

Naz Foundation International

Briefing Papers

Naz Foundation International

providing technical, financial and institutional support to MSM collectivities, groups, and networks in Asia to empower them to develop and promote their own sexual health services

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World Health Organisation definition of Sexual Health

The integration of physical, emotional, intellectual and social aspects of sexuality in a way that positively enriches and promotes personality, communication and love.

Vision

We believe in a world where all people can live with dignity, social justice and well-being

Mission

With a primary focus on marginalised males who have sex with males, our mission is to empower socially excluded and stigmatised males to secure for themselves social justice, equity, health and well-being through technical, financial and institutional support.

What we believe

We work and advocate in the countries of South Asia and internationally to ensure that issues of masculinities, sexualities and all types of sexual practices, with social justice and human rights concerns that arise from them are appropriately and adequately addressed in the provision of HIV/AIDS and sexual health services.

We strongly believe in the innate capacity of local MSM collectivities, groups and networks to develop their own sexual health services through self-help organising and community-building. We will always support such initiatives through technical assistance and capacity building programme.

Objectives

- To empower low-income MSM collectivities, groups and networks through technical, financial and institutional support to develop and deliver self-help sexual health programmes addressing their needs.
- To work with other organisations, institutions, and agencies to improve the lives and well being of MSM.
- To advocate on social justice and human rights concerns of MSM.
- To foster cooperation, understanding and support between organisations developing responses to STI/HIV/AIDS and sexual health needs of males who have sex with males and those with other constituencies.
- To undertake research that highlight the issues and problems that marginalised and socially excluded MSM face, identify solutions and pro-actively promote the resultant findings, as well as understand the context of

masculinities and sexualities which lead to more effective and sustainable sexual health promotion strategies for MSM.

- To identify and leverage appropriate funds, resources and technical assistance to support the above activities.

A Services Overview

□ Regional MSM Self-Help Programme

Provides technical assistance programmes to empower and support local MSM networks to develop their own sexual health programmes through training, resources, and institutional development.

□ Regional MSM Training and Resource Centre

Based in Lucknow at the NFI Regional Liaison Office, the Centre provides a range of training programmes on issues relevant to MSM sexual health concerns, as well as a growing library on masculinities, male sexualities, gender and sexual health issues.

□ Regional Network of MSM Trainers and Consultants

NFI has also developed a Regional MSM Trainers and Consultants Network to provide local technical assistance support to MSM sexual health projects

□ Research

Develops, coordinates and institutes a range of research studies into issues that affect MSM, masculinities and male sexualities.

□ Advocacy

Working with donors, international, national and local government and non-government institutions and agencies to advocate on MSM sexual health and human rights concerns. particularly in regard to those who are socially excluded and stigmatised.

□ Partnership Programme

Working with our MSM partner agencies, NFI facilitates networking, sharing of information and skills, as well regional support to MSM sexual health projects through its Partnership Programme, and developing ARMAN – Asian Region MSM AIDS Network.

□ Resource Development

NFI regularly produces a range of resources, including BCC materials, Briefing Papers, Handbooks, and Training Manuals, along with its quarterly Journal, *Pukaar*, focusing on male-to-male sexual behaviours, masculinities and male sexualities.

**NFI Documents
December 2002**

Documents

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

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 (2002)
10. MSM and a rights-based approach to prevention (2002)

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

Briefing Paper 1

Actions for Life

developing sexual health services for males who have sex with males

February 1999

Introduction

The challenge of HIV/AIDS confronts all countries and communities globally, and whilst the countries of Africa are confronted with increasing numbers that are dying from AIDS, the countries of South Asia (as well as other Asian countries) stand before the abyss of an uncontrollable epidemic. It is clear that Government, non-government, and community-based agencies, as well as many other institutions, must work together to face this challenge if there is to be any hope of effective strategies to control and manage HIV transmission so as to reduce the levels and rates of infection and thus AIDS.

There is no vaccine for HIV, and whilst there are a range of medical treatments available to prolong life and reduce the impact of HIV related illnesses, treatment costs are prohibitive, particularly so for developing countries.

At this juncture, as we approach the end of the 20th century and enter into a new millennium, it seems that the only real hope is to ensure that the countries of South Asia and beyond, develop an effective STD/HIV prevention strategy that addresses **all** risky behaviours and practices. No country can afford to ignore or deny what occurs within it, whether it is a particular risky sexual practice or a stigmatised identity that is deemed to be immoral, illegal, or supposedly against its culture. Such denial and stigmatisation creates ideal conditions for an increasingly rapid spread of HIV infections across the country.

Over the last few years, Naz Foundation International has conducted a series of sexual health risk and needs assessment amongst males who have sex with males in South Asia as part of a process of providing technical assistance to local sexual networks to develop their own sexual health service provision. In this work, issues that were explored included sex behaviours amongst males who have sex with males (including

anal sex between males and also between males and females), their sexual health seeking behaviours, access to condoms and lubricants, socio-cultural constructions of sexual behaviours, sexual and gender identities, and appropriate (if any) sexual health service availability. Much of this work had to be done under a general framework of male sexual health, invisibilised and hidden, since male-to-male sex was clearly stigmatised and those involved victimised whenever such individuals and behaviours became part of the public arena.

It should be clearly recognised that because of denial, invisibility, stigmatisation and illegality (often under both religious and civil laws and codes), males who have sex with males already face considerable risks of harassment, violence, and perhaps imprisonment, if not death. HIV/AIDS creates another framework for further victimisation. It is therefore perceived to be incumbent upon all National AIDS Programmes and AIDS service organisations to explicitly work towards preventing stigmatisation and victimisation of males who have sex with males, as much as towards preventing STD/HIV infections amongst them as one of the central issues of concern. It would only be through such an approach that HIV/AIDS/STD prevention services could increasingly be more effective and more accessible by males who have sex with males.

It needs to be clearly recognised that whilst many in authority, both religious and secular, government and non-government, would prefer to promote sexual abstinence before marriage and faithfulness within marriage, that those who are involved in male to male sex should stop their behaviour, there will always be those for whom these are essentially public acts of obedience, whilst in private other more secretive behaviours often come into play.

The corollary to this is to fully accept that the only effective and appropriate HIV/AIDS education and prevention strategy to ensure that the spread of STDS and HIV/AIDS was controlled would be to also promote safer sex behaviours amongst males who have sex with males. Such promotion to be successful would also need to ensure that appropriate and accessible sexual health services are available which also respect their confidentiality and anonymity and build upon their trust and respect.

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

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

It also needs to be recognised that not all males who have sex with males are gay-identified, homosexual, or whatever label we may wish to give them. Patterns of male-to-male sex are complex, dynamic and fluid. There are many reasons as to why males have sex with males, and not all of them are to do with identity or desire.

At the same time it is also understood that not all males who have sex with males will access services provided by generic sexual health agencies for a range of reasons, no matter how sympathetic or understanding they may be. It is Naz Foundation International's contention that it would be more appropriate and effective if the beneficiaries of services were also the agents of change. This means that it would be necessary to support the development of peer-led community-based AIDS service organisations working with males who have sex with males.

This is about saving lives. Silence is not golden! It is about being honest and open and accepting. If we are truly involved in preventing the spread of HIV and AIDS in our countries, then it is time to look again, time to be truthful, time accept that people will do what they do irrespective of our own morality, judgements or beliefs.

Based on these concepts, understandings and principles the following recommendations have arisen from the work of Naz Foundation International:

1. Behavioural, epidemiological, and anthropological research

If we are going to develop strategies for changing risky sexual practices towards safer practices, and in the context of there being a vaccine or cure against AIDS, maintaining such safer practices over a lifetime, then we need to understand actual sexual practices. But understanding sexual behaviour does not arise from what individuals actually do, or many times they do within a given period. It arises from placing such behaviours within a given socio-cultural context. What influences such behaviours? Why do people do what they do?

- 1.1 There is a need for qualitative information on socio-sexual histories and behaviours amongst males who have sex with males, the impact of locality, economics, religion, and so on, on these behaviours. Such understanding within its socio-cultural context would enable effective strategies of persuasion to develop and evolve. This is an urgent priority.
- 1.2 This requires appropriate behavioural and anthropological research methodologies that include the subjects of such research both as subjects and as observers. Such inclusion will facilitate access as well as ensure that those being studied are involved in managing the study and what happens to the results following such a study. For this to be achieved, academics and research institutions will need to develop different approaches to such research and understanding. Such research would of urgent necessity be action-based, leading to clear outputs towards reducing the spread of STD/HIV/AIDS.
- 1.3 Such research should recognise the wide diversity of sexualities, male genders, identities, and sexual behaviours of the “target population”, which would include those whose primary sexual behaviours would be male to male, as well as those whose male to male sexual behaviours are intermittent, secondary and discharge based.
- 1.4 If individuals, male sexual networks, social groups, and “communities” involved in male to male sexual behaviours are to be empowered towards an increase in their health seeking behaviours, then more effective research needs to be done to identify as to who, how and why various sexual identities and genders are constructed, their specific meanings, and how they can determine desire and sexual behaviours.
- 1.5 Research should look at frameworks of support for males who have sex with males towards encouraging them to practice safer sex as a normative

behaviour, levels of knowledge, understanding and acceptance by medical staff and social service agencies regarding males who have sex with males and their sexual practices, and what would work in promoting sexual health in the differing sexual frameworks and networks of males who have sex with males. For such research to be effective would require males who have sex with males to conduct such research themselves.

1.6 Areas of research amongst males who have sex with males should also include:

- 1.6.1 prison populations
- 1.6.2 military personnel
- 1.6.3 overseas and migrant workers
- 1.6.4 rural male populations
- 1.6.5 males in educational establishments
- 1.6.6 occupational groups
- 1.6.7 male sex workers in a variety of settings
- 1.6.8 males in refugee camps
- 1.6.9 male domestic servants
- 1.6.10 male street children
- 1.6.11 male factory workers
- 1.6.12 male child sex abuse
- 1.6.13 male rape
- 1.6.14 early male sexual activities
- 1.6.15 male suicides

1.7 In conducting any such research amongst males who have sex with males, several significant questions must always be asked by researchers:

- Who is going to conduct the research
- How is it going to be conducted
- How is information going to be collected and by whom
- What questions are going to be asked, how are they asked, and in what language
- What terminology will be used
- How will the information be analysed and who will do the analysis and in what way will it be used
- How will the data be used in developing appropriate STD/HIV prevention and sexual health services

- Who will develop such services and who will work in them

2. Risk and needs assessments

What is the STD/HIV/AIDS situation in a given locality? What are the socio-cultural factors that can impede safer sex practices? What are the levels of STD/HIV in a given area? Who is involved in risky practices?

- 2.1 Before strategies for change can be implemented, there is an urgent need to develop appropriate risk and needs assessments amongst males who have sex with males within different sexual networks, and amongst those expressing differing sexualities, identities, genders, and behavioural frameworks. Such information is a pre-requisite for ensuring local participation and involvement in programme design and implementation. With local involvement in both management and conducting these risk and needs assessments, there is often a greater likelihood of ensuring the validity of data, an appropriate analysis of the data, and adequate protocols on confidentiality.
- 2.2 It is therefore important to ensure that adequate and sufficient funding is made available for such risk and needs assessments to be conducted.
- 2.3 At the same time such research must assure respondents that any data collected will not be used against them, that their confidentiality and anonymity will be respected, and that the information will only be used to develop appropriate strategies for the prevention of STD/HIV/AIDS amongst them with their support and assistance.

3. Developing community-based AIDS service agencies

To be fully effective, prevention strategies must incorporate the means to stop the spread of HIV infection through whatever behaviour. However many of these issues are taboo, and to publicly discuss them creates issues of shame, fear, anger and hostility which will lead to resistance and denial.

Who has seen any public debate in the countries of South Asia about anal sex? In fact Naz Foundation International has substantial anecdotal information on changes of behaviour from vaginal sex to anal sex because there has been no debate on anal sex. These males have assumed that such a silence indicates no risk!

At the same it is recognised that in the South Asian context, providing prevention services that address anal sex as well as male-to-male sex behaviours can be extremely problematic in an environment of shame, stigma and violence. Who can you trust?

It is also recognised that non-government community-based agencies are often more effective in accessing stigmatised groups and behaviours and empowering behaviour change.

- 3.1 Community based agencies developed by males who have sex with males themselves need to be supported so they can provide such HIV prevention programmes without undue harassment or hindrance and within the rubric of “harm reduction” and “male sexual health”. Individuals, networks and groups who are involved in differing frameworks of male-to-male sexual behaviours should be empowered to address these issues for themselves and develop their own sexual health service agencies.
- 3.2 Acknowledging the lack of technical skills in developing such community-based sexual health promotion agencies addressing male to male sexual behaviours, whether it be infrastructure, developing service delivery and implementation, project management, financial accountability, appropriate outreach strategies, monitoring and evaluation, resource design and development, needs assessments, or producing budgets and accounts, such emergent agencies should also be provided with technical assistance to access these skills through training and capacity building from appropriate consultants.
- 3.3 At the same time, all agencies providing family planning, HIV/AIDS prevention, STD treatment, and/or sexual health services, should also be providing services regarding anal sex behaviours, whether between males or between males and females. Anal sex is not a restricted behaviour to a few stigmatised individuals.
- 3.4 Further appropriate agencies need to be developed that work with prisons populations, juvenile homes, young offenders institutions, orphanages, the military, police, and migrant workers, around STD/HIV/AIDS and issues involving male to male sex.
- 3.5 National AIDS Control Programmes and State AIDS Cells should be directly involved with such community based agencies developed by males who have sex with males in ensuring effective distribution of appropriate sexual health

- products and educational resources (such as condoms, lubricants and literature) targeting male to male sexual behaviours. This will mean resourcing such agencies to provide such appropriate products and resources.
- 3.6 Different distribution strategies will need to be explored and developed by these community-based agencies, such as social marketing, free distribution as well as distribution in a wide variety of private and public locations. Government and non-government agencies should support the differing strategies.
 - 3.7 Appropriate peer-led education initiatives should be actively encouraged and supported. Safe spaces will need to be developed where individuals and groups can gain access to confidential information as well as discuss issues around sexualities and sexual health within appropriate contexts.
 - 3.8 Psycho-social support programmes will need to be a part of any on-going sexual health programme for males who have sex with males. These could include telephone lines ('hotlines') providing free and anonymous advice and information, social support groups, counselling, sexual health discussion groups, and other services deemed appropriate and needful by males who have sex with males themselves.
 - 3.9 In terms of risky sexual practices, and because of the nature of the *kothi* identity being based upon feminisation as a means to attract males and anal penetration where there are high levels of multiple partners and multiple acts of penetration, *kothis* represent an identified socio-identity network and an emerging community which is particularly vulnerable and at risk of STD/HIV infections.

