

Situational Assessments Among MSM In South Asia

Naz Foundation International

**Situational Assessments In Sexual Health Among Males Who Have Sex With Males
And Their Sexual Partners in South Asia**

Implementing Agency: Naz Foundation International

Assessment Period: 3rd February - 6th June 2000

Principal Investigator: Shivananda Khan

Report Preparer: Shivananda Khan

Date of Report: 11th November 2000

Funded by: Family Health International

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Who Is Naz Foundation International?

Naz Foundation International is an NRI non-governmental organisation headquartered in the UK, specialising in the sexual and reproductive health of males who have sex with males and their sexual partners in South Asia.

We provide technical assistance, capacity building, training and support to emergent and existent locally based, community-led organisations developed and managed by males who have sex with males.

Since 1996 we have supported, and helped to develop MSM led sexual health initiatives in

Bangalore (Jagruthi-Gelaya)

Calcutta (Praajak and Pratyay)

Chennai (Prakriti - Sahodaran)

Cochin (Shramaa)

Hyderabad (Mithrudu)

Lucknow (Bharosa)

New Delhi (Naz India MSM Programme and DART)

Pondicherry (Sneghedhan)

And in Bangladesh

Bandhu Social Welfare Society operating in Chittagong, Dhaka and Sylhet.

We are currently developing a Liaison Office in India to coordinate these activities.

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I. Executive Summary

1.1 Background

In the sociocultural context of South Asia, the issue of male to male sexual behaviours and their impact upon the reproductive and sexual health of males and females have profound implications for the effective control and management of STDs and HIV infections in the region. However, the existence of MSM in South Asia, the extent of male to male sexual behaviours and its impact on the HIV epidemic have been largely ignored.

Because of social stigmatisation and public shame leading to invisibility and denial, in a region of 1.4 billion people, there are very few STI/HIV and reproductive and sexual health services focused on the issues of males who have sex with males. Sexual health information and services are primarily focused on so-called "heterosexual" behaviours, i.e. vaginal sex, and ignore the significant levels of anal sex, irrespective of the gender of the sexual partner. Formative research is urgently needed to understand how to design appropriate sexual health interventions regarding male to male sexual behaviours and MSM.

At the same time, male to male sexual behaviours in the region do not appear to "fit" into a heterosexual/homosexual framework, of fixed sexual identities leading to fixed and oppositional behaviours based on same-sex and gender versus opposite sex and gender patterns. To a significant extent MSM behaviour patterns reflect a gendered relationship between sex partners, and perhaps could be defined as same sex/different gender encounters. This leads to many of the "manly" partners who take on the penetrating role not perceiving themselves as "homosexuals", or that their sexual practice is "homosexual". But it should also be recognised that these labels do not always reflect actual sexual practices, and that for some, existing "under the blanket" so to speak, more flexible sexual behaviours do exist.

The dynamics of male to male sexual frameworks also include significant levels of male to female sexual encounters (other than their wives). Because the level of unprotected sex in the male to male sexual networks appears to be high, such behaviours increase the vulnerability not only of the penetrated males, but also of any female partners they may have. Beyond this, social and cultural structures such as homoaffectionalism amongst males in South Asian societies, the "apprenticeship" models in working environments, gender segregation, delayed marriages, and the high levels of poverty and unemployment, indicate the vulnerability of young males to STD and HIV transmission from sexual encounters with other males.

In such a sociocultural situation transmission of STIs/HIV is much more complicated than it would appear to be.

It is now generally accepted that male sexual practices must be taken into account and male involvement must be considered when developing reproductive and sexual health programmes. The issue of male to male sex is a vital component of that strategy if it is to have any significant impact upon reducing the spread of STI/HIV.

The consequences of unrecognised patterns of STI/HIV transmission through denial, invisibility and lack of appropriate prevention and treatment services should be clearly understood. The impact upon the epidemiological, social and economic frameworks need not be overstated where these have been discussed in other forums over the last 10 years. Clearly at the family level, such behaviours, should they lead to infections resulting in illness and possible death, will have a devastating impact upon its economic welfare.

1.2 Scope of Work

Goal

To establish model MSM sexual health interventions which reduce the risks of STI/HIV transmission among males who have sex with males in selected sites in South Asia

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Purpose

To conduct a series of situational assessments among MSM and their sexual partners in a number of selected cities in South Asia and develop appropriate responses to their reproductive and sexual health needs.

Objectives

To conduct action-based situational assessments of the sexual health needs of males who have sex with males in 4 selected cities in South Asia.

The situational assessments would include:

- * Qualitative/quantitative analysis of male to male sex behaviours, identities and genders in a given location
- * Range of sexual behaviours and risky practices
- * Levels of reported symptoms of possible STIs in terms of male to male sex behaviours, and accessing treatment
- * Sexual mapping of a given location
- * Family, marriage and gender issues
- * Access to condoms, lubricant, STI/HIV information, and STI services
- * Range of secondary stakeholders in the targeted cities
- * Demographic and ethnographic analysis
- * Defining technical needs and support mechanisms for developing peer-led services
- * Developing a strategic response framework responding to the sexual health needs of males who have sex with males within a given selected area
- * Presenting the assessments and project parameters to local State AIDS Control Societies, NGOs and other possible stakeholders, obtaining, wherever possible, their support
- * Designing project proposals for each specific site based on assessment findings and secure donor support for such interventions.

Institutional Participation

Naz Foundation International (NFI) has been networking with a range of agencies in sharing its experiences and advocating on behalf of MSM and their sexual health needs through a range of workshops, presentations, seminars, conferences, dissemination of reports, papers, etc. In this study, NFI established networks and presented the results of the Assessments to other potential stakeholders in each city, including State AIDS organisations, local NGOs, and STI treatment providers. Naz Foundation International also collaborated with international institutions, such as UNAIDS, UNDP, UNICEF, USAID, DFID, and other donor agencies/institutions promoting a recognition of male to male sexual behaviours and the sexual health needs of MSM to these institutions and advocating that such issues are included in any HIV/AIDS prevention strategy.

Target Cities

The following four cities were selected as Assessment sites

India: Hyderabad, Bangalore, Pondicherry

Bangladesh: Sylhet

The Assessment

The Situational Assessments consisted of:

- * Recruitment of a Local Focus Person (LFP) in each target city to manage the Assessment period, and an Assessment Team who conducted the Assessment and drawn from local MSM networks.
- * A six day training course for Team members
- * 200 MSM interviewed in each city utilising a set questionnaire consisting of 66 questions (written in the vernacular languages)
- * Tape-recorded interviews of up to 50 MSM in each city
- * 2 Focus Group Discussions in each city
- * Interviews and discussions with a range of secondary stakeholders facilitated by the Local Consultant,
- * Final assessment reports produced for each city
- * A Dissemination Meeting held for secondary stakeholders in each of the targeted cities,
- * A Project Design workshop for Assessment Team members and other MSM
- * A sexual health promotion project proposal developed for each targeted city

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- * These project proposals submitted to potential donors and negotiations developed with these donors for funding support
- * Technical assistance provided for development and implementation of these projects

The Assessment explored:

- * range of sexual behaviours and sexual health risks
- * levels of reported symptoms of possible STIs and accessing treatment,
- * sexual mapping,
- * family, marriage, and gender analysis,
- * access to condoms, lubricants, STI/HIV information,
- * access to STI services,
- * range and number of local NGOs, government and other institutions, and,
- * demographic and ethnographic analysis

It is noted that local MSM were accessed by Assessment Team members through their own personal networks and reflected the self-identities of the team members themselves. Hence the sampling did not reflect a random, high probability sample. These Assessments were not intended to develop a behavioural study, but to reflect the levels of understanding, risks and behaviours within certain MSM networks known to the Principal Investigator, the Local Focus Persons and members of the Assessment Teams.

Local Consultant

In order to facilitate the work with identifying appropriate secondary stakeholders, a Local Consultant was contracted to conduct such networking and facilitate discussions on MSM sexual health issues with such stakeholders.

India: Lalitha Kumaramangalam
Bangladesh: Nancy Jamieson

1.3 Constraints

- * Recruitment procedures

Recruitment relied on the networking skills and knowledge of the Local Focus Person. as well potential team members desire to participate, their availability, and their willingness to be consistent.

- * Quality of Assessment Team

Because of these issues, recruitment of appropriate MSM who were literate and understood the issues was difficult.

- * Restrictions imposed

Because the majority of recruited individuals were kothi-identified, accessing a broad range of differing MSM contexts was limited.

1.4 Major Findings

South Asia is a male dominated society where the social and public spaces are primarily male and masculine. As a homosocial and homoaffectionalist society, sexual boundaries between males can be readily crossed in certain contexts and may often become sexual acts. Whereas some of these acts can perhaps be called homosexual (within the context of local identities based upon female gender identification - also self-labelled as kothis) in that a sexual sense of a sexual self is operating within a framework of gender sex roles and desires, a majority of male to male sexual encounters should be seen within a context of semen discharge.

Thus in this gendered framework of male to male sex there is

- * the kothi-identified male - a person who identifies as a feminised gender, and usually takes the penetrated role in sex, and
- * those who penetrate. called panthis by kothis - and for the majority of these males male to male sex is not seen as homosexual but as semen discharge, i.e. a behaviour not an identity

To a significant extent the kothi identity is performative in that their public behaviour in certain sites is based upon a gendered performance of (often) exaggerated femininity as a mechanism to attract "real men", the panthi.

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Where the term "behaviourally homosexual" has been used by AIDS experts, perhaps we can also use the term "behaviourally heterosexual" as well, in the context of MSM issues in South Asia.

Kothi identified males, and those whom were called panthis by these kothis primarily were from low income, non-English speaking groups.

In major urban settings, certain men were identifying as gay. Primarily these men came from an English speaking urban elite or upper middle class. Others from the English speaking middle class did speak of themselves as "a gay" or practising "homosex". Certainly in Hyderabad and Bangalore, gay groups and networks existed, and were very active in developing a gay-identified sensibility modelled very much from the West. In Pondicherry and Sylhet no gay-identified men were accessed by the Assessment, and there were no visible gay group or organising.

There was very little sustainable interaction between gay-identified and kothi-identified men, primarily based on differing self-perceptions and gender performance, as well as class and social standing. In fact significant tensions existed where gay groups existed in terms of social exclusion and stigmatisation of kothis. Gay organising did exist in both Hyderabad and Bangalore only, but in both, such organising and networking appeared to be limited with their social meetings drawing an average of 15 to 20 regular participants.

The majority of participants in the study were kothi-identified. The issues of social exclusion, marginalisation and stigmatisation were key factors in leading them to act out situational identities. That is, within the family home and neighbourhood they will perform as young (or not so young) men, while in specific environments, perform as kothis with other kothis, or to draw the attention of potential male sexual partners.

Situational identities acted as a device to invisibilise identity choices, desire and behaviours, maintain social and family stability, and reduce levels of potential harassment and violence (of which none was observed by the Investigator).

From the range of interviews and the focus group discussions, there was a range of anecdotal reports of early sexual activities of many kothis, who often started their sexual life before the age of fourteen, and whose first sexual partner was usually a male relative such as a cousin or uncle.

Also being reported was a much broader context of male-to-male sex than only a kothi/panthi or gay dynamic and involved significant levels of males. Such sex encounters was going on in hotels amongst hotel staff and between hotel staff and guests, amongst street children, and street children and others, within a range of all male institutions such as boarding schools, madrassas, military establishments, hostels, prisons and so on. All sorts of males from across the spectrum of age, class and occupation were described as being involved in male to male sex, from police officers to beggars, from rich businessmen to movie extras, from rag pickers to truck drivers.

At the same time, the discussions generated a whole range of reasons why males have sex with males, from male to male desires, to "women don't do oral or anal sex", from protecting a girl's virginity to maintaining one's chastity, from "body heat" to "the anus is tighter than the vagina".

All the evidence points to significant numbers of males engaged in sexual encounters with other males, from adolescents to much older men, from close relatives to the domestic servant, from the rickshaw driver to the businessman, from the rag-picker to the shop-keeper. Many will engage in these behaviours sporadically, or over relatively brief periods of time. Many will also continue this behaviour infrequently over longer periods of time, beyond even their marriage. And many will engage in male-to-male sex as either an exclusive sexual behaviour prior to marriage, or as part of the sexual repertoire over their sexually active life.

Mapping

All the cities were mapped in regard to public sites for MSM activities.

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| City | Sites | City population (approximate) |
|------------|-------|-------------------------------|
| Hyderabad: | 92+ | 4 million + |
| Bangalore | 65+ | 4 million + |
| Pondichery | 16+ | 700,000 |
| Sylhet | 28+ | 700,000 |

Sites where men can meet other men include parks, bus-stands, railway stations, auto-taxi stands, cinema halls, public toilets, cemeteries, specific streets, bazaars, market places, shopping centres, any area where a measure of anonymity and access to males was possible. While sexual activities did take place in many of these sites, much also took place in construction sites, guest houses, lodges and hostels, as well as personal homes, where after meeting the partners the men would go for private sex.

Estimates of the MSM populations were almost impossible to quantify. Discussions lead to a range of guesstimates indicating MSM as a significant sexual framework in each city involving a minimum of 120,000 people in Hyderabad and Bangalore, and some 35,000 people in Pondicherry with 55,000 people in Sylhet. These figures are only guesses and cannot be taken as a true reflection of the size of the MSM networks. There is some anecdotal evidence to indicate that it could well be higher.

Psychosexual issues

Sex education was absent amongst the majority of the participants in the Assessment. Knowledge of male and female bodies, of reproduction, of the sex organs was almost non-existent.

This led to a variety of myths, beliefs and practices, which were accepted as true and helpful. A considerable tension existed regarding masturbation as a source of body and mental weakness that reduce the virility and functioning of the penis, if not producing damage of one sort or another. Members of the Assessment team as well as the Investigator were constantly asked about medical treatment for nocturnal emissions, masturbation, penile sizes and shapes. Many of these men used "quack" remedies from street vendors for their perceived weaknesses.

At the same time, the lack of knowledge of their own and female bodies led to a range of risky practices, such as anal bleeding, produced through dry and rapid penetrative acts.

Gender

It should be recognised that kothis play out the socially accepted gender roles, that their self-definitions, language and behaviours sustains a patriarchal framework of gender relationships and sexual behaviours, and that this has a strong likelihood of increasing their risk of STI/HIV infection and transmission.

This means that in a culture where women are devalued and stigmatised, kothis also experience this framework of social exclusion. It appears significant that for kothis, stigmatisation revolves primarily around their feminised identity as much as the fact of their being sexually penetrated by "real men". Stigmatisation is much less for these "real men".

Religion

The Assessment did not request specific information on religious affiliation although the issue was raised by the participants themselves.

Kothis expressed significant concerns about what their religion said about male-to-male sexual behaviours. No one knew of any specific statement in either Hindu or Islamic texts referring to male-to-male sex. There was a general consensus from these discussions that both religions condemned such behaviours. This further exacerbated the feeling of shame and exclusion.

Religious, social and family expectations followed a seamless context in which conduct, behaviour and expectations arose for all males to follow. Kothis felt particularly marginalised in terms of their desires, hopes and aspirations.

Both Hindus and Muslims expressed similar sentiments about family and social expectations, of performing as men, fulfilling duties, maintaining family honour, of marrying

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and producing children, particularly sons. Choice of marriage partner was still seen as a parental duty, and separation from the family as not an option.

Family

Joint and extended familial links are strongly held together by custom, tradition, belief, practice and economic need. Their value lies in providing a form of social security and welfare in a society that has neither. The elders are supported, as often are the unemployed, the unmarried, the range of children, the disabled. It is considered a moral duty for the family to stay together in this mutual support system, whether the staying together is physical or psychological. For example, leaving a small town or village to migrate to a major city for work, the individual will often stay with an extended family member already in that city.

Marriage

In South Asia, marriage is a social, cultural and religious necessity, a central issue within people's lives and a mainstay of family and community life. It should be seen as a socially and religiously compulsory duty towards maintaining family and community bonds. Marital status signifies adulthood, social responsibility and the achievement of personhood.

The majority of kothis and their sex partners in this Assessment accepted the social necessity of compulsory marriage, while some were already married. There appeared to be a fatalism operating here, and a sense of not being able to challenge family and society's strictures.

The unmarried kothis and panthis all stated that eventually they would have to get married. With those married MSM there was no significant evidence that marriage actually substantially decreased the levels of male-to-male sexual activity. Some of the married MSM that this was discussed with, stated that when they got married they believed they would stop, but either desire was "too strong to control", or because they received little sexual satisfaction from their wives they continued. Partly this was because they felt they couldn't ask their wives to perform certain sexual acts, and partly because sexual opportunities with their wives were not always available because of social conditions, such as appropriate accommodation, religious and cultural customs, joint families, and so on.

Apart from some gay-identified men (but not all), marriage was a central focus, and those who were not married stated that one day they would have to get married. Apart from their wives, at the same time, many panthis also stated that they have sex with females as well, primarily female sex workers.

Sexual activity with wives was relatively high with the majority of married respondents reported between 11-20 times in the previous month, except in Hyderabad where 42% of respondents reported more than 20 times in the past month.

Sexual Activities

Kothi-identified men appeared to be significantly more sexually active than gay-identified men in this study, with higher rates of anal and oral sex (average more than 3 times for the former and 2 times for the latter). At the same time the majority of kothis met their panthi partners in public sites, whereas gay-identified men tended to meet their partners in private spaces.

Hyderabad and Sylhet reported the highest levels of sexual activities (8100 for Hyderabad and 8800 for Sylhet where N=200). Pondicherry reported relatively low levels of sexual activity (2068, N=188).

Gay-identified men were primarily accessing their sexual partners through gay networks from the same class background, while kothis accessed men from a broad range of social, occupational and neighbourhood environments.

Further, sexual health risks were significantly different between gay-identified and kothi identified males. While levels of specific sexual behaviours were similar, actual practice was different, with kothi identified males primarily taking the "penetrated" role in oral and anal sex, and gay-identified men experiencing a greater mutuality in practice, i.e. both

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penetrating and being penetrated. Thus for kothis, being anally penetrated was the predominate act (95%). For gay men this was much less (33%).

Similarly, the differences between the sexual practices of those identifying as kothis, and those whom they call panthis was also significantly different, where panthis were primarily the penetrators.

However, significant levels of panthis were also being penetrated, and the anecdotal evidence indicates that some MSM identified with the "manly" framework, even though their sexual practice reflect a greater mutuality in sexual practice.

Kothis also had greater levels of sexual partners then either gay-identified men or panthis.

During this time, 180 respondents had more than 7 partners each, with 64.5% reporting partner levels of 21 or more. 20% respondents reported more than 51 partners each.

Multiple partners was the norm. Hyderabad and Sylhet reported the highest rates of partner change, where in Hyderabad 20% of respondents reported more than 51 partners in the previous month.

Condoms and lubricant

There were no appropriate condoms for anal sex available. While condom usage was on average around 30%, very few used condoms 100% of the time.

Condom use was determined primarily in terms of access, knowledge, shame, and sickness. With the condom equated with disease prevention, many participants either felt stigmatised through condom usage, or felt that their was no need to use condoms because either they or their sex partners were not sick.

The only water-based lubricant available in the market was Johnson and Johnson KY Jelly, which was priced beyond the capacity of most MSM. Further it was inappropriately packaged in 50gm tubes, unsuitable for most sex environments.

