborg Baldauf, excerpt from Die Knavenliebe in Mittel-asien: Bacabozlik, Freie Universitat Berlin, Forschungsgebiedsschwerpunkt Ethnizitat and Gesellschaft, Occasional Papers, Nr. 17 (Berin: Verlag Das Arabische Buch, 1988. The translation has been done by Gerard Mooorman)

In exploring the concept of sexual health in the context of the draft definition of the World Health Organisation,[36] several concerns emerged from the discussions. Primarily amongst these was the religious and legal concerns regarding what is considered licit sex (vaginal sex between husband and wife) and what is considered illicit (everything else). Afghanistan is called an "Islamic Republic" where the *Sharia* is co-existent with the civil code, and where the civil code is seen as supporting the *Sharia*.

So while it was agreed that the term sexual health needs to include physical, emotional, mental and social health, and services will need to be developed to address these needs in regard to the MSM and adolescent males who are sexually exploited, there appeared to be a hidden sub-text that reflected religiously held beliefs. This also impacted on discussions on size estimates and the level of same-sex behaviours throughout Afghanistan.

It appeared to the facilitator that participants (and possibly many Afghan people) hold contradictory attitudes and beliefs that must at times conflict with each other, producing a great deal tension. This could easily be reinforced in a conflict situation that exists in the country, and the use of western terminology to label same-sex behaviours adds to this tension. This issue needs to be explored further because it could be a significant constraint in developing appropriate health services for both MSM and vulnerable adolescent males.

It was clear that as the participants discussed gender, sexualities and masculinities, and explored who were MSM, and why males/men have sex with other males/men, that Afghanistan was not unique. The same patterns existed in other countries of South Asia. So when the working groups developed notes on these areas, and these were compared with similar discussion notes from South Asia, there was no difference. The only perceivable difference was the strong traditional pattern of *bachi bazi,* which has much less visibility (if existent at all) in these other South Asia countries (except for certain areas of Pakistan).

In identifying areas of health need and services, participants identified the following:

Adolescent males

- Access to non-stigmatising treatment for STIs (both penile and anal) as well as address specific rectal problems arising from early sexual debut and sexual abuse
- Access to clean water, sanitation, and better hygiene
- Promote health living and life skills
- Access to better diet and nutrition
- Effective legal protection from assault and incarceration
- Psychological support services and address low self-esteem and self-worth arising from sexual assaults
- Services should be provided in a non-discriminatory environment
- Supportive family and friends
- Access to trauma counselling
- Equal opportunities for education, health and social services irrespective of circumstances and poverty
- Sex education

[36] Sexual health is a state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, a well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. World Health Organisation, draft working definition, October 2002

In regard to adolescent self-identifying feminised males, participants also suggested that such males should have the freedom to be what they wanted to be and to express themselves, and that there should:

- Be no discrimination or stigmatisation
- Be no harassment
- Participate in social community
- Have the freedom to chose their social roles
- Have acceptance and recognition by community

There also needs to be considerable education around narcotics, and policies need to be developed around the protection of children, especially working street children, along with income generation and micro-credit schemes available to increase the numbers of young people in education and safer working conditions.

A key suggestion was the development of Child Health Centres with access to appropriately trained psychologists with a deep knowledge of Afghan culture.

MSM

The needs identified for MSM by participants indicated similar vulnerabilities as adolescent males, including stigma, harassment, sexual violence, and the need for physical, emotional, psychological and social health services. Also included was the need for safe spaces to meet others like themselves to develop a sense of solidarity and community, to gain social acceptance, and to address stigma and discrimination.

It was also agreed that those involved in law enforcement and the justice system need intensive and extensive training and sensitisation, along with those involved in the medical, education and social work professions. Along with this, participants also believed that there needs to be family education, as well as awareness for religious leaders.

Part 2: The Assessment

Participants expressed concerns that because of the significant levels of shame and invisibility around male-to-male sexualities and behaviours, it could be very difficult to identity appropriate respondents and collect data sufficient to the needs of the Assessment. Further, it was believed that for the male adolescent assessment, permission from the Ministry of Justice would be needed. At the same time it was believed that for the MSM component of the study, support would be required from the Ministry of Public Health (MOPH). It was agreed that the representative from NACP present during the workshop would facilitate this.

There was a lengthy discussion on the meaning of informed consent and what was required to ensure that this was achieved, along with ensuring confidentiality and safety of the respondents. Thus while NFI seeks a "waiver of consent" based on precedent from the Institutional Review Board (IRB), where parents of male adolescents need not be approached seeking permission to interview their male children for obvious reasons, the Assessment still requires permission from the adolescents themselves. Thus built into the consent process was the additional safety that any respondent can stop the interview at any time without any consequence.

Anonymity is to be guaranteed, and a system of coding was to be used to ensure this. At the same time, spaces for interviews should be selected by respondents themselves in order to ensure a measure of safety and anonymity. This would not be possible for male adolescents in detention homes, and the likelihood was that some sort of adult other than the interviewer would be present during the interview. To avoid any possible victimisation of a juvenile respondent in such a setting, the questionnaire to be used is designed to only have indirect questionnaires, and much of the interview process will be through observational analysis of the respondent.

In the session exploring information needs for the various categories of assessment respondents, participants expressed a clear understanding, and were able to identify the key components.

Thus for MSM:

- Socio-economic status
- Sexual history
- Current sexual behaviour
- Male sex work
- Sexual behaviour with females
- Health
- Knowledge

Adolescent males:

- Socio-economic status
- Living conditions
- Personal experiences of various forms of exploitation
- Psychological health
- Friendships
- Knowledge and awareness
- Knowledge of sexual abuse and exploitation
- Who does he confide in?

Recognising the sensitivity and age of respondents, questions relating to sexual history and abuse would be indirect rather than direct, i.e. "do you know if this has happened to anyone you know".

In regard to collecting date on sexual exploitation and abuse of male adolescents there would be three different components:

- Seeking information for law enforcement individuals and those involved in the juvenile justice system, lawyers and social workers
- Information gathering in a specific juvenile detention centre
- Discussions with street working adolescent males

The methodology to be used for collecting information on MSM would be through using snowballing techniques. For the Mazar study, a key information had already been identified and what present at the workshop, and through the practice session on interviewing, was able to demonstrate skills and knowledge, and as well as participation in his own networks to be able to fulfil the requirement of identifying and recruiting others for the study. The practice session also indicated that the interviews needed to be conducted by a team of two people, one being a self-identified MSM to develop a comfort zone for the interview, and the other to actually conduct the interview.

The Kabul team however demonstrated a central weakness, since none of the team were self-identified MSM. However, with the support from a member of the Mazar team, an appropriate person was identified in Kabul to provide the MSM component. Dr Rasheed offered to provide skills building to this individual post workshop.

A *dari* version of the draft questionnaire had been developed and was used in the practice session. The process enabled a refinement of the actual questionnaire and also enabled the Dari translation to be more accurate and appropriate. Amendments were made during the process of actually evaluating each question and possible response, as well as during the practice sessions.

In the final session, participants discussed the three questionnaires developed to collect information regarding sexual exploitation of male adolescents. Each questionnaire was reviewed, and the process of soliciting information through them was evaluated. The team responsible for this data collection were all involved in an agency that provides a range of services for working street children, and have a great deal of experience in conducting needs assessments amongst them, as well as working with children.

Outcome

Participants believed that not only did they gain a great deal of new knowledge and understanding regarding male-to-male sex, risks and vulnerability, including issues around adolescent male sexual predation and exploitation, but also a deeper understanding of issues, needs and concerns that such males have in regard to their broader health and social needs.

All participants believed that data collection for the Assessment was possible, and that it would be possible to use this information to design and develop appropriate health interventions to reduce risk and vulnerability to HIV and other sexually transmitted infections, as well as identify appropriate strategies to reduce sexual exploitation of adolescent males and address their health needs.