As a part of the sexual activities, *Kothis* access many other males with differing identities and different sexual behaviour frameworks.

Kothi networks should be supported through appropriate empowerment processes towards enabling them to develop their own sexual health promotion services amongst several sectors of males who have sex with males. For this to occur they would need institutional and government support because *kothis* represent publicly stigmatised behaviours and identities.

- 3.10 This would require effective relationships with local police to be developed in regard to the levels of harassment and blackmail that many *kothis* face in public

- spaces. Such working relationships with police would also be necessary to ensure that outreach and field workers from any agency themselves would not be harassed by either police or local people.
- 3.11 Other male-to-male sexual communities, which perhaps would not access services provided by the *kothi* networks, will also need to be developed. Such service development could be organised by the other emergent male-to-male sexual community, perhaps those who are gay-identified, with appropriate support and assistance.
 - 3.12 Attitudes of doctors and other medical staff towards such stigmatised males and identities should be addressed through sensitisation programmes and appropriate regulations.
 - 3.13 Issues of human rights abuse, freedom to receive information that will protect lives, advocacy for the right to services, will need to be effectively addressed.
 - 3.14 Because so much male-to-male anal sex takes place outside “cruising sites” and external to *kothi/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 would include rickshaw drivers, female sex workers, truck drivers, educational establishments, factory workers, overseas workers, and prison populations, et al.
 - 3.15 Government institutions and services will also have to address these issues through the provision of appropriate training and sensitisation.
 - 3.16 Because of the religious, cultural, political and social issues that such intervention work may raise, it will be important to recognise that different, and possibly non-public, strategies may need to be developed for such interventions.
 - 3.17 There should be regular consultation between such community-based AIDS service agencies and National AIDS Control Programme and its local affiliates to ensure that issues, needs and service development for males who have sex with males are always reflected in any National AIDS programmes and strategies.
 - 3.18 Networking enables the sharing of appropriate skills, educational materials, knowledge and information, which can enhance the capacity of an AIDS service agency. This should be actively encouraged and supported by Government through the provision of any necessary technical assistance so that these agencies addressing the needs of males who have sex with males can access and actively

participate in local, regional, national and international forums dealing with similar issues of concern.

- 3.19 In order for such service development and sustained effectiveness, such community-based AIDS service organisations would need to be provided with long term funding which would include core costs as well as project costs and sustainability issues must be thoroughly explored with such AIDS service organisation to ensure programme continuity.
- 3.20 It is also important that all agencies providing HIV/AIDS education, prevention and support should be effectively monitored for the quality and appropriateness of their services and their accessibility in regard to males who have sex with males. Quality of service delivery in relation to male-to-male behaviours should be assured where public (and private) funding is being used, whether these services are being provided by males who have sex with males themselves or by other agencies.
- 3.21 In order to ensure that these agencies can deliver a high quality of service, it is essential that appropriate skills training be offered to the policy makers of these agencies, their management boards, staff, and volunteers, on the sexual health needs of males who have sex with males. Such skills training should include issues on understanding the contexts of such behaviours, destigmatising, developing appropriate outreach programmes, community involvement, designing education and intervention strategies, needs assessments, project management, monitoring and evaluation, and educational resource development.
- 3.22 This will require a multi-sectoral approach including the provision of good quality sex education, easy access to appropriate and cheap sexual health products and information, accessible STD services that are appropriate to the needs of differing males who have sex with males, appropriate counselling and support, and development of support structures for those males who have sex with males living with HIV/AIDS.

4. Education for prevention

Changing behaviour requires desire, will, skill and power. It also requires appropriate knowledge. In South Asian countries, sexual knowledge, accurate information about STDs and its treatment, correct understanding of HIV and AIDS is sorely lacking. 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 STD/HIV prevention.

- 4.1 The lack of appropriate and accurate sex education should be urgently addressed and would require government action in order to provide an effective sex education programme which should be made available for both the formal and informal education sectors. Such education should be aimed at children, youth and parents, be available in educational establishments, hostels, male institutions, informal sectors, factories, et al.
- 4.2 Appropriate peer-led education initiatives should also be encouraged and supported and individuals and families should be able to access non-judgemental premarital counselling on all reproductive and sexual health issues.
- 4.3 Society as a whole should be mobilised in creating appropriate awareness of HIV/AIDS. It is essential for the whole community to work together to ensure that education and prevention strategies are effectively implemented to prevent the spread of HIV.
- 4.4 These education and prevention strategies could utilise a wide number of formats including posters, electronic and print media, leaflets, videos, audio-cassettes, cinema, theatre and so on, and involve political and religious leaders, doctors, veds and hakims, business and union leaders. But it is essential that they deal with all risky practices.
- 4.5 This will mean that all religious, political, medical, social, community, media, and business leaders be offered awareness and sensitisation programmes on HIV/AIDS and related issues in order to incorporate them into community education.
- 4.6 There is a need for specifically targeted resources to be developed that are aimed at differing social, economic and behavioural groups, including medical staff, family planning clinics, religious teachers, educational staff, factory workers, hotel staff, and so on.
- 4.7 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.

- 4.8 At the same time there is an urgent need for a broad range of educational resources, reflecting the sexual practices of all males including those who have sex with other males, and these should be made available in appropriate format and distributed as widely as possible.
- 4.9 Males who have sex with males' community-based agencies should be empowered to develop and deliver their own sexual health education resources appropriate to their needs that are explicit and direct.
- 4.10 Resources will also need to be developed that cater for those who are not literate, who are visually impaired, and other marginalised and physically impaired groups. For example, in one city, a young male of 16 years, with a below normal mental age was being regularly sexually accessed for anal sex by other young males in his neighbourhood.
- 4.11 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. Unless we are willing to confront the issue of AIDS head-on, we can never hope to stop its spread.
- 4.12 When developing appropriate education resources, the following questions should always be asked:
- How appropriate is the framework of education?
 - What language is it in?
 - What words and images are used
 - Is it appropriate to the cultural frameworks and context of delivery?
 - Who controls the agenda
 - Who produces the information?
 - Who receives the information?
 - Who delivers the information?
 - How is this information delivered?
 - Can we differentiate between culturally sensitive and culturally appropriate?
 - Do services exist to cater for expressed needs that such information may generate?
 - Who staffs these services

- What do they deliver?
- How do they deliver services?
- How are appropriate are they?
- What skills do they have?
- What messages are being delivered?
 - don't do it
 - do it safely
- What is the objective?
 - to inform?
 - to change behaviour?
 - to reduce the rate of HIV transmission?
 - to halt the spread of HIV?
 - to increase reproductive health of women?
 - of men?
 - how will this be achieved?

It is only when these questions can be answered satisfactorily should resources be developed.

5. Sexual Health Products

There is no point providing knowledge to change behaviours towards safer sex practices unless the tools to achieve this are not also being provided.

- 5.1 Condom promotion is usually left to family planning clinics (which are primarily visited by women), some ad-hoc local government poster campaigns (which of course necessitates literacy), STD clinics (if you attend them), and a range of HIV agencies, either through free access or through social marketing principles.
- 5.2 There needs to be a more vigorous approach to condom promotion through on-going multi-media campaigns and by all sexual health services and HIV/AIDS agencies.
- 5.3 Such campaigns should address accessibility. Many young people, and especially *kothis* will not go to a local shop, pharmacy, or some other outlet for condoms. Often many males do not think about condoms until a sex act is about to be done, and there are no condoms available at site. Taking condoms

hope is problematic with joint and extended families, and with lack of privacy and space.

- 5.4 Condoms should be available where they are needed. At the point where sex is being done, wherever that may be. Personal distribution networks should be explored and developed. Teashops could be used, food sellers in parks, on buses, trains, in toilets, wherever males congregate.
- 5.5 The nature of anal sex requires appropriate stronger condoms that are suitable. Less easily damaged, such condoms should be cheap and easily accessible, and should be made available to the general male public.
- 5.6 At the same time an urgently needed requirement for the promotion of safer sex is the easy and cheap availability of a suitable water-based lubricant in appropriate packaging that allows for a low market price and is easy to carry and use. Issues of distribution, availability and easy accessibility need to be addressed. Price and distribution would need to reflect accessibility for the poorest and the sexually active at locations where sexual activities take place.
- 5.7 As mentioned earlier, there is some evidence from anecdotal reports that there are some men who are practising anal sex (either with a female or a male) because they believe it will protect them from STD/HIV. The reason for this is because they have heard no discussion about the risks of infection through anal sex. It is an urgent necessity to ensure that future campaigns on condom promotion also address condom usage for anal sex.
- 5.8 Based on experience in a range of workshops for males who have sex with males in South Asia, Naz Foundation International found that over 70 per cent of the participants did not know how to use a condom safely and correctly. Considerable education needs to be done on the correct use of condoms.

6. STD Services

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.

7. Women And Sexual Health

The vast majority of males who have sex with males will be married or going to get married. The socio-cultural context of South Asia almost demands marriage of all males on reaching whatever appropriate age the parents of these males decide on. This means that the sexual behaviours of many males, whether they have sex with other males, or have sex with females outside of marriage, place their wives at considerable risk.

- 7.1 There is an urgent need to address issues of gender, empowerment of females, anal sex behaviours, and male sexual behaviours in any strategy for reducing STD/HIV rates, if women's sexual health is to greatly improve.
- 7.2 Appropriate strategies should 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.
- 7.3 Women's sexual health programmes should also 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.

8. Psycho-sexual counselling

Trained personnel providing psychosexual counselling should be available, perhaps through the establishment of Male Sexual Health Centres, which can offer non-judgmental, appropriate and accurate advice, information and support to males who have sex with males.

9. The Role of National AIDS Programmes

- 9.1 National AIDS Programmes (NAPs) should be playing a lead role in encouraging, and enabling the development of peer-led community-based AIDS service organisations by investing in, and empowering them, to deliver appropriate STD/HIV prevention and sexual health services for males who have sex with males.
- 9.2 Such an investment should be in the form of:
 - 9.2.1 provision of long term financial support
 - 9.2.2 provision of, or unhindered access to, technical assistance and financial support
 - 9.2.3 access to appropriate capacity-building training

- 9.2.4 addressing legal and regulatory constraints, which may hinder the development of such peer-led community-based agencies
- 9.3 In order for this to occur, NAPs, State agencies, and other agencies will need to ensure that they can gain the trust and confidence of males who have sex with males by ensuring confidentiality, safety, security, anonymity and support for developing their own sexual health services.
- 9.4 Recognising that not all males who have sex with males will be accessible to generic sexual health services, whether provided by government or community-based agencies, nor to peer-led services, NAPs will also need to develop appropriate frameworks for a national programme on sexual health education amongst the general public that takes into account the sexual behaviours of males who have sex with males, as well as anal sex.
- 9.5 NAPs 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 address the lack of knowledge and understanding. Such programmes should provide unbiased information and sensitisation, as well as destigmatise the issue.
- 9.6 Where laws, regulations and policies hinder males who have sex with males to access sexual health services and health information, 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 appropriate services. This should include the:
- 9.6.1 Repeal of the specific section in the Penal Code on “carnal intercourse” as a step towards increasing the confidence of males who have sex with males to access legal, judicial and sexual health services.
- 9.6.2 Training of the police and judiciary on issues regarding males who have sex with males and related sexual health concerns.
- 9.6.3 Development and/or support of 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.
- 9.7 NAPs should include in any advisory and/or technical committee appropriate representatives from non-governmental agencies and community-based

agencies delivering sexual health services specifically working with males who have sex with males.

- 9.8 NAPs should also develop national education strategies for the general population against discriminatory attitudes towards HIV/AIDS and sexual behaviours as well as to de-stigmatise male to male sexual behaviours through the use of mass-media and educational forums.
- 9.9 All sexual health programmes should include relevant and appropriate information on male to male sexual behaviours and anal sex issues, and should also involve schools, colleges and universities, families, business, the military and prisons.
- 9.10 NAPs and associated agencies 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.
- 9.11 NAPs should also ensure that all STD treatment service 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.
- 9.12 Such training should also include the sensitising of health staff regarding the needs of individuals and families in regard to possible infections through anal sex, and that the quality of service delivery regarding this issue should be regularly investigated to ensure that all individuals can access sympathetic and high quality services.
- 9.13 There should be effective collaboration between the National AIDS Programmes, community-based agencies, and international agencies such as UNAIDS, UNDP, UNICEF, UNHCR and others, towards implementation of agreed policies, recommendations and guidelines, locally adapted, to address concerns of human rights abuse and service development for males who have sex with males, accessibility to these services, and to reduce discrimination.

Naz Foundation International believes that if these recommendations become a part of all government and non-government response to HIV/AIDS then effective preventive bridges can be built across the AIDS abyss that confronts the South Asia region and elsewhere. We cannot wait till there is an appropriate vaccine and/or cure for AIDS. People are becoming infected every day. And in the process more and more people will die because we are unable or unwilling to confront the challenge of AIDS. It is time to “break the silence” and speak out, to do and to act.

Shivananda Khan

Briefing Paper 2

Community Mobilising

March 1999

1. Purpose

To reduce the risks of STD/HIV infections amongst males who have sex with males.

2. Goal

To enable males who have sex with males to practice safer sex as a normative behaviour, increase use of appropriate STD treatment services and reduce levels of STDs.

3. Belief

It is understood that safer sex practices amongst males who have sex with males can only be encouraged and maintained over the “long haul” if such practices become a normative behaviour amongst males who have sex with males. To achieve this goal, it therefore requires such safer sex practices to be adopted as a community behaviour, which requires the whole community to be involved in promoting and adopting such practices. However, this pre-supposes that an MSM community exists as a cohesive force. This is not a valid assumption in South Asia, where no such community(ies) exist.