The primary lubricant used was saliva, but a significant level of oil-based products was also being used.

These practices were also reflected in some of the complaints such as anal bleeding, and pain during sex.

Sex Work

There were high levels of male sex work amongst the kothis, related to low levels of income. Thus across the four cities, on average 40% of the respondents reported selling sex, while significantly fewer identified as sex workers. Frequency varied from once a week to over 10 partners in a day, with Sylhet reporting the highest level of sex work. 100% condom usage varied from a high of 27% in Bangalore to 1% in Pondicherry.

The study was able to access only kothi sex workers, although discussions with members of the gay groups, kothis, and others indicated that there was a much smaller network of middle class male sex workers who were available at a significantly higher price than kothi sex workers and expressed masculine male behaviours.

While kothi sex workers usually acted out the penetrated role, either in oral or anal sex encounters, the middle class sex workers would either penetrate or be penetrated and would also access female sex workers or and/other women.

Motivations also differed somewhat. For kothi sex workers the issue was very much to due with poverty and the need to financially support their families. For the middle class sex worker the motivation appeared to be increasing their own consumer purchasing power, or making potential useful contacts, or even for educational purposes, i.e. college costs.

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A significant level of men also bought male sex, these primarily being identified by kothis as panthis. The frequency of purchasing was at least once a week, with some men (average 10%) reporting buying sex at least 5 times a week.

Sexual health

Significant levels of unprotected anal sex existed. While actual knowledge about HIV transmission was relatively high, with a majority giving correct information regarding risks, condom use was on average about 35%.

In terms of possible current symptoms of STIs, Hyderabad and Sylhet reported significant levels of anal bleeding, anal and penile discharges, genital sores, and a variety of other symptoms, while Bangalore and Pondicherry were reporting much lower levels. This variance could be the result of faulty data collection in the two latter cities, rather than a reflection of the reality. It does however indicate an urgent need for very specific research of STI prevalence amongst MSM.

As expected, male sex workers reported higher levels of anal symptoms.

Treatment

Regarding treatment of their current symptoms, a majority of respondents either have done nothing, or they have gone to a pharmacy. Some 27% have gone to a hospital. Accessing a private clinic was not uncommon in Hyderabad, but much less so in Bangalore and Sylhet.

Discussions with several private and government doctors who had expressed a willingness to treat anal sex issues indicated problematic concerns. Knowledge, understanding, providing a sympathetic framework, and even a lack of skills, were evident. There is no anal STI algorithm available, with no treatment protocol developed. Most doctors expressed unwillingness to work in this area, and the level of stigmatising comments were high.

There was a concern regarding the suitability or appropriateness of these doctors and clinics, particularly in terms of acceptance of kothi and/or gay identities, as well as the stigmatisation of anal sex practices.

HIV/AIDS knowledge

Awareness of AIDS was high, with 85% in Bangalore having heard of AIDS to 57% in Pondicherry. At the same time, the knowledge of the specifics of transmission was also significantly high, with an average of 64% knowing the risks of unprotected vaginal sex and 63% similarly for unprotected anal sex. As expected knowledge was higher in Bangalore and Hyderabad (both major metro areas) compared with Pondicherry and Sylhet.

BCC Materials

No appropriate BCC materials for MSM existed in any of the cities. Anal sex as a risk behaviour was totally invisible.

HIV antibody testing

In Hyderabad out of 25 respondents who were tested for HIV, 1 was positive. In Bangalore, 6 tested positive out of 38, and in Pondicherry 1 out of 4 tested. In Sylhet no one had had an anti-body test.

Intravenous Drug use

IDU was not uncommon amongst MSM in Hyderabad, Bangalore and Pondicherry. No data was obtained from Sylhet on this question. An average of 9% reported IDU use in the previous year.

AIDS prevention among MSM

There was no systematic prevention work taking place amongst MSM, other than personal communications between individuals. In Hyderabad there was a limited intervention by a gay organisation, but this tended to focus on gay-identified men only.

NGO and Donor response

The lack of understanding and knowledge of many of the NGOs, STI clinics, donor agencies and other institutions regarding the constructions of male to male sexual behaviours and the frameworks of MSM behaviours and/or identities was demonstrated in the discussions with secondary stakeholders.

Too often these discussion demonstrated a "Western" preoccupation on a heterosexual/homosexual oppositional binary, with no cross-over. The concept of a polymorphous sexual behaviour within which gendered identities operate was not clearly perceived or understood. Since previous articulation on MSM and HIV/AIDS had been led by gay groups and organisations, and since the construction of intervention strategies and prevalence data focus on heterosexual or homosexual transmission, this is understandable. But this framing of male-to-male sexual behaviours creates many barriers to the development of appropriate and effective sexual health services for MSM.

At the same time, there was a high degree of acceptance of MSM existence in all the cities expressed by the range secondary stakeholders, with an expressed need to "do something". There was also a willingness to invest funding in developing MSM sexual health interventions, but methodologies, strategies, and frameworks for such interventions had not been clearly thought through.

Conclusion

For many men involved in male-to-male sex, MSM sexual behaviour is NOT based on sexual identities, but on semen discharge.

There appears to be two main frameworks of MSM, with an emergent third in major urban areas

* **Kothi framework**

Male to male desire based on feminised gendered roles and identification;
sexual acts based on gender roles

* **Discharge framework**

Male to male sexual behaviours based on immediacy, access, opportunity and
"body heat".

Many of these males will access kothis for anal sex. Many of these males do not see themselves as "homosexuals", or even their behaviour as "homosexual", since they take on the "manly", penetrating role in male-to-male sex. Such males are called panthis/giriyas by the kothis

This does not mean that all kothis are only penetrated, or that all panthis only penetrate. These terms refer to a public gender performance, but also refer to a predisposition towards certain sexual roles. Kothis seek out panthis as sex partners.

* **Gay Framework**

Male to male desire framed by a sexual identity ñ primarily used by English speaking middle and upper classes. Such gay-identified men usually seek other gay-identified men as sex partners.

The kothi/panthi framework is indigenous based and usually found amongst those who have no access to English, and/or low-income networks.

This means that this is the majority framework of MSM sexual behaviours.

Socio-cultural frameworks of male-to-male sexual availability include:

- * patriarchal and phallic social structures within a culture that is homosocial and homoaffectionalist
- * often leads to stigmatisation of women
- * public domain as a male space
- * gender segregation and power differentials
- * leads to women as invisible, non-sexual beings, of low status
- * beliefs regarding women as weakening men
- * females as vessels of male honour
- * socially compulsory marriage and reproduction

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- * lack of welfare social structures
- * poverty driven economics and personal survival strategies
- * large population levels and mass movement of males from rural to urban areas for employment
- * leading to urban overcrowding
- * resulting in shared beds and spaces
- * males who are penetrated constructed as a feminised gender - as "not men"
- * a man can sexually penetrate such males without losing his sense of "manliness"

In such a situation where condom use is low, where anal sex is a common and regular practice, and where multiple partners is also common, the possibilities of STI/HIV transmission is high both between males and between MSM and any female partners they have.

If appropriate support and technical assistance is given, it is possible to develop community building strategies amongst kothis, and use these emergent communities as a means of education and prevention interventions amongst kothis, their partners, and where kothis can be mobilised on behalf of improving sexual health among MSM generally.

However it should also be recognised that kothis do not have the experience, knowledge, or skills to develop, implement and sustain their own sexual health intervention without considerable initial and on-going technical assistance.

It is also clear that there are some distinct differences in regard to sexual health issues for gay-identified men and for kothi-identified males.

1.5 Management

The Project Manager for this study was Shivananda Khan of Naz Foundation International who was also the Principal Investigator conducting the Assessments.

In each of the target cities, a Local Focus Person (LFP) was identified and recruited from local MSM networks. This person identified and recruited other appropriate MSM from the local networks. The LFP provided local management of the assessment.

A data processor was also recruited to process the quantitative information.

1.6 Primary Recommendations

- * Adequate levels of funding must be provided towards developing kothi-led sexual health promotion programmes amongst MSM
- * An effective strategy, will be to utilise community building among MSM networks and mobilise the emergent community towards risk reduction in sexual practices
- * Developing an enabling environment is an essential step towards minimising the social exclusion and stigmatisation of MSM
- * Appropriate technical assistance and support will need to be provided for capacity building and skills development
- * Appropriate condoms for anal sex and sachets of water-based lubricant should be made available at affordable prices distribution
- * It may be necessary to initiate free distribution to begin with to build condom usage as a community habit.
- * It is an urgent necessity that an appropriate STI treatment service be accessible to MSM, which is confidential, accepting and of high quality
- * It is necessary to ensure that the STI service provider has acceptable and appropriate knowledge of MSM issues and concerns, and of anal STIs.
- * Enabling and empowering a kothi-led project to host its own clinic service should be considered as a priority
- * Safe social spaces for meetings, social development, and education such as drop-in centres, self-managed by beneficiaries are an essential component for any sexual health intervention among kothis and other MSM
- * Training and sensitisation programmes should be provided for local STI treatment centres, HIV/AIDS and sexual health NGOs and development agencies, as well as government services dealing with MSM issues
- * Appropriate and relevant BCC materials should be urgently developed for kothis and

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their partners using their own terminology, and distributed by themselves.

- * Anal sex issues should be an integral component of any sexual health promotion strategy and education materials.
- * The concept of peer education, community-building, and beneficiary led services is central to any effective and sustainable intervention strategy, and this should be supported by any donor and government

1.7 Materials/Products

- * Situational Assessment reports
- * Assessment Presentation reports
- * Project Design workshop reports
- * Project proposals for MSM sexual health service delivery
- * Final report

1.8 Outputs

- * HIV/AIDS and Assessment training workshops conducted in Hyderabad, Bangalore, Pondicherry and Sylhet. Four Assessment Teams developed
- * Four Situational Assessments completed for Hyderabad, Bangalore and Pondicherry in India Sylhet, Bangladesh
- * Situational Assessment Reports produced and distributed
- * Four Presentations workshops conducted in each of these cities to State government and local NGO officials
- * Four Project Design workshops conducted in each of these cities for Assessment Team members towards developing a local response to needs identified by the Situational Assessments
- * Funding proposals developed for these initiatives
- * Funding achieved for
Hyderabad - State Management Agency/Andhra Pradesh State AIDS Control Society
Bangalore - Karnataka State AIDS Prevention Society
Sylhet - USAID/FHI Bangladesh
- * Projects implemented in Hyderabad, Bangalore and Sylhet
Pondicherry awaiting donor decision to support project
- * FHI India organised a national dissemination meeting in October 2000
 - DFID India producing a synthesis report for broad international dissemination

II. Description of Project

A. Background

Project Context

In the socio-cultural frameworks of South Asia, the issue of male-to-male sexual behaviours and their impact upon the reproductive and sexual health for males and females, children, youth and adults, have profound implications for any effective control and management of STDs and HIV infections in the region. But because of cultural, religious and social reasons, these behaviours are marginalised and invisible. Male sexual behaviours in South Asia appear to be much more polymorphous than a heterosexual/homosexual divide would indicate, whilst anal sex between males and females is much more common than is assumed. In such a situation transmission of STD/HIV is much more complicated than it appears to be.

The consequences of unrecognised patterns of STD/HIV transmission through denial, invisibility and lack of appropriate prevention services regarding the management and control of the epidemic, should be clearly understood. The impact upon the epidemiological, social and economic frameworks need not be overstated where these have been discussed in other forums over the last 10 years. Clearly at the family level, such behaviours, should they lead to infections resulting in illness and possible death, will have a devastating impact upon its economic welfare. At the social level, the World Bank, UNAIDS, Harvard AIDS Institute and others have all clearly stated that the economic development of India and its surrounding countries could easily be set back ten years or more should the epidemic not be controlled over the next five years.

Because of social stigmatisation and public shame leading to invisibility and denial, there are almost no STD/HIV and reproductive and sexual health services focused on the issues of males who have sex with males and/or anal sex behaviours. Sexual health information and services are primarily focused on so-called "heterosexual" behaviours, i.e. vaginal sex, and ignore the high levels of anal sex, irrespective of the gender of the sexual partner.

It is now generally accepted that male sexual practices must be taken into account and male involvement must be considered when developing reproductive and sexual health programmes. The issue of male-to-male sex is a vital component of that strategy if it is to have any significant impact upon reducing the spread of STD/HIV.

For analysis of the issues involved see Naz Foundation publications: Making Visible The Invisible - sexuality and sexual health in South Asia - a focus on male to male sexual behaviours, 1996; Perspectives on males who have sex with males in India and Bangladesh, 1997; Sex, Secrecy and Shamefulness - developing a sexual health response to males who have sex with males in Bangladesh, 1997; Pukaar - newsletter of Naz Foundation International, published quarterly.

More appropriate support is urgently needed in order for MSM community-based, beneficiary-led reproductive and sexual health promotion services to be developed. At the same time, more generic reproductive and sexual health services need access to appropriate training and skills building on these issues to enable their services to be more appropriate and accessible.

There has also been a tremendous lack of will, expertise and appropriate skills on these specific issues. What skills and technical expertise exist are those which are based on Western 'gay/homosexual' - related frameworks that, to a great extent, are largely irrelevant to what occurs in South Asia.

Assessments conducted by Naz Foundation International and its partner agencies in a range of cities in South Asia indicate significant levels of males who have sex with males, with a majority of such males practising such behaviours without a "homosexual" identity. Further there appears to be a growing number of male sex workers due to poverty, economic pressure, and migration from rural to urban areas.

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Male to male sex appears to be highly gendered, with frequent partners, and for many, sexual access to females. Along with this are low levels of condom use with concomitant high risks of HIV/STI transmission. These behaviours are exacerbated by sociocultural factors such as gender segregation, economic disparities, age and gender power differentials, adult male ownership of social spaces, and adult male sexual privileges.

Because of social stigmatisation and public shame leading to invisibility and denial of male to male to male sex, there are few STI/HIV prevention and sexual health services in South Asia specifically focused on males who have sex with males, and/or anal sex behaviours. Sexual health information and services are primarily centred on so-called "heterosexual" behaviours, i.e. vaginal sex, and ignore the relatively high rates of anal sex, irrespective of the gender of the sexual partners.

It is now generally accepted that male sexual practices must be taken into account, and male involvement must be considered, when developing reproductive and sexual health programmes, including those involving HIV/AIDS prevention. The issue of male-to-male sex is a vital component of any strategy if there is to be any significant impact regarding reducing the spread of STI/HIV/AIDS in South Asia.

Vulnerable Groups

In the South Asian context, a significant number of male-to-male sexual encounters are framed by concepts of gendered roles. Here the penetrated partner is perceived as feminised, while the penetrator is perceived as "manly", a "real man". Both sexual partners subscribe to these gendered roles, and the penetrated partner feminises his public and sexual behaviour as a means to "attract real men".

In the light of these gendered performances, and with no access to appropriate condoms for anal sex, nor to water-based lubricant, the penetrated partner is particularly vulnerable to rectal damage and thus to STI/HIV infections.

Along with a general practice of sexual encounters in public spaces due to a lack of private opportunities, particularly amongst the low income groups, the rapidity of the actual sexual act, the frequency of penetrations, and with the significance of a society that makes marriage socially compulsory, with that of the penetrator perceiving his masculinity as being intact and that a male partner can be perceived as a substitute for a female, male to male sex plays a significant role in the spread of STIs/HIV.

Further because the level of unprotected sex with other males is high, with low levels of health seeking behaviours in regard to STIs, the vulnerability of low income MSM and their partners is exacerbated.

Along with females married to, or accessed by, MSM, adolescent males are also vulnerable, where significant levels of MSM have their first sexual encounters with a male relative or neighbour before the age of sixteen.

The Need

The following needs have been identified by Naz Foundation international in the development of its work:

1. There is a clear need to understand the socio-cultural dynamics of male sexual practices and behaviours and the social constructions of masculinities in urban and rural settings towards developing effective appropriate strategies for reducing the levels of unsafe sex amongst them.
2. There is an urgent need to develop and implement effective community-based strategies for the prevention of STD/HIV transmission and the promotion of reproductive and sexual health amongst males who have sex with males including any female sexual partners.
3. There is a need to ensure that government and non-government agencies recognise the significant levels of anal sex existent within South Asian countries and ensure that appropriate STD treatment and counselling services are available and accessible to males who have sex with males and any female sexual partners they may have.
4. Advocacy and human rights issues need to be urgently address in this context.

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5. International institutions such as UNAIDS, USAID, UNDP, UNICEF, as well as donor agencies and institutions should recognise that unless issues of male to male sexual behaviours are taken into account in any development of reproductive and sexual health programmes, then prevention of STD/HIV strategies will not fully succeed.
6. There is a considerable lack of knowledge, technical skills and the political and social will regarding
 - 6.1 socio-cultural issues of male-to-male sexual behaviours
 - 6.2 research into these behaviours in the context of South Asian countries
 - 6.3 development of appropriate locally owned community-based agencies managed by the beneficiaries of the services provided by these agencies, i.e. managed by males who have sex with males
 - 6.4 enabling other institutions to address the STD/HIV consequences of male-to-male sexual behaviours appropriately

In the light of these issues, Naz Foundation International selected four target cities in South Asia other than those where its partner agencies (and others) were already established, funded and providing an MSM sexual health service, and conduct situational assessments amongst MSM exploring their sexual health needs in these cities. Such assessments would then be presented to secondary stakeholders in each city, including State AIDS organisations, other NGOs and STD treatment providers. Project proposals would then be developed to deliver appropriate sexual health services to MSM and negotiations with appropriate donors would be conducted to secure funding for such proposals. Naz Foundation International would then provide appropriate technical support for developing and implementing such projects.

B. Scope of Work

Goal

To establish a model MSM sexual health interventions which reduce the risks of STI/HIV transmission among males who have sex with males in selected sites in South Asia

Purpose

To conduct a series of situational assessments among MSM and their sexual partners in a number of selected cities in South Asia and develop appropriate responses to their reproductive and sexual health needs.

Objectives

To conduct action-based situational assessments of the sexual health needs of males who have sex with males in each of a range of 4 selected cities in South Asia.

These assessments would include:

- * qualitative/quantitative analysis of male to male sex behaviours, identities and genders in a given location,
- * range of sexual behaviours and risky practices,
- * levels of reported symptoms of possible STIs in terms of male to male sex behaviours, and accessing treatment,
- * sexual mapping of a given location,
- * family, marriage and gender issues,
- * access to condoms, lubricant, STI/HIV information, and STI services,
- * range and number of local NGOs, government and other institutions,
- * demographic and ethnographic analysis,
- * define technical needs and support mechanisms for developing peer-led services,
- * develop a strategic response framework responding to the sexual health needs of males who have sex with males within a given selected area,
- * present the assessment and project parameters to local State AIDS Control Societies, NGOs and other possible stakeholders, obtaining, wherever possible, their support, and,
- * design project proposals for each specific site based on assessment findings and secure donor support.