Annexe 3

Rapid Assessment of Male Vulnerabilities to HIV and Sexual Exploitation in Afghanistan

Behavioural Assessment Questionnaire

The following questions are designed to help .....to develop appropriate HIV/AIDS education and prevention programmes addressing the health needs of vulnerable males highly at risk in……

THIS QUESTIONNAIRE IS STRICTLY CONFIDENTIAL

The questions are structured to gather information on a wide rang of topics relating to personal practices and knowledge.

No personal details will be taken, so that you cannot be identified.

Please answer all the questions honestly. If you have any questions regarding this questionnaire please ask your interviewer.

LOCATION _____

PERSON CODE _____

INTERVIEWER CODE _____

TIME OF INTERVIEW _____

DATE OF INTERVIEW _____

Prior to any interview discuss the issues regarding the information required, that there will be strict confidentiality kept, and that the individual providing information will not be linked in any way to the information itself.

Once agreement has been reached, the Interviewer must sign the statement of consent form in front of the interviewee.

Note: Because of the difficulties in obtaining signatures from possible respondents, the process being used is that of detailing to the respondent the need for the assessment, and the confidentiality of information, where the interviewer signs of the statement of consent.

Rapid Assessment Survey 2008

Social and Needs Assessment

Section 1: Yourself

I am now going to ask you some questions about yourself.

No	Questions	Coding		Move to
Q101	How old are you? If don't know ask respondent to make best estimate	Years Don't know	*Write* 98	
Q102	Have you ever attended school?	Yes No	1 2	 Q104
Q103	How many years of education have you completed?	Years completed	*Write*	
Q104	Are you originally from a	Village District City	1 2 3	
Q105	What is your marital status?	Unmarried Married Divorced Separated (Mard Bewa) Widowed	1 2 3 4 5	
Q106	Do you currently live with	Alone Your wife Your parent (s) With male friend a relative Other (Write)	1 2 3 4 5 6	
Q107	Are you currently employed?	Yes No	1 2	
Q108	If employed what is your occupation?	*Write in*		
Q109	What is your average monthly income? If not employed, but a monthly income is indicated than seek information on source	Below 1000 1000-2000	1 2	

	of income.	2000-3000 3000-5000 5000-10000 Above 10000	3 4 5 6	
Q110	How do you label yourself? Need to identify local terms for different types of MSM for this question.	Man etc Other (write)		
Q111	Have you ever had any sexual contact with another male/man?	Yes No	1 2	 Stop interview
Q112	Have you had any sexual contact with another male/man in the last two months?	Yes No	1 2	 Stop interview
Q113	Were you ever forced to have sex with another male/man?	Yes No	1 2	
Q114	If yes, when was the last time? Briefly describe the event	Write in		
Q115	Have you had any sexual contact with a woman in the last twelve months?	Yes No	1 2	
Q116	In the last month have you ever taken alcohol in any form?	Every day At least once a week Once in two weeks Did not drink alcohol in the last month Never drink alcohol	1 2 3 4 5	
Q117	In the last month have you taken any drugs other than alcohol Read list (local names)?	Yes No	1 2	
Q118	Have you injected any drugs this last month?	Yes No	1 2	
Q119	Have any of your sexual partners injected drugs this past month?	Yes No Don't know	1 2 98	

Social and Needs Assessment

Part Two: Your sexual history

No	Questions	Coding		Move to
Q201	What was your age when you first had sex with another male/man?	Below 10 years Between 11 – 15 years Between 16 – 18 years Above 18 years	1 2 3 4	
Q202	What was the age of the male/man you first had sex with? If the response is "DON'T KNOW", then ask the respondent to guess.	Below 10 years Between 11 – 15 years Between 16 – 18 years Between 19 – 25 Above 25 years Don't know	1 2 3 4 5 98	
Q203	What type of sex did you do on this first occasion	Receptive anal sex Penetrative anal sex Other (write)	1 2 3	
Q204	Who asked for this? Can respondent state who this person was? Teacher, law enforcement, friend, family person, etc?	Yourself The other person	1 2	
Q205	If the other person asked for this, were you forced? Ask respondent to describe situation and note here.	Yes No	1 2	
Q206	Can you describe how you felt? Write the expressed feelings here	Angry Guilt Shame Pleasure	1 2 3 4	
Q207	Did you receive any gifts or cash?	Yes No	1 2	
Q208	How many times have you been forced to have sex with another male/man in the last year?	Give number		

Part Three: Your current sexual behaviour

No	Questions	Coding		Move to
Q301	In the last month, how many different male sexual partners have you had?	Give number		
Q302	In the last month how many of these times did you have receptive anal sex?	Give number		
Q303	In the last month how many of these times did you penetrate in anal sex?	Give number		
Q304	In the last month how many times were your forced to have sex during this period?	Give a number		
Q305	Whenever you are doing anal sex are condoms being used?	Every time Sometimes Never	1 2 3	
Q306	Whenever you do anal sex is lubricant used?	Every time Sometimes Never	1 2 3	
Q307	What type of lubricant is used?	Saliva Oil Cooking oil Cream Other (write)	1 2 3 4 5	
Q308	In the last month where did you meet your sex partners? Respondents can mark several	Street School Your home His home Someone else's home Park Public toilet Bus station Bazaar	1 2 3 4 5 6 7 8 9 10	

		Shop Guest house Other place (write)	11 12	

Q309	In the last month where did you do sex with your partners? Respondents can mark several	Your home His home Someone else's home Park Public toilet Bus Car Shop Guest house Other place (write)	1 2 3 4 5 6 7 8 9 10	
Q310	Who were these sex partners? Can mark several	Your regular partner Friend Stranger Neighbour Male relative Male sex worker Paying client Other (write)	1 2 3 4 5 6 7 8	
Q311	Which occupational group did your sex partners come from Can mark several	Truck drivers Law enforcement Taxi-drivers Shopkeeper Military Mechanic Businessman Other (write)	1 2 3 4 5 6 7 8	

Part Four: Paid sex (*with other males only)*

No	Questions	Coding		Move to
Q401	Have you received money for sex?	Yes No	1 2	 Q 409
Q402	Last time how much have you received for the sex?	Give an amount		
Q403	Last time what type of sex were you paid for?	Receptive anal sex Penetrative anal sex Oral sex Masturbation Thigh sex Other (please state)	1 2 3 4 5 6	
Q404	The last time you were paid for anal sex, was a condom used?	Yes No	1 2	
Q405	If a condom was used, who decided this?	Yourself Your partner	1 2	
Q406	In the last month how many times have you been paid for sex?	Give a number		
Q407	In the last month how many times were condoms used if you were paid for anal sex?	Every time Sometimes Never	1 2 3	
Q408	In the last month if condoms were used for anal sex who decided this use	Yourself Your partner	1 2	
Q409	Have you ever paid for sex? (for sex with males only)	Yes No	1 2	 Q 501
Q410	How much did you pay the last time?	Give an amount		
Q411	What type of sex did you pay for?	Receptive anal sex Penetrative anal sex Oral sex Masturbation Thigh sex Other (please state)	1 2 3 4 5 6	

Q412	In the last month how many times have you paid for sex?	Give a number		
Q413	In the last month how many times were condoms used for anal sex, when you pay for sex?	Every time Sometimes Never	1 2 3	
Q414	In the last month when you have paid for anal sex, how many times did the other person ask you to use a condom?	Every time Sometimes Never	1 2 3	

Part Five: Your sexual behaviour with females

No	Questions	Coding		Move to
Q501	Have you had sex with females (other than your wife if you are married)?	Yes No	1 2	 Q 601
Q502	Have you ever paid for sex with a female?	Yes No	1 2	 Q 601
Q503	What type of sex did you pay for	Vaginal Anal Oral Masturbation Other (write)	1 2 3 4 5	
Q504	In the last one month how many <u>different</u> females did you pay for sex in the last month	Give a number		
Q505	In the last one month how many times were condoms used when you had sex with females	Every time Sometimes Never	1 2 3	