There is therefore an urgent need to understand the psycho-social-sexual constructions of male to male sexual behaviours, their frameworks within South Asian cultures, and their particular socio-sexual dynamics. From such an understanding appropriate strategies can be developed towards utilising shared characteristics as a form of “psychological community” as a means of mobilising shared actions.

4. Behavioural Summary

In South Asia, the vast majority of males who have sex with males fall within a range of behavioural dynamics. These are:

a. *kothis*

Males who feminise their behaviours (usually in specific situations/contexts), and who state that they prefer to be sexually penetrated anally or orally.

Note: for a kothi to take on the role of penetrator is seen as shameful and where this occurs is kept secret. Also most male sex workers are self-defined as kothis, but not all kothis are sex workers

b. *panthis*

A term given by *kothis* to the males who sexually penetrate them. The vast majority of *panthis* do not label themselves as such.

c. *do-parathas*

A label given by *kothis* to those who practice mutual sexual behaviours. Often such males are not respected as such by either *kothis* or *panthis*.

d. *others who may practice male to male sex as*

- i. a regular part of their sexual repertoire
- ii. non-access to females
- iii. all male institutions
- iv. "hotness"
- v. opportunistic discharge
- vi. desire
- vii. curiosity

Most of these males are considered *gopon/gupti* or secret

e. *gay identified males*

In the main small, English speaking, educated male networks

Whilst *kothis* may participate in a number of over-lapping social/friendship networks, these tend to be small and site-based, rather than within frameworks of "community".

Panthis and others as such are involved in different social networks that are to do with non-sexual friendship networks, ruralised frameworks, employment affiliation and so on. These tend to be neighbourhood based.

In other words, for males who have sex with males in South Asia, communities based around sexual behaviour and/or sexual identity as a primary focus does not exist.

To attempt to use the model of community mobilisation as a methodology towards empowerment and development of safer sex as a normative behaviour within an imagined community requires the construction and development of a community. This means defining what community means, and how affiliations to a community are developed, nurtured and explored.

What sort of community is needed then? On what basis is this imagined community emerging? Can such a community develop? What do people share in such a community?

In the male to male sexual environments in South Asia as has been pointed out before, the only emergent groupings that sexual health projects targeting male to male sexual behaviours can currently work with in developing such a community are the *kothis*. However, *kothis* do not form a community.

In South Asia, *kothis* are usually within small social/friendship personal networks, based upon sites and sexualised localities. Networks can overlap, with members within one network, also belonging to another network(s).

Kothis are stigmatised as feminised and penetrated males. They are perceived as not-women and not-men. In many ways the *kothi* is gendered as not-woman/not-man. Such characteristics enable *kothis* to recognise themselves as a “gender” apart, and to also recognise each other with shared characteristics of desire, behaviour and sexuality.

Since the primary community frameworks and social identities within South Asia revolve around family (the joint and extended family system), rural origins, i.e. shared village experiences, locational (where you live), work affiliations (truck-driver, rickshaw driver, student, etc.), marriage and children, making shared behaviour characteristic a basis for community building becomes a major initiative and a challenge to the social basis.

Kothis are the most vulnerable in terms of male-to-male sex. Multiple penetrations in a day, multiple partners, extremely low condom usage by their penetrating partners, low levels of knowledge, extremely low access to STD treatment services, high levels of

anal bleeding, and no lubricant use (apart from saliva - perhaps). Apart from these, the majority of *kothis*, like their penetrating partners, will choose to marry and have children due to social necessity.

In terms of community development, *kothis* represent the most effective opportunity. Their sexual choices enable them to access *panthis* from different socio-occupational communities, as well as a cross-section of society. They are already, for the most, embedded within behavioural and identity social frameworks, and their shared characteristics can be the basis for community building.

For the penetrating male, the most obvious route towards behaviour change would be to work through occupational and neighbourhood strategies. This means to ensure that those NGOs working with community/occupational based methodologies to promote safe sex must include anal sex within their discussions, whether they are working with truck drivers, rickshaw drivers, adolescents, schools, colleges, slums, low-income groups, or whatever.

5. Process

What makes a community?

Recognising the strengths of community affiliations, as they exist, this requires ensuring that *kothis* as a behavioural group/network are specifically targeted to draw them into an emergent community where affiliation is based upon behavioural and emotional characteristics as well as on personal friendships.

In this sense NFI promotes its partner agencies to work with *kothi* networks, expanding these networks, and networking amongst networks towards encouraging an emergent community.

Recognising social, cultural and religious realities in South Asia, enabling community development amongst *kothis* may be seen as very problematic and unobtainable in the foreseeable future. However, mobilising networks, encouraging network development, and networking of networks is feasible under current social realities and is being used first entry points into networks.

Our partner agencies working on sexual health promotion amongst males who have sex with males are developing a series of mechanisms to enable such mobilising of networks and towards building an emergent community amongst *kothis* with all the characteristics of a community, which are:

- Affiliation to a shared consensus
- Solidarity as a “community”
- Mutual support mechanisms
- Social support services
- Shared ideologies and social characters
- Socialising frameworks
- Mutual concerns
- Shared needs
- Shared rituals

These agencies thus manage a *kothi* sexual health promotion project (under the term male reproductive and sexual health programme as a screening device in conservative societies). However, the sexual partners of *kothis* and male sex workers are also being drawn into these service framework through contacts established by *kothis* and through collaboration with other sexual health promotion agencies and services.

Our partner agencies, who specifically work with male-to-male sex, ensures that all Board members, staff and volunteers are drawn from localised *kothi* social networks.

In this situation, community is not defined by some geographical space or locality, but rather as a sensibility, a psychological realm of shared concerns, sexual behaviours, needs, histories and desires.

6. Development

The following briefly outline the components being used towards developing a sense of community affiliation, of mobilising networks, and networking of networks creating frameworks in which condom usage and STD treatment can be promoted as normative behaviours.

6.1 Outreach/Networking

Using field workers drawn from these *kothi* networks to be site specific -based developing friendships in that specific site that can be extended beyond the sites through shared characteristics, socialising, support and enabling access to service provision.

Using site-based key informants (although the term informant is problematic, and we would rather use the term “site-buddies” who can provide supportive frameworks to the field worker with their knowledge and insight into specific sites and provide continuity within a site when the field worker is not present.

6.2 Socialising meetings

A range of of-site social groups developed, each facilitated by a Field Worker, drawing upon his own personal, social and fieldwork networks. These groups can act as a space within which personal friendships and bonding can be developed, experiences shared, and common purposes evolve.

6.3 Personal skills development

A range of educational classes offered including literacy, social skills, life skills, health seeking knowledge, vocational skills, income generation skills, and so on.

6.4 Employment and accommodation networks

Using *kothi* networks to identify employment opportunities and vacant accommodation, as well as emergency housing.

6.5 Savings and Loans Club

Using the Grammen Bank model, encouraging small-scale savings and loans amongst the *kothi* networks.

6.6 Advocacy

Police and *maastan/goonda* harassment are common factors amongst *kothis* who use public environments as social spaces, for sexual encounters and to sell sex. By developing legal aid services, challenging human rights abuses, and providing counselling and support, a framework of service use and access can be developed

which can be seen as a “community service”, encouraging affiliation to an “emergent sexual community”.

6.7 STD treatment services

Extremely problematic in mainstream services because of the stigmatisation of behaviours, *kothis* have extremely few choices to access appropriate treatment services, particularly around anal sex behaviours. *Kothi* services providing such appropriate STD treatment services, either as syndromic management, or through direct testing, ensures that *kothis* will be treated sympathetically, with respect and consideration, and access correct information and treatment.

6.8 Condoms and lubricants

Many *kothis* feel ashamed to access condoms from regular outlets (particularly if they are young and unmarried), nor do they access family planning clinics. Further south Asia does not have appropriate condoms for anal sex, nor any appropriately and cheaply packaged lubricant. Provision of condoms and lubricants in ways that are affordable and easily accessible through site distribution can increase condom usage.

6.9 Needs assessments

Regular surveys of service users, site surveys, and focus group discussions, ensure that assessments are conducted regularly as to how needs are being defined by the *kothis*. These needs can be felt needs, expressed needs and/or projected needs. These discussions and surveys built up consensus on shared needs, which can also be used towards building a sense of community. Such needs do not necessarily directly relate to STD/HIV/AIDS. However addressing such needs can build a sensing of shared concerns, which can be developed as a community sensibility.

Such needs can be:

6.9.1 *Social needs*

- education

- employment

- economic development

- human rights

- family, marriage and children

- vocational skills

socialising spaces

6.9.2 Personal and emotional needs

sexual abuse and violence

counselling

personal hygiene

friendship

identity and desire

emotional support

empowerment

personal skills development

personal health issues

6.9.3 Sexual health needs

appropriate condoms

appropriate lubricant

sexual spaces and privacy

access to appropriate treatment

psycho-sexual issues

counselling

knowledge

empowerment

negotiating skills

6.10 Responding to needs

It is essential that the service provision should build upon these needs and find appropriate ways to ensure that these needs are being adequately and appropriately addressed.

Thus, for example:

6.10.1 a health service that can look at non-sexual issues and provide appropriate treatment and care, i.e. chest infections, TB, and other potential illnesses

6.10.2 an employment agency/network

6.10.3 vocational skills development including reading and writing

6.10.4 an emergency housing network

6.10.5 address poverty issues, such as subsidised medicine and treatment, and access to low interest credit and small savings

- 6.10.6 socialising spaces that allow non-sexual friendships to be developed amongst *kothis* and non-*kothi* identified MSM
- 6.10.7 access to legal aid
- 6.10.8 addressing discriminatory laws and regulations
- 6.10.9 addressing police and *maastan/goonda* harassment
- 6.10.10 a sexual health service that is appropriate and sympathetic and easily accessible
- 6.10.11 a non-judgmental service provision irrespective of class, economic group, work affiliation, sexual behaviour/desire and feminisation
- 6.10.12 development of socialising rituals for community bonding, such as dance, music, prayer, songs, food rituals, etc.

The framework of all these actions is to create a psychological community that transcends family, locality, origin (where rural or urban), class, economic group, work affiliation. It is a psychological community with shared concerns and needs. It is utilising networks to network and build a community(ies).

7. Summary

- 7.1 In South Asia there is no community amongst males who have sex with males, and those who practice male-to-male sex
- 7.2 *Kothis*, however, do have a shared sense of identity and behaviour
- 7.3 *Kothis* are self-defined males who feminise their behaviour and are sexually penetrated.
- 7.4 There is a proviso to this, in that this is a performed and public identity. *Kothis* may penetrate other males, and/or have sex with other *kothis*, but this is perceived by *kothis* to be bad. Hence such behaviour is kept secret from other *kothis*.
- 7.5 However *kothi* should not only be seen as a sexual identity, but also as a gender term in the south Asian culture
- 7.7 *Kothis* are mainly within social/sexual networks, which are spread around in a range of public sites.
- 7.8 These sites are used for socialising as well as for sex with *panthis*.
- 7.9 To enable a development of a sense of community identity is to use these networks towards creating a psychological community.

- 7.10 Using socialising and community development process, such a community sensibility can be evoked
- 7.11 In evoking this community, sexual health promotion can be configured towards community normalisation.

Shivananda Khan

Briefing Paper 3

Developing community-based sexual health services for males who have sex with males in South Asia

August 1999

The challenge of HIV/AIDS confronts all countries and communities globally, and whilst the countries of Africa are confronted with increasing numbers that are dying from AIDS, the countries of South Asia (as well as other Asian countries) stand before the abyss of an uncontrollable epidemic. It is clear that Government, non-government, and community-based agencies, as well as many other institutions, must work together to face this challenge if there is to be any hope of effective strategies to control and manage HIV transmission so as to reduce the levels and rates of infection and thus AIDS.

At this juncture, as we approach the end of the 20th century and enter into a new millennium, it seems that the only real hope is to ensure that the countries of South Asia develop effective STD/HIV prevention strategies that addresses **all** risky behaviours and practices. No country can afford to ignore or deny what occurs within it, whether it is a particular risky sexual practice or a stigmatised identity that is deemed to be immoral, illegal, or supposedly against its culture. Such denial and stigmatisation creates ideal conditions for an increasingly rapid spread of HIV infections across the country.

Male-to-male sexual frameworks and behaviours is of major concern because it has been denied and invisibilised across the South Asia region. Yet significant evidence exists that such behaviours are substantive and have major consequences for any reproductive and sexual health programme if ignored.

Naz Foundation International, working with networks and groups of males who have sex with males in a number of cities in South Asia has developed a process for enabling such males to form their own HIV/AIDS prevention service agencies. This is a process of community building, mobilising, and empowered males who have sex with males towards providing and managing their own sexual health services.

This is part of a parallel process of ensuring that male to male sexual behaviours are acknowledged in any sexual health promotion programme.

- a. Community building and ownership by males who have sex with males for others who share similar frameworks, where the process utilises the already existent emergent community networks amongst some males who have sex with males, though accessing the shared sense of self, gender identity, and behaviours. This would also be true for gay-identified men.
- b. Encouraging **all** reproductive and sexual health programmes, STD treatment centres, and HIV/AIDS prevention programmes, incorporate the issues of anal sex behaviours (between males as well as between males and females) into their education, treatment, and service provision. This enables access to those males who penetrate other males but do not belong to any behavioural community, as well as those males involved in discharge or *masti* sex with other males, but who also do not belong to any behavioural community.

This document is about the former strategy, working primarily with *kothis* towards establishing community-based strategies for the prevention and treatment of STI/HIV/AIDS. This process of development has arisen from several years work providing technical assistance to several community-based *kothi* sexual health projects in South Asia.

Purpose

To reduce the risks of STD/HIV infections amongst males who have sex with males and their sexual partners in South Asia.

Goal

To enable and empower males who have sex with males to practice safer sex as a normative behaviour, and increase their access to appropriate STD treatment services, reducing levels of STIs.

Belief

It is understood that safer sex practices amongst males who have sex with males can only be encouraged and maintained over the “long haul” if such practices become a normative behaviour amongst themselves and with their sexual partners. To achieve

this goal, it therefore requires such safer sex practices to be adopted as a shared community response, which thus requires the whole community to be involved in promoting and adopting such practices. However, this pre-supposes that such a community exists amongst males who have sex with males as a cohesive force. This is not a valid assumption in South Asia. In the main no such community(ies) exist.

