

MSM, HIV/AIDS and Uttar Pradesh in India

A Briefing Paper for State Innovations in Family Planning Services Project Agency (SIFPSA)

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Naz Foundation International

Since 1996 Naz Foundation International¹, based on its knowledge and experience of working with MSM frameworks and networks, has provided technical assistance and support to develop some 28 CBO MSM sexual health projects in the South Asia region. As a part of this experience we have developed a range of tools and resources to support this activity.

Introduction

HIV/AIDS in India

Next to South Africa, India has the second largest number of persons living with HIV/AIDS in the world. According to the data on the National AIDS Control Organisation (website <http://naco.nic.in/vsnaco/indiascene/update.htm>: accessed on 12th January 2004), as of 30th November 2003, the cumulative total for AIDS cases in India was 57781, whilst the estimated numbers of HIV infection was almost 4.5 million. It is also estimated that 85% of HIV transmission is sexual, where NACO states that “The predominant mode of transmission of infection in the AIDS patients is through heterosexual contact...”²

HIV/AIDS and MSM

The contribution of MSM to the HIV/AIDS epidemic in India was officially set at 1 percent in 2001.³ But these estimates may seriously underestimate the significance of MSM behaviours to the epidemic in India, especially since global estimates suggest that 5 percent to 10 percent of HIV prevalence is attributable to sexual transmission between men.⁴ Truck drivers are a group known to have higher levels of homosexual behaviour than the general public.⁵ Therefore, the high rates of HIV infection among truck drivers may be an indicator of the importance of homosexual transmission in the India epidemic because homosexual behaviour also takes place outside of this particular group.⁶

In the **1998** data of NACO, it was stated that *among the 5204 AIDS cases reported* until March 1998, **heterosexual transmission** constituted **74.15%** and **homosexual transmission** constituted **0.58%**, Recipients of blood constituted 7.05%, injecting drug users - 7.3% and “others” - 10.92% (NACO, 1999). Thus according to the NACO, homosexual transmission contributed to only 0.58% *among the reported AIDS cases* until 1998. Current data does not distinguish between vaginal or anal transmission (i.e. heterosexual or homosexual), but produces a single figure for sexual transmission.

Data on AIDS cases provide a picture of HIV infection approximately ten years old. It is contended that in order to estimate recent trends in HIV infection, NACO should rely on data on HIV testing,

¹ See Annex document on NFI

² <http://naco.nic.in/vsnaco/indiascene/update.htm>: accessed on 23rd September 2001

³ Government of India, Ministry of Health and Family Welfare, National AIDS Control Organisation, *Estimation of HIV Infection among Adult Population* (New Delhi, India: Ministry of Health and Family Welfare, 2001)

⁴ *AIDS and Men Who Have Sex With Men (UNAIDS Point of View)* (Geneva, Switzerland: UNAIDS, 1998)

⁵ A.D. Bryan, J.D. Fisher, and T.J. Benziger, “HIV Prevention Information, Motivation, Behavioural Skills and Behaviour among Truck Drivers in Chennai, India,” *AIDS* 14, no. 6(14th April 2000):756-8

⁶ This paragraph was drawn from *Males Who Have Sex With Males (MSM) and HIV/AIDS in India: The Hidden Epidemic*, by Gregory Pappas, Omar Khan, Jason Talyor, Shivananda Khan, Lalitha Kumaramangalam, and Joseph O’Neill, *AIDS and Public Policy Journal*, 2001, Vol. 16, No. 1/2, pp4-17

HIV prevalence and incidence reports, and risk behaviours among men who have sex with men from centres that deal with MSM. Unfortunately, there is little reliable data on these.⁷

The reliability of HIV infection data among MSM is influenced by: (i) the lack of knowledge and understanding of MSM behavioural patterns as many MSM do not have a sexual conscious sexual identity/orientation; (ii) many do not consider reporting on their same sex behaviours even when asked; (iii) many do not identify their sexual behaviour as MSM since their partners are not perceived as men; (iv) many gay-identified men as well as others who have developed a sexual identity, are reluctant to identify themselves and disclose their same-sex behaviours or sexual orientation to health care providers, fearing stigma, discrimination and exclusion.

Similarly, confusion arises in how infections among *hijras* and their sexual partners are defined, and at the same time ignorance about same-sex behaviours and discrimination against MSM along with stigmatisation and social exclusion, affects the extent and reliability of data on HIV infection in this population, contributing to the paucity of studies among MSM and almost no funding, until recently, for HIV prevention programs for MSM.

As the SAATHI report⁸ stated, "There is no nation-wide data on the prevalence of HIV infection among MSM in India. National AIDS Control Organisation (NACO) of India says, "On HIV among MSM groups, little reliable data is available. Informal estimates suggest rapid increases may be taking place in this particularly vulnerable community" (NACO, 2000). Only a few studies from Mumbai have reported HIV seroprevalence among MSM. The prevalence of HIV infection among gay-identified men attending STD clinics in Mumbai metro was studied by the National Institute of Virology over a 6-month period in 1992 in collaboration with *Bombay Dost* (India's first gay newsletter). HIV prevalence was found to be 20.67%, which was very high given the fact that this studied cohort was of educated middle class and hence had the means and material to be adequately aware of the transmission routes of HIV. It therefore implies that HIV prevalence amongst MSM without a conscious self-identity of their sexual orientation would be higher (Ashok Row Kavi, 1999).⁹

A Mumbai study published in 1994 showed that about 16% (among 63 blood samples) of MSM attending STD clinics of Mumbai were seropositive for HIV (Nandi et al, 1994). HIV prevalence of 15% among MSM in Mumbai was been reported from the STD clinic of a non-governmental organisation (Humsafar Trust) working with MSM (Maninder Setia et al, 2000).

Data from NACO (2000) of 232 HIV sentinel serosurveillance sites across India, 2 of which targeted MSM, suggested HIV seroprevalence rates among MSM of 23.94% in Mumbai (in Maharashtra State) and 4% in Tamil Nadu State [in Chennai]. (NACO: <http://naco.nic.in/vsnaco/indianscene/overv.htm>: accessed on 23rd September 2001)

Naz Foundation International conducted Social Assessments among MSM in Bangalore, Hyderabad, and Poncherry in 2000. One of the questions in the study was about HIV+ve status, where 200 MSM in each city were interviewed.

| | Hyderabad | Bangalore | Pondicherry |
|----------------|-----------|-----------|-------------|
| No. tested | 25 | 38 | 4 |
| No. tested +ve | 1 | 6 | 1 |

⁷ HIV Prevention Among Men Who Have Sex With Men (MSM) In India: A Review Of Current Scenario and Recommendations – background paper prepared by SAATHI (Solidarity and Action Against The HIV Infection in India) working group on 'HIV prevention and care among Indian GLBT/Sexuality Minority communities', revised draft, April 2002, pp 50

⁸ See Note 7

⁹ Ibid

STD prevalence among MSM in India

Only limited data are available about STD prevalence among MSM in India. A preliminary analysis of STDs among 85 MSM attending an STD clinic in Mumbai gives the following information: 4 had clinical rectal gonorrhoea (among these 2 were culture-positive and remaining 2 were smear-positive), 4 had perianal warts, 3 had gonococcal urethritis, one case each of secondary syphilis, genital molluscum contagiosum and genital scabies. The point prevalence of HIV in this population was 15% and VDRL reactivity was 16% (Maninder Setia et al, 2000).¹⁰

In a 2001 study from Chennai, analysis of 51 MSM who attended a community-based clinic over a period of three months showed the following. Thirteen (26%) MSM were clinically diagnosed to have one or more STDs. Clinically the following pattern of STDs was found: Perianal warts - 4 (8%), Genital Herpes - 4 (8%), Perianal herpes - 1 (2%), Secondary syphilis - 1 (2%), Gonococcal urethritis - 1 (2%), Molluscum contagiosum - 1 (2%), Proctitis - 2 (4%), Scabies - 1 (2%) and Prostatitis - 1 (2%). Genital dermatoses like Candidal intertrigo - 4 (8%), Candidal balanoposthitis - 1 (2%), Perianal candidiasis - 1 (2%) and Tinea cruris were also found. Serological testing for syphilis (VDRL) was not routinely conducted due to financial constraints. Seven (14%) self-reported as HIV-positive (Venkatesan C and Sekar B, 2001).¹¹

MSM in India?

Who is MSM

What do we mean by the term “men who have sex with men”? Who are these “men who have sex with men”? Does this include men who have only had sex with another man once, twice, three times? Does this include males who just masturbate with other males?