Part Six: Your health

No	Questions	Coding		Move to
Q601	In the last six months did you have any symptoms in the… Ask respondent to describe symptoms	Genital area Anal area Inside the mouth None	1 2 3 4	 Q 603
Q602	If you have any symptoms what are you doing about them?	Nothing Self treatment Visit a government clinic Visit a private clinic Visit an STI specialist See a street "unani" Ask a friend or relative	1 2 3 4 5 6 7	
Q 603	If you do not have symptoms now, have you ever had any symptoms in these areas before?	Yes No	1 2	
Q604	The last time you had any symptoms in these areas what did you do?	Nothing Self treatment Visit a government clinic Visit a private clinic Visit an STI specialist See a street "unani" Ask a friend or relative	1 2 3 4 5 6 7	
Q605	Have you ever visited a clinic for any sexually transmitted infection?	Yes No	1 2	
Q606	Have you ever been tested for "AIDS"?	Yes No	1 2	 Q 610
Q607	What was the result?	Positive	1	

		Negative Don't know/ No response	2 98	
Q608	Where was the test conducted	Write response		
Q609	Were you counselled before the test?	Yes No	1 2	
Q610	Were you counselled after the test	Yes No	1 2	
Q611	Have you ever felt suicidal in the past year *Ask respondent to state why*	Yes No	1 2	

Interviewer's notes

Symptoms to watch for:

Genital Area
Pain while urinating

Genital warts

Pus or discharge from penis

Blisters or open sores on penis

Rash on or around penis

Anus
Itching or burning around anus

Pus or discharge with stools

Blisters or open sores around anus

Bleeding from anus

Bleeding while defecating

Warts around anus

Oral
Bleeding gums

Blisters or sores inside mouth

Part Seven: Your knowledge

No	Questions	Coding		Move to
Q701	Have you ever heard of AIDS?	Yes No	1 2	
Q702	What have you heard?	Write		
Q703	Where did you get this information from?	Write		
Q704	Have you heard of HIV?	Yes No	1 2	
Q705	What have you heard?	Write		
Q706	Where did you get this information from?	Write		
Q 707	Do you think you have risk of getting STI?	Yes No	1 2	
Q708	If yes, grade it: Ask respondent the reason for his answer	Low Medium High Don't know	1 2 3 98	
Q709	Tell us 3 different ways of getting infected with HIV	Write		
Q710	Tell us 3 different ways in which you can protect yourself from infection with HIV or an STI	Write		
Q711	If you know you have an STI or HIV will you tell your sexual partners?	Yes No Maybe Don't know	1 2 3 98	

Annexe 4: Consent

Rapid assessment of male vulnerabilities to HIV and sexual exploitation in Afghanistan

Statement of consent for key informant interviews

I researcher No….. have met with Key Informant No……..

I have explained to the Key Informant that I am working on a rapid assessment of male vulnerabilities to AIDS and sexual exploitation in Afghanistan with the Naz Foundation International, UK, and that we want to understand the issues, needs and concerns regarding these vulnerabilities so as to be able to better respond to reduce the risks of becoming affected by AIDS.

I have also explained that I will collect this information through asking a series of questions on these issues, needs and concerns, along with explaining that this information is strictly confidential, that no name or contact details will be taken, and that the information given cannot be linked with the Key Informant in any way, thus protecting him.

I have also explained that the Key Informant's participation in the interview is purely voluntary, and that he may decide to stop the interview at any time if they become uncomfortable and do not want to continue for any reason. I have told the Key Informant that there is no penalty for refusing to take part.

Researcher No_____

Signature ----------

Date_____

The Principal Investigator is:
Shivananda Khan: Executive Director, Naz Foundation International, London, United Kingdom
Telephone no. +91 9839221091

Local Investigator

For Mazar
Name:
Telephone No:

For Kabul
Name:

Telephone No:

Note: this consent form was produced in dari by Dr Abdul Rasheed.

Annexe 5

Waiver of Consent

1. **Regulations and Overview**
2. **Examples of situations where a waiver of consent request is not usually approved by the Board**
3. **Examples of situations where consent waiver may be reasonable**
4. **Waiver of Written Informed Consent (verbal consent still required and script)**
5. **Waiver or Alteration of all Elements of Consent (no verbal and no written consent)**
6. **Waiver of Consent in Emergency Care Research**
7. **Definition of Minimal Risk**

1. Regulations and Overview

Informed consent is mandated by Federal policy (45 CFR 46 Section 116). Informed consent is also one of the fundamental principles of ethical conduct in the use of human subjects. Occasionally there are reasons to waive written consent or to alter the requirements of consent. Only the IRB can make the determination to waive some (written) or all (written and verbal) consent requirements.
Under some circumstances, described in the Federal Regulations, an investigator may feel that his/her study justifies a request to waive consent. The essential conditions of a waiver are:
1) that the research pose no more than minimal risk to subjects; 2) no adverse effects as a result of the waiver or alteration; 3) without the waiver or alteration the research in question could not be carried out; and 4)information will be provided after participation is completed, if appropriate.
If these conditions seem to apply, investigators may wish to consult the federal regulations: Federal Policy for the Protection of Human Subjects **§46.116 General requirements for informed consent; §46.117 Documentation of informed consent.**
(http://ohrp.osophs.dhhs.gov/humansubjects/guidance/45cfr46.htm#46 (Section 116(d) and 117)

2. Examples of situations where a waiver of consent request is not usually approved by the Board

1. I don't have enough money in my research grant to print consent forms and distribute them and file them.
2. These are my patients so I see them anyway and they trust that I will not involve them in something that might harm them.
3. I already have access to the patient records.
4. There isn't any risk even though it would be possible to get consent.
5. I don't have a staff member who can handle all the paperwork involved in obtaining informed consent.
6. If I consent people, they will not want to participate in the study.
7. The consent form will scare people. It seems so legalistic.

3. Examples of situations where consent waiver may be reasonable

A. Example*: Conducting interviews with Chinese citizens about their religious beliefs. The only record of the name or other identifying information of the subject would be the signed consent form so the signed consent is waived.*
Sample reply*: If Chinese authorities found out that any of the subjects had spoken with me, let alone what their religious beliefs are, these subjects might be at serious risk for arrest, interrogation, or prison. To decrease this risk, I am not asking subjects to sign anything so that they may remain anonymous.*
Notes: Since Certificates of Confidentiality do not apply to researchers who are doing work outside the U.S., there is a possibility that respondents could be harmed for expressing their views on their religious beliefs.

***B. Example**: Conducting phone interviews with political staffers about how recent fundraising rules have changed the campaign process.*
***Sample reply**: It is not uncommon to ask subjects who work in a very public position (political staffers in this case) about their views on related political issues. I am not asking how they feel about the campaign rules but about how the rules have changed the campaigning process. I would like to waive having subjects be sent and then return a consent form for a simple 5 minute phone interview.*
Note: Supplying the interview schedule will confirm that the interview is a simple 5 minute call and that no questions are asked that compromise a person's confidentiality or position.