However, emergent sexual/social networks in a variety of locations do exist, and these should be utilised as central components in building an emergent community. Such a community would not be based so much on location, occupation, caste, or religion, but rather would act as a *psychological community* framed by the *kothi* gender identity.

Behavioural Summary

In South Asia, the vast majority of males who have sex with males fall within a range of behavioural dynamics. These are:

a. *kothis* (or their local equivalent)

Males who feminise their behaviours (usual in specific situations/context) and who state that they prefer to be sexually penetrated anally or orally.

Note: for a *kothi* to take on the role of penetrator is seen as shameful and where this occurs is kept secret.

Many male sex workers are self-defined as *kothis*, but not all *kothis* are sex workers. In terms of identities, the term *kothi* should be seen in the context of gender construction, rather than as a sexual identity.

b. *panthis* (or their local equivalent)

A term given by *kothis* to males who sexually penetrate them, or those whom they desire as "real men".

Note: the vast majority of *panthis* do not label themselves as such - they do not define themselves based on their sexual behaviours.

c. *do-parathas* (or their local equivalent)

Those who sexually penetrate and are also penetrated.

Note: this is another term given to such males by *kothis*

d. *others who may practice male to male sex (including anal sex) as*

- i. a regular part of their sexual repertoire
- ii. non-access to females

- iii. all male institutions
- iv. “hotness” and felt need for semen discharge
- v. opportunistic discharge
- vi. desire
- vii. curiosity

e. gay identified males

Primarily, English speaking, educated, middle class males with access to English/Western media.

Whilst self-identified *kothis* may participate in a number of over-lapping social/friendship networks, these tend to be small and site-based, rather than within frameworks of “community”.

Panthis and others as such are involved in different social networks that are to do with non-sexual friendship networks, locality frameworks, employment affiliation and so on. These tend to be neighbourhood, work, age, and village origin based.

To try to deal with male-to-male sexual behaviours as a unitary construct, is reductionist, and leads to significant gaps in service delivery and take-up. In such an approach many frameworks of male-to-male sexual behaviours will be completely missed.

To use the model of community mobilisation as a methodology towards empowerment and development of safer sex as a normative behaviour within an imagined community would require the construction and development of a community. This means defining what community means, and how affiliations to a community are developed, nurtured and maintained.

Community Building

What sort of community is needed then? On what basis is this imagined community emerging? Can such a community develop? What do people share in such a community?

In the male to male sexual environments in South Asia, as has been pointed out before, the only emergent groupings that sexual health projects targeting male to male sexual behaviours would be able to currently work with in developing such a community, are the self-identified *kothis* and gay men. This paper explores the issues of *kothis*. However, *kothis*, in the main, do not form a community.

In South Asia, *kothis* are usually within small social/friendship personal networks, based upon sites and sexualised localities. Networks can overlap, with members within one network, also belonging to another network(s).

Kothis are stigmatised as feminised and penetrated males. They are perceived as not-women and not-men. In many ways the *kothi* is gendered as not-woman/not-man. Such characteristics enable *kothis* to recognise themselves as a “gender” apart, and to also recognise each other with shared characteristics of desire, behaviour and sexuality. However, it should be noted that for many *kothis*, this gender play and practice is locational, and does not carry over into other situations and locations, i.e. in the home, with one's wife, or at work, and so on.

Since the primary community frameworks and social identities within South Asia revolve around family (the joint and extended family system), rural origins, i.e. shared village experiences, locational (where you live), work affiliations (truck-driver, rickshaw driver, student, etc.), and marriage and children, making shared behaviour characteristic a basis for community building becomes a major initiative and a challenge to the social basis.

Kothis are the most vulnerable in terms of male-to-male sex. Multiple penetrations, multiple partners, extremely low condom usage by their penetrating partners, low levels of knowledge, low access to STD treatment services, high levels of anal bleeding, and no lubricant use (apart from saliva - perhaps). Apart from these, the majority of *kothis*, like their penetrating partners, will choose to marry and have children due to social necessity and perhaps, desire.

In terms of community building and development, *kothis* represent the most effective opportunity form changing behaviour practices. Their sexual choices enable them to

access *panthis* from different socio-occupational communities, as well as a cross-section of society. They are already, for the most, embedded within behavioural and identity social frameworks, and their shared characteristics can be the basis for community building.

For the non-identified penetrating male, the most obvious route towards encouraging safer sex behaviours would be to work through occupational and neighbourhood strategies. This means ensuring that those NGOs working with community/occupational based methodologies to promote HIV/AIDS awareness, must also include anal sex behaviours and risks within their discussions, whether they be working with truck drivers, rickshaw drivers, adolescents, schools, colleges, slums, low income groups, or whatever.

What makes a community?

Recognising the strengths of community affiliations as they exist requires ensuring that *kothis* as a gendered group/network are specifically targeted to draw them into an emergent community, where affiliation is based upon behaviour, language, and emotional characteristics, as well as on personal friendships.

The characteristics of such a community, could be considered to be:

- ✓ affiliation to a shared consensus
- ✓ solidarity as a “community”
- ✓ mutual support mechanisms
- ✓ social support services
- ✓ shared ideologies and social characters
- ✓ socialising frameworks
- ✓ mutual concerns and issues
- ✓ shared needs
- ✓ shared rituals

Sexual health agencies using this framework thus manage what could be defined as a *kothi* sexual health promotion project (under the term male reproductive and sexual health programme as a screening device in conservative societies). However, the sexual partners of *kothis* and male sex workers can also being drawn into these service

frameworks through contacts established by *kothis* and through collaboration with other sexual health promotion agencies and services.

In this situation, community is not defined by some geographical space or locality, but rather as a sensibility, a psychological realm of shared concerns, sexual behaviours, needs, histories, identities, and desires.

Development

The following briefly outlines the components being used towards developing a sense of community affiliation, of mobilising *kothi* networks, and networking of networks, creating frameworks in which safer sex and STI treatment can be promoted as normative “community” behaviours and sustained.

Phase One

Establishing an initial community network

As stated above, “public” *kothis* form small friendship networks in a range of separated localities and public sex environment sites, which act as meeting places as well as sexual “cruising” grounds.

It is essential to identify these areas and the networks that operate within them before a project can be initiated.

Initial recruitment of a small group of appropriate and interested *kothis* from these networks should be conducted. Following a training programme that includes: -

- a. STI/HIV/AIDS awareness
- b. sexual health
- c. psychosexual issues
- d. behavioural and ethnographic assessment techniques and modalities

A small assessment team is developed and used to conduct the behavioural and ethnographic mapping of the intended constituency for a sexual health project.

The team operates from a small drop-in centre, developed specifically for this purpose, and managed by themselves. They explore the specific locality (town or city, or area of

a city), networking with the existent *kothi* social networks, conducting a behavioural and ethnographic survey, and mapping the sexual sites and any appropriate STI treatment services. Contacts are established with existent HIV/AIDS NGOs, government agencies, and other interested parties towards building a consensus on the need for action.

Individuals and groups from the *kothi* networks are referred to the drop-in centre for socialising meetings and a range of bonding events during this period. This helps to create a sense of affiliation across the city/town. The location of such a centre is critical in this process as it must be accessible across the particular area in which the eventual project would work.

Whilst the need for such an assessment is essential as a means of building a profile of male-to-male sex in the town/city, another primary reason for conducting the assessment is to network and build up friendships and affiliations by the core *kothi* team.

Following the assessment analysis, the team (with perhaps additional members identified through the drop-in process), participate in a second training programme, which includes:

- a. designing a community based sexual health promotion programme
- b. service development and management skills
- c. budgeting and financial management
- d. monitoring and evaluation
- e. project design

A proposal is developed and funding secured for its implementation and management.

Phase Two

Implementing and managing a sexual health promotion service for males who have sex with males

To be a community-based project, it is essential that *kothis* own the project, manage the services, as well as utilise the services. Such projects should be beneficiary-led, arising from the grass roots, where perhaps the only component which is external, may well be the provision of technical assistance.

The process of conducting the situational analysis provides the seed bed for community building, where *kothis* have been using the drop-in centre to socialise, meet each other, create an extended network, and access sexual health information and advice.

Phase Two upgrades and extends this service provision.

Through the experience of developing several such projects in south Asia, that such a service provision should include three central components.

1. *Field Services (outreach/networking)*

Trained full-time staff (called Field Officers) drawn from these *kothi* networks are fielded to work at specific sites (usually one or two on a continuous basis) and act as Team Leaders of a Field Team (now being called a Friendship Team), who provide outreach/networking services. These services include:

- a. friendship building and network amongst those attending a site, which includes *kothis*, their sexual partners, and others (e.g. tea-shop holders, rickshaw drivers, etc.)
- b. STI/HIV/AIDS information and education
- c. condom (and, wherever possible, lubricant) distribution and demonstration
- d. psychosexual advice, information, and counselling
- e. referrals to the Centre

The Friendship Team also includes:

Site Bandhus/Dosts (site friends/buddies)

These individuals are well known *kothis* at a specific site who may or may not be sex workers, but access the site for sexual partners, or friendship meetings with other *kothis*. These “site buddies” act as “key informants” for that site and introduce the Field Officer to other *kothis* and *panthis* who use the site, their sexual partners (potential or otherwise), and others at that site such as shop-keepers, rickshaw, truck, or bus drivers, and so on.

They are key networkers, who also act as peer educators, sharing information amongst their friends and sexual partners, and referring individuals to the Field Officer and

Centre services. They can also be used to monitor STI treatment compliance at the site, levels of safer sex behaviours, marital issues, socially market condoms, and so on.

As a measure of support and motivation, a monthly honorarium may given to them.

Site buddies operate under the direction of the Field Officer, and report to him directly.

Site Volunteers

These are individuals at the site who are interested in the programme, and offer support and networking to the Friendship Team and Project in a voluntary capacity.

Neighbourhoods

Wherever practicable, and where safety is assured, individual members of a Field Team are also encouraged to operate within their own neighbourhood areas, networking, making referrals, and distributing information and condoms amongst their friends and neighbourhood sexual partners.

Each Friendship Team operates on a regularly basis on a small number of sites close to each other where daily visits are possible. Usually these will number 2 to 3 such sites. The intention is to develop familiarity, consensus building, community building, and mobilising towards safer sex practices and access to STI treatment.

An identity card is given to the Field Officer and Site Buddy, which can be used in terms of the local police, or other official who may question the work being done. It is also necessary to establish links with such authorities and gain their support for the work being done.

Condom and lubricant distribution

Many *kothis* (and others) feel very ashamed to access condoms in regular outlets (particularly if they are young and/or unmarried), nor would they access family planning clinics. Provision of condoms and lubricants in ways that are affordable and easily accessible through site distribution can increase condom usage.

A significant problem is that South Asia does not have appropriate condoms for anal sex, nor any appropriately and cheaply packaged water-based lubricant.

2. *Centre-Based Activities*

a. *Drop-in service*

The drop-in centre services are expanded from the original assessment period to include increased numbers of people now being referred to the Centre. Such a service should provide entertainment (such as TV, games, etc.) as well as access to individual psychosexual counselling, instruction on condom use, and information and advice on STI/HIV/AIDS, as well as a safe space to meet each other.

b. *Socialising meetings*

A range of centre-based social groups should be developed, each facilitated by a Field Officer drawing upon his own personal, social, and fieldwork networks. These groups also act as a space within which personal friendships and community building can be developed, experiences shared, and common purposes evolve.

They can also include specialised groups for:

sex workers

students

married MSM

panthis

youth

c. *Sexual health education classes*

Operating within a limited period, each class has a fixed agenda addressing sexual health issues and providing information and knowledge.

d. *Personal skills development*

A range of educational classes should be offered including literacy, social skills, life skills, health seeking knowledge, vocational skills, income generation skills, and so on.

The Centre-based activities address:

i. *personal and emotional needs including*

sexual abuse and violence

- personal hygiene
- friendship
- identity and desire
- emotional support
- empowerment
- personal skills development
- personal health issues
- support and care for those living with HIV/AIDS

ii. social needs

- education
- employment
- economic development
- human rights
- family, marriage and children
- vocational skills
- socialising spaces

iii. Sexual health needs

- condoms
- water-based lubricant
- appropriate STI treatment
- Psychosexual counselling
- HIV/AIDS counselling
- knowledge
- empowerment
- negotiating skills
- Other services could be developed

i. Employment and accommodation networks

Using *kothi* networks to identify employment opportunities and vacant accommodation, as well as emergency housing.

ii. Savings and Loans Club

Encouraging small-scale savings and loans amongst the *kothi* networks.

iii. Advocacy

Police and *maastan/goonda* harassment are common factors amongst *kothis* who use public environments as social spaces, for sexual encounters and to sell sex. By developing legal aid services, challenging human rights abuses, and providing counselling and support, a framework of service use and access can be developed which can be seen as a “community service”, encouraging affiliation to an “emergent gender/sexual community”.

3. STI treatment Clinic

Extremely problematic in mainstream services because of the stigmatisation of behaviours, *kothis* have extremely few choices to access appropriate treatment services, particularly around anal sex behaviours. A centre-based STI clinical service, which provides syndromic management and prescription as well as access to subsidised medicine, creates a safe space for *kothis* and their partners to access and be assured of a supportive and sympathetic service. It is essential that an appropriate doctor be provided who understand the issues, particularly around anal sex behaviours and risks, and can provide a supportive environment.

These three interlinked and mutually supportive frameworks of service provision act as an enabling environment to create a wholistic programme for risk reduction and safer sex promotion. They create a psychological community that transcends family, locality, origin (where rural or urban), class, economic group, work affiliation. It is a psychological community with shared concerns and needs. It is utilising networks to network and build a community (ies) that generate a shared urgency around STI/HIV/AIDS and the promotion of sexual health as a normative concern

Terminology*Kothi*

Across South Asia, amongst males who have sex with males’ sexual networks, many males are self-defined as *kothi*. These *kothis* cut across income group, class, caste, religion and region. *Kothis* should be seen as a gender term rather than as a sexual identity, as one form of feminised maleness.