For many service providers and agencies it has become synonymous with “homosexuals”, or of “gay” men, while it is often signified within the context of discussions of “vulnerable groups”, or “target populations”, or “at risk groups”. In other words MSM is often taken to mean a specific and exclusive “sexual identity” in opposition to “heterosexuality”, where MSM form an exclusive and bounded group. Too often programmatic decisions are taken within this limited view of what is essentially a behavioural term.

Further, the use of the term “men” in MSM creates a generic category of MAN, ignoring local cultural constructions of what a “man” is. But the word “men” can be problematic in that it's significant and meaning will vary in different localities. In Indian cultures, manhood (and adulthood) is defined by specific responsibilities, duties and obligations, and not by biological age. Marriage and the production of children (particularly male children) are cornerstones in this socio-cultural definition of manhood.

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

Thirdly, those who do not conform to normative socio-cultural definitions of masculinity are not deemed men by their male sexual partners (and often do not perceive themselves as such) although they are biological males.¹²

Male-to-male sex then includes those who identify with same-sex sexual desire, often through gendered sex roles, as well as those who do not. It involves biologically adult males, as well as adolescent males.

¹⁰ Saathi report, see Note 7, pp51

¹¹ SAATHI report, see Note 7, pp51

¹² See NFI reports on a number of Situational And Social Assessments on MSM in a range of cities in South Asia accessible on its website www.nfi.net

If we only address HIV/AIDS risks for MSM based on identity/sexual orientation, then what happens to those males whose sexual behaviours with other males are outside the purview of such frameworks because they do not see themselves possessing a sexual orientation other than a normative masculinity as men?¹³

Thus to attempt to use the term “men who have sex with men” as a bounded and exclusive category in the context of India would not be valid. To do so leads to a greater invisibility of many divergent 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.

In this context, and from the reality of experience in India, Euro-American understandings and discourses on “gay identities”, heterosexuality, homosexuality, bisexuality, or even the use of the term “sexual minorities” can be misleading, and actually invisibilises to a significant extent the range and level of male-to-male sexual activities and those involved in them.

Contemporary research on sexualities and genders have clearly shown that the bipolar categories, such as ‘man’ or ‘woman’ or ‘heterosexual’ or ‘homosexual’, are not useful to describe the range of identities, desires and practices” (personal discussion with Carol Jenkins, Care Bangladesh, 1999) existing in India. The terms “gay” or “homosexual” are too contextualised 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, and about behavioural constructions. Where UNAIDS and others speak of behaviourally homosexual, we can also talk about behaviourally heterosexual in the Indian context.

In this 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.

Whereas some of the male to male sexual acts could perhaps be called ‘homosexual’ (within the context of a local sexuality based upon a feminised gender identification - also self-labelled as *kothis*¹⁴) in that a sexual sense of self is operating within a framework of gendered sex roles and desires, a significant majority of the male sexual partners of these *kothis* should be seen within a context of semen discharge rather than desire for another male. The sexual partners of *kothis* are called *giryas* or *panthis*¹⁵ by them, meaning “real men”. But it should also be recognised that within a gendered construct of male to male sex and desire, there are *giryas/panthis* who form emotional and sexual relationships with *kothis*. These *giryas/panthis* do not see themselves (nor are they perceived as such) as homosexuals, or even as “men who have sex with men”, but rather as “real men”, defined by their supposedly exclusive penetrating role that they take in the sexual encounter with a *kothi*.

¹³ See: The risks of categorisation, Shivananda Khan, Pukaar, Issue 21 April 1998; Varieties of homosexuality in Bangladesh, paper presented by Dr. Carol Jenkins at the 12th World AIDS Conference, Geneva, June 28-July 3, 1998, Pukaar, Issue 24, January 1999; Men and HIV: sociocultural constructions of male sexual behaviours in South Asia, Shivananda Khan, Pukaar, Issue 28, January 2000; Males who have sex with males in South Asia – a *kothi* framework, Pukaar, Issue 31, October 2000. Pukaar is the quarterly journal of Naz Foundation International and available on its website www.nfi.net as pdfs

¹⁴ *Kothi* - A self-identifying label for those males who feminise their behaviours (either to attract “manly” male sexual partners and/or as part of their own gender construction and usually in specific situations and contexts), and who state that they prefer to be sexually penetrated anally and/or orally. *Kothi* behaviours have a highly performative quality in social spaces. Self-identified *Kothis* use this term for males who are sexually penetrated, even when their performative behaviour is not feminised. This is the primary and most visible framework of MSM behaviours. *Kothis* state that they do not have sex with others like themselves, only “real men”. However many *may* also be married to women as a family obligation.

¹⁵ *Panthis/Giryas* - A *kothi* label for any “manly male.” A *panthi/girya* is by definition a man who penetrates, whether it is a woman and/or another male. *Panthis/Giryas* would most likely also be married to women and/or access other females. Their occupations vary across the social class spectrum from rickshaw drivers to businessmen.

It also should not be forgotten that the vast majority of *hijras*¹⁶ are also biological males, where many would not be castrated, and would be sexually accessed by normative males from the general community.

However, not all male to male sexual encounters in India fall into the *kothi/panthi* framework. Other constructs, desires, and patterns of sexual encounters exist, framing a complex, open-ended, and extremely porous 'group', or 'networks' of MSM. In fact the word 'group' is highly suspect, in that it does not fully frame the actual behavioural practices of males across Indian societies. The word 'group' implies an exclusive practice of a number of men/males, but this is not the reality. While *hijras* and "public" *kothis* may be considered a group in that their shared behavioural characteristics make them significantly visible, their partners are not, and can be defined as a part of the general male population whose public behaviour is 'manly' according to the socio-cultural definitions in India.

In a range of workshops conducted by NFI held with groups of *kothi*-identified males in a number of cities in India, when asked with whom they had sex, the response was a long list of occupational groups which ranged from street dwellers to businessmen, from the unemployed or low income groups to very wealthy men. These were primarily identified as *panthis*.

Thus what can be said to exist in India are a range of masculinities and genders with differing contextualisation of sexual behaviours, sex partner choices, perceived sexual needs, pleasures and desires, where male-to-male sex is seen primarily within a gendered dynamic, rather than in terms of sexual orientation or identity. This means that for many whom could be categorised as MSM would not define themselves as such because they would see themselves as normative penetrative males.

The frameworks of male to male sex then are substantially divergent and inclusive. It includes normative males who desire to penetrate as the only signifier, feminised males (*kothis*), along with *hijras*, who desire to be penetrated by other males, and adolescent and other males who do *maasti* together for fun, to experiment, or just to enjoy. Males are often easier to access for sex than females, while male sex workers are usually cheaper than female sex workers are. Such same-sex behaviours occur in neighbourhoods, all male institutions such as prisons, between male friends who seek release from "body heat" and semen discharge. It also includes self-identified gay men, primarily among the urban, English speaking elite and middle classes.

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

But this, if course, does not tell the whole story of male-to-male sexual behaviours in India.

Male-to-male sex work is also a significant factor in India cities where *kothis/hijras*, 'massage boys', male youth, and other males, will sell sex to men because of poverty and unemployment. Without a welfare system, and with significant levels of unemployment or low level incomes, male sex work can be a way out in terms of supporting the self and family. This is not to imply that males involved in sex work do not enjoy the sex with other males. Often they may also have a regular male partner, and/or a wife or girlfriend.

While there are substantial networks of visible *kothis* of all gradations in urban centres - from the very feminised and cross-dressing type to those who have moustaches and dress in shirt and trousers - their sexual partners could well be any masculine male who tend to be invisible. Sexually accessing these

¹⁶ *Hijras* - A self-identified term used by males who define themselves as "not men/not women" but as a "third gender." *Hijras* cross-dress publicly and privately and are a part of a strong social, religious, and cultural community. Ritual castration may be part of the *hijra* identity, but not all *hijras* are castrated. Sex with men is common, and like men who have sex with *kothis*, such men would see themselves as 'real men' and not homosexuals.

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

It also needs to be recognised that the issue of female sexual health in the context of male-to-male sexual behaviours is also highly pertinent and urgent. Cultural tradition makes marriage socially compulsory. Many MSM, of whatever framework or gender identification, are married or going to be married, even those who self-identified as *kothis*.

In summary, what is clear is that MSM should not be seen as a singular category of men who have sex with men. While there are men in India whose sexual orientation is clearly gay-identified, they are a minority within the category of MSM, and are urban-based and elite with access to English and the web. But among lower middle and low-income classes, the dynamic is primarily based on gendered perceptions of normative men accessing feminised males. Along with this would be male-to-male sex within prison populations and other all male institutions, male massage networks, male friendships, experimental male youth and so on.