***C. Example:** A chart review of approximately 2000 existing patient records to determine the recurrence rates of cancer after radiation treatment.*
***Sample replies**:*
1) *The current study will be reviewing pre-existing patient charts for information on treatment with radiation and cancer recurrence rates so there is very minimal risk to the subject.*
2) *The information taken from patient charts will not include any identifiable information so this study will not violate any of the subject's rights.*
3) *The study involves a chart review of all subjects diagnosed with breast cancer who went through radiation treatment at NMH in the last 10 years. It would be very difficult to contact over 2000 subjects, some of whom will no longer be alive and others whom will have no current address information available.*
4) *This is not appropriate to our current study because there is no common medium to notify subjects of our findings.*

4. Waiver of Written Informed Consent (verbal consent still required and script)

Waiver of written informed consent may be requested but this does not mean that verbal consent cannot be utilized.
A script for verbal consent should be submitted to the IRB for review. **A verbal consent script provides all of the elements of consent in a more informal style. In addition, each subject should be provided with an information sheet that describes the study and gives contact names and numbers.**

Normally, investigators will be asked to keep a log of those who were approached about the study, and offered verbal consent. A simple chart can indicate the subjects as subject 1, subject 2, and subject 3. A column can indicate that verbal consent was given and a date. Since a specific number of study subjects have been requested in the IRB application, it is important that investigators keep some record to indicate that they are not enrolling more subjects than they originally requested.

5. Waiver or Alteration of all Elements of Consent (no verbal and no written consent)

A request to waive written and verbal informed consent must be accompanied by a complete explanation in response to the four statements below. All of the criteria must be met to qualify for a waiver of both written and verbal consent.
1. The proposed research presents no more than minimal risk of harm to subjects.
2. The waiver or alteration of consent will not adversely affect the rights and welfare of the subjects.
3. The research could not practicably be carried out without the waiver or alteration.
4. Whenever appropriate, the subjects will be provided with additional pertinent information after participation.

6. Waiver of consent in Emergency Care Research

Obtaining a waiver of consent in emergency research is an involved and generally lengthy process. The federal regulations 21CFR50.24 describe the situations where this can occur. The information provided here does not cover situations for requests to waive consent in emergency research. Investigators should contact OPRS for assistance in planning emergency research. This should also not be confused with Emergency Use Requests. Emergency use requests are for one time only, do not

involve gathering data, and are not considered "research" in the standard definition, though such uses are approved by the IRB.

7. Definition of Minimal Risk

An individual is considered to be at more than minimal risk if exposed to the possibility of harm -- physical, psychological, social, legal, or other -- as a consequence of participation as a human subject in any research activity which departs from the performance of routine physical or psychological examinations and tests, or which departs from established and accepted procedures necessary to meet the individual's needs, or which increases the probability or magnitude of risks ordinarily encountered in daily life.

Example: *A chart review of approximately 2000 existing patient records to determine the recurrence rates of cancer after radiation treatment.*

Sample replies*:*

1) *The current study will be reviewing pre-existing patient charts for information on treatment with radiation and cancer recurrence rates so there is very minimal risk to the subject.*
2) *The information taken from patient charts will not include any identifiable information so this study will not violate any of the subject's rights.*
3) *The study involves a chart review of all subjects diagnosed with breast cancer who went through radiation treatment at NMH in the last 10 years. It would be very difficult to contact over 2000 subjects, some of whom will no longer be alive and others whom will have no current address information available.*
4) *This is not appropriate to our current study because there is no common medium to notify subjects of our findings.*

Annexe 6: Sexual exploitation of male adolescents

The study on sexual exploitation of juvenile males was most difficult because of the nature of the subject, the difficulty in obtaining consent from the respondents, and the physical, psychosocial and the religious-political environment in which the study was conducted. Possible physical dangers were also taken into account.

The questionnaires, consent forms, and actual interviews were all developed and conducted by staff of Aschiana, - an agency working with street working males with the provision of educational and psycho-social support in various cities in Afghanistan.

The design of these questionnaires and the interview techniques were designed to take on board the nature of the subject matter, potential backlash, and the need to reduce any risks and vulnerabilities that might arise in conducting such a study, as well as the potential religious conflict that this might induce in a contentious environment as in Afghanistan.

فورم سروی پسران آسیب پذیر به HIV ایدزدر افغانستان

مصاحبه شونده گان : اطفال آسیب پذیرمقابل HIV ایدس

Survey form for young boys exposed to HIV

معلومات:

Survey information:

نمبر مسلسل فورم: ( ) **تاریخ سروی: / /**

Form Serial No: **Date of the survey:**

اسم سرویر: ( ) **محل سروي ( )**

Location of the Survey: **Surveyor's name:**

نمبر فورم موافقه مصاحبه شونده ( ) **تاریخ آن / /** **امضا و یا شصت ( )**

Signature/ Finger print of the interviewed child **Date:** **Interviewed child consent form no:**

این سروي بمنظورجمع آوري معلومات درمورد میزان آسیب پذیری پسران (بچه ها) درمقابل مصاب شدن به HIV ایدس فلهذا معلومات دقیق وصادقانه باید ارایه گردد تا به اساس آن پروژه هاي آگاهي دهی از خطرات HIV و محافظت و وقایه درمقابل آن طرح واجراگردد.

معلومات ارائه شده به شکل محرم حفظ گردیده واز نام مصاحبه شونده ذکر به عمل نمي اید.

سرویر مکلفیت دارد تا در مورد سروي فوق معلومات همه جانبه به مصاحبه شونده ارائه بدارد. و موافقه آنرا قبل از آغاز مصاحبه اخذ نمائید.

The object of this interview is to gather as much information as possible regarding boys at risk of HIV and the condition they live in.

The questions need to be answered honestly and accurately in order for us to build a useful program to protect these children. The information obtained in this interview will remain confidential and the interviewed child's name will remain anonymous.

Before commencing the interview the survey's goals and objections needs to be explained fully and clearly to the interviewed child.

Also, the child or the guardian's consent needs to be obtained before commencing the interview.

1. محل تولد 1. Place of birth	قريه Village		ولسوالي District		ولايت Province		ناحيه City District
2. سكونت فعلي شما 2. Current living place	قريه Village		ولسوالي District		ولايت Province		ناحيه City District
3.چندسال داريد؟ 3. Which age group you belong to?	بين 8 تا 10 8 to 10		بين 10 تا 12 10 to 12		بين 12 تا 15 12 to 15		بالاتر از 15 Over 15
4. تعداد اعضاي فاميل شما؟ 4. How many members are in your family?	ذكوركاهل Adult males		اناث كاهل Adult females		دختران Girls		پسران Boys
5. با كي زندگي داريد؟ 5. Who do you live with?	پدر Father		مادر Mother		خواهر Sister		برادر Brother
اقارب ديگر Other relatives							

در صورت که جواب دیگر باشد واضح سازید؟

_____

_____

If the answer to above questions is other then, please specify:

و در مورد محل و حالت بود باش خود نیز معلومات دهید. شخصي ( ) كرايي ( ) گروی ( )
هوتل( ) وغیره .

Current accommodation:

Own house ( ) Renting ( ) Lump sum Rental ( ) Hotel ( )

Other ( ) please specify:

6. تعداد اطاق هاي بودباش تان چند ميباشد؟

6. How many rooms are in your house?

7. ايا شما تنها يا با كسي ديگر استراحت مينمائيد ؟ درصورتيكه با كسي ديگر استراحت مينمائيد نام ببريد وباشما چي قرابت دارد؟

Do you sleep alone or with others?

If you sleep with others then who you do sleep with what is his/ her relation to you?

8. آيا مكتب ميرويد؟ بلي ( ) نخير ( ) در صورت بلي صنف چند ميباشد؟

درصورت نخير چرا مكتب نرفتيد ؟ علت آنرا واضع سازيد؟

_____

_____

ويا اگر ترك نموده ايد علت آن تحرير گردد.

_____

_____

8. Do you go to school? Yes ( ) No ( )

If yes, what class you are in?

If no, why are you not going to school?

If you have left school, what made you do it?

9. چه مصروفيت داريد؟ _____

چند عايد داريد و چگونه آنرا بدست مياوريد؟ _____

9. What is your current job?

How much do you earn?