Kothis are identified in certain sexualised spaces through their public feminised behaviour, group language, and sometimes clothing, claiming to desire a 'real man' to penetrate them.

Thus to these *kothis*, any male who desires to be penetrated by another male, if not publicly declared through *kothi* behaviour would be classified as *gupti kothi* (a secret *kothi*).

This does not mean that *kothis* are "passive homosexuals" as is sometimes assumed. Many *kothis* are also married and penetrate their wives, sometimes other females, and sometimes they will also penetrate other males.

Kothis, whilst performing a gender identity, also form emergent community networks within specific spaces, localities, and sexual networks. These are framed by friendship, shared language, and behaviour.

Kothis will meet each other in specific locations in a particular urban area where they will also "cruise", attracting male partners through their public performance as *kothis*.

The actual term *kothi* may vary across South Asia, for example in Calcutta, *durani* is used, and in Cochin, the term is *menaka*. But the framework, sensibility and behaviour is consistent across the region.

Multiple partners, low condom usage, significant levels of STD infection, marriage, as well significant levels of sex work, particular amongst *kothis* from low income groups. It is not unusual for *kothis* to have several penetrative partners in one night.

Panthi

This is a *kothi* term signifying the penetrating male partner. These males do not identify themselves through such a term, seeing themselves as "masculine" men because they penetrate and are not penetrated. Their personal identities arise from vocational, locational and marital status. *Panthis* cut across vocation, class, religion, economic group, occupation. It is the act of anal/oral penetration that defines the

panthi. As such *panthis* are not a part of any behavioural community. They could be a rickshaw driver as much as film star, or businessman.

Once again the actual term may vary across the region, where in Delhi the word *giriya* is used, or in Cochin where *sridhar* is used.

Do-Paratha

A *kothi* term signifying a male who penetrates and is also penetrated.

Masti

There is a considerable level of discharge sex, whether masturbation, thigh sex, oral sex, or even anal sex between friends, relations, neighbours, work mates, where sexual encounters are defined often by age differences, levels of friendship, or effeminacy of one of the penetrated male partners.

Sex acts here occur secretly between such males, many who may be married. The dynamic appears to be “discharge” based, i.e. based on “heat”, “urgency” and “immediacy”.

Gay men

Amongst the educated, English speaking, urban middle and upper classes of south Asia, men who desire other men, irrespective of the role taken in the sexual behaviours, are beginning to adopt the Western term gay as a framework of sexual identity, and to remove themselves from the feminised frameworks of *kothi* as a self-defining term. Here gay men are stating that desiring other male does not imply a sense of feminisation. Rather one remains a masculine male as one desires other males.

Self-identified gay men form networks in urban areas, and recently have formed networks across the region. It can be said that gay identified men are forming an emergent community.

Whilst it could be assumed that *kothis* and gay men are both involved in emergent communities and that common services could be developed, it must be recognised that the *kothi* identity should be seen as a gender identity, whilst a gay identity should be

seen as a sexual identity. The separation between the two is not only around frameworks of differing identities, but also in terms of class, masculinity, and gender.

Technical Support

Most of these emergent sexual health agencies will require considerable technical support and training initial. That is because, most probably none of the project team will have had previous experience in working in an NGO environment, or providing sexual health services. It is essential that the appropriate technical assistance be secured to provide such a service. This will mean that the provision of technical support should come from an individual/agency that has a full understanding of the socio-cultural dynamics of male-to-male sex in South Asia.

Shivananda Khan

Briefing Paper 4

The Kothi Framework

November 2000

Introduction

It is often asked “how many MSM are there in Bangladesh? Or India?”, usually by Western donors, consultants, and representatives of many AIDS NGOs.

The question seems to be reasonable and make sense, but it actually represents a misconception of the context of male sexual behaviours in the region.

In this context we should really be talking about male-to-male sexual behaviours rather than men who have sex with men (MSM). Further, the way the question is phrased generates a conception of MSM as an exclusive group, an identity rather than a behaviour. But, even more contentiously, the question itself cannot be answered with any adequate response or accuracy.

In summary what we can say about male-to-male behaviours in Bangladesh and India is that

- For the majority of males involved in male-to-male sex, MSM is not an identity but most often a behaviour arising from a feminine gender identification, or a perceived "many" discharge need. Such behaviours are not contextualised within a heterosexual - homosexual paradigm.
- It appears to be that a significant level of MSM behaviours in the region is contextualised within a gendered framework - where a feminised gender performance frames the *kothi*.
- 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 gender roles in Bangladesh, i.e. the “penetrated” partner. *Kothis* construct their social roles, mannerisms and behaviours in ways that attract what they call *panthis* - “real men”, identifying as feminised males. In this context these *kothis* are usually the visible MSM in a range of public environments and neighbourhoods, but *panthis* are not, for they could potentially be any “manly” male.

- These “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*.
- In other words we have 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 physical count the number of *kothis* at a range of public sites, but this doesn’t address the so-called “goopon” or “gupti *kothis*” - the ones who are secret. Nor does this address the number of “manly” partners these *kothis* access in arenas other than the public spaces of parks, railway stations, and so on.
- 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, 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” - where sexual access to females is very limited. What appears to exist in Bangladesh and India is a core identity in terms of gender role, marital status and class.
- Gay relationships are based on a personal sexual identity, mutuality, friendship and exchangeable sexual acts - they are companionate relationships formed within a same sex/same gender dynamic.
- *Kothi* relationships, however, 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. For *kothis* this would be like having sex with their sister.
- This does not mean that *kothis* do not penetrate or that *panthis* are not penetrated. They do, but these behaviours are seen as crossing the gender barrier and are

considered even more shameful. They are kept even more secret. And while *kothis* have a term for such behaviours - *do-parathas*, *double-deckers*, *dubli*, and so on, generally such individuals are looked upon with scorn. A *panthi* who is penetrated is called a *gupti kothi*, while a *kothi* who is known to penetrate another male is seen as not a real *kothi*.

- Male sexual desire for another male should therefore be contextualised differently from male to male sexual behaviour.
- *Hijras* are a different framework altogether. They represent a sociocultural - religious identity, based on gender identification but not within the male-female binary opposition. While many people believe *hijras* are biologically hermaphrodites, this is not true. The vast majority of *hijras* are biologically male, where many will be fully castrated in a religious ceremony. Their social structures are based on the Hindu *Guru* system and female identified family structure. *Hijras* should not be perceived within hegemonic either/or gender opposition, but as a different gender altogether - perhaps as a “third gender”. Nor should *hijras* be called “eunuch”, or transvestites, transsexuals, or even transgenders. They are *Hijras*. (See Nanda, Serena: **Neither man nor Woman - Hijras of India**, Wadsworth, USA, 1990 and Jaffrey, Zia: **The invisibles - a tale of the eunuchs of India**, Weidenfeld and Nicholson, 1997.)

The MSM Context in Bangladesh and India

Men who have sex with men (MSM) 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 Bangladesh and India by donor agencies, NGOs and National AIDS Programmes. In Bangladesh and India, MSM can exist in a broad (often bewildering) variety of identities, behaviours, and practices. What seems to exist are a range of masculinities with differing contextualisation of a range of sexual behaviours, partner choices and desires.

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. The terms “gay” or “homosexual” are also too constricted 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 context.

Beyond all this are the gender categories of man or woman. Self-identities amongst MSM in India and Bangladesh vary across the spectrum of divergent categories, where those most public in the expression of same-sex desire, usually identify themselves as a different gender category which is 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 this is a socialising and socialised role, where a “new” *kothi* with emergent sexual desires for other males (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 is this *kothi* framework, which appears to dominate the MSM contexts in South Asia, in terms of the poor and low and middle-income sectors that represent over 70% of the population.

Kothis see themselves as the feminine in a masculine/feminine sexual partnership, and play out the perceived gender role in the culture. Most *kothis* feel relatively comfortable with their choice, although expressing a varying degree of shame in terms of the shame-based culture of Bangladesh and India. Those 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, *kothis*. 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 manly men. The label *panthi* is used by *kothis* to describe them, meaning a “real man”, a man who will penetrate them, and who most likely will also have sex with women. 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.

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".

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.

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 Indian culture.

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 males 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, guesthouses, hotels, and a range of vendor’s 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 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.

Kothis by their very number, “nature” and practices have access to a broad range of other males whom they access for sex, and can be seen as an entry point to the dominant framework of men who have sex with males in Bangladesh and India.

Perhaps where the term “behaviourally homosexual” has been used by UNAIDS and others, we should use the term “behavioural heterosexual” as well to get even a glimpse of the range of masculinities, male sexual behaviours, genders, identities, and the multiplicity of male to male sexual frameworks.

Situational Identities

Such beliefs and practices lead many *kothis* to act out what could be called situational identities. That is, within the family home and neighbourhood they will perform as young (or not so young) men, while in specific environments, they will perform as *kothis* with other *kothis*, or to draw the attention of potential “manly” male sexual partners. This behaviour often involves an exaggerated sway of the hips, loose wrist

actions, eye movements, touching the mouth with a finger, use of *ulti* and so on. These gestures demonstrate sexual availability to the *panthis*.

Situational identities act as a device to invisibilise identity choices, desire and behaviours, maintain social and family stability, and reduce levels of tension, potential harassment, and violence. This also means that the *kothi* identity has a significant level of performance as part of it. This has been clearly borne out in a range of the discussions where several *kothi*-identified males stated that they performed as a *kothi* with other *kothis* to be able to be a part of a social network that accepted them, rather than because of their sexual behaviour and identity choice, i.e. they saw themselves as men with both “active” and “passive” sexual encounters.

Support and friendship systems

For *kothis*, key support and friendship systems are provided by other *kothis* and their own families. This also expresses the gendered framework with which the majority of *kothis* identify with, as well as the living out situational identities.

In Bangladesh and Indian 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 men as potential *panthis*, and often treat them as such. It is seen as rare for a *kothi* to develop a non-sexual friendship with a “man”. *Kothis* expressed the desire to “find a husband”, 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 develop friendships with other neighbourhood males and relatives keeping his identity choice and sexual behaviour secret. But even in this arena, *kothis* sometimes speak of sex with friends, with these male friends. But never, never, with another *kothi*.

Support systems tended to be expressed within a narrow arena of *kothi* friendship networks, 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 can often become sexualised, as *kothi* friends will bring their *panthis* to access the privacy of the space.

Kothis who have strong bonded relationships, will often call each other in feminine relationship terms, such as sister, aunty, mother, and so on.

Here there are several lateral and vertical relationships based on female family structures, which requires acknowledgement, but sometimes it also generates “sibling” rivalry and discord over access to apparel, make-up, appearances, and potential sex partners.

Kothis will always turn to other *kothis* for moral, emotional and financial support where the family could not, or would not provide this.

Family

Joint and extended familial links are strongly held together by custom, tradition, belief, practice and economic need. Their value lie 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 are the focus.

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 marriage is 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. To have no children can be seen as a curse.

But such marriages are not usually based on mutual friendship, desire and love. Extremely few of married MSM have informed their wives about their extra-marital behaviour with other males, or for that fact, other woman. They believe that all they need to do is to function adequately as husbands in terms of economic support for their wives and engage in sexual intercourse in order to have children. Marriage is considered a duty and sex with one's wife 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".

Psychosexual issues

Sex education is largely absent. Knowledge of the male and female bodies, of reproduction, of the sex organs, is almost non-existent.

This leads to a variety of myths, beliefs and practices, which are accepted as true and helpful. A considerable tension exists regarding masturbation as a source of body and mental weakness that reduces the virility and functioning of the penis, if not producing damage of one sort or another. Constantly questions are asked about medical treatment for nocturnal emissions, masturbation, penile sizes and shapes. Many men use “quack” remedies from street vendors for their perceived weaknesses.

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

Reproduction also carries its own myths and beliefs, where many young males have no idea how babies are born, or even formed.

Gender

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 *hijras*, then *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*. Many *kothis* speak of “finding a husband”, seeking for a “real man” with an *akka likam* (meaning a big penis).

But there are often intense contradictions here. *Kothis* in a public space (like *hijras*) can be extremely voluble, sexually assertive (it is often the *kothi* who usually approach 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.

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. There is much diversity in all of this.

But it should be recognised that because *kothis* play out the socially accepted gender roles, that their self-definitions, language and behaviours sustains a patriarchal framework of gendered relationships and sexual behaviours, this increases their risk of STI/HIV infection and transmission.

Shivananda Khan

Briefing Paper 5

Anal Sex and anal STDS

October 2001

In a study from Pune (1), reported in India's new journal, *AIDS Research and Review*, a large cohort study of the incidence of HIV between 1993 and 1998 found 7.6% new infections per 100 person years. In this cohort, 3% of 9300 persons (male and females were combined) reported anal sex in the past three months. The incidence of HIV among those who were receptive partners was very high, 42.5% with a relative risk of 8.6, the highest among all the possible risk factors analysed. The authors did not indicate the sex of these receptive partners but it is clear that the anal sex issue has emerged as a significant factor in India's epidemic.

The stigma attached to anal sex in South Asia is such that few doctors can be found who will openly discuss the topic. Most appear simply not to believe anal sex takes place. My own experience shows that, even the most experienced STD doctors maintain it is rare and not a problem in their areas. But I can send my interviewers on to the streets and into the parks in the same cities and they can find dozens of boys or men and a handful of girls or women walking around with anal discharge, anal ulcers, in pain and under no reasonable treatment regime. They almost all claim they would be too embarrassed to go to a doctor with these symptoms, cannot afford private doctors, and mostly try to treat themselves with home-made pastes or something recommended by a friend and bought at a pharmacy.

Anal sex is not only restricted to gay or homosexual men or to men in India. Gender constructions of masculinity and manhood in South Asia countries and elsewhere in many other countries in Africa, South America, South East and East Asia, and probably in Western countries, indicate that many men who do not define themselves as homosexual will penetrate another male if he is feminised or adolescent as neither of these can be considered men. In other words anal sex is not an exclusive property confined with a heterosexual/homosexual paradigm. It is a part of the sexual repertoire of many men as the penetrating partner. Those who are penetrated tend to be male adolescents and youth, feminised males (whether transvestites, transgendered, or otherwise), and women. To penetrate is a manly prerogative.