Size Estimation

In India

As discussed above MSM as a category is highly complex, diverse, and for many significantly gendered which makes it extremely difficult to make any effective size estimation. Simplifying this complex scenario, it is composed of two or more populations, those that are relatively visible, i.e. *public kothis and hijras*, and those invisibilised because such males are a part of the normative male population, non-public *kothis*, males in all male institutions, neighbourhood encounters, and so on.

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

Behavioural surveillance studies are often problematic, inadequate and badly designed. Many procedural and ethical issues are problematic where inappropriate questioning is the norm, poor formatting of studies, lack of confidentiality, stigmatisation by researchers, or even no mention of same-sex relations. This poverty in information and knowledge is further enhanced through a lack of understanding of the dynamics and frameworks of same-sex behaviours in an Indian context.

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

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

Sexual behavioural studies in India have classified homosexual as anything from 1% of the sexually active male population to nearly 28% of the 'occasionally homosexually behavioural males'.

Quantitative studies conducted in India include:

- A survey at Patna medical college in India in 1992 revealing that 25% of male medical students and doctors had had same-sex relationships (H.V. Wyatt, 1993)
- A postal survey of the readership of 'Debonair', an English men's magazine from Mumbai revealing that of 1500 men who replied, 29.5% had sex with another man, before the age of 20 years in 80% of the cases (Roy Chan, et al, 1998)
- A survey of 527 truck drivers in northeast India revealing that 15% had sex with men (S.I. Ahmed, 1993)
- A major study conducted in Pune cities, where only 1.2% of men interviewed said they had homosexual relations although the authors did add, "we do feel it is extremely difficult to get an accurate estimation of homosexual experience in a general survey like we did". The researchers agree that a completely different kind of questionnaire has to be designed to get more information on the prevalence of homosexual behaviour (Roy Chan et al, 1998)
- A postal survey of rural and semi-rural men in Tamil Nadu to which 1200 men replied found that 8% had sex with other men (Shreehar Jaya, 1994)
- According to a report on MSM in developing countries, the prevalence of MSM behaviours in the Indian male population range from 8 to over 50% (Neil McKenna, 1996)
- In a study of sexual behaviour among 1600 college students in Chennai, (Hausner D, 2000) it was found that approximately 20% of male students reported having had sex at least once in their lifetime and among these, 35% had their first experience with another male.

Sexual behaviour of the American male - otherwise known as The Kinsey Report, 1948

No questioned: 5,300 white Americans

The Kinsey study titled '*Sexual Behavior of the American Male*' is one of the most thorough studies of sexual behaviour. It was basically a study of white Anglo-Saxon population, but it did procure some baseline data regarding homosexual behaviours. Its main result was the famous Kinsey graph where number 6 on the scale was 'permanent practising homosexual' and number 0 on the scale was "permanent practising heterosexual".

From the report:

- 37 per cent of the total male population has at least some overt homosexual experience to the point of orgasm between adolescence and old age. This accounts for nearly two out of every five that one may meet.
- 50 per cent of the males who remain single until the age of 35 have had overt homosexual experience to the point of orgasm, since the age of adolescence.
- 58 per cent of the males who belong to the group that goes into high school, but not beyond, 50 per cent of the grade school level, and 47 per cent of the college level have homosexual experience to the point of orgasm if they remain single to the age of 35.
- 30 per cent of all males have at least incidental homosexual experience or reactions over at least a three-year period between the ages of 16 and 55. This accounts for one male out of every three in the population who is past the early years of adolescence.

- 25 per cent of the male population has more than incidental homosexual experience or reactions for at least three years between the ages of 16 and 55. In terms of averages, one male out of approximately every four has had or will have such distinct and continued homosexual experience.
- 18 per cent of the males have at least as much of the homosexual as the heterosexual in their histories for at least three years between the ages of 16 and 55.
- 13 per cent of the male population has more of the homosexual than heterosexual for at least three years between the ages of 16 and 55.
- 10 per cent of the males are more or less exclusively homosexual for at least three years between the ages of 16 and 55.
- 8 per cent of the males are exclusively homosexual for at least three years between the ages of 16 and 55.
- 4 per cent of the white males are exclusively homosexual throughout their lives, after the onset of adolescence.
- 46 per cent of the male population has engaged in both heterosexual and homosexual activities to the point of orgasm throughout their adult lives.

It is clear that male sexual behaviours are not divided into exclusive categories of “heterosexual” or “homosexual”. Rather while there were some males with exclusive behavioural choice, there were more who moved between these categories of behaviour in varying degrees.

While the Kinsey study has been rightly criticised in many respects, its basic data has been validated in a range of multi-cultural studies around the world. There is therefore no reason to believe that his benchmark of about 5% of the sexually active male population forms a core exclusive homosexual population in India. But this is of course complicated by the fact that in India, marriage is socially compulsory. And it does not take into account patterns of male-to-male sex encounters outside of this “homosexual” dynamic.

Thus five percent of the sexually active male population comes to a core homosexual population of 13.5 million homosexual males in India. This figure was obtained from the 1991 census, by calculating the sexually active male population as 60% of the population (males falling between the ages of 15 and 60 years) and then computing five percent of that figure. Another 37.5 million males fell in the ranges between number 3 to number 5 on the Kinsey scale. These males eroticised other males at some time or other in their lives and had occasional sex with them, when they could. Some of these males are behaviourally bisexual or moved up or down the Kinsey scale according to the circumstances. However, the final figure of Indian males practising homosexual behaviour was found to be nearly 50 million by adding up these figures, which is quite considerable. (Ashok Row Kavi, 1999).

There is however, socio-cultural evidence and anecdotal reports from across India which suggest that possibly male-to-male sex may well be higher than this for a broad range of reasons, including gender segregation and social policing of women, delayed marriage, difficulty accessing females for sex, overcrowded living conditions, high levels of poverty, unemployment amongst unmarried males, and so on.

It would be pragmatic to stay close to the Kinsey estimates even if the data suggests otherwise. Factors like, non-recognition of same-sex behaviours not being classified as ‘sex’, the declining female-male ratios in the country further distorted by rural-urban migrations, all point to higher male-male sexual transactions in India.¹⁷

¹⁷ pp56, Saathi Report, see note 7

MSM and risk behaviours

Not all MSM are at risk of HIV infection because not all practice risky behaviours such as anal sex.

In 2000 Naz Foundation International conducted social assessments of MSM in a range of urban settings within networks of the most publicly visible of MSM networks – what were known as ‘public *kothis*’, including Bangalore, Hyderabad and Pondicherry.¹⁸

From this report, where in each city 200 MSM-identified individuals were interviewed:

Profile of respondents

| Age | Hyderabad | Bangalore | Pondicherry |
|-------|-----------|-----------|-------------|
| 18-21 | 17% | 15% | 28% |
| 22-30 | 58% | 58% | 46% |
| 31-40 | 18% | 18% | 22% |
| +41 | 7% | 9% | 4% |

Marital Status

| | | | |
|-----------|-----|-----|-----|
| Unmarried | 75% | 70% | 74% |
| Marries | 25% | 30% | 26% |

Self Labeling

| | Hyderabad | Bangalore | Pondicherry |
|----------------|-----------|-----------|-------------|
| Kothi | 52% | 36% | 64% |
| Panthi | 15% | 11% | 12% |
| Double-decker | 15% | 42% | 19% |
| Heterosexual | 1% | 2% | 4% |
| Homosexual/gay | 15% | 8% | 1% |
| Other | 2% | 1% | - |

Multiple partners in previous month

| No. of partners | Hyderabad | Bangalore | Pondicherry |
|-----------------|-----------|-----------|-------------|
| 1-3 | 4% | 22% | 22% |
| 4-6 | 6% | 18% | 20% |
| 7-10 | 6% | 13% | 26% |
| 11-15 | 5% | 12% | 14% |
| 16-20 | 15% | 13% | 10% |
| 21-30 | 25% | 13% | 7% |
| 31-50 | 19% | 7% | 1% |
| 51+ | 20% | 2% | 0% |

Anal sex in previous month

| | Hyderabad | Bangalore | Pondicherry |
|--------------|-----------|-----------|-------------|
| Insertive | 24% | 35% | 23% |
| Receptive | 76% | 65% | 77% |
| Total number | 7029 | 3754 | 2182 |

Condom used

| | | | |
|----------------|-----|-----|-----|
| Insertive acts | 35% | 45% | 34% |
|----------------|-----|-----|-----|

¹⁸ see *Situational Assessments among MSM in four cities in South Asia, 2000: Bangalore, Hyderabad, Pondicherry and Sylhet*, an NFI study for Family Health International

| | | | |
|----------------|-----|-----|-----|
| Receptive acts | 29% | 45% | 36% |
|----------------|-----|-----|-----|