10. از رفقايتان نام ببريد و درمورد قرابت آنها باشما نيز معلومات دهيد؟ _____

10. Who are your friends and do you have any family relation with them?

11. رفقايتان تان چه كار ميكند؟ _____

11. What work do your friends do?

12. آيا گاهي با رفقاي تان به تفريح ميرويد؟ بلي ( ) نخير ( )

درصورت بلي به كجا و چگونه تفريح واضع سازيد؟

_____

_____

12. Do you go out for fun with your friends? Yes ( ) No ( )

If yes, where do you go and what do you do for fun?

13. ايا گاهي به مهماني به خانه رفقاي تان ميرفتيد ؟ بلي ( ) نخير ( )

ايا شب در خانه و يا در محل ديگربا رفقايتان يكجا ميبوديد؟ بلي ( ) نخير ( )

در صورت بلي به خانه كي و ديگر كي ها ميبود به همرايتان؟ واضح سازيد._____

_____

اشخاصيكه با شما شب ميبودند آنها از شما بزرگتر بودند و يا كوچكتر؟ كوچكتر ( ) بزرگتر ( )

13. Do you ever go to your friend's house? Yes ( ) No ( )

Have you ever spend the night with your friends at their house or other places? Yes ( ) No ( )

If yes, whose house was it and who else was there?

Were the people you spent the night with older or younger than you? Younger ( ) Older ( )

14. مصارف كه براي ميله و تفريح مينموديد از كجا بدست مياوريد؟ _____

_____

14. Where do you get the money to go out for fun?

15. ايا سينما ميرفتيد ؟ بلي ( ) نخير ( )

درصورت بلي با كي سينما ميرفتيد ؟ واضع سازيد پول تكت و ديگر مصارف را كي ميپرداخت؟

_____

15. Have been to the cinemas before? Yes ( ) No ( )

If yes, who did you go with and who paid for the movie tickets?

16. ايا بر علاوه هم سن تان كدام دوست از كلان سالان نيز داريد؟ بلي ( ) نخير( )

درصورت بلي واضع سازيد چه كار ميكند و چه قرابت دارد به شما. _____

16. Do you have any adult friends? Yes ( ) No ( )

If yes, what does he/she do and what is your relation to this friend?

17. ايا كدام دوست تان معتاد به مواد مخدر است؟ بلي ( ) نخير ( ) در صورت واضع سازيد

17. Are any of your friends addicted to drugs? Yes ( ) No ( )

If yes, could you please tell us who this friend is?

18. ايا گاهي به محافل ساز و رقص رفته ايد؟ بلي ( ) نخير ( )

درصورت بلي با كي و براي چه مدت در آنجا بوديد؟ _____

_____

آيا هميشه ميرفتيد و يا گاه گاهي؟ گاه گاهي ( ) هميشه ( )

در اين گونه محافل سازو سرودو رقص چه را زياد خوش داشتيد ؟ واضع سازيد _____

كي شما را به آن محافل ميبرد و چه قرابت با شما دارد واضح سازيد؟

18. Have you ever been to a dancing party? Yes ( ) No ( )

If yes, who did you go with and how long were you at this party?

How often do you go to these parties? Regularly ( ) Sometimes ( )

In these parties do you enjoy the dancing and the music?

Who takes you to these parties and what is your relation to this person?

19. ايا گاهي در مورد مواد مخدر از كس شنيده ايد و يا انرا خودتان مشاهده نموده ائيد؟ بلي ( ) نخير ( )

در صورت بلي از چند نوع مواد مخدر نام برده مي توانيد؟ _____

19. Has any one ever told you about drug usage or have you witnessed it yourself? Yes ( ) No ( )

If yes, how many drugs can you name?

20. چند نوع مواد مخدر را شما شخصاً ميشناسيد آنرا نيز نام ببريد؟

چگونه اين مواد مخدر را شناختيد؟ لطفآ واضح سازيد_____

20. How many drugs you personally know and can you name them?

How did you get to know about these drugs?

21. ايا كسي را مشناسيد كه مواد مخدر استعمال ميكند؟ بلي ( ) نخير ( )

در صورت بلي چند ساله ميباشد و به شما چه قرابت دارد و از چگونه مواد مخدر استفاده مي كنند؟

_____

_____

21. Do you know someone who uses drugs? Yes ( ) No ( )

If yes, how old is he/she and what is your relation to this person?

What kind of drug he/she uses?

22. ايا از دوستان تان ويارفيقهاي تان كس به اين شخص ارتباط دارد؟ بلي ( ) نخير ( )

در صورت بلي كي است و چند ساله ميباشد؟ _____

22. Is this person related to any of your friends? Yes ( ) No ( )

If yes, who and how old is your friend?

23. ایا کسي را میشناسید که مواد مخدر را از طریق پیچکاري اخذ بدارد

23. Do you know anyone who injects drugs? Yes ( ) No ( )

24. ایا از دوستان تان شنیده اید که توسط پیچکاري مواد مخدر استعمال کنند؟ ؟ بلي ( ) نخیر ( )

درصورت بلی واضع سازید

24. Have you heard any of your friends say they inject drugs? Yes ( ) No ( )

If yes, can you please explain?

25. ایا در مورد HIV ایدس معلومات دارید؟ بلي ( ) نخیر( )

درصورت بلي واضح سازید چگونه معلومات دارید؟

25. Do you have any information about HIV? Yes ( ) No ( )

If yes, can you please explain what you know about HIV?

26. از کجا شما این معلومات را بدست آورده اید؟

_____

_____

26. Where did you obtain this information from?

27. ایا چه فکر میکند که کدام افراد به HIV مصاب میگردد بطور مثال 3 نوع رانام ببرید؟

27. Can you name three types of people who are most exposed to HIV?

1.

2.

3.

28. ایا گاهي در مورد کدام طفل پسر و یا دختر شنیده اید که تجاوز جنسي بالاي آن صورت گرفته باشد؟ بلي ( ) نخیر ( )

در صورت بلي کي بود ( ) چند ساله بود ( ) از طرف کي تجاوز بالایش صورت گرفته بود واضع سازید؟

28. Have you heard of a boy or girl who has been sexually assaulted? Yes ( ) No ( )

If yes who was this child?
How old is he/she?
Who did the assaulted?

29. ایا اکنون در مورد آن طفل معلومات دارید که چه میکند ودر کجا میباشد و در چه حالت قرار دارد؟

---

29. Do you know where the child is now and how he/she is doing?

30. طفل که بالایش تجاوز شده بود در مورد تجاوز براي کسي اطلاع داده بود؟

30. Did the abused child inform others about the assault?

31. فعلاً همان شخص که بالاي طفل تجاوز کرده بود چه مي کند ودرکجا میباشد؟ _____

---

31. Do you know where the man who did the sexual assault is and what is he doing now?

32. ایا اکنون هم طفل به همراي آن شخص رابطه دارد؟ بلي ( ) نخیر ( )
درصورت بلي چگونه رابطه؟ _____

32. Is the child still having any elation with the abuser? Yes ( ) No ( )
If yes, what kind of relation they are having?

33. آیا چي فکرمیکنید که حادثات تجاوزجنسي بالاي اطفال ازطرف بزرگسالان ویا هم اطفال دیگرکم است ویازیاد؟
زیاد ( ) کم ( )
در صورت زیاد تجاوز بزرگ سالان بالاي اطفال ؟ ( ) و یا از اطفال بالاي اطفال خورد سن ؟ ( )
شما ازچند مورد تجاوز آگاهي دارید واضح سازید؟

---

33. Do think that this area has more sexual assaults than other areas or less?
More ( ) Less ( )
If it is more then, what sort of sexual abuse is done here? Older children to younger children ( )
Adults to children ( )
How many sexual assault have you heart about? Can you explain about these assaults?