But what doctors and STD clinics even bother to ask about anal sex as a behaviour. Rather what we talk about is heterosexual or homosexual transmission, rather than vaginal or anal transmission. Which doctors have the knowledge and skills to understand about anal discharge and anal damage as vectors of STD/HIV infection/transmission? Which doctor is able and willing to anal proctoscopic examinations?

All the documentation about syndromic management of STDs that have been issued by government (and even by UNAIDS) does not mention anal STDs and their symptoms.

Research and assessment data from South Asia indicate that anal sex is widely practised, especially among the various groups of men who have sex with men, including *hijras* and brothel based female sex workers. Those with the most stigmatised identities, IDUs, *hijras*, and male sex workers, had the highest reported rates of current STDs, an indicator of their lack of access to adequate STD services. These hard-to-reach men need specialised, affordable services that can handle their various health problems, not just their STDs, and that do not scare them away with disapproval of their behaviour. Raising the profile of anal STDs among medical personnel could help. Conducting further research on the true epidemiological picture of these infections is a must.

In this region, anal STDs receive little attention among health providers. Although they are mentioned in some medical textbooks, there is little written to guide our physicians. Even in the international world of STD research, very little has been focused on anal STDs and, to date, no syndromic guidelines exist for the management of anal STDs, whether found in male or female bodies. There are real questions of medical practice to be answered before such guidelines could be written and promoted. We do not know how widespread are these infections, i.e. the extent of the problem. Everything appears to be based on assumptions. We do not know what proportion of anal STDs of which types are asymptomatic. We do not know if and when proctoscopy is required. We do not know how to conduct proper verbal screening for all types of patients. We do not know which drugs to use for anal vs oral or urethral symptoms. The topic remains taboo in most medical circles and, where skills and knowledge exist, these are most often found in developed countries where special

efforts were made to handle gay men's health after AIDS became an additional threat. The epidemiological profiles of those nations may bear no resemblance to what would be found in Bombay, Dhaka or Karachi, or perhaps Mombassa, Nairobi or Durban. In order to promote such research and the eventual adoption of syndromic guidelines for anal STDs, we need advocacy among sexual health providers in both the private and public sectors as well as with national AIDS programmes.

With so little guidance available, there is almost no practical experience available as models apart from the experience of gay sexual health clinics of the West, or clinics like that is managed by Bandhu Social Welfare Society in Dhaka, Bangladesh, which manages an MSM sexual health programme.

These clinics incorporate the points raised about, to include verbal screening, questions by the doctor, visual inspections, proctoscopic examinations when indicated and treatment. With no treatment guidelines available either, often it is left to the doctor to discover for himself/herself what needs to be done.

But all this requires that the clinic staff and programme staff must be accepting, non-stigmatising and totally confidential for those who practice anal sex to comfortably access treatment and counselling. Too many reports speak of doctors cursing and accusing clients sin, bad behaviour and "dirty" people.

Anal Problems

The following anal conditions have been identified as common clinical presentations among MSM and *Hijra* patients:

- Anal pain
- Anal discharge
- Anal tumours (usually warts)
- Anal ulcers
- Anal bleeding
- Anal burning / itching
- Anal fissure / tear / injury

Principles of syndromic management

Basic principles of syndromic management were discussed and their limitations in the management of anal conditions were identified, especially for conditions not usually associated with STIs. The need for single dose, oral therapy was discussed and the rationale and limitations of the three diagnostic approaches were described.

Diagnostic approaches

Etiological (diagnosis and management based on the demonstration of the causative organism - if the condition is infectious)

Clinical (diagnosis and management based on history and examination alone)

Syndromic (diagnosis and management based on presenting signs and symptoms according to standardized guidelines)

Discharge

Genital discharge	GC/CT	
Anal discharge	GC/CT	proctitis enteritis etc
Management	Ceftriaxone, Ciprofloxacin, Metronidazole	

Warts

Management options can be limited and essentially is based on cryotherapy in static clinics or referral to hospitals or private doctors.

Condylomata lata may occasionally be seen and, given what may be high local prevalence of syphilis, they should be considered in the differential diagnosis of flat, moist anal wart-like lesions. Syphilis serology should be assessed where feasible and any patients with suspicious lesions should be treated for syphilis at their first visit.

Anal Pain

The difficulties of specific diagnosis should be recognised.

History

Issues that could be explored in history taking include:

- lack of lubricant
- fast and rough sex
- constipation
- tenesmus or other symptoms suggesting colitis
- sexual violence
- use of sex toys such as vibrators, dildoes etc (said to be rare or used only by the very affluent, although it was acknowledged that little is known about the use of sex toys locally).

Examination

Examination could elicit signs of conditions that could be managed locally including:

- tears and fissures
- constipation
- secondary infections and abscesses
- proctitis
- herpes

Management

Management options for anal pain clearly depend on the diagnosis and it should be recognised that many conditions have little to do with STIs. Apart from managing specific lesions, other options include:

- referral to surgeons if needed
- analgesia (e.g., lignocaine)
- counselling about sexual technique

- provision of lubricant (water-based for use with condoms)
- harm reduction messages regarding the damage caused through the inappropriate use of topical antibiotics and antiseptics
- suggestions about alternative sexual practices to minimize anal trauma (e.g., masturbation, interfemoral or 'thigh' sex and oral sex)

Anal bleeding

Appropriate management of patients with anal bleeding need to be developed and the difficulties of specific diagnosis recognised.

History for anal or rectal bleeding

Several issues need to be explored in the history of a male with anal or rectal bleeding.

Most importantly:

- the possibility of a bowel neoplasm should always be kept in mind.
- timing and nature of bleeding (e.g., during or after sex, fresh or altered blood, malena)
- use of lubricant
- history of trauma or violence (e.g., use of foreign objects, sexual assault)
- use of sex toys (see above)

Examination

Some conditions will be diagnosed specifically on examination whereas other will require empirical management.

- Hemorrhoids
- Fissure
- Shigellosis
- Neoplasm
- Digital rectal examination

Proctoscopic examination may be necessary, and with this will be the need for good light as well as cleaning and sterilising facilities.

Anal burning & itching

A range of possible causes for anal burning or itching include:

- Trauma
- Eczema
- Scabies
- Pediculosis (said to be rare in Bangladesh)
- Fungal infections
- Parasitic infections (e.g., helminthic infestations)

Management

Scabies and pediculosis:	Permethrin 5% cream or benzyl benzoate solution
Fungal skin infections:	Topical antifungals (e.g., clotrimazole)
Eczema:	Topical corticosteroids (e.g., hydrocortisone)
Helminthic infestations:	Systemic albendazole

Centre for Disease Control (USA) Guidelines**Management of Proctitis, Proctocolitis and Enteritis**

Reference: Centers for Disease Control and Prevention. 1998 Guidelines for treatment of sexually transmitted diseases. MMWR 1998;47(No. RR-1):104-5.

Sexually transmitted gastrointestinal syndromes include proctitis, proctocolitis, and enteritis. Proctitis occurs predominantly among persons who participate in anal intercourse, and enteritis occurs among those whose sexual practices include oral-fecal contact. Proctocolitis can be acquired by either route depending on the pathogen. Evaluation should include appropriate diagnostic procedures (e.g., anoscopy or sigmoidoscopy, stool examination, and culture).

Proctitis is an inflammation limited to the rectum (the distal 10 -12 cm) that is associated with anorectal pain, tenesmus, and rectal discharge. *N. gonorrhoeae*, *C. trachomatis* (including LGV serovars), *T. pallidum*, and HSV usually are the sexually transmitted pathogens involved. In patients coinfecting with HIV, herpes proctitis may be especially severe.

Proctocolitis is associated with symptoms of proctitis plus diarrhoea and/or abdominal cramps and inflammation of the colonic mucosa extending to 12 cm. Fecal leukocytes may be detected on stool examination depending on the pathogen. Pathogenic organisms include *Campylobacter sp.*, *Shigella sp.*, *Entamoeba histolytica*, and, rarely, *C. trachomatis* (LGV serovars). CMV or other opportunistic agents may be involved in immunosuppressed HIV-infected patients.

Enteritis usually results in diarrhoea and abdominal cramping without signs of proctitis or proctocolitis. In otherwise healthy patients, *Giardia lamblia* is most frequently implicated. Among HIV-infected patients, other infections that usually are not sexually transmitted may occur, including CMV, *Mycobacterium avium-intracellulare*, *Salmonella sp.*, *Cryptosporidium*, *Microsporidium*, and *Isospora*. Multiple stool examinations may be necessary to detect *Giardia*, and special stool preparations are required to diagnose cryptosporidiosis and microsporidiosis. Additionally, enteritis may be a primary effect of HIV infection. When laboratory

diagnostic capabilities are available, treatment should be based on the specific diagnosis. Diagnostic and treatment recommendations for all enteric infections are beyond the scope of these guidelines.

Treatment

Acute proctitis of recent onset among persons who have recently practiced receptive anal intercourse is most often sexually transmitted. Such patients should be examined by anoscopy and should be evaluated for infection with HSV, *N. gonorrhoeae*, *C. trachomatis*, and *T. pallidum*. If anorectal pus is found on examination, or if polymorphonuclear leukocytes are found on a Gram-stained smear of anorectal secretions, the following therapy may be prescribed pending results of additional laboratory tests.

Recommended Regimen

Ceftriaxone 125 mg IM (or another agent effective against anal and genital gonorrhea),

PLUS

Doxycycline 100 mg orally twice a day for 7 days.

NOTE: For patients who have herpes proctitis, refer to Genital Herpes Simplex Virus (HSV) Infection.

Follow-Up

Follow-up should be based on specific etiology and severity of clinical symptoms. Reinfection may be difficult to distinguish from treatment failure.

Management of Sex Partners

Sex partners of patients who have sexually transmitted enteric infections should be evaluated for any diseases diagnosed in the patient.

WHO Guidelines for the Management of Sexually Transmitted Infections

(WHO/HIV_AIDS/2001.01 and WHO/RHR/01.10)

Management of Gonococcal and Chlamydial Proctitis

GONOCOCCAL INFECTIONS

A large proportion of gonococcal isolates worldwide are now resistant to penicillins, tetracyclines, and other older antimicrobial agents, which can therefore no longer be recommended for the treatment of gonorrhoea.

It is important to monitor local in vitro susceptibility, as well as the clinical efficacy of recommended regimens.

Note

In general it is recommended that concurrent anti-chlamydia therapy be given to all patients with gonorrhoea, as described in the section on chlamydia infections, since dual infection is common. This does not apply to patients in whom a specific diagnosis of *C. trachomatis* has been excluded by a laboratory test.

UNCOMPLICATED ANOGENITAL INFECTION

Recommended regimens

Ciprofloxacin, 500 mg orally, as a single dose

OR

Azithromycin, 2 g orally, as a single dose

OR

Ceftriaxone, 125 mg by intramuscular injection, as a single dose

OR

Cefixime, 400 mg orally, as a single dose

OR

Spectinomycin, 2 g by intramuscular injection, as a single dose.

Note

Ciprofloxacin is contraindicated in pregnancy. The manufacturer does not recommend it for use in children and adolescents.

There is accumulating evidence that the cure rate of Azithromycin for gonococcal infections is best achieved by a 2-gram single dose regime. The 1-gram dose provides protracted sub-therapeutic levels, which may precipitate the emergence of resistance. There are variations in the anti-gonococcal activity of individual quinolones, and it is important to use only the most active.

Alternative regimens that may be useful in some countries, depending on the prevalence of resistant gonococci:

Kanamycin, 2 g by intramuscular injection as a single dose

OR

Trimethoprim (80 mg)/sulfamethoxazole (400 mg), 10 tablets orally, as a single dose daily for 3 days.

Note

Kanamycin and trimethoprim/sulfamethoxazole should only be used in areas where in vitro resistance rates are low and are monitored at regular intervals. In addition, second-line treatment with recommended drugs should be available.

**CHLAMYDIA TRACHOMATIS INFECTIONS
(OTHER THAN LYMPHOGRANULOMA VENEREUM)**

Uncomplicated urethral, endocervical, or rectal infections

Recommended regimens

Doxycycline, 100 mg orally, twice daily for 7 days

OR

Azithromycin, 1 g orally, in a single dose

Alternative regimens

Amoxicillin, 500 mg orally, three times a day for 7 days

OR

Erythromycin, 500 mg orally, four times a day for 7 days

OR

Ofloxacin, 300 mg orally, twice a day for 7 days

OR

Tetracycline, 500 mg orally, four times a day for 7 days.

Note

Tetracyclines are contraindicated during pregnancy and lactation.

Current evidence indicates that 1 gram single dose therapy of azithromycin is efficacious for chlamydia infection.

There is evidence that extending the duration of treatment beyond 7 days does not improve the cure rate in uncomplicated chlamydia infection. Erythromycin should not be taken on an empty stomach.

Follow-up

Compliance with the 7-day regimens is critical. Resistance of *C. trachomatis* to recommended treatment regimens has not been observed.

SYNDROMIC ALGORITHM FOR ANAL DISCHARGE

(No laboratory support available)

Note: the specific efficacy of this algorithm has not been evaluated

1. Chief complaint:
Patient complains of an anal discharge (+/- anal pain or tenesmus)

2. Action:
 - a) take history;
 - b) conduct PE including inspection of anus; c) perform anoscopy

3. Decision node:
 - a) ulcer/vesicle present?
Action: If yes, treat for syphilis and chancroid, educate (4 C plus lubricant), dispense condoms (e.g. 2.4 million IU IM plus erythromycin 500 mg qid x 7 days)

 - b) mucopurulent discharge present?
Action: If yes, treat for GC and CT, educate (4C plus lubricant), dispense condoms (e.g. ceftriaxone 250 mg IM plus doxy po 100mg bid x 7 days)

 - c) fever/diarrhoea/cramps (proctocolitis)?
Action: If yes, treat for enteric infection, educate (4 C plus lubricant), dispense condoms (e.g. cipro 500mg po qid for 7 days)

 - d) fissure present?
Action: treat with Sitz bath and antibiotics?, educate (lubricants) etc...