Reported symptoms

| | Hyderabad | Bangalore | Pondicherry |
|--------------------------|-----------|-----------|-------------|
| Pus/discharge in stools | 7% | 0% | 0% |
| Penile pus/discharge | 13% | 2% | 0% |
| Genital sores | 16% | 1% | 9% |
| Oral sores/blisters | 16% | 3% | 3% |
| Bleeding when defecating | 22% | 2% | 16% |
| Rash on genitals | 25% | 5% | 13% |
| Pain when defecating | 28% | 7% | 0% |
| Pain while urinating | 29% | 10% | 31% |
| Rectal itching/burning | 30% | 9% | 28% |
| Pain during sex | 37% | 9% | 0% |
| Others | 19% | 1% | 0% |

Treatment

| | Hyderabad | Bangalore | Pondicherry |
|-----------------|-----------|-----------|-------------|
| Nothing | 40% | 62% | 30% |
| Pharmacy | 20% | 1% | 7% |
| Private doctors | 20% | 7% | 35% |
| Hospitals | 27% | 27% | 28% |
| Others | 24% | 3% | 0% |

Knowledge and awareness

| | Hyderabad | Bangalore | Pondicherry |
|---------------------------------|-----------|-----------|-------------|
| <u>Have you heard of AIDS?</u> | | | |
| Yes | 71% | 85% | 57% |
| No | 29% | 15% | 43% |
| <u>What have you heard?</u> | | | |
| An STD | 5% | 5% | 3% |
| Multiple partners | 7% | 2% | 0% |
| Sex with an FSW | 7% | 15% | 10% |
| Not using condom | 10% | 38% | 3% |
| No idea | 14% | 7% | 36% |
| Dangerous disease | 57% | 30% | 42% |
| Bad sexual relations | - | 3% | 6% |
| <u>Personal risk assessment</u> | | | |
| Large | 47% | 3% | 54% |
| Small to medium | 7% | 39% | 7% |
| Don't know | 46% | 58% | 39% |

How can you get infected with HIV?

| | Hyderabad | Bangalore | Pondicherry |
|-----------------------------------|-----------|-----------|-------------|
| Oral sex | 33% | 27% | 43% |
| Sexual contact with a woman | 19% | 23% | 34% |
| Vaginal sex without a condom | 67% | 75% | 59% |
| Anal penetration without a condom | 63% | 72% | 63% |
| Sharing needles | 65% | 56% | 71% |
| Deep kissing | 23% | 10% | 22% |
| Swallowing semen | 49% | 37% | 39% |

Prevention

| | Hyderabad | Bangalore | Pondicherry |
|--------------|-----------|-----------|-------------|
| Using condom | 47% | 36% | 54% |
| Don't know | 37% | 30% | 33% |
| Others | 16% | 34% | 13% |

See Annex 2 for an attempt to map MSM behaviours and networks

Uttar Pradesh

Demography

Total population in UP: 166,052,289
Males: 87,466,301
Females 78,586,558

Gender ratio: 2001 898 females per 1000 males

Workers Ratio 2001: 32.63%

Literacy rate: 57.36%
Males: 70.23%
Females: 42.98%

Per capita income: Rs. 9,721
National average: Rs. 16,487

All data drawn from the 2001 Census obtained from www.upgov.nic.in/upinfo/census.htm accessed on 12th January, 2003.

In Delhi, 21.50% of migrants are from U.P.
(from http://delhiplanning.nic.in/Economic%20Survey/chapter_3.htm, accessed on 12th January, 2004)

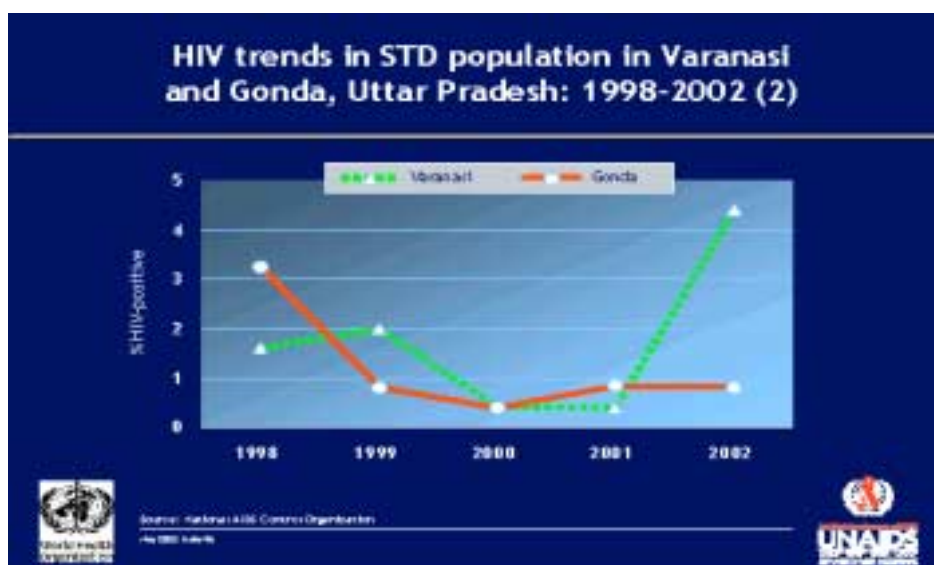
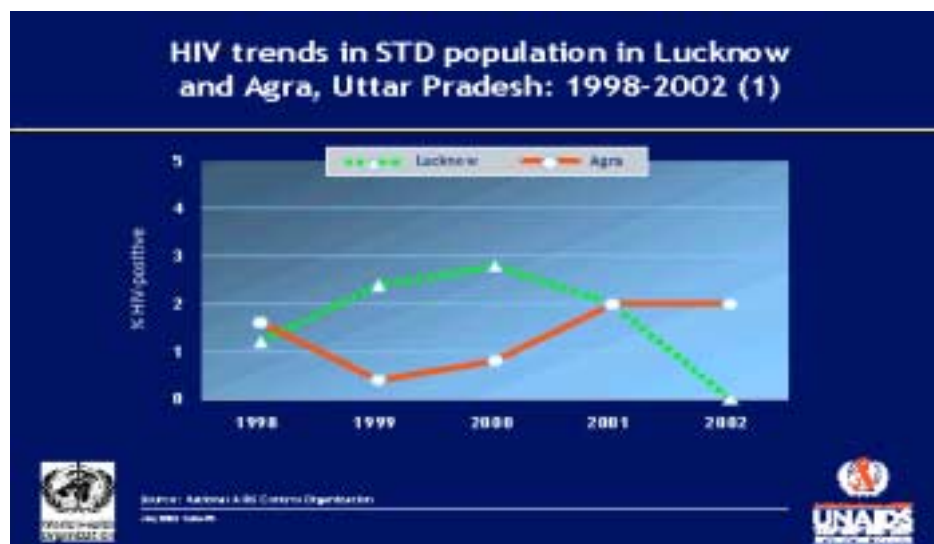
HIV/AIDS

There appears to be very little information on STI/HIV prevalence in the state. According to NACO, as of 30th November 2003, 1202 cases of AIDS have been reported¹⁹.

¹⁹ see NACO website – <http://www.naco.nic.in/indiascene/overv.htm>, accessed 12 January 2004

From the same data source and in terms of HIV prevalence:

| Nature of testing site | No of sites | HIV Prevalence |
|------------------------|-------------|----------------|
| STD clinic | 17 | 0.80% |
| Anti-natal care clinic | 17 | 0.25% |



Charts accessed on 12th January 2004 from http://www.unaids.org/html/pub/topics/epidemiology/slides09/HIVTrendsSTDPopns_UttarPradesh.htm

Uttar Pradesh is thus defined as a low-prevalence state. However, the data above should not be taken as the definitive statement of HIV rates in the state because of poor data collection and a lack and inadequate testing facilities.

MSM in Uttar Pradesh

A mapping of vulnerable groups in Uttar Pradesh that included MSM was conducted by ORG Centre for Social Research²⁰. However, the author was unable to review the methodologies, data collection procedures, study protocols, as well as the questionnaires used.

Looking at the data presented in this report, it does appear that this is an inadequate study and presents a false picture of the size estimations being presented, perhaps for reasons identified above. For example, under Lucknow, the report states that there were 21 sites and an MSM population level of 262. But, in a 1997 NFI study in Lucknow, 400 MSM were contacted and interviewed and their guestimate of the numbers of *kothi*-identified males in the city was 3000, excluding the number of their male partners. A simple calculation in terms of the number of different partners that these *kothi*-identified males access in a month (see below) would give a minimum figure of approximately some 40,000+, and this in Lucknow only!