34. طفل که بالایش تجاوز جنسي صورت گرفته چگونه صورت گرفته بود؟ به خواهش خودش ( ) جبر ( )

34. How was the sexual abuse done? With the child's consent ( ) by force ( )

35. ایا طفل بعد از تجاوز جنسي به شفاخانه برده شد بود؟ بلي ( ) نخیر ( )

35. Was the child taken to the hospital? Yes ( ) No ( )

36. ایا طفل بندي شده بود؟ بلي ( ) نخیر ( )

36. Did the child get arrested? Yes ( ) No ( )

37. اکنون طفل چه مي کند؟ _____

_____

37. How is the child doing now?

38. ايا طفل اکنون با تعداد زياد اطفال رفاقت دارد و يا کم ؟ کم ( ) زياد ( )
روفقاي وي از خودش بزرگتر هستند و يا خورد تر؟

38. Has this child currently got more friends than before the assault or fewer friends?

Fewer friends ( ) More friends ( )

Are his friends younger or older than him?

39. زيادتر با رفقاي خود در کجا ميباشد؟ _____

39. Where does he spend most of his time with friends?

40. ايا گاهي ديده ايد که کدام طفل از مواد مخدر استفاده کند؟ بلي ( ) نخير ( )
در صورت بلي کيست وچند ساله ميباشد؟ واز چگونه مواد مخدر استعمال مي کند؟ ودفعات استعمال آن چند ميباشد؟ واضح سازيد

_____

_____

40. Have you ever seen a child using drugs? Yes ( ) No ( )

If yes who is this child?
What drugs he/she uses and how often?

41. ايا کدام طفل را ميشناسيد از جمله روفقا و يا دوستان تان که درمورد روابط جنسي با شما صحبت کرده باشد و قصه خود و يا کسي ديگر را براي شما نموده باشد؟ بلي ( ) نخير ( )
در صورت بلي چگونه بوده واضح سازيد.

_____

_____

41. Do you know any child (either your friends or others) who has mentioned any thing about a sexual assault done to him? Yes ( ) No ( )

If yes, can you please explain how this was done?

42. ايا خودتان دراين مورد با دوستان تان قصه نموده ايد؟ بلي ( ) نخير ( )
در صورت بلي با کي ( ) ايا هميشه باهم در مورد روابط جنسي قصه مي کنيد ويا هم گاهي واضع سازيد .

_____

_____

بيشتر اين قصه ها را چه وقت در كجا مي كنيد واضع سازيد؟ _____

42. Do you ever tell your friends about sexual assault? Yes ( ) No ( )

If yes, who you talk to and how often?

Where and when do you talk about it?

43. ايا كدام يكي ازرفقايتان با كدام كس روابط جنسي دارد؟ بلي ( ) نخير ( )

در صورت بلي چگونه فهميدي واضع سازيد؟

_____

_____

43. Are any of your friends in a sexual relation with anyone? Yes ( ) No ( )

If yes, how do you find out about it?

44. ايا از اين روابط جنسي رفيق شما كس ديگر نيز اگاهي دارد؟ بلي ( ) نخير ( )

در صورت بلي واضع سازيد. _____

44. Does anyone else know about your friend's relation? Yes ( ) No ( )

If yes, can you please explain more about it?

45. ايا شما گاهي هراسان شديد كه بالاي شما كسي تجاوز جنسي نكند؟ واضع سازيد

_____

_____

45. Do you some times fear that a sexual assault could be done to you?

46. چرابراي شما اين ترس بوجود امد؟ واضح سازيد

_____

_____

چه وقت ( ) شخص كي بود ( ) بعد از آن در اين مورد با كسي گفتيد ( )

چه وقت اين موضوع را با كس ديگر گفتيد ( ) ايا با اعضاي فاميل خود گفتيد؟ بلي ( ) نخير ( )

او كي بود؟ ( )

چه وقت اين موضوع را بكسي گفتيد؟_____

چگونه اين موضوع را به آن شخص گفتيد؟_____

در صورت بلي با كي ( ) چه كرد. و اگر نگفتيد چرا؟ واضع سازيد؟

46. How you think a sexual assault could happen to you?

When?

By whom the assault could be done?

Have you advised your family about this? Yes ( ) No ( )

Have you told any one else about this?

When did you tell someone about it?

How did you tell them?

What did this person do after you told him/her about it?

If you have not told any one, can you please explain why?

47 . ايا كدام دوست تان كه بالايش تجاوز صورت گرفته باشد ازشما كمك خواسته و راز خود را با شما شريك ساخته است؟

بلي ( ) نخير ( )

چگونه راز واضع سازيد _____

در صورت بلي چگونه كمك واضع سازيد _____

47. Has any of your friends who have been sexually assaulted asked you for help or told you about his secret?

Yes ( ) No ( )

If yes, what was his secret?

How did you help your friend?

48. ايا مي دانيد كه از ايدز HIV چگونه خود را محافظت كنيد؟ بلي ( ) نخير ( )

در صورت بلي تشريح سازيد _____

48. Do you know how to be protected from HIV? Yes ( ) No ( )

If yes, can you explain how?

توافق نامه شخص مصاحبه شونده در مودر آسیب پذیر اطفال به HIV
Interviewed child consent form

نمبر مسلسل توافقنامه ( )

Consent form serial no:

این توافقنامه فی بین اینجانب ( ) بحیث مصاحبه کننده و محترم
( ) به حیث مصاحبه شونده به موافقه خود طفل عقد گردیده است.

نوت:
در صورتیکه موافقنامه کدام شرایطه داشته باشد تحریر گردد.

This agreement is between ( ) as the surveyor and
( ) as the interviewed child or his representative.

Note:
Condition of agreement (if any):

_____
_____
_____

محل امضا و یا شصت مصاحبه شونده
Interviewed child signature or finger print

محل امضا سرویر
Surveyor signature

تاریخ / /
Date

تاریخ / /
Date

فورم سروی درمورد آسیب پذیري پسران معروض به خطر ویروس HIV ایدزدر افغانستان

مربوط مسولین وپرسونل مراکز اصلاح و تربیت اطفال، پولیس و یا سایر اشخاصیکه با اطفال کارمي کند

Survey form Regarding Afghani boys with exposure to HIV

For staff at Juvenile Rehabilitation Centers, Police Officers and other people working with children

معلومات عمومی:

General Information

نمبر مسلسل فورم **Form serial no**		**تاریخ سروی** **Date of the survey**	
اسم سرویر **Surveyor name**		**محل سروي** **Place of the survey**	
شخص مصاحبه شده **Interviewed staff name**		**وظیفه و محل آن** **Position and location of the interviewed staff**	
Interviewed staff phone number			

این سوال نامه بمنظور جمع آوری معلومات در مورد حالت آسیب پذیري پسران بهHIV میبا شد تا به اساس این معلومات بتوانیم پروگرامهای آگاهي دهی ومحافظتی برای اطفال طرح گردد. معلومات فوق بکلي محرم نگداري میگردد. در صورتیکه شخص مصاحبه شونده نخواهد که از اسم ویا هم از وظیفه وي یاد آوري بعمل آید بدون ذکر اسم و وظیفه شخص مذکوراین فورم تکمیل میگردد.

جوابات ارائیه شده به سوالات باید بسیار دقیق باشد تا به اساس ان پروگرام هاي آینده طرح وتطبیق گردند.

The information collected in this interview will be used by Aschiana to help build an assistance program for Afghani boys at risk of HIV.

The information will be kept confidential and the name and position of the interviewed staff does not need to be stated.

The questions need to be answered honestly and accurately in order to build a useful program.

معلومات در مورد حالت اجتماعي و آسيب پذيري به HIV

Information regarding children's social background and their vulnerability to HIV:

1- آيا شما گاهي با اطفال كارنموده ايد كه در معرض خطر مصاب شدن به HIV بوده با شد ؟ بلي ( ) نه خير ( )
در صورت بلي اطفال فوق ازلحاظ اجتماعي ، اقتصادي داراي چي وضعيت بودند؟

1. Have you ever worked with children who were at risk of HIV? Yes ( ) No ( )
If yes, from what social background and what were their wealth status?