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The Assessment

The Assessment consisted of:

- * recruitment of Local Focus Person (LFP) and a training group of 15 individuals drawn from MSM networks in each targeted city,
- * a six day initial training programme for these individuals,
- * an Assessment Team developed from this training group, who will conduct the assessment managed by the LFP,
- * 200 MSM interviewed through set questionnaires in each city, each consisting of 66 questions,
- * up to 60 tape-recorded interviews on MSM in each city,
- * 2 Focus Group Discussions in each city, each group consisting of 15 MSM,
- * Interviews and discussions with a range of secondary stakeholders facilitated by a Local Consultant,
- * data analysis assessment Reports produced for each city,
- * a Dissemination Meeting held for secondary stakeholders in each of the targeted cities,
- * a Project Design workshop for the Assessment Team and others,
- * project proposals developed for each targeted city,
- * project proposal submitted to potential donors and negotiations developed with these donors for these proposals to be funded, and,
- * technical assistance provided for development and implementation of these projects.

The Assessment explored:

- * range of sexual behaviours and risky practices,
- * levels of reported symptoms of possible STIs and accessing treatment,
- * sexual mapping,
- * family, marriage, and gender analysis,
- * access to condoms, lubricants, STI/HIV information,
- * access to STI services,
- * range and number of local NGOs, government and other institutions, and,
- * demographic and ethnographic analysis

Institutional Participation

Naz Foundation International has been networking with a range of agencies in sharing its experiences and advocating on behalf of MSM and their sexual health needs through a range of workshops, presentations, seminars, conferences, dissemination of reports, papers, etc. In this study it was proposed that NFI will establish networks and present the results of the assessments to other potential stakeholders in each city, including State AIDS organisations, other NGOs, and STD treatment providers. Naz Foundation International would also collaborate with international institutions, such as UNAIDS, UNDP, UNICEF, USAID, DFID, and other donor agencies/institutions to promote a recognition of male to male sexual behaviours to these institutions and to advocate that such issues are included in any HIV/AIDS prevention programme.

Target Cities

The following four cities were selected as sites where the situational assessments among MSM and their sexual partners would be conducted.

India: Hyderabad, Bangalore, Pondicherry
Bangladesh: Sylhet

Local Consultant

In order to facilitate the work with identifying appropriate secondary stakeholders, a Local Consultant was to be contracted to conduct such networking and facilitate discussions on MSM sexual health issues with such stakeholders.

India: Lalitha Kumaramangalam
Bangladesh: Nancy Jamieson

Staffing

The Project Manager for this study would be Shivananda Khan of Naz Foundation International who would also be the Principal Investigator conducting the Assessments.

Situational Assessments Among MSM In South Asia

In each of the target cities, a Local Focus Person (LFP) would be identified and recruited from MSM networks. Such a person would identify and recruit appropriate MSM from the local networks to be trained and act as peer researchers. He would also provide local management of the assessment.

A data processor would also be recruited.

Work Plan

1. Pre-Assessment Phase 1: Initial Networking

This phase involved initial networking in the targeted cities to identify appropriate MSM networks and the LFP.

This period included:

- * the development of assessment documents including the developing the questionnaire
- * tape-recorded interview framework designed,
- * informed consent procedures and forms developed,
- * first training workshop designed, and,
- * initial discussions with the Local Consultants.

2. Pre-Assessment Phase 2: Visiting targeted cities

Each targeted city visit in sequence to

- * establish local contacts,
- * recruit a Local Focus Person on a four month contract (initiated at the beginning of each assessment period),
- * identify key stakeholders,
- * identify appropriate resources,
- * explore with Local Focus Persons recruitment strategies for the programme,
- * establish likely political/religious response,
- * arrange for translation/printing of documents, and
- * conduct initial local site visits and meet MSM networks.

3. Pre-Assessment Phase 3: Creating Local Networking

In each city, following the initial visit each LFP completed

- * translation/typesetting and printing of documents,
- * local networking,
- * recruitment for 1st group meeting, and
- * book appropriate accommodation and arrange venues.

4. Assessment Phase 1: Meetings with secondary stakeholders

The Local Consultant also visited each city under their contract and discussed the range of issues as they affect MSM and their sexual health needs with relevant stakeholders. Interviews and review of stakeholders were conducted. Stakeholders included:

government
NGOs
Clinics
others

India: Laliitha Kumaramagalam
Hyderabad, Bangalore and Pondicherry
Bangladesh: Nancy Jamieson
Sylhet

5. Assessment Phase 2: Implementing Assessment

The Principal Investigator visited each targeted city in sequence linking with the Local Consultant for that city.

The following tasks were completed

- a. obtain appropriate accommodation for meetings and interviews
- b. meeting with LFP and conduct an evaluation of documents and recruitment
- c. 1st meeting: social gathering
outline of project, process, and training workshop given
selection of 15 persons for workshop

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- d. 6 day training course and selection of peer ethnographers
- e. assessment period includes
 - 200 questionnaires
 - one on one interviews: 20 transport workers
20 MSWs
20 others
 - focus group discussions: 2 (each with 15 participants)
- f. translation of documents on-going

6. Data input and analysis

Assessment documents shipped to Naz Office for input and analysis following each city assessment.

7. Initial Reports produced

Ethnographic and assessment information combined with stakeholders report for an initial assessment report

8. Reports reviewed and amended

- * Assessment report finalised and 30 copies produced for presenting at Presentation workshop
- * Stakeholders presentation workshop designed

9. Presentation Workshop held for Stakeholders in each city

A one day workshop held in each target city presenting findings and developments to other potential stakeholders including city State AIDS Society, NGOs, and STD treatment providers.

10. MSM sexual health project design workshop held with beneficiaries in each city

A three day workshop on MSM and sexual health project design organised in each city. Facilitated by the Project Manager, Consultant and LFP. At the workshop, project proposals were designed for each specific site based on assessment findings.

11. Project proposals developed and submitted to donors

Project proposals were written for submission by the MSM NGOs to international or domestic donors to secure funding support.

Indicators

- 1. no. of cities
- 2. no of focus persons recruited
- 3. no. of stakeholders interviewed
- 4. 4 training workshops conducted
- 5. no. of workshop participants
- 6. 200 questionnaires completed per city
- 7. 60 interviews conducted per city
- 8. 2 focus group discussions per city
- 9. each city mapped for
 - public sex environments
 - meeting sites
 - STD treatment services
- 10. 4 reports produced
- 11. 4 assessment presentation workshops conducted
- 12. numbers attending these workshops
- 13. 4 project design workshops conducted
- 14. numbers attending these workshops
- 15. 4 project proposals developed and submitted

Outcomes

- 1. situational assessment and risk analysis of MSM conducted in four cities
- 2. development of links with potential stakeholders and data presented for each city
- 3. project design workshops conducted in four cities
- 4. project proposals developed for MSM sexual health services in each city
- 5. four service agencies for MSM developed

III. Implementation

A. Process

Questionnaire

Based on previous studies done by Naz Foundation International, and following discussions with a range of experts, a questionnaire was developed with 66 questions that explored:

- * demographic details, such as age, education, income, and self-labelling,
- * personal sexual behaviours and practices,
- * sexual partners and meeting places,
- * access to, and use of, condoms,
- * male sex work,
- * female partners of MSM,
- * possible STI symptoms and treatment seeking, and
- * HIV/AIDS knowledge and awareness.

Interviews

A framework for tape-recorded interviews was also developed. Four broad themes will be explored

- a. life story
 - family, schooling, work, marriage, children
 - sexual history, early activities, first partners
 - how do you find partners, sexual practices
- b. self-perception
 - concepts of self-identity, concepts of partner's identity, gender identities,
 - sexual attraction, social support, sex education, notions of friendship and love
- c. the future
 - what will happen and why, marriage, children,
 - changes in practices and behaviours if any
- c. health and social issues
 - STI/HIV knowledge and beliefs, STI treatment seeking behaviours,
 - concepts of risk and health, society, religion and self

Focus Group Discussions

Further to this, a framework was developed for the Focus Group Discussions. These discussions will be generated on concerns, issues and needs of men who have sex with men, including STI/HIV/AIDS. Other issues to be discussed will be:

- * situational and/or self-identities,
- * personal support systems,
- * health seeking behaviours,
- * language,
- * social roles,
- * MSM mapping of the targeted city,
- * access to existent STI treatment services,
- * social and religious issues,
- * family, marriage and children, and
- * male sex work

The training programme

A six day training workshop was designed for MSM participants for the initial phase of the assessment study. The workshop would explore:

- * issues relating to sex, sexual behaviours, and sexuality in South Asia.
- * increasing knowledge of male and female bodies and psycho-sexual issues relevant among males in South Asia.
- * discussions on MSM in the context of the targeted city, which will include mapping.
- * sexual health issues, including STI/HIV transmission and prevention,
- * methodologies to be used in the Assessment,
- * use of questionnaire,
- * tape recorded interviews,

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- * focus group discussions, and
- * site observations.

Hyderabad Assessment

Following preliminary meetings with the Local India consultant, interviews and discussions were held with a range of secondary stakeholders including

Andhra State AIDS Control Society (SACS)

Project Director

NGO Advisor

DFID sponsored State Management Agency

Director

Programme Manager

Nrityanjali: slum project

Pragathi: street children

IRDS: female sex workers

Saathi : gay group

Expressions: a gay group

Local Focus Person

representatives of a number of MSM networks

Information fed-back to Project Manager

The Hyderabad Local Focus Person had identified

- appropriate workshop venue
- recruited 15 individuals for workshop
- invited these and a further 15 individuals to the 1st Social Meeting

He had further completed the translation and typesetting and printing of 200 questionnaires in Telugu, as well as the consent forms.

The first social meeting for 30 MSM was held where the Assessment was explained, and this was followed by the 6-day training programme with fifteen participants. From the training group ten participants were selected for the Assessment Team and a briefing meeting was held.

A steering group was developed by the LFP to provide assistance for the Assessment, and the group with members of the Assessment Team decided to organise themselves as a group naming itself as Mithrudu. The Steering Group solicited funds from its networks and rented accommodation to host itself and the Assessment study. This was felt to be better than utilising personal accommodation.

Field visits were made to six public sex environments and observational analysis was conducted along with one-on-one discussions with individuals at these sites, assisted by the LFP.

Following the discussions held by the Local India Consultant, the Project Manager also held meetings with

AP State Management Agency

State AIDS Control Society

and three NGOs working with
street children: Pragathi

slums: Nrityanjali

female sex workers: IRDS

5 doctors providing STI treatment

(2 MSM doctors agreed to provide anal STI syndromic management)

Bangalore Assessment

Following preliminary meetings with the Local India Consultant, discussions were held with a range of secondary stake-holders including

Karnataka State AIDS Prevention Society (SAPS):

Project Director

NGO Advisor

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Jagruthi: a street children's project and funded by SAPS to conduct an outreach programme amongst MSM
Samraksha: a female sex workers project
G.A.Y representatives
Sangama: a sexualities and human rights documentation centre
HIVOS, a Dutch donor agency, based in Bangalore
Community Health Cell, providing HIV/AIDS information
Samuna, working with female sex workers
Freedom Foundation, working with street children
Local Focus Person
representatives of a number of MSM networks

Information was fed-back to Project Manager

In Bangalore Local Focus Person had identified

- i. appropriate workshop venue
- ii. recruited 15 individuals for workshop
- iii. invited these and a further 17 individuals to 1st Social Meeting

He had also completed the translation and typesetting and printing of 200 questionnaire and consent forms in Kannada

The first social meeting was held for 32 participants, which was followed by the 6 day training programme for 15 pre-selected participants. Following the training programme, ten participants were selected and formed into an Assessment Team.

Since first meeting in January, Jagruthi, a local AIDS NGO who has been given funds by the Karnataka State AIDS Prevention Society to develop an MSM AIDS prevention project.

This had complicated the issues somewhat, particularly since Jagruthi had no previous experience of working with MSM (the project director had attended a number of meetings presented by Sangama, a documentation centre on sexualities and related concerns). Nor did Jagruthi have links with MSM networks in Bangalore apart from individual contacts with English speaking gay - identified men. However, since the State AIDS Prevention Society has already funded Jagruthi, they would not consider another MSM project.

This information had not been revealed to the Project Manager during the January pre-assessment visit when he met with Jagruthi, but arose in the discussions held with the India consultant.

For this reason, following discussions with the Local Focus Person and the Assessment Group, negotiations were conducted with the Director of Jagruthi in regard to the Assessment and any potential follow on work. Jagruthi agreed to the following:

- i. house the assessment group and the assessment period
- ii. access the assessment group as a core group towards developing an MSM outreach programme
- iii. help develop a steering group charged with the responsibility of managing the assessment and developing the MSM sexual health project the model of development would be that of the Sahodaran Project in Chennai
- iv. sign a network partnership agreement with Naz Foundation International in regard to its MSM sexual health project, allow Jagruthi to access the MSM resources of Naz Foundation International
- v. called its MSM sexual health project GELAYA as desired by the assessment group and Local Focus Person
- vi. accept the conditions of the assessment period

Jagruthi enabled the Assessment Group to use its office for the assessment.

The Project Manager held further meetings and discussions with
State AIDS Prevention Society
Jagruthi
Samraksha

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G.A.Y
Swabhav

and individual meetings with 3 doctors regarding STI treatment and MSM. All 3 doctors (2 MSM) agree to provide anal STI syndromic management

Pondicherry Assessment

Pondicherry is a small enclave neighbouring Tamil Nadu and only 2 hours from Chennai by car. The local language is Tamil.

The Project Manager had solicited Sahodaran assistance (which had links with some MSM networks in Pondicherry) in recruiting an Assessment Team and Local Focus Person. On arrival the original Local Focus Person had decided not to participate. This required an immediate and intense rapid survey amongst MSM in a number of sites in Pondicherry with a seconded person from Sahodaran. Within 3 days the required numbers for the Assessment Team were recruited along with a potential Local Focus Person, and the Assessment process was.

Due to the lack of management experience with regard to the choice of Local Focus Person (he was chosen for his other skills), Sahodaran also agreed to second one of its Field Workers to Pondicherry to provide initial technical assistance and training to the LFP for a limited period time. Funding for this was provided by NFI. This assistance was completed on 19th May.

Because of the way the State government funds NGOs, where such NGOs need to have had 3 years audited accounts, and with no appropriate NGO being available in Pondicherry, it was believed that a working relationship between the Pondicherry Project and Sahodaran in Chennai should be developed. Funds for an MSM Pondicherry project could be channelled through Prakriti-Sahodaran. This would mean developing the Pondicherry Project as a branch project of Prakriti-Sahodaran.

Following the rapid networking process, forty people attended the first social meeting and fifteen individuals were recruited into the training programme.

Sahodaran had already translated the Assessment documents into Tamil, typeset, and printed the 200 questionnaires and consent forms.

Following the social meeting, the six day training programme was conducted, and the Local Focus Person recruited with support to be provided by the Sahodaran seconded staff for a period of 6 weeks.

Field visits were made to 3 major cruising sites for observational analysis and a range of discussions were held with participants of MSM networks utilising these sites, with assistance from the LFP.

Two Focus Group discussions were also held.

Along with Local India Consultant, meetings were held with
Pondicherry State AIDS Society
2 STI treatment doctors
government STI clinic staff
APAC, Tamil Nadu
Assessment Team
Sahodaran seconded staff

A range of local NGOs were approached, but none wished to discuss issues.

Sylhet Assessment

In Sylhet, following the January visit, and with assistance from Bandhu Social Welfare Society (an MSM sexual health project based in Dhaka and developed with technical assistance from Naz Foundation International), a local individual was recruited as Local Focus Person. All appeared to be progressing satisfactorily until the second visit to Sylhet in the beginning of May.

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It became rapidly clear that this individual was unsatisfactory as the implications for what the work entailed (even though this had been explained right at the beginning) in regard to MSM issues in Sylhet was felt. The LFP felt increasingly insecure and afraid of any public exposure of himself as he was well known in the city. The concern was exacerbated by the fact that the Assessment Team he had recruited were not self-identified MSM (if any of them they were MSM at all) and the Investigator stated that the principle of the Assessment was that it should be peer-led. This also meant recruiting male sex workers and other MSM who were active in the city and working with them.

It also became clear that he had taken on the responsibility for other reasons than the Assessment itself, and had not thought through the implications of the work.

Two days of intense discussions followed. The LFP resigned stating that he could not take the risk of any exposure in what he defined as a very conservative and traditional society. Bandhu immediately sent two representatives to Sylhet and within two days following the resignation of the LFP with the members of the initial Assessment Team, a new team had been recruited. The training programme followed, a LFP was recruited from the participants, following the workshop from the participants, and the Assessment initiated. Bandhu Social Welfare Society agreed to provide on-going oversight during the Assessment Period, and also in terms of follow-on work.

This process was used, since

- i. Bandhu Social Welfare Society is the only MSM project in Bangladesh
- ii. NFI has a four-year working relationship with Bandhu
- iii. In the context of potentially developing a new MSM sexual health service and the issues of emergent NGOs in Bangladesh, a relationship had been developed in the context of the Sylhet work
- iv. Any MSM sexual health service would need to operate as a branch office of Bandhu Social Welfare society. The Investigator had involved BSWS all through the initial phases of the process

Bandhu Social Welfare Society also agreed to act as a resource base and management back-up for the Local Focus Person and would regularly visit Sylhet over the Assessment Period.

Due to time constraints, Nancy Jamieson, as the Bangladesh consultant assessing secondary stakeholders had come to Sylhet ahead of the Project Manager and had already met a range of NGOs, doctors, and others along with original Local Focus Person (who knew these people and organisations personally), and a rapport had been built, it was believed that rather than the Investigator dialogue after the rupture with relationships with, that Bandhu, during its visits to Sylhet, would continue the dialogue towards building effective cooperation and support.

The range of organisations accessed by the Bangladesh consultant were

Interplast
Sylhet Samaj Kallyan Sangstha
Urban Health and Family Planning Project
Marie Stopes Clinic Society
Voluntary Association, Rural Development
Social Marketing Company
Sylhet Medical College
Sylhet Municipal Corporation
5 STI treatment doctors

Following a social group meeting of 35 MSM, 15 individuals were identified and recruited for participation in the training workshop and Assessment, a week behind schedule. Further to this, both representatives of Bandhu Social Welfare Society stayed on in Sylhet for the workshop, and to continue dialogue with the Local Focus Person and Assessment Team members.

Bandhu Social Welfare Society had already translated, typeset and printed the questionnaire and consent forms.

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Following the social meeting, the six day training programme was conducted and 9 participants were recruited to form the Assessment Team, along with the Local Focus Person.

Two Focus Group discussions were also held, and local field visits were made to 6 public sex environments, where a series of one-to-one discussions were held with a range of individuals, facilitated by the LFP.

Data Analysis

Data input had begun with the Hyderabad questionnaires in the beginning of May. Bangalore questionnaires were completed in mid-May and had been forwarded for data input. The Pondicherry questionnaires had been completed by the end of May and had also been forwarded.

There had been some problems with the tape-recorded interviews, where there have been several spoilt tapes due to

- a. poor recording conditions
- b. lack of clarity in some of the recordings
- c. unclear statements

In Hyderabad, this led to a loss of ten such audio-tapes, while in Bangalore a loss of thirteen.

Further to this there had been some difficulties with translations and transcription, which had delayed access to this information. In Hyderabad transcription of the taped interviews was completed these had been forwarded to London for analysis.

Data input for Hyderabad was completed by June and forwarded to London. Along with the notes from the Focus Group discussions, site visits, and those from the local India consultant, enabled the Hyderabad Situational Assessment to be completed along with the Hyderabad Presentation Workshop design.