Bharosa Trust was formed soon after this NFI study was completed as an MSM CBO providing sexual health promotion. This small-scale unfunded organisation with inadequate staffing who work part-time and a small drop-in centre has been able to access over 4000 *kothi*-identified males since then. This appears to be a clear indication of the poverty of the ORG study.

Apart from these two studies, no MSM mapping exercise has been done in Uttar Pradesh, either with the general male population, or among self-identified MSM categories. Thus it is impossible to give any adequate data on size estimations, even guestimates.

It is however fairly certain that there would be no significant difference between male sexual behaviours in Uttar Pradesh than in other parts of the country. Further, HIV infection amongst MSM may well be significantly high because several factors exist that make males in UP particular vulnerable. These include significant migration to major urban areas such as Mumbai and New Delhi for those seeking work, intra-state migration for similar reasons. Poverty, low education levels, poor health service infrastructure, lack of quality STI clinical facilities, major trucking routes, and so on add to this vulnerability.

From the NFI study on the risk and needs assessment amongst males who have sex with males in Lucknow²¹ where 400 self-identified MSM were interviewed in 1997.

Age

| Age range | % of respondent |
|-----------|-----------------|
| 16 – 21 | 29.50 |
| 22 - 35 | 50.25 |
| 35 – 49 | 17.00 |
| 50 - | 3.25 |

²⁰ Mapping Of Population Groups Vulnerable to HIV/AIDS In Uttar Pradesh, submitted to Uttar Pradesh State AIDS Control Society, Compiled by ORG Centre for Social Research, New Delhi, October 2003

²¹ NFI publication, 1998 funded by Department for International Development, UK

Marital Status

| Marital Status | % of responder |
|--------------------|----------------|
| Married | 40.50 |
| Unmarried | 59.50 |
| N-238 | |
| Intending to marry | 96.64 |

Self-identities

| Label | % of responder |
|-----------------------------|----------------|
| Kothi | 39.00 |
| Giriya | 14.00 |
| Double-decker ²² | 6.50 |
| Gay | 5.00 |
| Homosexual | 3.75 |
| No identity given | 31.75 |

Frequency of different sexual partners in previous six months

| Quantity | % of respondent |
|----------|-----------------|
| 0 | 0 |
| 1-5 | 3.00 |
| 6-14 | 18.00 |
| 15-30 | 26.00 |
| 30+ | 53.00 |

Current sexual practice

| Sexual practice | % of respondents |
|-------------------------|------------------|
| Body rubbing | 74.50 |
| Anally penetrated | 30.25 |
| Be anally penetrated | 68.25 |
| Give oral-penile sex | 85.50 |
| Receive oral-penile sex | 49.50 |

Female partners

162 respondents (40.50%) stated that were married and had regular sex with their wives. 31.50% of these reported sex with sexual encounters with other women, while 30% of unmarried males reported sex with females.

Knowledge

In this 1997 study, 62.25% of respondents had no knowledge of HIV/AIDS, while only 6.00% had good knowledge.

Condom use

82% of respondents never used condoms, while 48% experienced some form of STI symptom in the past two years.

In conducting this study, MSM researchers stated that they had no difficulty identifying the 400 primarily *kothi*-identified MSM to interview. There were sufficient indications and anecdotal reports that provided evidence to show that MSM **as a behaviour** was substantive and spread across economic

²² Double-decker, or sometime known as two-in-one is a *kothi* term referring to those males who are penetrated and penetrate other males

groups, classes, employment and education, and that the majority of such behaviours take place outside the sexual orientation dynamic.

Bharosa, as far as can be determined, is the only MSM managed HIV/AIDS project in Uttar Pradesh. To this date, it has never received any funding, state or otherwise, and exists through small donations.

MSM, Vulnerability and Stigma²³

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

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

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

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

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

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

Many *kothis* and *hijras* not only face harassment, sexual violence and rape from law enforcement agents, but also from those whom they have called friends in schools and colleges, from those in positions of trust such as relatives, neighbourhood elders, elder friends, and teachers. Gang rape is not uncommon. And of course such forced sex is always unsafe and often results in serious physical injury

²³ See NFI Briefing Paper No. 7: Social Justice, human rights and MSM

such as a ruptured rectum, internal haemorrhage and so on.

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

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

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

Strategies for intervention and address vulnerability

Apart from vulnerability to STI/HIV infection through unprotected anal sex, multiple partners, low condom use, and low access to early STI treatment, *kothis/hijras* and their sex partners also act as a “bridging population” to both the female population through marriage and sexual encounters with other females, but also to the general male population where most of their male sexual partners come from.

It is also clear that legal, judicial, political and social advocacy would be urgently needed that not only address rights abuse through living with HIV/AIDS, but also will need to include rights for MSM, as well as challenging accepted notions of masculinity and femininity so that discrimination and stigmatisation, social exclusion and marginalisation can be effectively challenged as they confront the daily lives of *kothis* and *hijras*.

NACO policy is reflected in its AIDS Prevention and Control Policy document, where to quote:

7. Implementation Strategy

*7.5 As socially marginalised sections like commercial sex workers, injecting drug users, street children, men having sex with men, etc. are not normally accessible through traditional government machinery, involvement of non-Government organisations and community-based organisations should be secured to effectively reach these populations through a holistic approach of targeted intervention programmes. These programmes should aim at prevention and control of sexually transmitted diseases, deliver relevant IEC messages which are in the local idiom and are interactive in nature, promote condom use for effective prevention of the spread of HIV/AIDS and create an enabling environment that reduces vulnerability of these groups...*²⁴

However, while NACO policy is clear about mobilising MSM networks to delivery a range of “targeted interventions... to reduce the spread of HIV/AIDS”, this is compromised by social, legal and judicial impediments, particularly in regard to behaviour. IPC 377 that criminalises “sexual behaviour against the order of nature” which is legally defined as sodomy (anal sex), oral sex, mutual masturbation, thigh sex. This law has been primarily used against males who have sex with males. It is also used to arrest and harass MSM who are conducting outreach activities who are often accused of acting under the guise of “promoting homosexuality”, even though the policy of the Health Ministry clearly states that “promoting condom use” should be a part of an intervention strategy amongst MSM.

²⁴ from the NACO website, <http://www.naco.nic.in/nacp/ctrlpol.htm>, accessed 8th January 2004

With all these considerations in mind, the following recommendations are being made:

1. Social and Needs Assessments

The lack of knowledge, understanding and data on MSM behaviours, dynamics and social constructions make such activities and individuals invisible. Such invisibility denies that access to appropriate services to prevent the spread of STI/HIV amongst them and their partners. There is an urgent need to conduct a range of such assessments as soon as possible with appropriate research institutions and individuals that involve MSM themselves. This could be achieved through building the research skills of MSM themselves and partnering researchers involved in these studies. Confidentiality must be assured, and the researchers themselves will need training and sensitisation in regard to MSM dynamics and issues. These should be conducted in each of the significant urban areas, along with major village and small towns.

2. Increasing Coverage

It is clear from what has been stated in this paper, that many MSM are highly vulnerable to STI/HIV infections, while being highly socially discriminated against increasing their vulnerability. At the same time, apart from a small unfunded MSM CBO service in Lucknow, no specific MSM intervention exists.

2.1 Lucknow

Bharosa Trust has provided a small MSM intervention programme since 1997 reaching some 4000 MSM in this period. It has been implementing a service model developed by NFI, which is also being implemented by other MSM CBOs that NFI works with in India. It has received no funding support and works through dedicated part-time staff. Since NFI is also based in Lucknow, it has provided external management support to *Bharosa*.

It is recommended that *Bharosa Trust* should receive funding to upgrade the skills of its current staff, recruit new staff, and expand its prevention activities across the city of Lucknow.

2.2 Uttar Pradesh

Naz Foundation International has developed a model for rapid scaling up process that has been tested in Bangladesh and also is currently being implemented in Andhra Pradesh. This model is based on community building and mobilising using kothi-identified males as service providers.

The model consists of developing an MSM CBO nodal agency in the State capital that provides services in that capital and which develops networks in other urban environments across the state. Through assessments, specific cities can be identified with there are significant populations of MSM who are at risk, and through them implement a local level CBO providing services in that particular city.

Through experience, NFI (and others) have found that utilising non-MSM NGOs to implement an MSM intervention programme does not have sustainability since these NGOs do not involve MSM in decision making processes of ownership of the services being provided.

It is suggested that while *Bharosa Trust* is being upgraded to become the MSM CBO nodal agency in Uttar Pradesh, other NGOs are identified who can begin an intervention process supervised by *Bharosa* whereby each of these NGOs develop an implement an MSM CBO in their locality. These emergent MSM CBOs will then form a network, with *Bharosa* as the lead agency.