2- از نظر شما خطرات جدي براي اين گونه اطفال چه ميبا شد؟ اگر واضح سازيد بهتر خواهد شد.

2. What serious dangers do you think these children are facing?

3- آيا شناسائي گرديده است كه تعداد زياد آنها در قريه جات زندگي مي كند؟ ويا در شهر هااگر واضح سازيد بهتر خواهدبود.
اكثرآ درقريه جات ( ) اكثرآدر شهرهاً( ) اكثرآدرشرايط مهاجرت ( ) اكثرآدر كمپ هاً ( )

3. Do you know where the majority of these children live? Can you please pick from list below?
In camps ( ) Migrating ( ) In cities ( ) In villages ( )

4- كدام عوامل عمده اين پسران را در معرض خطر قرار ميدهد اگر واضح سازيد بهتر خواهد بود؟

4. What are the main factors that put these boys at risk of AIDS?

5- آيا پلان هاي روي دست است كه اين پسران را از اين حالت بيرون بكشد؟ بلي ( ) نخير ( )
در صورت نه خير از ديد شما چه بايد شود.

.1

.2

.3

شماچه گونه رول را میتوانید بازي کند؟ اگر واضح سازید بهتر خواهد بود ؟

5. Are there any plans in progress to protect these boys from HIV? Yes ( ) No ( )

If no, what do you think could be done?

1.

2.

3.

What roles could you play in the plans you have in mind? Can you please explain?

6- آیا تا کنون با بچه های نیزمواجه شده اید که فکر کند مصاب به HIV میباشد ؟ بلي ( ) نه خیر ( )
در صورت بلي درمورد چه اقدام نموده اید؟

6. Have you ever met boys who think they might be HIV positive? Yes ( ) No ( )
If yes, what have you done about it?

7- آیا با اشخاص نیز روبرو گردیده اید که بالاي پسران تجاوز جنسي نموده باشد ؟ بلي ( ) نه خیر ( )
در صورت بلي علت این تجاوز براي شما معلوم گردیده ؟ بلي ( ) نه خیر ( )
در صورت بلي واضح سازید و چه باید شود که این گونه اعمال صورت نه گیرد.

7. Have you ever met anyone who has sexually assaulted under aged boys? Yes ( ) No ( )
If yes, did you find out their reasons for the assault? Yes ( ) No ( )
What do you think could be done to stop these sexual assaults on young boys?

8- آیا بعد از تجاوز جنسي بالاي طفل ویا روابط جنسي طفل خون آن معاینه گردیده است ؟ بلي ( ) نه خیر ( )
8. Does any one arrange for a HIV blood test to be done on the child? Yes ( ) No ( )

9- آیا به نظر شما اشخاص که مشخصآ با اطفال وبچه ها روابط جنسي دارندعلل آساسي آن را دراین محیط میدانید؟ بلي ( ) نخیر( )
درصورت بلي کدام ها اند؟
الف: براي شخص تجاوز کننده
.اقتصاد قوي ( ) 2. حسادت ( ) 3.حس انتقام جوئي ( ) 4.عدم تطبیق قانون ( )

ب: براي طفل تحت تجاوز قرار گرفته شده.

.عدم آگاهي ( ) 2.اقتصاد ضعيف ( ) 3.عدم توجه والدين به اطفال ( ) 4.محروميت اجتماعي( )

5.نداشتن والدين ( ) 6. روابط خراب فاميلي( ) 7. اعتياد مواد مخدر( ) 8. وديگر عوامل واضح سازيد.

9. Do you think that there are more people in this area who sexually assault young boys than anywhere else? Yes ( ) No ( )

If yes, do you know why?

a: for the abuser:

1. Economic power ( ) 2. Jealousy ( ) 3. Revenge ( ) 4. Lack of law enforcement ( )

b: for the abused child:

1. Lack of education or knowledge ( ) 2. Being from poor family ( ) 3.Lack of family care ( )

4. Being socially deprived ( ) 5.Being an orphan ( ) 6. Bad family relations ( )

7. Drug addiction ( ) 8.Others, please explain below:

10- آيا با اطفال هم مواجه شده ايد كه آنها بالاي ديگر اطفال تجاوز نموده باشد؟ بلي ( ) نه خير ( )

در صورت بلي انواع تجاوزات وعوامل مختلف در قبال آن چه بوده اگر؟ واضح سازيد بهتر خواهد بود.

10. Have you ever met children who have abused other children? Yes ( ) No ( )

If yes, what kind of abuse and the reasons behind it?

11- به نظر شما بهترين راه براي جلوگيري از مصاب شدن اطفال بهHIV چه ميباشد؟

.1

.2

.3

.4

.5

.6

11. What do you think is the best way to protect these children against HIV?

1.

2.

3.

4.

5.

6.

12- آيا به نظر شما هم جنس بازي كدام علت خاص دارد؟ بلي ( )نه خير ( )

در صورت بلي واضح سازيد ؟

درصورت نخير نيز واضح سازيد پس چرا اين اعمال صورت ميگرد؟

12. Do you think that there are special reasons for same sex relations? Yes ( ) No ( )

If yes, could you please explain?

If no, then why do you think some people have these relations?

نوت:

در صورتيكه معلومات اضافي نزد شما موجود باشد كه در سوالات براي آن جواب داده نشده باشده ميتوانيد آنرا ارائه بداريد.

Note:

If you think that you have any other information that can be useful to build a program to protect boys against HIV please let us know:

Consent form for the interviewed staff at Juvenile Rehabilitation Centers, Police Officers and other people working with children

Subject of the interview: Boys at risk of HIV and the sexual assaults on boys in Afghanistan.

I Mr Maktabi from Non Government Organisation of Aschiana am currently working on a project to support sexually assaulted boys who are living a very hard life and to find a solution to their physical and mental health. We need to collect relevant and accurate information in order to understand the reasons behind these sexual assaults and to find ways to stop them.
This investigation will enable us to understand the abused children's situation, their needs and to help and support them in their physical and emotional recovery.

The conducting parties of this survey are the international organisation of Naz, located in England in conjunction with Aschiana in Afghanistan.

The international organisation representative:
Shivananda Khan,
Operational Manager, Naz Organisation
London, England
Ph: +91 9839221091

The domestic organisation representative:
Engineer Mohamed Yousef
Director, Aschiana
Kabul, Afghanistan
Ph: + 93 700277280

If you have any questions, please do not hesitate to contact us.

With your consent I would like to interview you for any information you might have regarding sexually assaulted young boys.

Name and signature of the interviewed staff: Date: / /

Surveyor name: Date: / /

ASCHIANA

فورم جمع آوري معلومات درمورد پسران معروض به خطرHIV درافغانستان
محل جمع آوري معلومات مراكز اصلاح و تربيت اطفال
Survey form for Afghani boys with exposure to HIV

Collected in Juveniles Rehabilitation Centers in Afghanistan

معلومات:

Survey information

نمبر مسلسل فورم: ( ) تاريخ سروی: / /

Form serial no: Date of the survey: / /

اسم سرويز: ( ) محل سروي : ( )

Surveyor's name: Location of the Survey:

نمبر فورم موافقه شخص مصاحبه شونده ( )

Interviewed child consent form no:

نوت: قبل از اغاز مصاحبه سرويز مكلف ميباشد بخاطر روشن شدن موضوع براي مصاحبه شونده در مورد هدف سروي معلومات واضح ارائيه بدارد تا مصاحبه شونده بصورت درست به سوالات جواب دهد. و همچنان موافقه طفل را قبل از آغاز مصاحبه اخذ بدارد. و نيز وي را مطمين سازد كه معلومات داده شده توسط وي محرم نگهداري ميگردد.