Data from the Bangalore Assessment was also forwarded to London and the Bangalore Situational Assessment Report was being completed.

Data from the Pondicherry and Sylhet Assessments were forwarded to London. The Bangalore Situational Assessment was completed, along with the Pondicherry and Sylhet Assessment. Reports were produced along with the Presentation workshops.

Copies of these reports were forwarded to the FHI Asia office, along with USAID in India and Bangladesh, FHI India, DFID in India and Bangladesh, and the local Assessment Teams.

Project design workshops were developed for all targeted cities. A work schedule was developed and implemented for the next phase of the Assessment project.

Hyderabad

A one day Assessment Presentation/workshop was conducted for

- Assessment team members
- Local Focus Person
- 3 male sex workers
- AP State AIDS Control Society
- AP State Management Agency

State Government STI specialist

2 STI treatment doctors

representatives from 4 NGOs

- Nrityanjali
- Pragrathi
- IRDS
- Saathi

Local consultant

The 3 day Project Design workshop was held following the presentation, A project proposal was developed. The implementing agency was to be Mithrudu, while the donor for submission was the Andhra Pradesh State AIDS Control Society.

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Bangalore

A one day Assessment Presentation/workshop was conducted for

- Local Focus Person
- Assessment Team members
- Jagruthi representatives
- Karnataka State AIDS Prevention Society
- Representatives from
 - G.A.Y
 - Sangama
 - Samraksha
 - Samuna
- Local consultant

The 3 day Project Design workshop was held and a project proposal was developed. The management agency would be Jagruthi with Gelaya acting as its implementing component. The proposal was submitted to Karnataka AIDS Prevention Society.

Pondicherry

A one day Assessment Presentation/workshop was conducted for

- Local Focus Person
- Assessment Team members
- Pondicherry State AIDS Control Society
- Tamil Nadu State AIDS Control Society
- APAC
- Rural Education and Development
- Society for Development Research and Training
- Society for Community Development and Rehabilitation

The 3 day Project Design workshop was held co-facilitated and a project proposal was developed. The management agency would be Prakriti with Sneghedhan acting as its implementing component. The proposal was submitted to USAID India and FHI India.

Sylhet

A one day Assessment Presentation/workshop was conducted for

- Local Focus Person
- Assessment Team members, and representatives from
 - Bandhu Social Welfare
 - FHI/IMPACT Bangladesh
 - Social Marketing Company
 - Marie Stopes Clinical Society
 - Sylhet Jubo Academy

The 3 day Project Design workshop was held co-facilitated and a project proposal was developed. The management agency would be Bandhu Social Welfare Society and the local project as a branch office acting as its implementing component. The proposal was submitted to USAID/FHI Bangladesh.

Negotiations with donors were held with the following results:

Hyderabad

Mithrudu, the group formed following the Assessment has secured funding for 5 years from the AP State AIDS Control Society.

Bangalore

The Karnataka State AIDS Prevention will upgrade its grant to Jagruthi for its MSM programme to include a drop-in centre and ancillary services.

Pondicherry

At this juncture still awaiting confirmation from USAID/FHI India.

Sylhet

Bandhu Social Welfare Society has been funded by FHI to operate a branch project in Sylhet.

Unanticipated Activities

DFID India

Has agreed to fund a synthesis report of all the four Assessment Reports and disseminate this report internationally.

FHI India

Organised a dissemination for the India National AIDS Control Organisation and a range of donors in New Delhi.

Outputs Achieved

- * Four HIV/AIDS training workshops conducted in Hyderabad, Bangalore, Pondicherry and Sylhet
Total number of 60 people trained
Four Assessment Teams developed
- * Four Situational Assessments completed in Hyderabad, Bangalore and Pondicherry in India
Sylhet, Bangladesh
- * Situational Assessment Reports produced and distributed
- * Four Presentations workshops conducted in each of these cities to State government and local NGO officials
- * Four Project Design workshops conducted in each of these cities for Assessment Team members towards developing a local response to needs identified by the Situational Assessments
- * Funding proposals developed for these initiatives
- * Funding achieved for
Hyderabad - State Management Agency/Andhra Pradesh State AIDS Control Society
Bangalore - Karnataka State AIDS Prevention Society
Sylhet - USAID Bangladesh
- * Funding being negotiated for Pondicherry
- * social group developed in Pondicherry
- * Projects implemented in Hyderabad, Bangalore and Sylhet
- * FHI India organised a national dissemination meeting in October 2000
- * DFID India to produce a synthesis report for broad international dissemination

B. Methodology

Cities in this study had been selected for situational assessments based on population, evidence of increasing levels of HIV (though the evidence is very poor due to the lack of effective surveillance centres), and significant known levels of MSM and male sex worker networks identified through anecdotal materials and through the knowledge of Naz Foundation International (NFI) and its partner MSM sexual health projects.

The initial phase consisted of networking in the target cities to identify appropriate MSM networks through contacts already established by NFI and its partner agencies

This enabled the recruitment of an appropriate Local Focus Persons (LFP) who had access to these networks, as well as being a part of them. It was an important principle for this study that all participants in the Assessment would be MSM themselves and from the same networks that were being assessed.

These LFPs recruited 15 other individuals from these networks who were interested and willing to participate in the training workshops as well as conduct the assessments.

Prior to the workshops, participants and friends were invited to Social Meetings where food and refreshments were provided. These meetings were used as a socialising space for Assessment participants to get to know each other as well as introduce the project. At these meetings, the Oral Informed Consent Statement was read out to all present in the local language by the Local Focus Persons and assent taken. Outlines of the workshop agenda and the purpose of the Assessment were given and discussed.

Six day training programmes were conducted for the participants and the LFPs. The training programme consisted of:

- i. issues relating to sex, sexual behaviours and sexuality in South Asia

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- ii. increasing knowledge of the male and female body and psycho-sexual issues relevant amongst males in South Asia
- iii. discussions on MSM in the context of Hyderabad, which included mapping the city for specific MSM public locations
- iv. sexual health issues, including STI/HIV transmission and prevention
- v. methodologies to be used in the Assessment
 - a. use of the questionnaire
 - b. focus group discussions
 - c. taped interviews
 - d. a range of site observations conducted by the Investigator

The workshops were presented in English by the Investigator and translated into the local language as an on-going process by the Local Focus Persons. All documents were also translated and printed in the local language.

Following the workshops, Assessment Teams were developed, based on levels of literacy and skills required for the study.

From these groups, smaller teams were selected to conduct the taped interviews. Audio-cassette recorders were provided with blank audio-cassettes with 90 minutes recording time. A further one-day session was provided for these team to enhance their interviewing skills.

Two hundred survey questionnaires, between forty to fifty in-depth taped interviews (where some were poorly recorded), and two focus group discussions were conducted in each city. The discussions generated by the workshops were also taken as a third and on-going six day focus group discussion - this was not the original intention but the quality of information raised during the workshop was too invaluable to ignore.

The Assessment Teams was supervised by the Local Focus Persons. The LFPs were supervised by Naz Foundation International through the Project Manager.

Potential participants were approached by the members of the Assessment Teams at a range of sites and asked if they would be willing to be interviewed. These participants were part of the Assessment Teams members own networks.

It should be noted that since the Assessment Teams members in the main were kothi - identified, the majority of respondents come from their own networks and were kothi-identified themselves.

If individual MSM agreed to be interviewed by questionnaire and/or the taped interview, the Oral Informed Consent Statement was read out and signed and dated by the Interviewer.

Interviews were conducted in the home of the Local Focus Person (well known in the MSM networks) where privacy could be assured whenever possible. Other locations included the sites themselves, or local tea-shops. In Hyderabad, a drop-in centre was used, while in Bangalore, Jagruthi's office was used.

Members of the Assessment Teams also invited 30 interviewees in each city (from both questionnaire and taped pools) to participate in 2 Focus Group Discussions, each group consisting of 15 participants and facilitated by the Investigator and the Local Focus Persons acting as translators. A room was hired for these discussion groups. Before the Focus Group Discussion began, the Verbal Informed Consent Statement was read out in the local language, and following assent, was signed by the Programme Manager.

At all levels, participants were assured of anonymity and confidentiality, where no identifying characteristics would be collected. All participants were 18 years and above.

No remuneration was made for participation. Participants who attended the focus group discussions were reimbursed for their travel costs.

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Following the questionnaire and taped interviews, as well as the focus group discussions, participants were given information on STIs/HIV/AIDS, safer sex and condom use, and condoms were distributed.

The Investigator also visited several of the main public sites where men can meet other men for sex on. One-on-one discussions also took place at each of these sites with a number of MSM facilitated by the Local Focus Person, following an assurance of anonymity and confidentiality, and an explanation of purpose.

A consultant was also recruited to discuss MSM issues with a range of secondary stakeholders involved with sexual health promotion, and to evaluate issues of their concern, support, and possible resistance to an MSM sexual health project developing in the city.

Sampling

As noted above, access to the MSM networks for data collection and interviews was through the personal networks of members of the Assessment Teams.

This was because members of the team as well as the Principle Investigator believed (based on prior experience), that with the nature of the questions to be asked, and because of the MSM living in a social context of shame and invisibility, accessing a random MSM sample would be difficult, if not impossible.

Thus, samplings were based on personal networks and friendship, and were non-random, non-probability samples. It was not intended to develop a behavioural study, but to reflect the levels of understanding, risks and behaviours within certain MSM networks known to the Principal Investigator, the Local Focus Persons and members of the Assessment Teams.

However, the choices of the Assessment Team members were determined by:

- * Local Focus Persons access to networks
- * a willingness and desire to become involved
- * the time to do so
- * an ability to be open about their own sexual desires, identities and behaviours
- * MSM identified

The majority of the members were self-identified kothis. This meant that the members of the assessment teams accessed MSM they knew or through people they knew, and since members of the teams were kothi-identified, these were also kothis.

It was not possible to bring panthis together for group discussions (see MSM context below). However the discussion groups held a mixture of kothis from different occupational groups, male sex workers, and in Hyderabad and Bangalore, gay men.

This selection process limited access to a number of possible networks. However, while the majority accessed were self-identified kothis with a number of kothi sex workers, it was felt that it was this network that expressed the higher risk for STI/HIV transmission, as well as often the lowest income, and the largest number of members.

While this process gives information on the sexual behaviours and practices of kothis and their panthi partners, it could not provide adequate information on the actual level of male-to-male behaviours in the target cities, or the numbers of MSM. Estimates of the number of "public" (meaning visible by demeanour, behaviour and use of public meeting places) kothis and male sex workers were made by the Assessment Teams members as well as the Investigator in terms of his field visits, but these can only remain as guesstimates. No claim is being made in terms of accuracy, but these guesses have been made by those involved in the networks themselves.

Data Analysis

The survey questionnaires were identified by a code number. Completed questionnaires were kept in a locked cupboard until all had been done. Necessary translation into English was done by the Local Focus Person. Following this the questionnaires were analysed using SPSS programme.

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In terms of the taped interviews, the Local Focus Persons translated and transcribed the spoken vernacular into written English. Each tape-recording was identified by a code number. Following transcription the audio-cassettes were destroyed. After all the audio-cassettes had been transcribed, the transcripts were then forwarded to the Principal Investigator for analysis.

While the original intention to record the Focus Group Discussions, the recording quality were found to be very poor. Further the process was very laborious since it required passing the tape-recorder back and forth between individuals all the time. Written notes and summaries were taken for each session.

Field observation, notes were written as summaries and included discussions with individuals at the sites, numbers present, behaviours observed, geographical details, and so. The Principal Investigator was supported by the Local Focus Person who took him to the specific sites, acted as translator while facilitating meetings between him and a range of individuals.

C. Findings

MSM contexts in South Asia

(For a more detailed analysis of the findings for each of the targeted cities please see the individual Situational Assessment Reports)

To attempt to use the term men who have sex with men as a bounded framework for this Assessment would have been incorrect leading to a greater invisibility of differing contexts of male to male sexual behaviours, expressed in an often bewildering variety and range of personal identities, behaviours, gender identifications and practices, which defy such a simple categorisation.

Further men who have sex with men should not be seen as an exclusive category of people, defined by a specific occupation or activity, unlike perhaps female sex workers and IDUs, or even truck drivers and slum dwellers, categories used in by NGOs and the State AIDS Control Society or the State Management Agency.

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

While for some MSM there are frameworks of male to male desire, identities and visibility which may make it easier to access and quantify numbers, for the majority who sexually access these males and whose desires are around discharge rather than gender/sex roles, and who perceive themselves as 'manly' and 'normal men', it is almost impossible to quantify. Access would probably be easier through their kothi partners than directly.

Further, in the broader context perhaps we should be talking about male to male sexual behaviours rather than men who have sex with men (MSM) for the word "men" can be problematic.

Contemporary research on sexuality and gender have clearly shown that bipolar categories, such as man or woman as gender categories, and heterosexual or homosexual as sexual categories, are "not useful to describe the range of identities, desires and practices" (personal discussion with Carol Jenkins, Care Bangladesh, 1999) existing in South Asia generally and Hyderabad specifically. The terms "gay" or "homosexual" are too framed by a specific history, geography, language and culture to have any significant usefulness in a different culture from their source. In this we should be talking about sexualities, genders, and at the least, homosexualities and heterosexualities. Where UNAIDS and others speak of behaviourally homosexual, we can also talk about behaviourally heterosexual in the South Asian content.

Even the word bisexual, used to label those who have sex with both men and women, is not a useful category in differing cultures. At the same time the term men who have sex with men is also beginning to lose whatever usefulness it may have had, as this too has become a bounded category. What does the word "men" mean? What does the word "sex" mean? This was clearly seen in Sylhet during a range of discussions, where some

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of those who do not identify as kothi or gay are using this term to give expression to their personal desires and behaviours.

In all the focus group discussions and workshops the word "men" was defined by physical and behavioural characteristics of a performance nature, not some innate quality of masculinity.

Self-identities amongst MSM varied across the spectrum of divergent categories, where those most public in the expression of same-sex desire usually identified themselves as a different gender category, which was feminised, expressing themselves in feminine language, sometimes through dress, make-up and mannerisms, and who also have access to their own specific "secret" language (ulti - a derivative of the hijra language) which is unavailable to the majority population. These individuals call themselves kothis, but it should also be recognised that this is a socialising and socialised role, where a "new" kothi with emergent desires (and often not so emergent, but in full force) will make friends with "older" kothis and learn the characteristics, roles, behaviours (including sexual), mannerisms and language. And it was this kothi framework which appeared to predominate among MSM in all the targeted cities.

Kothis see themselves as the feminine in a masculine/feminine sexual partnership, and play out the perceived gender role in the culture. Most kothis in this study felt relatively comfortable with their choice, although expressing a varying degree of shame. The men who access these kothis for sex, and sometimes for sexual relationships and partnerships, are seen as "real men" by the kothis, men who play the "dominant", "active" and "penetrating" role. Such men do not see themselves as "homosexuals", since the people they have sex with are not "men", but feminised males. They do not have a sexual identity term for themselves, but practice a sexual behaviour, very often based on "discharge" and "body heat". They see themselves as men. The term panthi is used by kothis to describe them, meaning a "real man", a man who will penetrate them, and who also will have sex with women given the opportunity. Many kothis speak of all men as potential panthis, accessible to them as sexual partners, accessible, not based on male to male desire, but because of what was perceived as an urgent need for sexual discharge, and gendered roles.

Another emergent dynamic appears to be the "double-decker", "AC/DC", or "do-paratha". This is a behavioural term used by kothis for those who are "both ways". That is they penetrate and are also penetrated. However, this term is now being adopted as an identity label by some MSM. In Bangalore particularly, Analysis of the behavioural data, and discussions with individuals indicate that use of this label was a response to the social stigmatisation of kothis as well as the increasing levels of police harassment, while the behavioural profile indicated a more kothi pattern of sexual encounters. Another explanation could also be the influence of the gay organising in Bangalore where the term "gay" does not translate into Kannada. Similar structures were operating in Pondicherry, where a public gender performance would not necessarily indicate specific sexual roles.

These frameworks provide a sense of amorphous and shifting identities, gender identification, and actual behaviours, whether based on male to male desire, or desire for specific acts (i.e. anal sex), or just semen discharge arising from "body heat". They indicate a fluidity and an emergent, or even evolving, framework of sexual identities. Such an evolutionary process may well indicate a "homosexualisation" of male to male sexual patterns as a result of vernacular media speaking of Western gay cultures and Indian gay movements. What was interesting was that the Investigator did not come across the word "gay" as a defining essence amongst the MSM networks that were accessed by the Assessment. This may well be because those accessed were primarily from low income groups who did not speak English.

Another possible reason based on discussions with groups and individuals may also arise from the fluidity of gender identification, and the visibilising among these networks of the double-decker behaviour and desire. Among, what is known elsewhere as real kothis, double-decker behaviour is totally denied and frowned upon. Yet, it is known that secretly such behaviours do go on among kothis and their partners. The emergent double-decker

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framework indicates that networks of those involved in male to male sex are recognising and acting out desires based on male genders and not on sex roles.

As more and more individuals begin to express these frameworks so socialising among themselves begins to develop and become more extensive. Kothi-identified males may still call double-deckers kothis, but there is also a growing resistance to this. The significant difference appears to be based more on performance rather than actual sexual behaviours. Double-deckers have significantly less feminine performance to their public-site demeanour.

Perhaps this is primarily because the kothi label is more stigmatised, and identifying with the term double-decker can reduce the sense of self-stigmatisation. Certainly these double-decker males did not perceive themselves to be kothis, and usually their body language and expressions were not kothi-based.

As part of their public gender performance, many low income group kothis take oral contraceptives (many can't afford, or can't access, hormone injections) as a means of developing breasts, stating that panthis like to "squeeze" their breasts as a part of their sexual practice. From the range of discussions, taking oral contraceptives by these males is a significant activity, not as a means to become more like women, but as a tool to attract panthis as sexual partners.

Sociocultural, religious and family pressure ensure that the majority of kothis will eventually marry and produce children, no matter how long they attempt to delay this process. The choice is often stark. Stay with your family, or leave! And with no social welfare system available, there is a perception of no choice. This intense pressure produces a range of psychological effects, a depression and fear of non-performance with their wives, to a constant search for a "real man" who will "marry" them and look after them. In the discussions several kothis stated that they will even sometimes use female sex workers "for practice". For panthis, marriage and children are key identity markers for manliness.

Some of the kothis from low income groups become sex workers as a source of generating and income. Usually this income was to support their family. But it should be noted that not all male sex workers are kothis, and not all kothis are sex workers. Although in this study kothi sex workers by far were the majority in the sex worker category. But while poverty was a significant determinant for many male sex workers, it was also clear that pleasure and discharge were also involved.

Panthis are less clearly defined, being men of all ages and types, married and unmarried, across the spectrum of income and employment, who, at least at times, enjoy sex with other men or stated they could not access females, and they could not control their "body heat" and "needed to discharge". There was a strong sense of immediacy, urgency, opportunity and availability to their sexual behaviours with the kothis.

And of course all panthis will either be married or will get married eventually, fulfilling the social, religious and family expectations for all men in South Asian cultures.