Since *Bharosa Trust* is a partner agency of Naz Foundation International, access to training, BCC, and other tools will be possible.

Such scaling up across the State should be possible with a five-year period.

See Annex for the NFI model of development and Service Provision Model.

3. STI Clinical Services

Early treatment of STIs is a significant factor in reducing vulnerability to HIV infection. However, *kothi*-identified males tend to exhibit anal STIs while the knowledge that is demonstrated by STI clinicians tend to be based on penile/vaginal STIs. In fact there is no appropriate training, information or protocol that deals with anal related STIs.

For effective STI treatment programme, doctors will need to be sensitised to the needs of *kothis* and other MSM in regard to anal (and of course penile) STIs, female partners of MSM, confidentiality, not only about infection but also about sexual behaviours. Further, protocols will need to be developed that deal with anal infections and symptoms.

Clinics then will need to be ascertained as to whether they are suitable and appropriate to the needs of MSM, and the local intervention agency can refer MSM to them for early treatment.

Another possibility, and one which this author prefers, is for *Bharosa* and others like it, to house a STI clinical service within the project itself. This will enable better monitoring and evaluation of service provision and data collection.

4. VCTC

Appropriate Voluntary Testing and Counselling Centres are an essential component for any effective intervention strategy. This is even more so for at-risk MSM. However, it will be essential to ensure that all staff at such a Centre are thoroughly sensitised to the issues of MSM, have a clear understanding of the dynamics of MSM constructions, can provide strict confidentiality, appropriate counselling (both pre- and post-test), as well as ensure that such MSM can access appropriate support and care services. Well supported links will need to be established with MSM service providers.

5. Condom and lubricant

Many at-risk MSM have significant levels of penetrative sex on a regular basis, so it will be essential that sufficient good quality condoms are easily and cheaply available at different outlets. Further since condoms suffer additional stress when used for anal sex, it will also be essential to ensure that adequate supplies of affordable water-based lubricants suitable packaged are also readily accessible.

6. Counselling

Any MSM intervention must include appropriate counselling on psychosexual and personal concerns. As mentioned above, many feminised MSM such as *kothis* and *hijras* have low-esteem and a deep sense of disempowerment and self-hatred which leads to higher levels of risk and self destructive behaviours. With all this there are deep issues of concern around families, wives and children that also must be addressed, particularly in regard to family knowledge of sexual, STI and HIV status.

7. Advocacy and legal issues

As discussed in the body of this paper, stigma, discrimination and social exclusion are central in many at-risk MSM, particularly those with feminised identities, such as *kothis* and *hijras*. Legal and judicial impediments to effective community-based interventions among MSM will need to be address. Advocacy will need to be conducted with legal and judicial services, as well as parliamentarians towards addressing these concerns, in particular Section 377 of the Indian Penal Code.

Further, advocacy work will need to be conducted with the media and the public to destigmatise MSM behaviours, while MSM will need to be trained on their legal rights.

8. Training of the judiciary and law enforcement agencies

As an urgent necessity, the judiciary and local law enforcement agencies will need to be sensitised to the issues of MSM, their own STI/HIV risks, and the needs of specific MSM sexual health interventions. This will mean a closer relationship between Home and Health Ministries as well as the judiciary and police forces.

9. Working with other NGOs general male population

As discussed above, the MSM category does not only include feminised males, but also their more “manly” partners who are from the general male population and do not define themselves as MSM. While it will be possible to access many of these males through their *kothi/hijra* partners, it will also be necessary to ensure that any HIV/AIDS awareness programme and specific interventions with particular occupational groups, such as rickshaw drivers, auto-drivers, truck-drivers, factory workers, street children and so on, must include anal sex as a risk factor in HIV and not only discuss female sex workers and vaginal sex. This will mean collaborative work with other HIV/AIDS and sexual health NGOs working with the general male population. This will further require that these NGOs will need to be sensitised and educated about the dynamics of male-to-male sexual behaviours in Indian society.

10. IEC materials

Education and sexual health promotion materials can be an effective component of any intervention towards preventing the spread of STI/HIV/AIDS. However to be such it requires that such resources are meaningful to their users. This will mean ensuring that appropriate language and imagery are used that makes sense to those accessing these resources.

11. Funding and commitment

It is clear from what has been discussed above that at-risk MSM are a substantive population which are extremely vulnerable to HIV in terms of themselves, but also in regard to the general population through their bridging role. Therefore, it makes sense to ensure that support for MSM led interventions is also substantial, significant, and that a strong commitment from government and donors is made. Funding needs to be adequate and at appropriate levels to achieve this, and should be provided to the appropriate agencies, while assistance is also provided to develop such agencies. UNAIDS and others strongly believe that community-based agencies are the appropriate and best interventions agencies. In the case of this paper, this means MSM based and owned agencies would be appropriate.

12. Women’s sexual health

As discussed above, many MSM, both feminised and manly, are married, or will get married. Further substantial numbers of manly MSM also access female sex workers and other females. It is therefore essential that women’s sexual health needs are taken on board by any service provider in the field of MSM sexual health and HIV/AIDS prevention. This will mean that all training programmes should also discuss risks for women and children, and women’s sexual health services should also be cognisant of MSM behaviours and patterns. STI and VCTC providers will also need to be sensitised to this issue.

Certainly these primary recommendations for action are not the only areas that need to be developed. There are others that perhaps can be seen to be as equally important. Discussions should be initiated with local experts in the field of MSM sexual health so that a comprehensive strategy can evolve that is significant, sustainable, and well supported. It will require a strong political and social will to achieve this.

Annex 1

Naz Foundation International

Institutional Work

| | |
|-------------|--|
| 1996 – 1997 | Ford Foundation Sexual Health Risk Assessment of male-to-male sex in Dhaka, Bangladesh |
| 1997-1998 | DFID Sexual Health Risk Assessments of male-to-male sex in Lucknow and New Delhi, India |
| 1999-2000 | FHI ARO Social and Behavioural Assessments of male-to-male sex in Bangalore, Hyderabad and Pondicherry, India, and Sylhet in Bangladesh |
| 2001-2002 | World Bank Social and Behavioural Assessments of male-to-male sex in Lahore, Pakistan |
| 2002 | UNDP India Impact of legal, socio-cultural, legislative and socio-economic impediments to effective HIV/AIDS intervention with MSM in Bangladesh (in conjunction with Bandhu Social Welfare Society) |
| 2002-2003 | Catalyst Consortium Study on the formulation of sexual and reproductive health behaviour among young men in Bangladesh |

Naz Foundation International

NFI Documents

December 2003

1. Under The Blanket: bisexualities and AIDS in India, Shivananda Khan, in Bisexualities and AIDS, Taylor and Francis, 1998
2. Through a window darkly: males selling sex to males in Bangladesh and India, Shivananda Khan, in Men Selling Sex, Taylor and Francis, 1998
3. Conspicuous by their absence? - men who have sex with men (MSM) in developing countries - implications for prevention - a joint paper with Richard Parker and Peter Aggelton, published in Critical Public Health, 1998
4. Interventions for men who have sex with men in developing countries - joint chapter with Peter Aggleton and Richard Parker, in Preventing HIV infection in developing countries, editor: L. Gibney, R. DiClemenete & S. Vermund, New York: Plenum, 1998
5. HIV and men who have sex with men: perspectives from selected Asian countries with Roy

- Chan, Ashok Row Kavi, Greg Carl, Dede Oetomo, Michael Tan and Tim Brown, 1998
6. Males who have sex with males (MSM) and HIV/AIDS in India: The Hidden Epidemic: Gregory Pappas, Omar Khan, Jason Taylor Wright, Shivananda Khan, Lalitha Kumaramagalam, Joseph O'Neill, AIDS and Public Policy Journal, 2001, Vol. 16, No. 1/2, pp4-17

Briefing Papers

1. Actions for Life, 1999
2. Community Mobilising, 1999
3. Developing community-based sexual health services for males who have sex with males - The Process, 1999
4. The Kothi Framework, 2000
5. Anal sex and STIS, 2002
6. MSM and female partners, 2002
7. Social justice, human rights and MSM (2002)
8. The context of social constructions of masculinities in south Asia the kothi framework (2002)
9. Know Your Rights
10. MSM and a rights-based approach to prevention