Note: Before the interview, the surveyor must ensure that the interviewed child is fully aware of the survey's purpose. Also he needs to be ensured that the information gathered in the interview will be kept private and confidential and that the child's full consent is necessary in order to commence the interview.

محل امضا سرويز ( )

Surveyor's signature: ( )

1 . محل تولدطفل 1.Place of birth		قريه Village		ولسوالي District		ولايت Province	
2. محل بودوباش فعلي 2. Current residential place		قريه Village		ولسوالي District		ولايت Province	
3.محل بودباش اصلي 3.Permanent residential place		قريه Village		ولسوالي District		ولايت Province	
4. سن 4.Age							

5 – باكي زنده گي مينمائيد؟ مشخص سازيد بهترخواهد بود.

5. Who do you normally live with? Please list these people below:

6 – آيا در مورد ايدز و يا HIV معلومات داريد ؟ بلي ( ) نخير ( )

در صورت بلي چگونه معلومات داريد و از كجا اين معلومات را دريافت نموده ايد؟ اگربلي واضح سازيد چي معلومات وازكجا اين معلومات رابدست آوريد.

6. Do you know anything about HIV or AIDS? Yes ( ) No ( )
If yes, what do you know and where did you obtain this information from?

7 – آيا ميخواهيد دراين مورد معلومات بيشتر داشته باشيد ؟ بلي ( ) نخير ( )

درصورت بلي از اين معلومات چه استفاده مي كنيد؟ اگر واضح سازيد بهتر خواهد بود.

7. Would you like to know more about HIV and AIDS? Yes ( ) No ( )

If yes, please explain what you would use this information for?

8 – طروق مختلف كه باعث انتقال HIV ميگردد نام ببريد ؟

.1
.2
.3

8. Could you name 3 ways by which HIV can be transmitted to others?

1.
2.
3.

9 - از كدام طريقه انتقال HIV شما زياد هراس داريد ؟ لطفاً واضح سازيد.

9. Which one scares you the most?

10 – آيا كسي را ميشناسيد كه ويروس HIV را داشته باشد ؟ بلي ( ) نخير ( )

در صورت بلي آن شخص كي ميباشد و به شما چه رابطه ياقرابت دارد؟ اگرواضح سازيد بهتر خواهد بود.

10. Do you know anyone who is HIV positive? Yes ( ) No ( )
If yes, what is your relation with him/her?

11 – آيا كدام مرد را ميشناسيد كه با بچه ها روابط جنسي داشته باشد ؟ بلي ( ) نخير ( )

درصورت بلي شخص مذكور كي است وبه شما چه روابط ويا قرابت دارد واضح سازيد ؟

و چگونه روابطه جنسي با بچه دارد؟ اگر واضع سازيد بهتر خواهد شد.

11. Do you know any adult male who has sexual relation with under aged boys?
Yes ( ) No ( )
If yes, what is your relation with this man?

What type of sexual relation this man has with boys?

.

12 – آيا كدام يك از رفقايت با كدام مرد روابط جنسي دارد ؟ بلي ( ) نخير ( )

درصورت بلي كيست؟اگر واضح سازيد بهتر خواهد بود.

12. Do any of your friends have sexual relation with an adult man? Yes ( ) No ( )

If yes, who is your friend and how would you describe your friend's relation?

13 – كدام يكي ازرفقايت با دخترها ويا خانم ها روابط جنسي دارد ؟ بلي ( ) نخير ( )

در صورت بلي چگونه رابط جنسي دارد؟ اگر واضح سازيد بنخواهد بود.

13. Do any of your friends have sexual relation with girls or women? Yes ( ) No ( )

If yes, how would you describe your friend's relation?

14 – آيا به نظر شما چه شود كه جلوگيري از انتقالHIV گردد. ؟

14. What do you think should be done to stop HIV from transmitting to others?

15 – آيا دوست ويا رفيق داريد كه راز شخصي خود را با شما شريك كند ؟ بلي ( ) نخير ( )

درصورت بلي كي ميباشد و كدام راز هاي خود راباشما شريك نموده است.

15. Do you have any friend who shares his/her secrets with you? Yes ( ) No ( )

If yes, who is your friend and what secrets has he/she told you?

16 – آيا راز ها شخصي خود را با دوستان و رفقايت شريك مينمائيد ؟ بلي ( ) نخير ( )

درصورت بلي كدام راز ها را ؟ اگر واضح سازيد بهتر خواهد بود.

در صورت نخير چرا ؟ اگر علت آنرا واضح سازيد بهتر خواهد بود.

16. Do you confine any secrets with your friends? Yes ( ) No ( )

If yes, what secrets have you told him/her?

.

If no, why not? Can you please explain your reasons?

17 – درصورتيكه بالاي كدام رفيقت تجاوزجنسي صورت گيرد؟ چه مي كنيد؟ وچگونه آنرا كمك مينمائيد ؟

17. If someone sexually abuses any of your friends, what would you do and how would you help your friend?

18 – آيا رفقايت به تفريح و ميله ها ميروند ؟ بلي ( ) نخير ( )

درصورت بلي به چگونه ميله ها ميروند واضح سازيد به كجا و همراي كي هابه ميله ميروند.

18. Do your friends ever go out for fun? Yes ( ) No ( )

If yes, where would they go and who they go out with?

19- ايا گاهي شب ها نيز به مهماني با رفقايت ميرويد؟ بلي ( ) نخير ( )

در صورت بلي واضح سازيد كه در آن مهماني ها ديگر كي ها ميباشد و درجريان مهماني چه مصروفيت ميداشته باشيد؟

19. Do you ever go to your friend's house at night time? Yes ( ) No ( )

If yes, who else would be there and what would you do at nights?

20 – آيا گاهي هم احساس نموده ايد كه كدام يكي از رفيقايت و يا هم شخص ديگر نيت تجاوز جنسي بالايت نموده باشد ؟
بلي ( ) نخير ( )

در صورت بلي شخص مذكور كه بود و شما چه عكس العمل از خود نشان داديد؟ اگر واضح سازيد بهتر خواهد بود.

20. Have you ever felt that one of your friends or others might want to sexually abuse you? Yes ( ) No ( )

If yes, who was this person and how did you react?

21 – آيا گاهي خودت تصوركرده يي كه با رفيق و يا كدام پسر ديگررابطه جنسي(تجاوز) جنسي بكنيد ؟
بلي ( ) نخير ( )
در صورت بلي كي بود و چه عمل را انجام دادي؟ اگر واضح سازيد بهتر خواهد بود

21. Have you ever thought of sexually assaulting any of your friends or others? Yes ( ) No ( )

.

If yes, who was this person and what did you do? Could you please explain?

نوت :
به فكر شما اگر كدام معلومات اضافي در اين سوالنامه وجود نداشته نزد تان باقي مانده باشد لطفاً غرض تكميل معلومات به منظور كمك درساختار پروگرام هاي آگاهي و محافظتي در مقابل HIV ارائيه بداريد بهتر خواهد بود.

Note:

If you have any other information that can help us build a protection against HIV program, please let us know:

توافق نامه شخص مصاحبه شونده در مودر آسیب پذیر اطفال به HIV
Interviewed child consent form

نمبر مسلسل توافقنامه ( )

Consent form serial no:

این توافقنامه فی بین اینجانب ( ) بحیث مصاحبه کننده و محترم

( ) به حیث مصاحبه شونده به موافقه خود طفل عقد گردیده است.

نوت:
در صورتیکه موافقنامه کدام شرایطه داشته باشد تحریر گردد.

This agreement is between ( ) as the surveyor and ( ) as the interviewed child or his representative.

Note:
Condition of agreement (if any):

_____
_____
_____

محل امضا و یا شصت مصاحبه شونده
Interviewed child signature or finger print

تاریخ / /
Date / /

محل امضا سرویر
Surveyor signature

تاریخ / /
Date / /