This report has been reproduced by Naz Foundation International through the work of:

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CDC 1998 Guidelines for treatment of STIs

WHO Guidelines for the management of STIs, 2001

Briefing Paper 6

Female Partners of MSM

February 2002

Introduction

Bandhu Social Welfare Society in Dhaka, Bangladesh and Sahodaran in Chennai, India, both partner MSM sexual health projects of NFI, held a series of Focus Group Discussions with married MSM to discuss a range of issues in regard to the sexual health concerns of their wives. Each discussion group consisted of between 5 - 10 married MSM. Some participants were a part of several of these discussions groups. A total of 150 married MSM were involved.

A range of issues was addressed at these discussions. These were:

- Why did you get married?
- What do you feel and think about your wife
- What do you think of your sexual behaviour/choice in relationship to your wife and family?
- Why do you continue with MSM behaviours after your marriage?
- Does the wife have knowledge?
- Would you inform your wife if you become infected with an STI/HIV?

As a part of these discussions, the Moderator talked of:

- risks of infecting partner
- risks of re-infection
- consequences for wife and reproductive health
- economic issues
- personal responsibilities
- safer sex behaviours

Purpose

The intention of these focus group discussions was to explore ways of

- accessing female partners of MSM if male partner is infected
- how to promote condom use with wives

- how to promote social and sexual responsibility of MSM

Issues

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.

It was also believed that most *kothi*-identified MSM who were not married would eventually have to get married, or will choose to marry. Social and family pressure was too intense to avoid what for many was seen as one's fate.

But there were also several married MSM who stated that they also liked sex with women, and got married as a choice. While many stated that they wanted to continue the family line, i.e. have children, as a reason to accept marriage.

One of the issues constantly raised was “who will look after me in my old age...” and “I will be lonely in my old age...”

Avoidance of marriage was, for almost everyone, was not seen as an option.

Thinking and feeling

This issue brought a broad range of responses from the discussants, some of which showed considerable confusion and an unwillingness to explore this in much depth. A wife was seen as a social and familial necessity, “so what is there to think about”. The issues were around duty, performance, reproduction, the wife's duty to her husband while some of the discussants also spoke of their love for their wife, and that they enjoyed the relationship.

When the issue focused on what they thought of their own sexual behaviours with other men, there was a similar broad range of responses. This included “its none of her

business what I do..” to “sometimes I feel very bad about this..” For the most, there was some degree of guilt feelings, but in the main the feeling was that as long as they performed their duty to the wife in terms of sex, money, and support, their behaviours and choices were not of concern to the wife.

Children, in this context, are the purpose for the wife and marriage. Once a child is born the wife will have other things to occupy herself, and she will need her husband less. Some believed that the wife’s sexual need (even though a few believed that she had no sexual need), will be reduced.

For the *kothi*-identified men, there were strong issues to address around desire and performance. Most stated that when they do sex, they “switch off” their *kothi*-identity, and “switch on” a *panthi* behaviour. Others would imagine having sex with a *panthi* while they do sex with their wife. While a few stated that they would have sex with a *panthi* before they have sex with their wife.

Most did realise that their desires and behaviours with other men did affect the amount of time with their wives, often reaching home late in the evening because they were at some cruising site before. Several had long standing difficulties with this, and some *kothis* stated that they often spent more money on their *panthis* than on their wives. This too had brought tensions in the home.

Does this affect your wife?

While some of the men in the discussion groups believed that their desires, behaviours and feelings did have an effect on their wives, the cultural belief that the husband was primary, and that women really don’t have sexual desires, but are there for servicing the husband, appeared to be very strong.

Some of the men did feel “guilty” that they could not be a “proper husband”, but they managed this “guilt” through a belief that they provide for the wife’s needs, usually meaning children, money, and shelter.

Several spoke of their wife’s complaints about late nights, spending time with friends and not with her, money be spent outside the home, but rarely about a lack of sex.

So while the men in the discussion groups accepted that their life-style did affect their wives, they felt that nothing could be done about. Several did state that when they first got married they tried to stop having sex with other males, but their desires or “needs” was too strong to “control”.

They also expressed understanding that perhaps some of the intra-marital tensions may have arisen because of the “distancing” they experienced with their wives. *Kothis* expressed this the most strongly, and in particular their own sense of inner tension because of the need to play the husband “role” and perform as a husband sexually. At times, they said, these tensions produced irritation, anger and frustration, which they tended to take out on their wives and children.

Continuing MSM behaviours after marriage

Most of the *kothi*-identified men stated that their “heart’s desire” was for *panthis*, and that was also their fate. They could not control their desires, and they had no intention of stopping this. For them the quest to find a “husband” was a central issue of concern.

Some non-*kothi* identified married MSM also stated that they liked sex with other men, and that they could not stop.

Others stated that sometimes they were “hungry”, and their wife was not always available. It was easier to go to a cruising site and find a sex partner who would do the type of sex they like, acts which they felt to be ashamed to ask their wife to do, or just to find a male sex partner when they felt “hot”.

Does the wife have knowledge?

For the majority of the participants in the focus group discussions, there was a complete denial that the wife would have any knowledge of their sexuality and/or sexual practice. How could she know? was the general understanding. A wife just would not think of these things. She has never been taught about them. If anything, if the wife became suspicious about late nights and absences, she may suspect other women.

Even the *kothi*-identified men believed this to a large extent. A few did state that the wife might guess because of their effeminate behaviours in the house, and one even stated that his wife had seen him in make-up and sari. He told his wife that he was practising for a street play!

Even if they wife should know, the question was what would she do. Divorce, separation, telling her family, were all attached to ideas of shamefulness, not fulfilling the sexual “needs” of the husband, and so on. In other words, the wife shoulders the blame. Participants believed that while they would do everything to hide their desires and practices, even if the wife should find out (and this would be very shameful for the man), the consequences perhaps may be managed to some extent, as long as she was satisfied in other ways, i.e. with children, a good home, and enough money. But the risks that she might tell her family, the neighbours, and so on were too enormous to take on board as a conscious thought for many others.

STI/HIV

All the participants acknowledged the risks of STI/HIV infection for themselves and possible transmission to their wives. All also understood the need to use condoms with their male partners. However, in regard to condom use with their wives was another issue altogether. These issues reflected concerns that the wife may become suspicious if the husband uses condoms (why?), that this would interfere with the need for a son, and raise the whole issue of discovery. Using family planning as an excuse for condom use also generated heated discussions, because this was seen as the wife’s responsibility, and most services were female orientated.

Partner notification

These discussions on STI/HIV infection led to a discussion on partner notification. Do you tell your wife you have an STI or HIV? And how would you do so? What would you say? Would this mean you have to speak about your extra-marital sexual encounters? Do you say it was with a woman, or do you tell her the truth?

There was a recognition that infection and re-infection were significant issues and needed to be appropriately addresses, but the question “how” was a big stumbling block. The need was recognised, but no solution arose. Great differences emerged

among participants. Some said they would tell their wives they became infected through have sex with a female sex worker, some said they would get themselves treated and ensure their wives also were treated but would not tell her why (they would make up some excuse, i.e. for the general health), others refused to participate in the discussion and not acknowledge the issue.

Very few of the participants were willing to inform their wives of the sero-status.

Conclusions

The issue of marriage, married MSM and sexual health concerns that arise from this situation is extremely serious in that in South Asia, marriage is a common denominator of all men, irrespective of the sexuality/identity. Most MSM would eventually become married in a culture that believes marriage to be socially/religiously compulsory.

While the issue of wives and other female partners of MSM was clearly recognised as one that carries its own risks, very little thought had been given to consequences until the focus group discussions highlighted these concerns. Whether this was because of ignorance, lack of clarity in thinking, or sheer denial was difficult to gauge.

Informing their female partners and wives of either their sexuality/identity/behaviour or of their STI/HIV status arising from male to male sexual encounters, was clearly not an option for the majority of discussants. The best option in their eyes should such a status arise and something had to be said was to blame another woman. At the least, would be to provide treatment as a general health treatment package without any discussion about STI infections or their source. In other words, to insist upon denial and confidentiality.

None of the discussants believed they could stop their MSM behaviours, or even desired to, even though a few stated that they tried. Most *kothi*-identified discussants would have chosen not to get married, but did so because of family pressure, while some others did want sons (to continue the family line), and others also sexually desired women as well, while others only desired women, but did sex with other males because of “need”, “heat” and shame with their wives.

From all these discussions, it is clear that the issue of female partners of MSM is an extremely difficult and complex one, both in terms of women's empowerment, as well as their reproductive and sexual health.

A broad range of ethical concerns are involved, from confidentiality, right to treatment, the right to knowledge, sexuality and identity. None of these are clearly resolvable without a range of compromises that may have to be made so the rights of both partners are protected, while attempting to ensure that both partners have access to appropriate treatment.

Without a radical change in the sociocultural frameworks of Bangladesh culture where freedom to choose marriage is an integral part of the society, where social welfare systems are existent, and where shame and dishonour around the whole issue of male to male sexual behaviour and concepts of femininity and masculinity are challenged and changed.

Male to male sexual encounters, and the gender roles that so many males play in male-to-male sex clearly carry high stigmatising markers across the society, leading to marginalisation, denial and invisibility. Directly addressing these concerns raises possibilities of further stigmatisation, harassment and violence against MSM themselves. And yet these issues must be addressed.

Recommendations

1. *Developing a sense of sexual responsibility*

This means ensuring that all MSM sexual health projects ensure that

- a. service users fully aware of the issues around female partners and their sexual health needs
- b. understand fully the consequences of unprotected sex with their female partners in terms of infection and re-infection
- c. develop skills around condom negotiation both with male partners as well as female partners and wives
- d. encourage and promote the development of sexual responsibility

This requires two levels of intervention

- i. ensure that these issues are an integral part of education and sexual health promotion of all project staff as well as in any outreach work
- ii. integrating these issues into community building and mobilising programmes

2. *Skills building of STI treatment centres*

All clinic services should be sensitised and trained on issues of male to male sex and female partners, and their services should take into account the possibility of MSM having female partners as well and integrate this issue into service delivery being sensitive to the confidentiality needs of MSM themselves. Methods need to be explored that allow female partners of MSM to have access to treatment packages should their male partners be STI positive.

Clinics should have the skills to sensitively enquire about the sexual practices of male client in an environment, which encourages honesty and openness, so that appropriate counselling can be offered to married MSM and other MSM who also have sex with females.

3. *HIV+ networks and groups*

All HIV+ networks and groups should not only be sensitised and trained on the issues of positive MSM, but also on the issues of female partners of MSM. Confidentiality and stigmatisation is not only about positive status, but also around sexual practice and male femininity.

4. *Reproductive and sexual health agencies*

All reproductive and sexual health agencies, both focusing on male or female health must be sensitised and trained on MSM issues and integrate these issues into their programmes in a sympathetic and sensitive manner.

5. *HIV/AIDS programmes*

All STI/HIV agencies and programmes, both focusing on male or female concerns must be sensitised and trained on MSM issues and integrate these issues into their programmes in a sympathetic and sensitive manner.

6. Donors, government institutions and CSOs

Training and awareness programmes must be offered to official and non-official organisations, groups and agencies on the issues of MSM and their female partners in a way that enhances the safety and integrity of MSM themselves without further victimisation.

7. Victimisation

While recognising the concerns of female partners of MSM, MSM themselves should not be victimised as a vector for female infection because of socio-cultural norms, but should be supported to understand the issues and reduce risks. This means socio-legal issues that impede effective health promotion needs to be addressed appropriately.

Shivananda Khan

Briefing Paper No. 7

Social justice, human rights and MSM

October 2002

In May 2002, with technical support from Naz Foundation International, Bandhu Social Welfare Society, Bangladesh (an NFI partner agency) conducted a major and significant study into social justice and the human rights violations of MSM and the impact upon their vulnerability, social exclusion, with the increased risks for STI/HIV infection that such violations and injustice bring about.

This was the first time that such a study had been conducted in the region specifically looking at MSM. The principal researcher was Aditya Bondyopadhyay an NFI consultant, along with IDHRB in Bangladesh.

Such a study was deemed an urgent necessity because it was clearly recognised that whilst Bandhu had developed a range of sexual health promotional tools and strategies were in place specific to the needs of its constituents, its risk reduction work amongst the already vulnerable and socially excluded MSM was being further compromised and impeded by a range of constant human rights violations and abuse. In other words, sustainable behaviour change strategies were being hindered by social factors outside the direct control of Bandhu Social Welfare Society. Further, this study was seen as equally important to all the other NFI partner agencies, since they share similar target populations and social dynamics.

It was also recognised that it was the process of stigmatisation that arises from concepts of masculinity in Bangladesh culture that led to such marginalisation and social exclusion and abuse of the most vulnerable of MSM – those with feminised identities. Along with this was an understanding that social exclusion had a personal and social history that led to negative impacts on educational and employment opportunities, which, of course, increases poverty and concomitantly increases the potential for sex work activities as a source of income for self and family and a survival strategy.

In other words, social justice and human rights issues for MSM were a complex matrix

of issues, concerns, and needs that reflected personal psycho-sexual histories, economics, social-cultural polices and attitudes, as well as legal concerns, that create a context for MSM, but particularly for feminised males, of low-esteem, disempowerment, and marginalisation that leads to further abuse, violence and social exclusion.

With funding support from UNDP Regional programme, along with technical assistance from Naz Foundation International and IDHRB, Bandhu explored these urgent issues of concern towards developing an action plan to address them. Using participatory methodologies of Focus Group Discussions, as well as one-on-one interviews and questionnaires, 124 MSM (kothi-identified) were accessed from four cities: Chittagong, Dhaka, Mymensingh and Sylhet. Along with the study, staffs from local Bandhu projects were also trained on the rights of MSM, HIV/AIDS law, and collecting data for the study.

The study looked at the power inequality dynamics arising from Bangladesh constructions of masculinity, social attitudes towards feminised males and their sexual practices, sexual abuse, assault and rape, stigmatisation and poverty, discrimination and disempowerment. All of these issues 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 increase vulnerability and disempowerment. And this leads to significant increases to STI/HIV infection risks as well as impedes successful implementation of risk reduction strategies. Without addressing these psychosocial concerns appropriately and with urgency, sexual health promotion programmes targeting MSM would not be able to adequately develop sustainability in risk reduction and behaviour change.