Pukaar – NFI quarterly journal

NFI Training Manuals and Handbooks

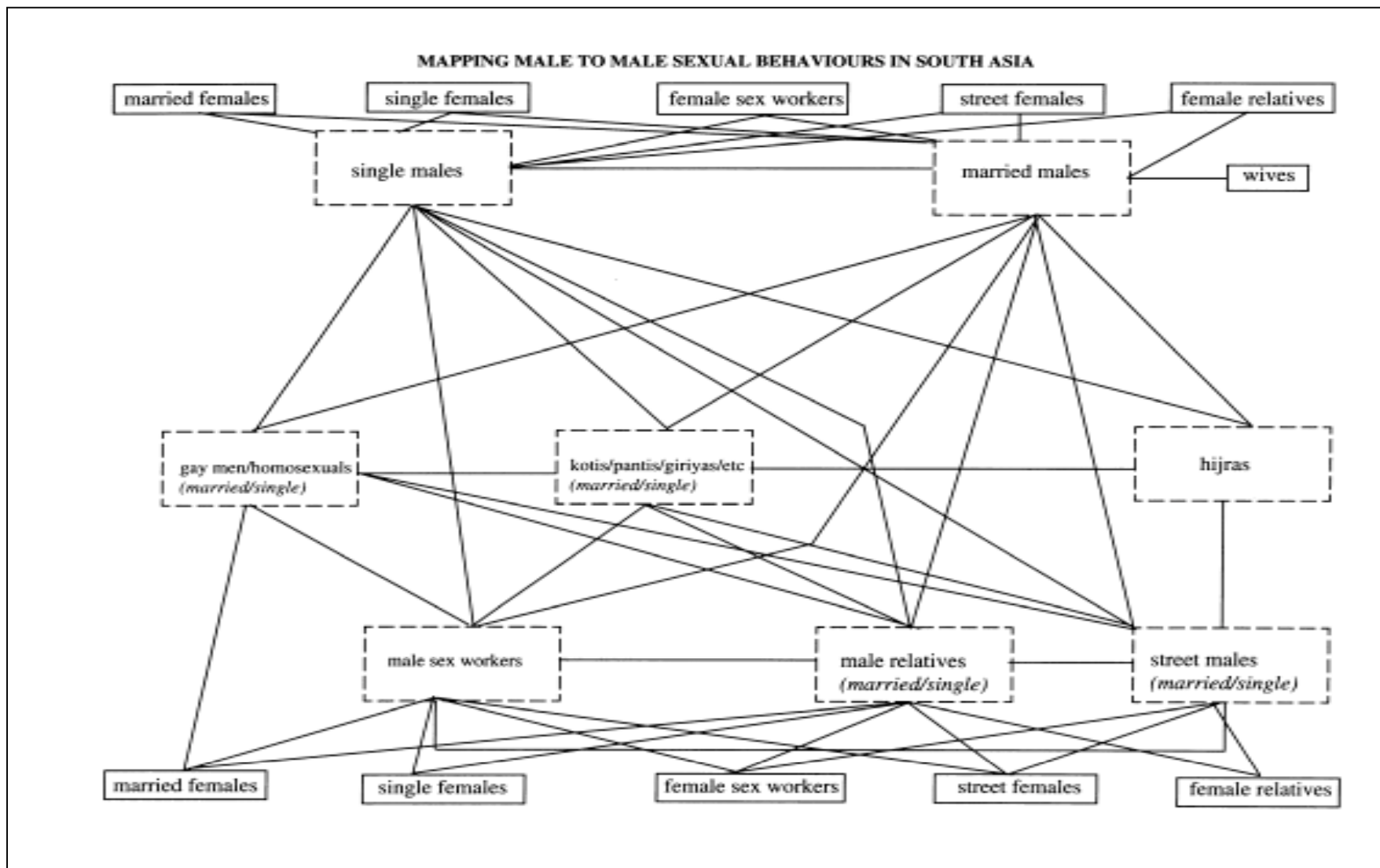
1. Jagruti - developing a street performance group in New Delhi promoting HIV/AIDS awareness and safer sex - a training pack including a video and manual, March 1998
2. Project Workbook - consists of a range of resources to assist new and emergent sexual health promotion projects, including sample monitoring forms, job descriptions, policies and guidelines.
3. Project development Volume I: a training manual for management and field staff for MSM sexual health agencies - includes over 60 overheads.
4. Project development Volume II: a training manual on capacity building and project management of MSM sexual health projects.
5. Male to male sexualities and sexual behaviours in south asia - a training manual for reproductive and sexual health agencies and policy makers.
6. Male sexual behaviours and STD/HIV prevention: a training manual for peer educators
7. Handbook for developing MSM community-based organisations for implementing sexual health projects, 2001

Naz Publications

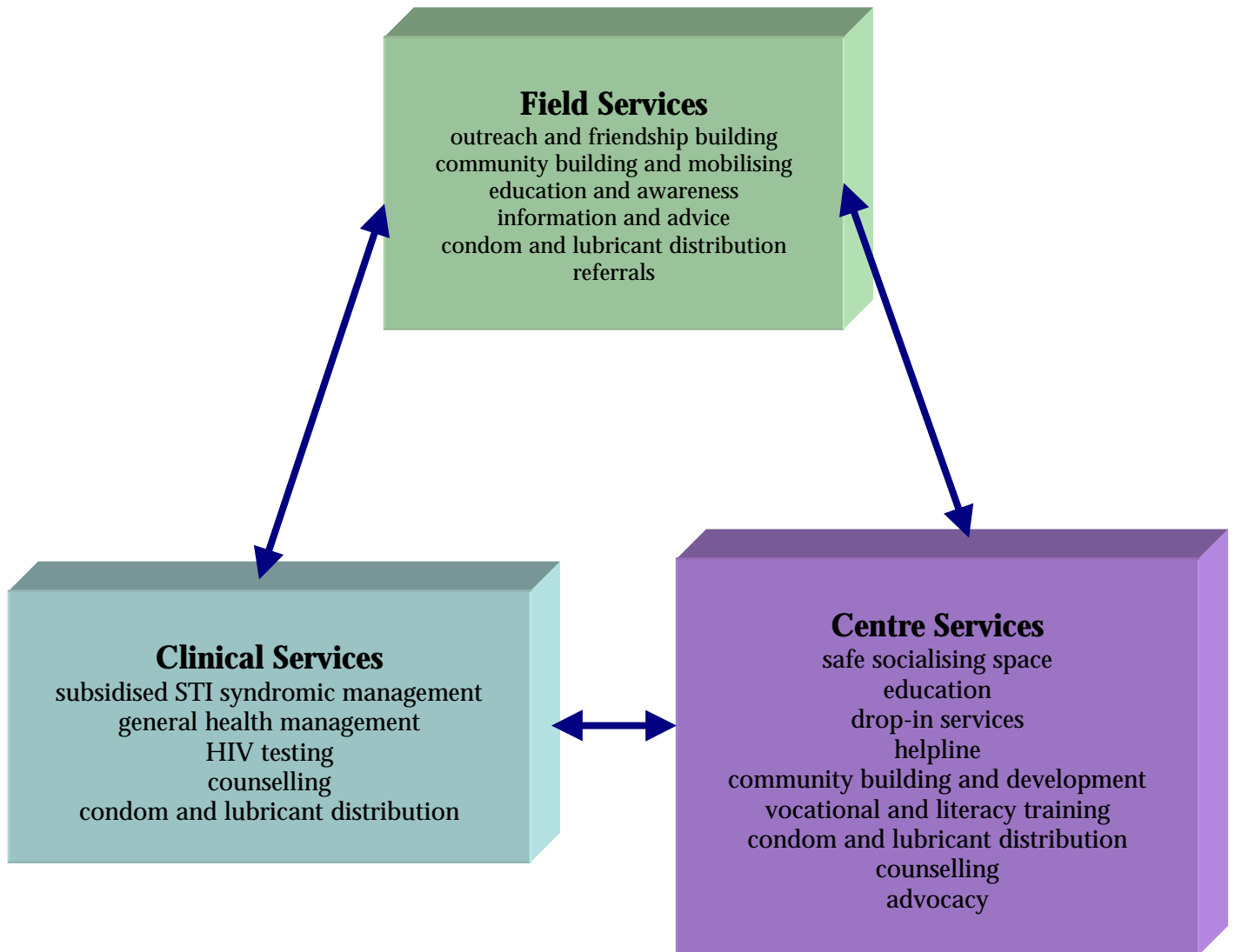
1. **The KHUSH Report:**
Report on the needs of South Asian lesbians and gay men in the UK based on research conducted by The Naz Project, 1991
2. **Challenge and Response:**
a report on the First European Conference on HIV/AIDS for the Muslim and South Asian Communities, held by The Naz Project 1992
3. **Sexuality and Sexual Behaviour in India:** A Naz Report, 1993
4. **History of Alternate Sexualities in South Asia:** Report on a 3 day seminar, New Delhi, India, 1993, organised by Sakhi and sponsored by Naz Project
4. **Contexts - Race, Culture and Sexuality:** Report and needs assessment on South Asian communities, based on analysis and research by The Naz Project, 1994
5. **Emerging Gay Identities in India - Implications for Sexual Health:** Report on a conference held in Bombay, organised by Humsafar Trust and sponsored by Naz Project, 1994