But beyond this "public" framework of identities, desires, and behaviours is a context even more invisibilised, an issue also relevant to HIV prevention. An unknown proportion of men experience male-to-male sex while young, often before male-to-female sex and often with family relatives such as cousins or uncles, or even with friends. Such behaviours are outside the "public environments" taking place in neighbourhoods, private homes, hostels, guest houses, hotels, and a range of vendors shops and other private places. Here the contexts may well play out a kothi/panthi framework, but often it is where access, immediacy and opportunity play a significant role in prevalence of this behaviour. Very often both of the partners involved in the sexual activity do not express a sexualised identity, but rather speak of need and urgency, "the heat of the moment", or "I did it in my sleep".

Some may well find that their experience of sex between men resonates with their own sexual desires and gender role preferences, and should they meet with kothis, develop

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their own kothi identity. Others give no voice or name to their experiences, and may well stop upon marriage, or continue in their neighbourhoods with local kothis and boys.

This does not imply that these sexual roles are limited to what they publicly speak of, i.e. "active" or "passive" since it is known that sexual acts and roles may well shift and change where space and time permit. Behind closed doors and under the blanket much more diverse behaviours may exist, where the kothi may well penetrate what was perceived previously as a panthi.

A kothi identity is very much around performance, both public and private, of declaring one's sexual interest and preference. It is a socialising role, a framework to meet similar individuals and share common desires, feelings and behaviours. It is also a mechanism of self-recognition and recognising others. To be socially excluded is devastating. Sexual behaviour is a component of identity, and if behaviour falls outside the identity parameters and it becomes known to others, then the person can fall outside the socialising role.

But such "cross-gender" behaviours are seen by kothi and by the so-called panthi himself as even more shameful, and both will consistently deny involvement in such behaviours. Kothis use disparaging terms (in the context of Hyderabad) such as gupt kothi, meaning someone who acts like a "real man" in his mannerisms but behaves like a kothi in the sex act, i.e. is penetrated.

A range of disparaging terms are used by kothis for those kothis who have sex with other kothis, where kothis perceive each other as "sisters". At the same time, those men who have a broader sexual repertoire with other men and desire to be penetrated as well as penetrate have been termed as AC/DC or double deckers by kothis also usually in a disparaging way. They will still be seen by kothis as kothis. Even gay men are seen as kothis by kothis.

For many of these men kothis are seen as disgraceful, shameless and not to be identified with, so kothis will also call them gupti (secret) kothis. What has been interesting has been a emergent tendency amongst such males to begin to explore identity developments that express their desires of mutuality in sexual behaviours and choices. Those who come from the middle classes and have access to English will call themselves gay, or bisexual.

Labelling seems to be class and education based. Upper and upper-middle class who speak English will call themselves "gay", whatever their mannerisms and sexual behaviours. Kothi is a term most used by lower-middle and lower class MSM.

Relationships between these diverse networks is usually class based, where gay-identified men will also disparage kothis for being shameless, dirty, low class and uneducated people.

In Hyderabad and Bangalore, relationships with the gay groups in these cities and some more educated kothis were usually a termed as friendly but seen as different. However in many discussions kothis felt very uncomfortable with gay-identified men because of a lack of English skills, class and economic differences and being marginalised by these gay-identified men. The sexual networks and "cruising" areas often differed, and rarely was there any socialising and mixing between them. In Pondicherry and Sylhet there appeared to be no gay organising or networks accessed by the Assessment studies.

Secrecy and shame control the frameworks of visibility and denial in regard to behaviours deemed outside the social and cultural norm. Not talking about sex and sexual behaviours is one way of not only invisibilising such behaviours and practices, but also of marginalising them as a peripheral phenomena, particularly in regard to male to male sexual encounters.

This form of social control is constructed by traditional concepts of honour and shame. Honour, not so much as what is deemed to be personally honourable, but in terms of one's standing in the community and family. Honour as a possession, not a quality. Shame, not so much as what may be deemed as wrongful (or even sinful), but by behaviour and conduct which brings shame to the family and/or community as a whole.

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These two intersecting frameworks arise out of understandings of value systems around what is public and what is private. What is visible and what is invisible.

Public behaviour, behaviour which is visible, is bound within a context of family duty, honour and obligation (both familial and religious). In this context any behaviour which is visible to the community (and/or family) falls within the scope of public behaviour and therefore falls within concepts of honour and shame.

Night time creates invisibility. Bushes, trees, dark construction sites, badly lit alleyways, behind houses, under blankets, any place where space is available for mutual sex encounters and where darkness reigns. Darkness invisibilises behaviours creating deniability. It is in the dark that most male to male sex occurs.

In summary what we can say about male to male behaviours in South Asia is that:

- * For many men involved in male to male sex, MSM is not a sexual identity but a behaviour based on desire for discharge.
- * Most MSM behaviours are not contextualised within a heterosexual - homosexual paradigm but within a gender framework and role play, where a feminine gender performance signifies the role taken in a sexual act.
- * This gendered framework is constructed within a kothi/panthi dynamic, where the kothi perceives himself and his desire for other males in the context of feminine gender roles in India, i.e. the "penetrated" partner. Kothis identify as feminine males, constructing their social roles, mannerisms and behaviours in ways which attract what they call panthis - "real men".
- * In this context many kothis are visible in a range of public environments and neighbourhoods, but panthis are not, for they could potentially be any "manly" male.
- * This does not mean that the targeted cities do not have any gay-identified men as it is understood in the West. It does. But these men are primarily English speaking, usually middle class, and a minority amongst men who have sex with men. Gay identified men are much less visible in public arenas because of their identity construction is not based on gender desire.
- * Nor does it mean that kothis do not penetrate, or that panthis are not penetrated. Some do cross over these gender roles. But such cross-over is secret, and is not discussed with friends. Such gender role cross-overs are seen as even more shameful. Similarly for a kothi to admit to having sex with another kothi is also considered shameful, and crosses the "incest" boundaries, i.e. kothis will state that they perceive each other as "sisters". A new term being used by kothis for such sexual encounters when known is "lesbian".
- * Kothis have their own words and language, a derivative of the hijra language.
- * Panthis, or "real" men, do not see themselves as homosexuals or less masculine because of their sexual involvement with kothis. They penetrate kothis who are not "real men" - they are kothis. Their personal sense of manliness is safe.
- * In other words there appears to be a spectrum of masculinities.
- * In a culture that excludes females from public spaces, that socially polices females and controls their access by males, and where sexual behaviours are based on gender identification rather than sexual identity, it is possible that for many "manly" males, sexual access will be with kothis or those deemed less "manly", i.e. young males and adolescents.
- * With this gendered dynamic it may be possible to physically count the number of kothis at a range of public sites, but this doesn't address the so-called gupt kothis - the ones who are secret. Nor does this address the number of "manly" partners these kothis access.
- * Beside the kothi frameworks, there is another dynamic of male to male sexual behaviours, which because of a shame-based culture cannot be readily accessed. This includes inter-family male to male sex, sex between friends, sex within male only spaces. Such behaviours are not identity-based where desire is based on same-biological sex, but rather on immediacy, "body heat" and felt "discharge" needs.
- * Such behaviours could be significantly high since there is a limited social construction of heterosexuality - perhaps we can call this "behaviourally heterosexual" - and where sexual access to females is very limited. What appears to exist is a core personal identity in terms of gender role, marital status and class. Identities are not based on sexual object choices.

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- * Gay identities have evolved (and are evolving) from the globalising of Western lesbian and gay frameworks. In Hyderabad such gay-identified men were primarily English speaking, middle and upper-class, with extensive contacts with Western gay culture and/or emergent gay groups across India through the internet.
- * Gay relationships are usually based on a personal sexual identity, a mutuality, friendship and exchangeable sexual acts - they are companionate relationships formed within a same sex/same gender dynamic. What this means is that gay men are sexually and emotional attracted to other men. They identify as men.
- * Kothi relationships are based on gender roles - a "husband and wife" relationship.
- * Kothis are not friends with their panthis, but "wife". This is a relationship based on same sex/different gender identification dynamic. Kothis make friends with other kothis with whom they "never" have sex with. For kothis this would be like having sex with their sister.
- * Kothis are attracted to panthis. Kothis perceive themselves as kothis, not "real men". The focus of desire is in terms of penetration.
- * Many men who sexually access kothis do so for semen discharge, not because the other person is a male.
- * Male to male sexual desire should be contextualised differently from male to male sexual behaviour
- * No organising appears to exist among the kothi/panthi networks. There are limited social networks at specific sites.
- * Gay organising however does exist in Hyderabad and Bangalore, major metropolitan areas. Both of these cities have gay groups, regular meetings, as well as affirming networks.

Gay identity and organisations

From all the anecdotal information, personal observations, and discussions with the gay groups in Hyderabad and Bangalore, there appears to be very few gay-identified men amongst the MSM networks, and all these men were from the middle-class, English speaking networks in the city., including a significant number of undergraduate or graduate students. There were none identified in Pondicherry and Sylhet.

In the two metropolitan cities, several gay men had developed gay organisations and support groups. Relationships between these gay groups and with educated kothis were usually termed as "friendly" but each network was seen as irreconcilably different and separate. In many discussions kothis expressed an uncomfortableness with gay-identified men because of a lack of English skills, class and economic differences and also often felt marginalised and "looked down upon" by these gay-identified men. The sexual networks and "cruising" areas often differed, and rarely was there any socialising and mixing between them.

Some initiatives had been attempted to try and bring these two very differing networks together, but with very limited success. As of the Assessment period, very little had been achieved in this area, primarily because of language, class, and income differences. Several gay-identified men strongly expressed their distaste for kothis, calling them "dirty", "low class" and other disparaging epithets.

As a rough guide, those who call themselves gay can be seen as English speaking and higher incomes, whilst those who call themselves kothis as speaking in vernacular languages. and with lower incomes and also with predominately "feminised" mannerisms and sexual behaviours choices.

In brief, identities, practices, and desires were not completely congruent, allowing for considerable flexibility and producing a complex picture of male-to-male sex that bears little relationship to that described in the literature for most other parts of the world.

Situational Identities

Such beliefs and practices led the majority of participants in this study to act out situational identities. That is within the family home and neighbourhood they will perform as young (or not so young and married) men, while in specific environments, perform as kothis amongst other kothis, or to draw the attention of potential male sexual partners. Such involved an exaggerated sway of the hips, loose wrist actions, eye movement,

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touching the mouth with a finger, and so on. These gestures demonstrated sexual availability to the panthis.

The cross-over from one to another can be remarkably swift and immediate. Crossing a road and entering a "cruising" site the actions and mannerisms changed immediately. When this was discussed, the kothis stated this was for safety and security in the general society, to keep their desires and behaviours secret from family and friends, and to ensure invisibility on the streets away from what were perceived as safe areas, i.e. "cruising" sites. This somewhat contradicted the statements about levels of harassment in the city.

Situational identities then act as a device to invisibilise identity choices, desire and behaviours, maintain social and family stability, and reduce levels of potential harassment and violence (of which none was observed by the Investigator). This also meant that the kothi identity has a significant level of performance as part of it. This was clearly borne out in some of the discussions where several males stated that they perform as a kothi with other kothis to be able to be a part of a social network, rather than because of the sexual behaviour and identity choice, i.e. they saw themselves as men with both "active" and "passive".

Social Context

India, while rapidly developing, is still mainly bounded by traditional and conservative value systems expressed through religious and cultural norms and expectations. Both Hyderabad, and Bangalore are become noted for their information technology expertise.

A growing urbanisation has led to significant levels of rural young men migrating to these cities in search of employment as often as for excitement.

It should be noted that perhaps only between 20 - 30 per cent of Indians are urbanised, while the remainder still live in rural areas. And of this perhaps only 15-20 per cent of these can be called middle or upper middle class and English literate. Thus the vast majority of Indians, should be seen as low-income vernacular speaking

Hyderabad

Hyderabad has a strong Muslim culture with a long history of Muslim rule prior to Indian Independence.

It is believed by many in the city that this history has evolved a more tolerant attitude towards male to male sex practices, as long as it was not too visible to become a "public nuisance". This has led to what appears to be a low key profile of police activities in the various "cruising" sites, and a higher degree of openness amongst the kothis. For example, many kothis were seen at the local bus-stands outside a major "cruising" site after its closures behaving in a public performance of being a kothi, and "cruising" the men at these bus and taxi stands quite openly. At the same time, a range of sexual activities between men were also taking place in the more darkened areas of the site during evening time prior to closure, with, as far as can be determined, no attempt to stop the behaviours by the patrolling wardens. Kothis in the assessment spoke of little police harassment, and what did exist was usually about accessing sex and money from the kothis.

The sense of a degree of safety did not translate into a reduction into the levels of shame expressed by many kothis. Shame in this context was about breaking social and family norms, of being outside of socially acceptable behaviours. Social, religious and family expectations were strongly expressed in the workshop, interviews and discussion groups. The sense of not being able to fulfil these expectations created the context of shame felt. This feeling of shame also strongly factored risky behaviours and practices as well as treatment seeking, particularly those from low income groups.

Bangalore

While Bangalore also has many Muslims, the social relationships between Hindu and Muslim kothis and DDs, while appearing friendly, were observed to have some undercurrents. For example, Muslim kothis/double-deckers were called "Pakistani" by Hindu kothis/double-deckers, both in the workshop and the discussion groups. And yet,

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unlike Hyderabad, more Muslims were accessed by the Assessment Team and Investigator. This needs to be further investigated.

The kothi/double-decker social and sexual networks seemed to be extensive and spread across Bangalore (to some extent this was also true of the gay networks), moving around from one site to the other in the course of an evening. But their sense of ease regarding the kothi "performance" was greatly tempered because of the constant fear of possible police and local(rowdy) harassment. In comparison to the kothis in Hyderabad, Bangalore kothis were very much more quieter and restrained, with a great deal less of public performance. Several cases of police harassment and arrest and violence from rowdies were reported. These acted as a restraining framework and an increased fear of discovery. A range of cruising sites had also be raided by the police in previous months, which had the impact of reducing activities in those localities, and shifting them to other arenas.

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Pondicherry

Pondicherry is a small town of some 700,000 people, with a French history intermingling with Tamil Hindu and Muslim cultures. As a special enclave of Tamil Nadu through its history of being a French colony prior to Independence. Its architecture and the existence of a French consular office reflects this history.

Close to Pondicherry is the Aurobindo Ashram, international renowned and drawing many Westerners in search of spirituality, as well as Western back-packer tourists. Some of these are gay-identified, and can be seen at a number of sites.

Pondicherry is industrially under-developed, relying on tourism as a significant source of income. There are significant levels of unemployment or under-employment, with low levels of income and poverty. This has led to many kothis and double-deckers to sell sex.

Kothi and double-decker social and sexual networks seemed to be localised, each network somewhat separated from another with different individuals operating within them. Further to this many kothis and double-deckers were also coming into the Pondicherry sites from nearby outlying villages.

Police harassment does exist, but this is not systemic, rather it is localised around individual acts, and usually based on accessing sex and money from kothis and male sex workers. Kothis felt vulnerable regarding possible police harassment at some sites, and also the possibility of harassment from local rowdies or thugs.

Sylhet

Bangladesh is still mainly bounded by traditional and conservative value systems expressed through religious and cultural norms and expectations. Sylhet, even though it has a strong links with Bangladesh Sylheti migration to the UK, is seen as particularly so. Religious custom and belief are strongly entwined with social customs and traditions.

With a strong Muslim culture and Islamic tradition, with many following a Sufi customs, the boundaries are clearly delineated. Females are not visible in the evenings. It is a male dominated society. Friendship and physical affection is between males. Males are isolated from females. Even where female sex workers exist, access to them is limited by social tolerance and cost.

A sensing of a religiously conservative and small town mentality was pervasive amongst mainly the middle class MSM, whose fear of being found out controlled their lives and public expressions constantly.

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Sylhet is a small city of some 600,000 people with very strong class and income divisions. Even among kothis this was clearly expressed, and created difficulties in conducting the Assessment, where Assessors were primarily drawn from the middle-classes.

There is a Sufi tradition based around mystical beliefs and spiritual teachers called Pirs. Following death many shrines are built and mosques are built around these shrines. But a part of the Sufi tradition (one that is disavowed by both Sunni and Shia belief) is that of singing and dancing within a religious context. In Sylhet, ganja smoking also seemed to be a part of this tradition. At one major shrine, on a late Thursday night visit (after 11pm), the Investigator observed several groups of men (on average 10 members to each group) sharing a pipe filled with ganja. The site is very large with approximately over 500 males wandering around, or standing talking in small groups. In several locations in this site were groups of men housed in medium sized rooms where singing was going on, and the air thick with ganja smoke.

Amongst all these men were approximately 60 kothis. While some wore a little make-up, all wearing male dress, moving in between the men, flirting and making it obvious what they wanted. Such behaviour was ignored generally. It was reported by several of these kothis that they had success in picking up men for sex for money. They would go outside the grounds for sex.

So here amid religious and ganja intoxication, amongst so many men, were kothis, tolerated, or at the least ignored, as long as they were not outrageous in their behaviour. And here men can meet kothis for sex, almost every day, but most frequently on a Thursday night.

Consistently, the higher the income and social status, the more fear of discovery was expressed, where many MSM spoke of possible harassment, or potential violence against them. This was not observed. And yet, the Investigator was able to visit several low-income kothis in their homes. Many took oral contraceptives for breast developments (as a positive choice to attract men), or who cross-dressed and or just wore make-up, who appeared to be socially tolerated or accepted by their neighbours. These neighbourhoods were primarily bustees. In several instances, these kothis stated that they had been approached by local youth and men for sex. During each visit, neighbourhood children would casually drop by, and even adult females and males would do so. The kothis stated that this was quite normal and frequent.

Sylhet has a high level of unemployment, and even many who do have work, have a low income. This has led to many kothis to sell sex. Poverty was always stated and in some cases extreme. For many kothis, living conditions were very poor, with hygiene, food, clean water, and adequate shelter very problematic. The urgency of survival was clearly visible and painful.

Kothi social and sexual networks seemed to be mainly localised around specific sites where they would go regularly. But yet these networks were also extensive across Sylhet. In a town of half a million people, the Assessment Team identified 28 sites, some on the outskirts of the town near to the local tea plantations.

The significant levels of shame felt by kothis as well as other MSM, like elsewhere in South Asia, reduced their ability to purchase condoms at local shops or attend STI treatment centres.

Police activity appeared to be low key. Several kothis spoke of having sex with a range of police officers. On a range of site visits made by this Investigator, my kothi escort knew several policemen on very friendly terms, even though he was obviously a kothi. He told me that he had sex with all these police officers at one time or another.

In all these cities, public environment sex was very rapid, leading to discharge in a few minutes. Such a methodology involving anal penetration led to several kothis speaking of anal bleeding and pain. Combined with a lack of sexual knowledge, low condom usage, low access to treatment, no access to an appropriate water-based lubricant, this type of sexual practice created high risks for STI/HIV transmission.

Sociocultural frameworks of male to male sexual availability

In terms of the sociocultural frameworks, both contemporary and traditional, that appear to shape and construct male sexual behaviours in South Asia, the following points need to be remembered:

- * Marriage is considered a social and religious duty and a family obligation, not one based upon personal desire and choice. It is therefore seen as compulsory and a social necessity.
- * To remain unmarried is seen as strange, if not an aberration. Cultural and religious beliefs dictate that a male achieves social responsibility and thus personhood upon marriage.
- * Marriage may often be delayed till the male is in his late twenties or early thirties, because of the economic costs as well as perhaps for a lack of interest and desire.
- * The central objective of marriage is the production of children, specifically male children. Marriage is thus seen not as egalitarian and companionate and based upon mutual friendship, but rather as a source of reproduction of children.
- * In this context sex is seen as reproductive. Sociocultural traditions in South Asia, frame women as not equal to males, as inferior vessels of male honour, to be sexually controlled, if she is allowed any form of sexuality. Sex with ones wife is often seen as a duty, rather than as pleasure. The statement "I do duty to my wife" is quite common, meaning I have sex with my wife. Also asking one's wife to perform certain sexual acts, such as oral sex or anal sex becomes shameful. She is the vessel of one's children.
- * This often lead to a concept of sexual pleasure of men as only available outside of marriage. Others would be asked to perform sex acts that could not be asked of a wife.
- * Here what matters is not the pleasure of the partner, but the pleasure of the self. Sexual behaviour becomes one of sexual discharge.
- * Gender segregation, female virginity, loss of honour, and so on often makes it easier to access other males for sex than females in a homosocial and homoaffectionalist society, because women are more policed and socially controlled.
- * South Asian cultures focus on public shame rather than personal guilt as frameworks of social control. It should be recognised that fulfilment of social, religious and family duty is central to an Indian or Bangladeshi. Here duty is seen as a public duty, to be visibly performed. Thus the sense of shame and dishonour arises from a public (community) perception about visible personal behaviours.
- * Concepts of sexuality, sexual behaviours and sexual identities are bound up within concepts of gender roles (the penetrated and the penetrator) and semen discharge. Such a framework will often leads to high frequency of sexual partners.
- * For some males who sexually penetrate (the panthi), the gender of the sexual partner can often be irrelevant. What matters is to discharge.
- * Because South Asian culture is homosocial and homoaffectional, both in public and private, it is not uncommon for two or more males to share a bed. This enables opportunities for sexual encounters much more easier. Very often this takes place in the dark, under the blanket, when partners can disassociate themselves from the act - "it was in my sleep".

These characteristics of South Asian cultures, which also include extreme over-crowding, poverty, males sharing spaces, a substantial number of males below the age of thirty and unmarried, difficulties in sexually accessing females, and a lack of privacy, create conditions which frame its male to male sexual behaviours, and in a sense encourage its differing manifestations.

Age can also play a significant role in terms of penetration. As Michael Rocke states in his book *Forbidden Friendships - homosexuality and male culture in Renaissance Florence*, "the restriction of the 'womanly role' to adolescents actually permitted all mature men to engage in sex without jeopardising their 'manly' identity". (page 13, Oxford University Press, 1996).

The same framework exists to some extent in India, whilst Mughal history is replete of "boy love".

All the evidence points to significant numbers of males engaged in sexual encounters with other males, from very young adolescents to much older males, from close relatives

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to the domestic servant, from the rickshaw driver to the businessman. Many will engage in these behaviours sporadically, or over relatively brief periods of time. Many will also continue this behaviour infrequently over longer periods of time, beyond even their marriage. And many will engage in male to male sex as either an exclusive sexual behaviour or as part of the sexual repertoire over their sexually active life.

To quote Michael Roche again, "homosexual activity formed part, at one time or another and with varying significance and degree of involvement, of the life experience of many males" and that there was "an absence of conceptual categories based on sexual object choice" (page 15).

Roche then goes on to say that male to male sex "...did not constitute a separate world or a truly distinctive 'subculture'. Both casual sexual encounters and more durable relationships occurred or evolved in largely familiar everyday social contexts and were tightly insinuated into other forms of male sociability from the camaraderie of gangs of youth or bonds of work and neighbourhood to relations between patrons and clients or the sodaliture of kin and friendship networks (page 115).

All this does not imply that loving bonds between males does not exist. It does. Intense emotional and sexual relationships do exist, but these will be framed by the cultural necessity of marriage and children. Very few males are able to escape this cultural necessity.

There are frameworks for desire for a specific gender, i.e. males who specifically desire other males and seek other males for sex (and sometimes love). These males will often frame their relationship as "husband and wife", a panthi with a kothi (with a very few exceptions of mutuality and equality).

South Asian public spaces are supremely male. The street, the bus stand, the park, the railway or bus station, these are the arenas of contact. Such publicness leads to quick sex, penetrative or otherwise, in the darkness of parks, behind bushes, in alleyways.

Many workers in the service sectors also a part of these networks. Whether just for sexual release, money, or actual desire for sex with other males, is a difficult question to answer. Taxi-drivers, rickshaw drivers, barbers, room service and housekeeping males in hotels, waiters and table boys at restaurants, shop assistants. The framework is ubiquitous. The glance, the second glance, the smile, the appropriate questions, sometimes "for a few rupees more", sometimes just khel.(play). It is anywhere, in the right conditions, the right time, the right space.

But perhaps we should accept that often South Asian male sexualities are amorphous, opportunistic, spatially bound, discharge oriented, time-based, as well as those based upon same sex desire and love. .

In doing so we have to recognise that the impact upon any STI/HIV/AIDS prevention and control programme which does not address male to male behaviours will be doomed to failure. To deny their existence, or to contextualise it within the limited heterosexual or homosexual paradigm will ensure that no such programme will successfully contain the spread of AIDS.

Mapping

Local sites identified:

| | |
|-------------|-----|
| Hyderabad: | 92+ |
| Bangalore: | 65+ |
| Pondicherry | 16+ |
| Sylhet | 28+ |

They included parks, bus-stands, railway stations, auto-taxi stands, public toilets, cemeteries, specific streets, bazaars, market place, shopping centres, any area where a measure of anonymity and access to males was possible. Also construction sites, guest house, lodges and hostels, as well as personal homes were accessed.

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Discussions in the workshop and Focus Groups generated guesstimates of

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|------------------|-----------|-----------|-------------|---------|
| male sex workers | 2000 | 2000 | 1000 | 1000 |
| kothis | 15000 | 15000 | 3000 | 5000 |
| panthis | 100000+ | 100000+ | 30000 + | 50,000+ |

These figures could be higher or lower. Their accuracy could not be verified

Some of these were significantly large and complex areas. For example a major site in Hyderabad held over 300 kothis during a weekend evening, whilst one in Secunderabad held a similar number at a same time and day. In these sites mixtures of different frameworks of MSM operated in conjunction with a few female sex workers. Rich in variety, the investigator observed kothis in their diversity, from male sex workers who identified as kothis, kothis who cross-dressed, kothis dressed as men, kothis from middle class as well as from low income groups, kothis who sold sex as well as kothis who did not, and the richness of the language of description and labelling, of identities and desires. At the same time, the investigator also saw a few gay-identified men seeking sexual partners, and other men (what kothis call panthis) seeking sexual discharge with these males. At a particular site the Investigator physically counted 130 males selling sex, and an approximately equal number not selling sex, on a single weekend visit. Along side these, the investigator also counted 20 female sex workers.

But at the same time, kothis would also cruise men in just about any public space where men were; in restaurants, tea-shops, shopping centres and malls, at any time.

Support and friendship systems

For kothis accessed by this Assessment, their key support and friendship system was other kothis. This also expressed the gendered framework in which the majority of kothis identified with.

In South Asian cultural systems, men and women rarely make friendships. The public arena is male dominated. And male to male friendships are expressed in the public domain.

But kothis see all men as potential panthis, and treat them as such. It was seen as rarely for a kothi to develop a friendship with a man without a sexual component. Kothis expressed the desire to "find a husband", or just to find sex, but even in this context kothis recognised that this "husband" will get married and live with his wife.

In a situational context kothis will perform as males in other public contexts and in the home, and thus will friendships with other neighbourhood males and relatives. But even in this arena, kothis spoke of sex with friends, these male friends. Never with another kothi.

Thus it is clearly seen that support systems tended to be expressed in a narrow arena, usually in a public environment, although sometimes kothis will visit other kothis at their homes, particularly so when that kothi has a room to himself. Here again this space becomes sexualised as kothi friends will bring their panthis to access the privacy of the space.

This investigator was able to access several such homes to talk with small groups of kothis who had strong bonded relationships with each, who called each other by feminine names and relationships, such as sister, aunty, mother, and so on.

Within this were several lateral and vertical relationships based on female Indian family structures, which required acknowledgement, as well as "sibling" rivalry and discord over apparel, make-up, appearance, and potential sex partners.

Kothis would usually turn to other kothis for moral, emotional and financial support.

Poverty and sex work

A majority of kothis were from low income groups or were unemployed. Literacy levels were low as were the number of years of education.

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Many kothis from low income groups, unemployed, or low-paid, will turn to sex work to generate extra income. The study was able to access only kothi sex workers, although discussions with members of the gay groups, educated kothis, and others indicated that there was a smaller network of middle class male sex workers who were available at a significantly higher price than kothi sex workers and expressed "normal" male behaviours, i.e. they both penetrated and were penetrated.

Motivations also differed somewhat. For kothi sex workers, the issue was very much to do with poverty and the need to financially support their families. For the middle class sex worker the motivation appeared to be the self, extra gifts, increase their own consumer purchasing power, or making potential useful contacts, or even to pay for tuition and/or college fees.

Psychosexual issues

Sex education was absent amongst the participants in the Assessment. Knowledge of the male and female bodies, of reproduction, of the sex organs was almost non-existent. What did exist was gained from friends, pornographic videos, and magazines.

This led to a variety of myths, beliefs and practices which were accepted as true and helpful. A considerable tension existed regarding masturbation as a sign of body and mental weakness, that reduce the virility and functioning of the penis, if not producing damage of one sort or another. Constantly the Assessment team as well as the Investigator were asked about medical treatment for nocturnal emissions, masturbation, penile sizes and shapes. Many of these men used "quack" remedies from street vendors for their perceived weaknesses.

There was a significant focus on the penis, by both kothis and panthis. Size, shape, semen quality, as well as frequency of discharge generated a high degree of myths as well as urgent concerns for medical treatment to "correct" a perceived problem. Night discharge as well as masturbation, generated their own mythologies and fears of weakness and illness.

At the same time, the lack of knowledge of their own and female bodies led to a range of risky practices, such as rapid discharge, or anal bleeding, achieved through dry and rapid penetrative acts.

Reproduction also carried its own myths and beliefs, where many men had no idea how babies are conceived, developed in the womb, or even born.

Gender

It is the belief of the Investigator that the accepted gender polarity of male and female is not so clearly divided in Indian society, and this seems to be borne out in the Assessment. In terms of men who have sex with men there appears to be a range of masculinities, a spectrum of possibilities, where at one end are kothis and then what kothis define as "real men", panthis. Kothis are not men believing they are women, or even want to become women. They appear to see themselves as "less than men" but "more than women". While they identify with the feminine, much of the identification is around performance as a means to attract these "real men" as sexual partners.

Male and female gender roles are strictly divided through sexual positions, appearance and dress, mannerisms, and work functions. These roles are hierarchical and oppositional. Women are "passive", "servile", "domiciled", wife and mother. Kothis, through their gender identification are also supposed to "passive", "servile", "domiciled" and "wife" to their panthis. The kothis in the Assessment always spoke of "finding a husband", seeking for a "real man" with an "akka likam" (meaning a big penis).

But there were intense contradictions here. Kothis in a public space (like hijras) can be extremely voluble, sexually assertive (it is the kothi who usually approaches the panthi in the cruising sites), and will often dominate the sex act, even though he is being penetrated. And it should be recognised that many kothis also play the role of husband and father with their wives.

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It cannot be taken as a given that because kothis identify with the feminine, that they only take the receptive role in the sex act, and use feminine terms for each other, that they are passive. Similarly it cannot be assumed that panthis only take the "active" role. There is much diversity in all of this.

But it is recognised that the fact that kothis play out the socially accepted gender roles, that their self-definitions, language and behaviours sustains a patriarchal framework of gender relationships and sexual behaviours, and increases their risk of STI/HIV transmission.

Such a framework maintains patriarchal culture and as long as "real men" maintain their gender role, as long as there is no publicness, then social order is maintained. Concepts of gender is central here where the penetrating "manly" male is not defined as a homosexual even if such a man sexually and emotionally desires other males, regularly acts out his desires, or even "marries" the "penetrated" partner. He has to be seen as performing the "manly" role. Here also marriage and children are key components for a "manly" identity. Marriage and reproduction are not only necessary and essential to maintain the fabric of family and society, they also represent key indicators of manly masculinity. If a male is married and performs his husbandly duty with his wife, then he is a man. If he is a father, particularly a son, then he is even more manly. He is now a social person, an adult male able to make adult decisions and take on adult social responsibilities.

To be unmarried, to have no son, is to be somewhat "feminised" within such a cultural framework. In such a case the person is "less of a man".

In these cultures developing a sexual identity is problematic. We can even say that South Asia is not primarily a heterosexual culture! While "men" are "behaviourally heterosexual" and some will be "behaviourally homosexual", the sense of identity will be focused on marriage, children and position in the joint and extended family. For those who are kothi-identified, identity will be both in this context as well as in feminised gender identification.

Thus in terms of males who have sex with males there appears to be a range of masculinities, a spectrum of possibilities, where at one end are kothis, and then what kothis define as "real men", panthis. In between are the double-deckers and those who do "homosex/gaysex", who kothis will also call secret kothis. Kothis are not men believing they are women, or even want to become women. They appear to see themselves as "less than men" while "more than women". While they identify with the feminine, much of the identification is around performance as a means to attract these "real men" as sexual partners.

Religion

India and Bangladesh, despite being considered secular countries, have strong religious beliefs, traditions and practices.

Here I am not attempting to define the religions of the region in terms of their specific and particular beliefs, traditions, and practices. What I wish to briefly attempt to do is to locate these religions within the cultural context, the interaction of religion and sociocultural dynamics. For example, Hindus in Bangalore, while having a similar faith as Hindus in Pondicherry, will often have very different customs and traditions, which will also be different from Hindus in Hyderabad. Similarly Muslims in Hyderabad may have different traditions to Muslims in Bangladesh. This is because of different languages, different histories, different geographies, different traditions and so on. Further while sometimes Hinduism and Islam are sometimes seen as monolithic, they are not. Hinduism has many different, often contradictory beliefs and customs, whilst Islam, has several different branches. Each will have their own localised traditions and customs partly based on historical and cultural factors, of the particular locality, and partly based upon their singular interpretation of the religious texts.

What needs to be clearly understood is that religion, culture, tradition and social practice are not isolated from each other, nor do they represent the same thing, but are interwoven in complex dynamics. While the religions may specify particular and specific social practices, beliefs and attitudes, very often cultural traditions and customs will

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outweigh these religious beliefs and statements. What matters is interpretation, social customs and historical traditions. But who does the interpretation? Where interpretation of religious texts interpenetrate cultural beliefs and customs, then very often these customs and practices will take on a sanctity that never existed in the original sacred text.

It should also be remembered that in contrast to the way that Christianity is viewed and practised, where it is seen as very much a matter of personal choice and individual response, Indian religions relate to how a community functions as a whole. Religious and secular life centres in the temple, mosque, gurdwara. Religion is a faith of community.

This does not mean that there isn't an intense personal belief and practice for many people. The personal prayer, or the private namaz. Religious belief can provide personal solace, meaning and context to one's life. But with all this goes the daily observances, the food a person eats, his or her relationships with others and the family, interactions with his community and community structures, religious celebrations and festivals. These are all interlinked and interdependent. This is the visible side, the proof of one's religious observance and community participation. Private and public are co-joined.

Religion becomes an obligation to the community, a duty to the community. Not to accept this duty can bring shame and dishonour to the family and to the community. Thus we can say that community participation, more than a personal belief, has a greater relevance. It relates a lot more to what you are seen to do than what you actually do. Participation involves submission to the daily rituals, customs and traditions that surround a specific religious belief. It is public acceptance rather than a private knowing.

All those interviewed professed affiliation to a specific religious tradition accepted their specific religious traditions. None could conceive anything else.

Yet these respondents found ways to balance their sexual practices, identities and desires within the context of being a Hindu or a Muslim, or a Christian. Whilst many of those who identified as kothi would speak of shame, guilt, dishonour, they also believed that what they were, who they were, and what they did, was between themselves and God. Religious belief was still important to them and a central part of their self definition.

While the Assessment questionnaires did not request information on religious affiliation, this issue was raised during the interviews and discussion groups.

Both Hindus and Muslims expressed similar sentiments about family and social expectations, of performing as men, fulfilling duties, maintaining family honour, of marrying and producing children, particularly sons. Choice of marriage partner was still seen as a parental duty, and separation from the family as not an option.

In this context marriage is an expected duty to be fulfilled. Very few kothis stated they would refuse to marry, whilst the majority expressed a sense of dread and fear. Where family pressure was already being exerted, several kothis spoke of depression and mental tensions. What was noticeable was that in this situation, a higher partner level seemed to be in operation.

Religious, social and family expectations followed a seamless context in which conduct, behaviour and expectations arose for all men to follow. Kothis felt strongly marginalised in terms of their desires, hopes and aspirations.

Family

Joint and extended familial links are strongly held together by custom, tradition, belief, practice and economic need. Their value lies in providing a form of social security and welfare in a society that has neither. The elders are supported, as often are the unemployed, the unmarried, the range of children, the disabled. It is considered a moral duty for the family to stay together in this mutual support system, whether the staying together is physical or psychological. For example, leaving a small town or village to migrate to a major city for work, the individual will often stay with an extended family member already in that city.

Such extended family systems can be a liberating experience in terms of the social conditions of individual members. To rely on the family for such support, emotional, physical, or financial, relieves much of the burden for sustaining the self. But as a consequence, the concept of individuality becomes lost. Personal choice and desire becomes subsumed within family choice and desire. Marriage, children and duty to parents is the focus.

In this study, family links were extremely strong and well maintained by all participants, even where an individual was living alone or with other men in shared accommodation. Most respondents lived with their families. Being a member of a family gave security, context, position and identity.

Marriage

In South Asia, marriage is a social, cultural and religious necessity, a central issue within people's lives and a mainstay of family and community life. It should be seen as a socially and religiously compulsory duty towards maintaining family and community bonds. Marital status signifies adulthood, social responsibility and the achievement of personhood.

Traditionally, marriages are arranged between two extended families. Such arrangements are based around economic and inter-family connections. In urban environments there may be a matter of choice and concepts of "love marriage" are growing in the middle classes, but ultimately all in the Assessment saw marriage as no choice. As Herdt states in his book *Same Sex Cultures*, "full personhood is not achievable until people have married and produced children" (p5).

To remain unmarried is often seen by the family and others as an aberration, a sickness, bringing shame and dishonour upon the family, creating social and family disorder. And to have no children can be seen as a curse.

But marriage is not based on mutual friendship, desire and love. None of the married men in this study have informed their wives about their extra-marital behaviour with other males, or for that fact, other woman. They believed that all they need to do is to function adequately as husbands in terms of economic support for their wives and engaging in sexual intercourse in order to have children. Marriage was considered a duty and sex as a means to have children.

The wife is seen as the bearer and mother of his children, not as a friend and lover. Marriages are not seen as companionate and egalitarian. And because of the dominant male ideology and male social spaces, a male should be seen spending more times with other males, otherwise he would be seen as being weak and perhaps "womanly".