6. **Developing Appropriate Strategies:** Report of a Consultation Meeting of representatives from non-governmental organisations working on HIV/AIDS prevention and care issues within Muslim countries/communities, held in Karachi, Pakistan, hosted by The Naz Project and Pakistan AIDS Prevention Society, October 1995.
7. **Making Visible The Invisible:** sexuality and sexual health in South Asia - a focus on male-to-male sexual behaviours, July, 1996
8. **Sexualities, Sexual Behaviours and Sexual Health:** consultation meeting of representatives from governmental organisations working on HIV/AIDS prevention issues from the Central Asian Republics, March, 1997
9. **Perspectives on males who have sex with males in India and Bangladesh,** September, 1997
10. **Sex, Secrecy and Shamefulness - developing a sexual health response to the needs of males who have sex with males in Dhaka, Bangladesh,** 1998
11. **Risk and needs assessment amongst males who have sex with males in Lucknow and New Delhi - a report,** 1998
12. **Report on the South Asia regional consultation meeting on male reproductive and sexual health and hiv/aids,** held in Calcutta, India, 4th - 7th March, 1999 for males who have sex with males, organised by NFI
13. **Situational Assessments among MSM in four cities in South Asia,** 2000: Bangalore, Hyderabad, Pondicherry and Sylhet, an NFI study
14. **Report on the NFI partners Conference,** held in Hyderabad, 7th-10th December 2000
15. **Social Assessment and mapping of MSM in Lahore, Pakistan, an NFI study** 2002, World Bank
16. **The impact of legal, socio-cultural, legislative and socio-economic impediments to HIV/AIDS intervention with MSM – an NFI/BSWS study conducted in Bangladesh,** UNDP India, 2002
17. **Report on the 3rd NFI Regional MSM Consultation Meeting,** 5th – 7th April 2003, New Delhi India

Annex 2: Mapping MSM networks in India



NFI Sexual Health Promotion Service Model



NFI Model for MSM sexual health interventions

Introduction

The Naz Foundation International (NFI) has developed a model for the implementation of interventions for men-who-have-sex-with-men (MSM), their partners and families, to prevent HIV transmission and other sexually transmitted infections, and improve the general health and welfare of this group. The model has a number of key features, key processes and utilises a number of key tools. These are described below, and a summary of the model appears at the end of this paper.

Key features of the model

1. An intimate knowledge of MSM issues and needs

This is gained from:

- A range of studies and needs assessments that NFI has undertaken and documented over the last 7 years,
- Ongoing monitoring and evaluation from existing community based initiatives,
- Ongoing development of new research partnerships to address specific concerns.

2. A clearly defined community development strategy

This includes the development of state-level community based organisations (CBOs) addressing MSM behaviours, which in turn develop district-level activities within their state, with ongoing support from NFI.

3. A strong advocacy, policy and ongoing support strategy

The model includes a strong component of upstream advocacy and policy development, to help create a positive political, social, legal and policy environment for the work to be sufficiently well resourced and enabled. NFI also provides a range of ongoing support activities to MSM intervention programmes.

Key processes

1. State/country MSM CBO programme development

Using an NFI developed framework and tools, NFI provides training and support to develop new or existing state or country partner organisations to undertake needs assessments and develop MSM led CBO programmes.

2. Scaling-up across a state/country – support for local MSM CBO programme development

Building on established State level MSM CBO programmes, NFI provides support and training for these CBOs to develop locally based MSM led CBO programmes across their states.

3. Upstream advocacy and policy development and ongoing support

A range of upstream advocacy and policy development work is undertaken to create the necessary political, social, legal and policy environment for the resourcing and enabling of state and district level MSM CBOs services to take place.

NFI also provides a range of ancillary support services to the MSM CBO programmes, which includes regular training events, provision of a monitoring and evaluation service, help in developing intervention resources and organisational development support.

Key Tools

NFI has developed a broad range of comprehensive tools for MSM CBO development which includes:

- Training manuals, guidelines and handbooks specific to the needs of MSM led CBO programmes,
- A monitoring and evaluation system,
- Model behaviour change communication resources for MSM CBO programmes.

Under development:

- An enhanced and computerised version of the monitoring and evaluation system,
- Multiple languages of the NFI MSM CBO development tool-kit,
- Anal sexually transmitted infection algorithm,
- Advocacy tool-kit.

Model Summary

A summary of the model, in terms of inputs, outputs and outcomes, processes and activities is described in the figure below:

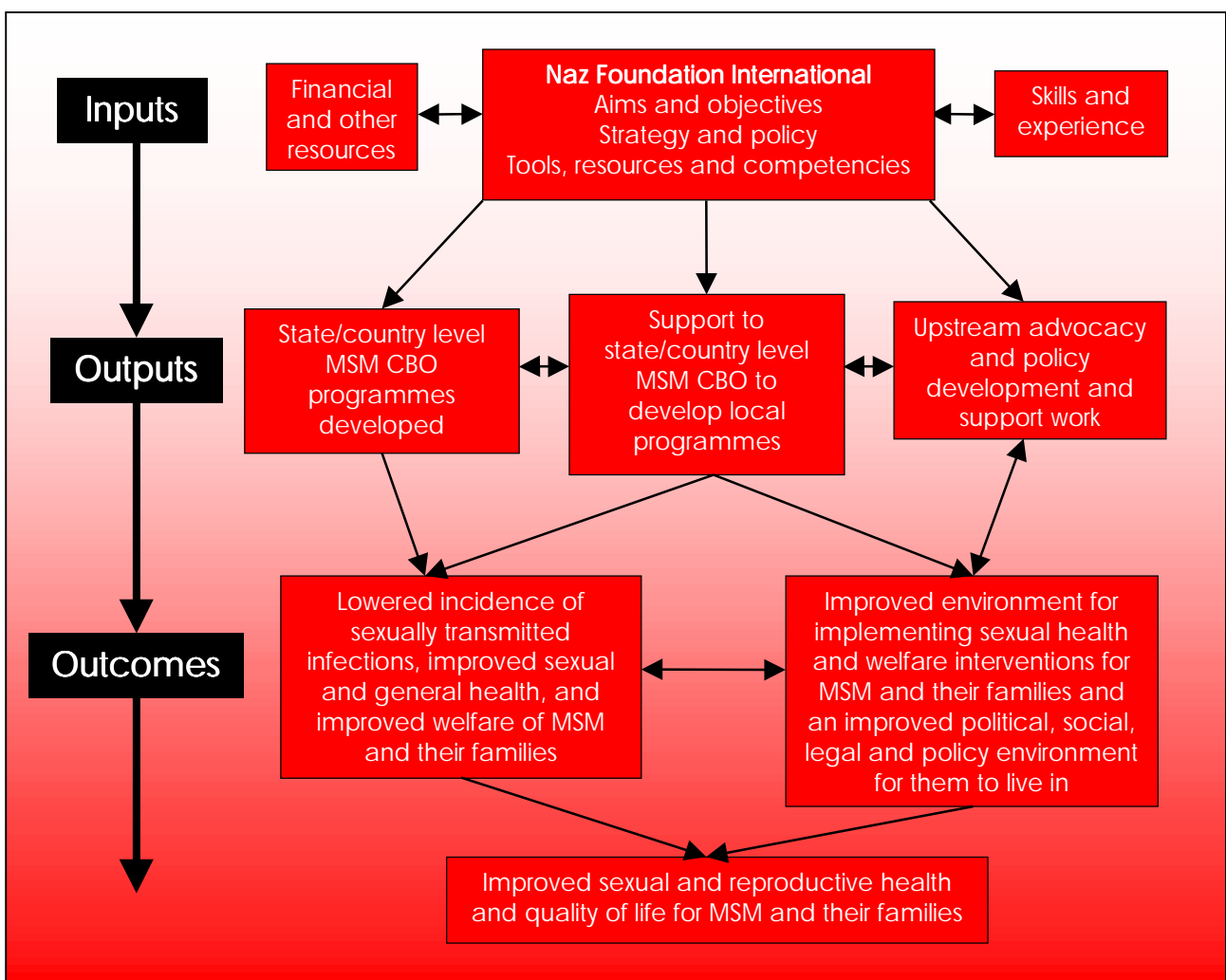


Figure: A summary of the NFI MSM intervention model, in terms of inputs, outputs and outcomes, processes and activities