All of the kothi/double-deckers and their sex partners in this study accepted the social necessity of compulsory marriage, while some were already married. There appeared to be a fatalism operating here, and a sense of not being able to challenge family and society's strictures.

Sexual behaviours and impact on sexual health concerns

As indicated above, the kothi/panthi framework of male to male sex is the predominant pattern in the targeted cities. The Assessment studies indicated high levels of unprotected anal sex, higher levels of anal sex compared to oral sex, high levels of multiple partners, significant levels of possible symptoms of STIs, and a significant degree of untreated symptoms.

There was a significant difference in the issues between gay-identified men and kothi/panthis in the Assessment studies in Hyderabad and Bangalore, where gay men were reporting much lower rates of anal sex, lower rates of multiple partners, with a greater tendency for a single partner, as well as earlier treatment of STI symptoms, and more condom use.

It was noted that saliva was the common lubricant used for penetration, but that a significant number of assessment participants also reported using oil-based lubricant as an aid to penetration, even with condoms. Only those who could afford it would use KY

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jelly, a water-based lubricant, and these were primarily gay-identified men, and those kothis who knew about KY jelly and who could afford the price.

While the majority of assessment participants had heard of HIV/AIDS, and had a relatively good understanding of infection risks, personal risk assessments varied a great deal with a significant proportion not "knowing" their own risk. But awareness and knowledge was not being translated into safer sex practices.

In the taped interviews and focus group discussions it became clear that kothis appear to start their sexual activities at an earlier age than gay men and panthis. There are a range of sociocultural reasons for this, around availability and opportunity. What was significant that many kothis started their sexual histories in adolescence and usually by 12 to 14 had some experience, usually with a male relative such as an uncle or cousin. In fact this seemed to be a predominant pattern.

During these discussions and interviews it also became clear that there were other frameworks of male to male sex outside of a kothi/panthi dynamic or even a gay dynamic.

Participants indicated male to male sex was going on in hotels amongst hotel staff and between hotel staff and guests, amongst street children, and street children and others, within a range of all male institutions such as boarding schools, madrassas, military establishments, hostels, prisons and so on. All sorts of males from across the spectrum of age, class and occupation were described as being involved in male to male sex, from police officers to beggars, from rich businessmen to movie extras, from rag pickers to truck drivers.

At the same time, the discussions generated a whole range of reasons why males have sex with males, from male to male desires, to "women don't do oral or anal sex", from protecting a girl's virginity to maintaining one's chastity, from "body heat" to "the anus is tighter than the vagina".

Most male sex workers were kothi-identified and primarily involved in anal sex as the receptive partner. The majority come from low income groups, unemployed and poor. A significant number were illiterate or poorly educated, with low levels of knowledge of STI/HIV/AIDS. Condom use was minimal among male sex workers, and prices were low.

Most MSM will also be married, usually by the time they are in their late twenties or thirties, whether they are kothis or panthis. It was clear from the interviews and discussions that marriage is a central issue in the lives of MSM, even those who were gay-identified. A familial and social necessity, the vast majority of those assessed who were not already married believed that they would have to get married, whether it was their choice or not. It was only a few gay-identified men who said they would resist their family's pressure. It was noted that these men also were financially independent and lived alone.

In such a situation where condom use was low, where anal sex was a common and regular practice, and where multiple partners was also common, the possibilities of STI/HIV transmission is high both between males and between MSM and any female partners they have.

Many panthis accessing males will also access females for sex, particularly female sex workers.

A significant number of assessment participants were reporting a range of symptoms that could be related to various infections including STIs in Hyderabad and Sylhet. Reported symptoms in Bangalore and Pondicherry were very low, and it is suspected that this does not reflect the reality. This belief arises from a range of personal comments and the taped interviews which give a different picture. A more detailed analysis would need to be done, possibly using blood samples.

A significant number were not seeking treatment, either currently or when previously symptomatic. Male sex workers were reporting higher rates of symptoms as expected.

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In Hyderabad and Bangalore there was some evidence to indicate that HIV infection was already with MSM networks. Another factor was the significant level of intravenous drug use amongst some MSM.

From this information it is clear that there were distinct differences in regard to sexual health issues for gay-identified men and kothi-identified males. It is also clear that the levels of risk for STI and HIV infection and transmission are considerable, and that this risk also affects female partners of MSM as well as male.

BCC Materials

No appropriate BCC materials for MSM existed in any of the target cities. In Hyderabad, the local gay group conducted small scale intervention using a leaflet (produced by another agency working with female sex workers) which spoke of vaginal sex but not anal, which asked MSM to practice partner reduction or abstinence, and which talked of water-based lubricant without indicating where appropriate resources could be obtained. The intervention observed by the Investigator was conducted amongst gay men only.

NGO and Donor response

Discussions by both the consultant and by this Investigator with a number of local NGOs working on HIV/AIDS issues, the various State AIDS Control Societies, and other relevant institutions indicated a high degree of support for an intervention amongst MSM. But the perceptual framework of these institutions and agencies reflected a heterosexual/homosexual binary paradigm, which the Assessment studies clearly showed was inappropriate as a basis for a sexual health intervention.

While a number of the doctors interviewed said they would be willing to accept referrals, actual ability to work non-judgmentally and effectively with these male clients was doubtful. An impression was gained that these doctors were stating what seemed to be appropriate to the Investigator. Further doctors apparently did not have any significant knowledge of anal STIs, nor was an appropriate algorithm available as a treatment protocol.

There were significant issues of concern regarding the very poor level of knowledge of MSM issues, needs and concerns among donors and NGOs, as well the degree of stigmatisation of kothis and male to male sexual behaviours generally amongst medical practitioners.

It also was abundantly clear that extensive advocacy and training would have to be given to NGOs, government institutions, STI doctors, and other relevant stakeholders on MSM issues and the contexts in which male to male sexual behaviours take place in South Asia.

Conclusions

In exploring male to male sex in the targeted cities this report highlights the following issues (in no specific order):

- * There are significant levels of males who have sex with males where a kothi/panthi dynamic was the most prevalent framework of MSM in the city.
- * Some gay identity and organising does exist in Hyderabad and Bangalore, but this was very limited and middle class-based. No gay organising existed in Pondicherry and Sylhet.
- * High rates of anal sex exist between males particularly kothis/panthis with lower rates for gay-identified men (almost two-thirds less in fact).
- * Significant levels of male commercial sex work exists where MSWs were primarily kothi-identified males.
- * High levels of partner change amongst kothi-identified males, less so among gay-identified males.
- * High rates reported of possible STI symptoms in Hyderabad and Sylhet, less so in Bangalore and Pondicherry.
- * Low levels of appropriate health seeking behaviours.
- * Inadequate appropriate STD treatment services regarding anal transmission of STIs.
- * No appropriate condoms available suitable for anal sex.
- * No affordable, accessible and appropriately packaged water-based lubricant available.
- * No appropriate BCC resources for MSM available.

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- * Many males who have sex with males begin their sexual activities in early adolescence, where their first sex partner is usually a male relative.
- * Many males involved in male to male sex do not have a sexual identity.
- * There are no appropriate education resources dealing with male to male sexual behaviours and/or anal sex available.
- * Low levels of appropriate knowledge of STIs/HIV/AIDS amongst males who have sex with males.
- * Low levels of condom usage
- * To a significant extent, MSM behaviours are usually invisible because of secrecy, shamefulness and denial as well as a lack of understanding the context in which they take place.
- * Many males who have sex with males will be married and many will get married.
- * Kothis find partners among panthis and/or double-deckers.
- * Gay identified men on the other hand usually find sex partners among other gay-identified men.
- * Kothi-identified men usually come from low income groups.
- * Technical skills for developing an MSM sexual health intervention among kothis were low.
- * Significant investment would be required to build skills amongst kothi networks towards building a beneficiary-led service.
- * Local STI treatment services were often inappropriate and unsympathetic.
- * Low levels of knowledge amongst NGOs, donor and government institutions in regard to MSM contexts.

To a significant extent MSM in the target cities do not comprise an easily identifiable or visible target group apart from those who identify as kothis, or even gay men. There appears to little gay identity and no commercialised gay venues. To insiders, male sex workers are easy to find, but, unlike female sex workers, relatively invisible in most social spaces. Therefore, reaching these men through their own collectivities, a strategy that was very successful in Western nations, is not directly applicable here without a considerable investment in community building. The wives and other female partners of MSM comprise a very vulnerable group and will be particularly difficult to reach. Therefore, both for reasons of efficiency and cost-effectiveness, a peer-led process of developing collectivities must begin.

Anal sex is a common practice, placing MSM, particularly kothis, at high risk of STIs and HIV, especially when poorly lubricated and not protected by condoms. Anal STIs are not well understood by most doctors and there is no syndromic algorithm for anal infections. Condom usage was low, and even with low quality of STD services available, access was marginal.

Accessing adequate STD care is very difficult for the poor and uneducated within these networks. Embarrassment and lack of money, coupled with providers' ignorance of MSM's sexual practices and the lack of a syndromic algorithm for anal STIs adds up to poor treatment and continuing infection.

Anal sex, as it is practised in the targeted cities, has a high likelihood of producing anal damage. Any blood present during sex increases the risk of acquiring HIV, and this is probably enhanced by the presence of piles.

The considerable level of partner change and sexual networking evident in the Assessment studies, coupled with the significant levels of reported current anal STI symptoms, demonstrates the potential of this group of men and youth for a concentrated HIV epidemic.

Given their fairly extensive sexual networks and contacts with women, kothis and their partners represent a "core group" for transmission. Whether their practices are approved of by society or not, they exist, appear to be numerous, and have a long history of tacit tolerance. Specialised services and sensitive outreach programmes will be required to address their needs.

Kothis sexually access many different men across each of the targeted cities. They have extensive social networks with other kothis. They usually come from poor, marginalised

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and socially excluded communities. If support and technical assistance can be given, it is possible to develop a community building strategy amongst kothis, and use this emergent community as a means of education and prevention intervention amongst kothis and their partners, where kothis can be mobilised on behalf of improving sexual health among MSM generally.

But it should also be recognised that kothis do not have the experience, knowledge, or skills to develop, implement and sustain an MSM sexual health intervention without considerable initial and on-going technical assistance.

D. Summary Data

From the discussion groups and workshop
Reasons why males have sex with males

- * male to male desire
- * desire for anal sex
- * sexual release and pleasure - meeting "physical needs"
- * free sex and for masti and fun
- * delayed marriage
- * wife may not be available for sex
- * for money
- * women don't do oral or anal sex - can't ask wife to do these acts
- * anus is tighter than vagina
- * females are not easily available
- * males are more easily available
- * nobody is suspicious if mixing with other males
- * males can share beds without a problem
- * male sex workers are usually cheaper than
- * female sex workers
- * it is believed to be safer
- * social space is male
- * overcrowding
- * lack of privacy
- * maintaining chastity
- * girls virginity must be protected
- * no chance of pregnancy
- * easier to seduce boys than girls
- * easier to get along with males than females
- * no financial involvement
- * no marriage involvement
- * be aloof from girls

Evidence points to a significant numbers of males engaged in male to male sex which involves young adolescents to much older males. from close relatives to the domestic servant and from the rickshaw driver to the businessman. Many will engage in male to male sexual behaviours sporadically, or over relatively brief periods of time. Many will also continue this behaviour infrequently over longer periods of time, beyond even their marriage. And many will engage in male to male sex as either an exclusive sexual behaviour. Particularly before marriage, or as part of the sexual repertotire over their sexually active life.

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From the discussion groups and workshop

Based upon personal experience who is involved in male to male sex?

- | | | | |
|---|-------------------------------|---|---------------------|
| * | defence personnel | * | labourers |
| * | doctors, male nurses | * | shop keepers |
| * | company reps | * | teachers |
| * | reporters | * | private tutors |
| * | hoteliers and hotel staff | * | security guards |
| * | pharmacists | * | office employees |
| * | pick-pockets and thieves | * | cinema goers |
| * | actors and dancers | * | massage boys |
| * | tailors | * | barbers |
| * | students and school boys | * | male friends |
| * | drivers | * | businessmen |
| * | politicians | * | rag-pickers |
| * | restaurant and tea shop staff | * | street children |
| * | auto, tempo and taxi drivers | * | prison staff |
| * | stewards | * | prisoners |
| * | bus drivers, conductors | * | mechanics |
| * | bank employes | * | rowdies/goondas |
| * | policemen | * | stall holders |
| * | railway staff | * | labourers |
| * | canteen staff | * | hijras |
| * | coolies | * | double deckers |
| * | lawyers and advocates | * | kothis |
| * | rikshaw drivers | * | gay men |
| * | travellers and tourists | * | panthis |
| * | boatmen | * | travellers/tourists |

Situational Assessments Among MSM In South Asia

1. Profile of respondents

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|---------------------------|-----------|-----------|-------------|--------|
| Age | | | | |
| 18 - 21 | 17% | 15% | 28% | 23% |
| 22 - 30 | 58% | 58% | 46% | 49% |
| 31 - 40 | 18% | 8% | 22% | 19% |
| + 41 | 7% | 9% | 4% | 9% |
| Marital Status | | | | |
| unmarried | 75% | 70% | 74% | 78% |
| married | 25% | 30% | 26% | 22% |
| Employment | | | | |
| employed | 57% | 72% | 74% | 84% |
| unemployed | 43% | 28% | 26% | 16% |
| Income (in Rps/Tk) | | | | |
| below 1000 | 24% | 8% | 20% | 17% |
| 1000 - 2000 | 42% | 33% | 51% | 29% |
| 2000 - 5000 | 21% | 39% | 22% | 26% |
| above 5000 | 13% | 20% | 7% | 28% |
| Education | | | | |
| none | 14% | 8% | 7% | 15% |
| up to 10 years | 29% | 50% | 76% | 31% |
| 10 + 2 | 34% | 22% | 9% | 11% |
| further | 23% | 20% | 8% | 43% |
| Self labelling | | | | |
| kothi | 52% | 36% | 64% | 68% |
| panthi | 15% | 11% | 12% | 24% |
| double-decker | 15% | 42% | 19% | 5% |
| heterosexual | 1% | 2% | 4% | 1% |
| homosexual/gay | 15% | 8% | 1% | - |
| other | 2% | 1% | - | 2% |

Situational Assessments Among MSM In South Asia

2. Sexual Behaviours

Multiple partners in previous month

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|---------|-----------|-----------|-------------|--------|
| 1 - 3 | 4% | 22% | 22% | 1% |
| 4 - 6 | 6% | 18% | 20% | 6% |
| 7 - 10 | 6% | 13% | 26% | 15% |
| 11 - 15 | 5% | 12% | 14% | 20% |
| 16 - 20 | 15% | 13% | 10% | 19% |
| 21 - 30 | 25% | 13% | 7% | 12% |
| 31 - 50 | 19% | 7% | 1% | 6% |
| 51 + | 20% | 2% | - | 21% |

Anal sex in previous month

| | | | | |
|-------------------------------|------|------|------|------|
| insertive | 24% | 35% | 23% | 22% |
| receptive | 76% | 65% | 77% | 78% |
| total number of anal sex acts | 7029 | 3754 | 2182 | 6692 |

Condoms used

| | | | | |
|----------------|-----|-----|-----|-----|
| insertive acts | 35% | 45% | 34% | 33% |
| receptive acts | 29% | 45% | 36% | 31% |

Main reason for not using condoms (multiple answers)

| | | | | |
|------------------|-----|-----|-----|-----|
| don't know | 46% | 59% | 49% | 56% |
| not satisfying | 64% | 70% | 69% | 53% |
| hard to dispose | 15% | 20% | 21% | 8% |
| not used before | 32% | 39% | 41% | 48% |
| shameful to buy | 31% | 35% | 36% | 44% |
| am not sick | 45% | 66% | 43% | 2% |
| partner not sick | 48% | 49% | 32% | 7% |
| partner faithful | 38% | 41% | 41% | 36% |
| not easy to use | 19% | 15% | 22% | 20% |

Situational Assessments Among MSM In South Asia

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|---|-----------|-----------|-------------|--------|
| <i>Lubricant use</i> | | | | |
| saliva | 87% | 61% | 53% | 56% |
| oil products | 55% | 60% | 41% | 35% |
| vaseline | 35% | 4% | 2% | 56% |
| KY jelly | 26% | 21% | 2% | - |
| soap | 9% | 5% | 2% | 11% |
| <i>Relationships with sex partners</i> | | | | |
| friends | 16% | 17% | 29% | 27% |
| strangers | 33% | 64% | 37% | 21% |
| neighbours | 4% | 2% | 5% | 13% |
| male sex workers | 6% | 1% | 8% | 14% |
| relatives | 1% | 1% | 5% | 2% |
| servants | 1% | 2% | 5% | - |
| paying clients | 38% | 11% | 6% | 19% |
| others | 1% | 2% | 5% | 4% |
| <i>Meeting places</i> | | | | |
| hotel/guest house | 5% | 5% | 4% | 8% |
| entertainment venues | 6% | 7% | 18% | - |
| other spaces | 6% | 13% | 11% | 2% |
| private homes | 18% | 5% | 30% | 27% |
| public spaces | 65% | 70% | 37% | 63% |
| <i>places for sex</i> | | | | |
| private homes | 40% | 22% | 34% | 20% |
| public spaces | 24% | 40% | 34% | 49% |
| hotel/guest/hostel | 15% | 7% | 5% | 2% |
| entertainment venues | 6% | 14% | 13% | 11% |
| others | 15% | 13% | 14% | 18% |

Situational Assessments Among MSM In South Asia

3. Male sex workers

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|--|-----------|-----------|-------------|--------|
| % of respondents reporting being paid for sex during the previous month | | | | |
| Frequency | 42% | 40% | 44% | 39% |
| 1 - 5 | 11% | 10% | 10% | 4% |
| 6 - 10 | 18% | 19% | 16% | 8% |
| 11 - 15 | 11% | 15% | 19% | 14% |
| 16 + | 60% | 56% | 55% | 74% |
| What sex? | | | | |
| anal insertive | 3% | 4% | 4% | 18% |
| anal receptive | 54% | 53% | 53% | 52% |
| oral insertive | 4% | 4% | 4% | 5% |
| oral receptive | 33% | 31% | 31% | 19% |
| masturbation | 3% | 5% | 4% | 4% |
| other | 3% | 3% | 4% | 2% |
| Total number of paid sex acts | 2355 | 1122 | 1168 | 5948 |
| no. involved | 62 | 60 | 72 | 56 |
| Condom use with previous 5 clients | | | | |
| never | 40% | 34% | 92% | 52% |
| sometimes | 48% | 39% | 7% | 39% |
| all times | 12% | 27% | 1% | 9% |

Situational Assessments Among MSM In South Asia

4. Paying for sex

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|--|-----------|-----------|-------------|--------|
| respondents reporting paying for sex in the previous month | 25% | 22% | 28% | 17% |
| Frequency | | | | |
| 1 - 4 | 21% | 34% | 31% | 18% |
| 5 - 10 | 38% | 34% | 45% | 55% |
| 11 - 20 | 31% | 26% | 14% | 15% |
| 21 + | 10% | 6% | 10% | 12% |
| Type of sex purchased | | | | |
| anal insertive | 56% | 59% | 58% | 43% |
| anal receptive | 14% | 11% | 11% | 20% |
| oral insertive | 26% | 27% | 26% | 37% |
| oral receptive | 5% | 2% | 3% | 5% |
| Condom use | | | | |
| | 24% | 46% | 58% | 24% |

Situational Assessments Among MSM In South Asia

5. Female partners of MSM

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|--|-----------|-----------|-------------|--------|
| <i>% of respondents reporting being married</i> | 25% | 30% | 26% | 22% |

Sex with wife during previous month (insufficient data from Sylhet)

frequency

| | | | | |
|---------|-----|-----|-----|--|
| 1 - 5 | 12% | 14% | 55% | |
| 6 - 10 | 7% | 36% | 16% | |
| 11 - 20 | 39% | 43% | 24% | |
| + 20 | 42% | 7% | 5% | |

Sex with other females in previous month

% of respondents reporting sex with females other than their wife

| | | | | |
|--|-----|----|-----|--|
| | 14% | 9% | 10% | |
|--|-----|----|-----|--|

Relationships with these females

| | | | | |
|-----------|-----|-----|-----|--|
| friend | 29% | 17% | 18% | |
| relative | 1% | 3% | 14% | |
| servant | 4% | 2% | 13% | |
| neighbour | 10% | 8% | 4% | |
| FSW | 53% | 70% | 33% | |
| others | 3% | - | 18% | |

Condom use with last five female partners

| | | | | |
|-----------|-----|-----|-----|--|
| never | 37% | 62% | 85% | |
| sometimes | 59% | 38% | 10% | |
| all times | 4% | - | 5% | |

Situational Assessments Among MSM In South Asia

6. Sexual Health

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|-----------------------------|-----------|-----------|-------------|--------|
| Reported symptoms | | | | |
| pus/discharge in stools | 7% | - | - | 16% |
| pus/discharge from penis | 13% | 2% | - | 4% |
| genital sores | 16% | 1% | 9% | 6% |
| sores/blisters inside mouth | 16% | 3% | 3% | 1% |
| bleeding when defecating | 22% | 2% | 16% | 16% |
| rash on genitals | 25% | 5% | 13% | 11% |
| pain when defecating | 28% | 7% | - | 20% |
| pain while urinating | 29% | 10% | 31% | 54% |
| itching/burning around anus | 30% | 9% | 28% | 51% |
| pain during sex | 37% | 9% | - | 60% |
| others | 19% | 1% | - | 2% |
| For male sex workers | | | | |
| pus/discharge in stools | 12% | - | - | 41% |
| pus/discharge from penis | 13% | - | - | 8% |
| genital sores | 20% | - | 5% | 10% |
| sores/blisters inside mouth | 21% | 1% | 5% | 2% |
| pain while urinating | 25% | 14% | 23% | 69% |
| rash on genitals | 33% | 5% | 14% | 19% |
| bleeding when defecating | 37% | 2% | 18% | 27% |
| pain when defecating | 42% | 12% | - | 63% |
| pain during sex | 48% | 11% | - | 83% |
| itching/burning around anus | 53% | 5% | 35% | 64% |
| Treatment | | | | |
| nothing | 40% | 62% | 30% | 22% |
| pharmacy | 20% | 1% | 7% | 42% |
| private doctor | 20% | 7% | 35% | 9% |
| hospital | 27% | 27% | 28% | 31% |
| others | 24% | 3% | - | 7% |

Situational Assessments Among MSM In South Asia

7. Knowledge and awareness

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|--|-----------|-----------|-------------|--------|
| <i>Have you heard of AIDS?</i> | | | | |
| yes | 71% | 85% | 57% | 69% |
| no | 29% | 15% | 43% | 31% |
| <i>What have you heard?</i> | | | | |
| an STD | 5% | 5% | 3% | 14% |
| caused by multiple partners | 7% | 2% | - | - |
| sex with an FSW | 7% | 15% | 10% | - |
| not using a condom | 10% | 38% | 3% | 4% |
| no idea | 14% | 7% | 36% | 30% |
| dangerous disease | 57% | 30% | 42% | 36% |
| infectious disease | - | - | - | 16% |
| bad sexual relations | - | 3% | 6% | - |
| <i>Personal risk assessment</i> | | | | |
| large | 47% | 3% | 54% | - |
| small to medium | 7% | 39% | 7% | 19% |
| don't know | 46% | 58% | 39% | 81% |
| <i>How can you get infected with HIV?</i> | | | | |
| oral sex | 33% | 27% | 43% | 46% |
| sexual contact with a woman | 19% | 23% | 34% | 20% |
| vaginal sex without a condom | 67% | 75% | 59% | 55% |
| anal penetration without a condom | 63% | 72% | 63% | 54% |
| sharing needles | 65% | 56% | 71% | 55% |
| deep kissing | 23% | 10% | 22% | 10% |
| swallowing semen | 49% | 37% | 39% | 50% |

Situational Assessments Among MSM In South Asia

Prevention

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|--------------|-----------|-----------|-------------|--------|
| using condom | 47% | 36% | 54% | 35% |
| don't know | 37% | 30% | 33% | 40% |
| others | 16% | 34% | 13% | 25% |

8. Other issues

HIV anti-body testing

| | | | |
|-----------|----|----|---|
| no tested | 25 | 38 | 4 |
| no. + | 1 | 6 | 1 |

Injecting drug use

| | | | |
|--------------|----|-----|-----|
| personal use | 8% | 9% | 11% |
| partners use | 7% | 12% | 8% |

No data from Sylhet was obtained.

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9. Comparisons between kothi and gay-identified men in Hyderabad and Bangalore in sexual practices

| | Hyderabad | Bangalore |
|--|-----------|-----------------------|
| <i>Oral sex practices in previous month</i> | | |
| kothi | 30% | 29% - of all sex acts |
| gay | 39% | 37% - of all sex acts |
| <i>Receptive Oral Sex</i> | | |
| kothi | 98% (25%) | 95% (15%) |
| gay | 62% (16%) | 60% (39%) |
| <i>Insertive Oral Sex</i> | | |
| kothi | 2% (24%) | 5% (20%) |
| gay | 38% (45%) | 40% (48%) |
| <i>Anal sex practices in previous month</i> | | |
| kothi | 70% | 71% - of all sex acts |
| gay | 61% | 63% - of all sex acts |
| <i>Receptive Anal Sex</i> | | |
| kothi | 96% (28%) | 95% (35%) |
| gay | 33% (19%) | 33% (51%) |
| <i>Insertive Anal Sex</i> | | |
| kothi | 4% (24%) | 5% (27%) |
| gay | 67% (28%) | 67% (60%) |

Note: Percentages in brackets reflect acts covered by condoms.

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10. Comparisons between kothi, double-deckers/do-parathas and panthis in Pondicherry and Sylhet

| | Pondicherry | Sylhet | |
|--|-------------|-----------|-------------------|
| <i>Oral sex practices in previous month</i> | | | |
| kothi | 34% | 37% | - of all sex acts |
| double-decker | 35% | 24% | - of all sex acts |
| panthi | 30% | 40% | - of all sex acts |
| <i>Receptive Oral Sex</i> | | | |
| kothi | 80% (18%) | 93% (38%) | |
| double-decker | 81% (28%) | 95% (54%) | |
| panthi | 20% (28%) | 7% (42%) | |
| <i>Insertive Oral Sex</i> | | | |
| kothi | 20% (24%) | 20% (35%) | |
| double-decker | 19% (46%) | 5% (50%) | |
| panthi | 80% (43%) | 93% (38%) | |
| <i>Anal sex practices in previous month</i> | | | |
| kothi | 66% | 63% | - of all sex acts |
| double-decker | 65% | 76% | - of all sex acts |
| panthi | 70% | 60% | - of all sex acts |
| <i>Receptive Anal Sex</i> | | | |
| kothi | 90% (7%) | 89% (39%) | |
| double-decker | 52% (17%) | 62% (31%) | |
| panthi | 31% (7%) | 49% (31%) | |
| <i>Insertive Anal Sex</i> | | | |
| kothi | 10% (18%) | 11% (57%) | |
| double-decker | 48% (16%) | 38% (44%) | |
| panthi | 69% (7%) | 51% (57%) | |

Note: Percentages in brackets reflect acts covered by condoms.

IV. Recommendations

Introduction

In terms of developing and implementing an HIV/AIDS intervention strategy for males who have sex with males in the main metro cities of South Asia, the issue of implementing a gay OR a kothi framework needs to be thought through thoroughly, particularly in terms of levels of impact, numbers of MSM reached, accessibility, appropriateness and outcomes. While there may be gay organisations existing (which did in Hyderabad and Bangalore), their ability to reach out to the poorer, marginalised and socially excluded MSM, the majority of whom are kothi-identified males and their male sexual partners, was seen to be clearly limited.

The reasons for this, as were identified previously, are

- * Significant differences in class, education and gender identification where gay-identified men are primarily from middle-classes, while kothis and the sex partners are primarily from low income groups.
- * This leads to different and inclusive social networks which do not mix or socialise
- * The vast majority of male sex workers are kothi-identified.
- * The evidence points to a higher rate of risks amongst kothis than amongst gay-identified men.
- * Kothis and their male sexual partners make up a majority of accessible MSM
- * While gay-identified men can access some other gay-identified men, kothis are able to access, not only other kothis, but also their male sex partners - panthis - in significant numbers.
- * Kothis can access many other males with differing identities and different sexual behaviour frameworks.
- * Kothis represent an identified network and an emerging community which is at particular risk of STD/HIV infections.

For these reasons the following recommendations are being made.

1. Behavioural and anthropological research

- 1.1 Academic and action-based research needs to be done in the constructions of masculinities and male sexual behaviours (particularly male to male) in South Asia and their implications for HIV prevention and sexual health. Such research can provide information for developing effective and sustainable intervention strategies in regard to male to male sex.

Other areas of research should explore:

STI prevalence amongst MSM with a focus on anal STIs

General prevalence of MSM behaviours among males with a focus on anal sex

Female partners of MSM including wives with a focus on risk of STI/HIV infections

2. Developing an MSM community-based AIDS service agencies

- 2.1 Funding the development of local community-based MSM sexual intervention projects through empowering local networks of kothis to implement and manage such interventions should be made a priority.

Assessment Team members were primarily kothi-identified. A secondary process that evolved through conducting these assessments led to group formations in all the cities. In Hyderabad the group called itself Mithrudu. In Bangalore the group named itself as Geleya, which allied itself to the local project Jagruti which was being supported by the Karnataka State AIDS Prevention Society to develop an MSM sexual health project. In Pondicherry the group finally named itself Sneghedhan. Because of funding issues in Pondicherry the group allied itself with Prakriti-Sahodaran, based in Chennai. In Sylhet, because of local issues and potential funding support, the group became a branch of Bandhu Social Welfare Society based in Dhaka, Bangladesh.

It is recommended that
Mithrudu be funded in Hyderabad

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Jagurthi-Geleya in Bangalore obtain additional funding support to extend the programme

Prakriti is funding to manage the programme in Pondicherry which will be implemented by Sneghedhan

Bandhu Social Welfare Society be funded to develop and implement a project in Sylhet, Bangladesh

- 2.2 However it is also recognised that the gay group Saathi in Hyderabad has been doing a small scale intervention amongst other gay-identified men, and they should also be funded to expand and continue this work amongst other gay-identified men in that city. It is clear that condom promotion and outreach is essential for gay men also.
- 2.3.1 Safe spaces will need to be developed in each city where individuals and networks can gain access for confidential information as well as discuss issues around sexualities and sexual health within an appropriate context. These would function as drop-in centres providing support, counselling, advice and information.
- 2.4 Acknowledging the lack of technical skills in developing such community-based sexual health promotion agencies addressing male to male sexual behaviours, including:
- * infrastructure development
 - * service delivery and implementation
 - * project management
 - * financial management and accountability
 - * appropriate outreach strategies
 - * monitoring and evaluation
 - * BCC resource design
 - * production of budgets and accounts,
- These projects must be provided with appropriate technical assistance to access these skills through training and capacity building.
- 2.5 Different distribution strategies for condoms and lubricant will need to be explored by such a community-based agencies, such as social marketing, free distribution as well as distribution in a wide variety of private and public locations. These differing strategies must be supported by Government and non-government agencies by enabling access to sufficient condoms and water-based lubricant of appropriate quality, quantity and affordability.
- 2.6 Psycho-social support programmes need to be part of any on-going sexual health programme for males who have sex with males. These would include telephone lines ("hotlines") providing free and anonymous advice and information, social support groups, sexual health discussion groups, and other services deemed appropriate and needful by males who have sex with males themselves. These services should also be funded.
- These support services create an enabling environment that can foster behaviour change towards safer sex practices as a community norm.
- 2.7 Effective and supportive relationships with local police need to be developed and facilitated by an appropriate advocacy agency in cooperation with the MSM service provider.
- 2.8 Further, attitudes of doctors and other medical staff towards such stigmatised identities and behaviours will need to be adequately and appropriately addressed through sensitisation programmes and appropriate regulatory practices.
- 2.9 Because significant levels of male to male anal sex takes place outside of public sites and external to khoti/panthi dynamics, other NGOs developing sexual health services will need to promote safer sex behaviours that include anal sex in their programmes of education and prevention. These include rickshaw drivers, female

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sex workers, truck drivers, IDUs, educational establishments, street children, factory workers, overseas workers, prison populations, et al.

- 2.10 There should be regular consultations between such MSM community-based AIDS service agencies and the State level AIDS Control Societies and/or programmes, to ensure that issues, needs and service development for males who have sex with males is always reflected in any national, regional or State AIDS programmes and strategies.
- 2.11 Such MSM community-based AIDS service organisations should be provided with long term funding which would include
 - * core costs
 - * infrastructure
 - * access to technical skills and capacity building
 - * equipment
 - * programme costs
 - * clinical support
 - * condoms and lubricant
 - * BCC materials
 - * networking
- 2.12 Sustainability issues must be thoroughly explored with such AIDS service organisation to ensure programme continuity over a period of years.
- 2.13 It should be recognised that community building and development processes as a means to achieve sustainable behaviour change take several years of sustained activity.

3. Education and Prevention

- 3.1 There is an urgent need to address the high levels of incorrect beliefs about sex, sexual functioning, the male and female body, and all aspects of sexual behaviours. These beliefs are damaging and impede any effective development of STI/HIV prevention.
- 3.2 The lack of appropriate and accurate sex education must be addressed and requires governmental action to provide an effective sex education programme which should be made available for both the formal and informal education sectors.
- 3.3 There is an urgent need for a broad range of educational resources, reflecting the sexual practices of males who have sex with males, as well as specifically anal sex, to be made available in appropriate formats and be distributed as widely as possible.
- 3.4 Specifically targeted resources should be developed that are aimed at differing social, economic and behavioural groups, including medical staff, family planningclinics, religious teachers, educational staff, factory workers, hotel staff, and so on.
- 3.5 This would also mean educating and updating all health and social care workers skills with regard to prevention, care, management, counselling and related issues on HIV/AIDS, including issues on anal sex and males who have sex with males.
- 3.6 Resources also need to be developed that cater for those who are not literate.
- 3.7 Further to this there should be educational campaigns that de-stigmatise the public discussion of sexual behaviours through multi-media efforts that involve government, non-government and business institutions and agencies.

4. Condoms and lubricant

- 4.1 Appropriate stronger condoms suitable for anal sex behaviours and which are affordable and easily accessible, must be made available to the general public.

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- 4.2 An urgently needed requirement for the promotion of safer sex and risk reduction is the availability of a suitable water-based lubricant in appropriate packaging that allows for a low market price and is easy to carry and use.
 - 4.3 Issues of distribution, availability and easy accessibility need to be addressed. Price and distribution would need to reflect affordability and accessibility for the poorest at locations where sexual activities take place.
 - 4.4 Considerable education will need to be done on the correct use of condoms.
- 5. STD Services**
- 5.1 Because of the stigmatisation of males who have sex with males, particularly kothis, any kothi community-based agency should be supported to host their own STD treatment service to ensure confidentiality, safety, acceptance and accessibility.
 - 5.2 Because of the level of poverty amongst many kothis, treatment should be subsidised.
 - 5.3 All STD medical staff should be trained in the issues surrounding anal sex behaviours, whether between males or between males and females, in regard to symptoms, treatment and counselling. Further abuse and harassment at such services by staff must be stopped. All staff should be sensitised to the needs of males who have sex with males, particularly those with stigmatised behaviours and identities. Confidentiality and anonymity must be available in accessing such services.
- 6. Women And Sexual Health**
- 6.1 Appropriate strategies must be developed that address the sexual health issues of wives and other women that arise from the sexual behaviours of males who have sex with males, without a loss of confidentiality and trust.
 - 6.2 Women's sexual health programmes must address the issues of anal sex between males and females and also confront the issues of male to male sexual where they impact upon women's sexual health.
- 7. Psycho-sexual counselling**
- 7.1 Trained personnel providing psychosexual counselling should be available, perhaps through the establishment of Sexual Health Centres which can offer non-judgmental, appropriate and accurate advice, information and support.
- 8. The Role of the State AIDS Control Societies, Government, and Donors**
- 8.1 The State AIDS agencies, and donors must play a lead role in encouraging and enabling the development of a peer-led community-based AIDS service organisation by investing in, and empowering them, to deliver appropriate STI/HIV prevention and sexual health services for males who have sex with males.
 - 8.2 Such an investment in the development of appropriate sexual health services for males who have sex with males would be in the form of:
 - 8.2.1 provision of long term financial support
 - 8.2.2 provision of, or unhindered access to, technical assistance and financial support
 - 8.2.3 access to capacity-building training
 - 8.2.4 addressing legal and regulatory constraints which may hinder the development of such peer-led community-based agencies
 - 8.3 In order for this to occur, State agencies and others will need to ensure that they can gain the trust and confidence of males who have sex with males by ensuring confidentiality, safety, security and anonymity.
 - 8.4 State AIDS agencies should provide training and awareness programmes to government and non-government agencies providing sexual health services on the social and sexual health needs of males who have sex with males in order to

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address the lack of knowledge and understanding. Such programmes will provide unbiased information, sensitisation, as well as destigmatise the issue.

- 8.5 Where laws, regulations and policies hinder males who have sex with males to access sexual health services, or discriminate against them through intimidation, fear, harassment, violence, denial or the risk of imprisonment, then these should be amended or repealed to empower such males to access these services. The State AIDS agencies should be providing advocacy support for this.
- 8.6 Training of police staff and the judiciary on issues regarding males who have sex with males and sexual health concerns should be provided
- 8.7 State AIDS agencies should develop and/or support advocacy programmes for males who have sex with males to ensure the human rights of individuals are being respected, and that those who are harassed or violently abused can seek legal redress.
- 8.8 All sexual health programmes should include male to male sexual behaviours and anal sex issues, and should also involve schools, colleges and universities, families, business, the military and prisons.
- 8.9 State AIDS agencies and associated institutions need to ensure that appropriate condoms suitable for anal sex and suitably packaged water-based lubricants are readily available and accessible to males who have sex with males, ensuring good quality, affordable prices and adequate distribution in a variety of locations. Such distribution should also include appropriate educational materials in the correct usage of such products.
- 8.10 State AIDS agencies should ensure that all STD services staff, private or government, as well as all sexual health services provided by government and non-government agencies receive appropriate training on ALL frameworks of sexual behaviours which must include anal sex as a practice both between males and between males and females towards improving the quality, accessibility and delivery of these services to all sections of society.