The study also exposed the significant levels of male-on-male rape and sexual abuse of feminised males from early childhood to adulthood. It uncovered lost opportunities for educational and economic advancement due to social concepts of masculinity, harassment and discrimination. It made visible the significant levels of violence targeted at such males from early childhood. It also highlighted the significant levels of suicidal impulses and self-damage of these males because of low self-esteem and self-worth. The study told a story of woe, unhappiness, despair, and a lack of hope for the future.

Along with these personal vectors, governmental policies for combating HIV/AIDS are often in conflict with the penal laws and the actions of local law enforcement agents. On the one hand the government recognises the need to address the HIV/AIDS concerns of male-to-male sexual behaviours, but on the other, the continuation of the criminalisation of such behaviours often leads to threats of blackmail, sexual abuse, and violence, if not arrest. It discourages those in need of information and services to seek the same. In addition to this programme staff and target populations are vulnerable to local police excesses and abuse without adequate ways and means of addressing such abuses.

Some findings of the study

Demographic profile

A total of 124 respondents participated in the study from Chittagong, Dhaka, Mymensingh and Sylhet, Bangladesh. 47.5% of the respondents were between 20-25 years. 43% of the respondents came from villages. In detailed interviews it became apparent that many had migrated to the city looking for employment. 51% of the respondents had studied up to 4th standard or less.

25% of the respondents were married. Only 4 out of 31 married respondents said that they had got married because they wanted to. Only one said that he had a love marriage as opposed to an arranged marriage. 19 out of 31 respondents claimed that they got married due to family pressure.

32% of the respondents also had sex with female sexual partners who were not their wives. 10 out of 31 married respondents said that their wife knows the fact that they have sex with other men. Only 3 of this 10 say that their wife has accepted this fact. All the marriages where the wife had not accepted the fact that the respondent had sex with other males were arranged marriages done under family pressure.

56% of the respondents have a monthly income of Taka 1000 to 3000 (US\$ 0.60-1.70 per day). Only 8% of the respondents earned more than Taka 5000 a month (US\$ 2.80 per day).

In response to the question as to who all were aware that the respondent had male-to-male sex, 98% reported that their friends knew. Yet almost a third [33%] of the

respondents also said that friends were the ones who had subjected them to sexual assault or rape.

Assault of a sexual nature*, or rape at the hands of friends' i.e. those who the respondent knew and trust, at 33%, is next only to sexual assault or rape at the hands of *mastaan* [traditional terms for hoodlums or bullies] and the Police.

**The cultural understanding of rape involves the act of penetration. The law on rape in Bangladesh as it stands in the Bangladesh Penal Code also reinforces this belief. However many times a person is sexually assaulted in a way where he may receive grave psychological and/or physical injury, but it may not involve anal penetration. This fact was explained to the outreach staff in the workshops, and they were asked to include all grave assault of a sexual nature {as opposed to minor harassment of a sexual nature} that may not have resulted in actual penetration in the response to the questions on sexual assault.*

64% of the total respondents reported facing harassment of one kind or the other at the hands of the police.

One of the most prevalent forms of abuse is the rape or sexual assault of *kothis***. It often results because the accepted notion amongst many *mastaans* as well as some police is that *kothis* are available for sex. Their will/choice is rarely respected when police or *mastaans* want to have sex with them.

***Kothis – a self-defined label used for feminised males who actively attract masculine males for sex through exaggerated behaviour. Kothis always state that they assume the penetrated role in anal sex. A significant number of kothis sell sex due to poverty. Many kothis may also be married to female partners. Also see the chapter on the social constructions of male-to-male sexual behavior.*

Rape and sexual assault also results when *kothis* or male sex workers refuse to pay the extortion demands of hoodlums or policemen.

Mymensingh, Dhaka, and Sylhet reported gang rape by policemen, where *kothis* were

rounded up and taken either to police barracks or the police post and raped by groups of policemen. Such forced sex is always unsafe and often results in serious physical injury like ruptured rectum, internal hemorrhage etc. It also generates risks for the police officials.

48% of the respondents reported that they have been sexually assaulted or raped by policemen, and 65% have reported that they have been sexually assaulted or raped by *mastaans*.

Another factor that contributes to the reduction of the basic safety of MSM and *kothis* in public areas is that *mastaans* are often in cohorts with the local policemen. *Kothis* therefore do not receive any protection from the police when any harassment or assaults by the *mastaans* are actually reported. This was clearly evidenced in the FGDs as well as in the in-depth interviews. When a participant in Mymensingh was asked as to why he did not tell the beat policeman about the fact that a well known *mastaan* had forcibly had anal sex with him and had thereafter snatched his money, he replied 'I was injured and bleeding in the anus. When I reached the place where the police persons usually stand, I found that the *mastaan* was taking money out of my wallet and giving it to the police. I was afraid that if I went to the policeman, he would force me to have sex with him too. I was in no condition to endure that.' This pattern is repeated in all the cities. In all the cities participants of FGDs were clearly reluctant to approach the police for any protection. They cited the basic sense of insecurity they felt from the police and the fact that in the past the police had victimized them instead of preventing or acting against the assaulter, as a reason for this reluctance.

Other than sexual assault, rape, and gang rape, the other harassment that respondents reported facing at the hands of police range from, extortion on the threat of imprisonment, prolonged blackmail, beatings, restriction of movement in public places, and disclosure of sexual practices to *mastaans* and family, amongst others.

71% of the total respondents stated that they had faced some or the other form of harassment from *mastaans*. Other than rape, these are, extortion [38%], beatings [45%], threats and blackmail [31%].

87% of the respondents stated that they had been subjected to sexual assault or rape

simply because they were effeminate. This is of course an indication of the whole issue of feminised males and gender, but it is also indicative of the high percentage of MSM who suffer sexual assault and rape.

One of the main findings of the study is that often it is effeminacy and not the factual knowledge of homosexual behaviour that leads to harassment. Many of the interviewees as well as the FGDs show that harassment results from the fact that many *kothis* do not live up to the expected normative standards of masculine behaviour.

In response to the question “how did people who know that you like to have sex with other males, find out this fact?” 62% of the total respondents replied that they guessed as much from their feminised behaviour.

41% of those who had faced some form of harassment at the hands of the police say that the police guessed that they were MSM from their feminised behaviours. 55% of those who had faced harassment from *mastaans* also reported that the *mastaans* guessed they were MSM from their feminised behaviour.

It is clear that there is a predominate pattern of male-to-male sex focused on gendered behaviours of both sex partners. This is accepted both by the respondents themselves as well as the public they interact with. It is also understood that male feminised behaviour is considered to be less worthy than the accepted standards of how a man should behave. This leads to a notion that those who are feminised can be exploited and abused, that being feminised somehow weakens the person, a notion often harbored by the *kothis* themselves. One of the interviewees in Chittagong said “I don’t mind if my *Panathi*** beats me up. It only shows how manly and powerful he is.” When probed further, he replied that, “actually when my *Panathi* beats me, I feel as helpless as a woman. Since I want to be a woman, it actually makes me feel good” .

****Panathi:** *The term that kothis give to their male partners. A panthi can be any man who is not effeminate. He is therefore largely invisible and enmeshed with the mainstream, and almost impossible to target with any kind of intervention for HIV. The only way to reach them is via the kothis along with those programmes that target males in general.*

Accepted notions around effeminacy are therefore one of the major factors that lead to disempowerment and opens *kothis* to abuse and assault. The fact that *kothis* themselves have internalized these notions so strongly, means that specific tools need to be developed for *kothis* in order to empower them to start valuing their lives and enhancing their self respect.

92% of the respondents stated that they considered themselves to be *kothis*. 83% of those who consider themselves *kothis* stated that they had faced unprovoked sexual harassment at some point in their life. 41% of them have responded that they have faced such harassment a few times [i.e. more than just once or twice].

62% of the respondents stated that the fact that they have sex with other males has had an economic impact on their lives. 43 out of the 78, i.e. a majority of the respondents who claimed that they had been economically affected due to the fact that they had sex with other males say that they are better off economically due to this reason. This may seem like a contradiction, for in a discriminatory setting it is more likely that a person would suffer economically than would benefit. On further analysis it was clear that most of the respondents who stated that they have benefited economically were involved in sex work.

Sex work is often not a matter of choice, but of economic necessity. Interviews with sex workers revealed that if they had other source of income, they would not take up sex work. One interviewee in Sylhet said, “I have been trying for a very long time to save and start a small shop, so that I do not have to do sex work. Then I shall stay as if married with only one *panthi*. But everything I earn is used up by my family or for my own needs. I just cannot save enough.” When asked why he was not looking for a job, he replied “I have worked as a domestic servant for 6 months. All the three sons of the employer repeatedly had sex with me and never gave me anything extra. They beat me up often. With my own shop at least I would not be harassed by employers.” He also mentioned “if the employer, like the three sons of my earlier employer, are to forcibly have sex with me anyway because I am a *kothi*, I might as well do sex work and get money for having sex”. The fact that most sex workers in the FGDs had education levels up to 4th standard or less, and that they had faced harassment in any small jobs that they could find, also meant that they were forced to take up sex work. Another factor that contributed to this economic necessity is that they often migrated to the cities to earn a livelihood and their

families depend on them for income. This acts as a pressure for taking on sex work. These factors are also borne out by the fact that 57% of the respondents stated that the fact that they were effeminate had affected their workplace. 77% say that if they were not *kothi* they would have found it easier to find work, or would be doing better in their present employment. 76% of the respondents felt that because of being a *kothi*, they do not get similar income opportunities as others.

Often sex work itself is disempowering and reduces negotiating capacity and increases vulnerability. In Chittagong 2 interviewees revealed that they would have unsafe sex if the client paid enough. They also stated that many clients are powerful and they are helpless in front of them and cannot insist on safer sex. This pattern is reflected in various degrees in all the cities.

29% of the respondents stated that some members of their direct family knew that they had sex with other males. Of the 25 respondents whose near relatives were aware, only 6 said that they had accepted it. The rest stated that their family had reacted negatively with beatings, forced marriage, disinheritance, throwing the person out of the house, taking them to doctors for curing them of homosexuality and so on.

48% of the respondents stated that fellow students or teachers had harassed them in school or college because they were effeminate. 55 out of the 60 respondents who said that they have faced harassment by teachers or fellow students also said that their studies have suffered due to this, and that they could have progressed more if such harassment had not taken place.

Of the 59 respondents who have said that they did not face harassment in the educational institutions, 40 had studied up to 4th standard or less, 13 up to secondary level, and 5 up to higher secondary level. All those who had gone to university reported sexual harassment in either school or college. This is a clear indication that the rate of harassment of *kothis* is more significant in higher education establishments. This could also be a factor for the low levels of education and literacy, and high early drop out rates, amongst *kothis*.

It is clear from the in-depth interviews as well as from the FGDs that economic

deprivation was a result arising from harassment during education. In Mymensingh, in one FGD, six out of seven participants stated that one of the main reasons why they left school was the harassment that they faced. “How can you study when all the time the classmates are making fun of you” is a common refrain. One interviewee in Sylhet said “My teacher called me to his house on the pretext of teaching me maths. But there he forced me to have sex with him. Then he told another teacher who also made me have sex with him. He also threatened to tell the principal that I am a bad person and I have sex. I was so scared, I refused to go to school any more. I was then in my 6th standard. I never studied any more.” They also stated that they couldn’t get a good job because of this and that many are forced to take sex work as a source of livelihood. The same interviewee from Sylhet states later “I think my teacher is responsible for my being a sex worker. I am sure I would get a job if I could have studied further. But I know that now and it is too late. If I had then known what I know now, I would have exposed my teacher, and continued my studies.” One person who is a graduate from a university participated in an FGD in Chittagong. He said, “My results in the finals were not good, and therefore I have to work in an NGO. Otherwise I would have gotten a good government job. I just could not study due to all the mental torture that my classmates subjected me to. Even the professors used to make fun of me in class.”

In effect there is a direct correlation between harassment at educational institutions and vulnerability, since such harassment result in eroding earning potential, disempowerment, and may even be responsible for forcing *kothis* into sex work.

36% of the respondents reported that they had faced harassment from religious leaders due to their sexuality.

In FGDs and in the in-depth interviews there was clear evidence of the lack of self-esteem and self worth amongst the respondents. In FGDs in Dhaka and Mymensingh, the participants reported instances where they had subjected themselves to self-inflicted injuries. These injuries ranged from shaving of their heads to make them look ugly, slashing their wrists with blades, cigarette burns etc. On enquiry they revealed that they did it to punish themselves, to draw the attention of someone, or at times, to draw sympathy. One participant in the FGD at Mymensingh stated that he drank kerosene to commit suicide. He said, “I really did not want to die. That is why I did not take pesticide,

although it was available. I just wanted my *panthi* to feel sorry.” Another person in Chittagong stated that he would have unsafe sex if someone paid the right price. When asked what if he got infected with HIV, he stated, “So what if I die. Is this any life? It is like death.” Similar instances had been reported by eight of the 12 interviewees.

From the results of the FGDs, the interviews and questionnaires the reasons for this lack of self-esteem and self worth can be identified as the following:

- *Kothis* often have a deep sense of guilt, as many seriously believe that either there is something wrong with them and that is why they are not ‘normal’, or that they are committing and/or living a life of sin. “I think Allah is punishing me by making me *kothi*” said a university graduate. He also mentioned that he tried hard to give up his desire for men, and attempted suicide when his desires did not go away. A sex worker said that he never prayed after he had sex. He just did not feel clean.
- Often *kothis* internalise the pain and trauma of the various repeated and harsh abuses that they face due to their feminised behaviours and their sexual preferences from a very young age. This is co-joined with the fact that they are rendered helpless in finding any remedy or recourse to justice. This leads to an intense frustration with their own self. A sex worker who had slit his wrist once said, “If I had my way I shall castrate all the *panthis*. They are all bastards [*haraami*]. Especially my uncle who raped me when I was 14. I feel so helpless.”
- There is no psychological or psychiatric help available to deal with the trauma of rape, which most had suffered at some point. This, when related with the double stigma of sexual violation and of the notions of shame in a society that proscribes any public discourse on male-to-male sexual behaviour, also leads to intense frustration and self-hatred.
- There is a deep sense of failure arising from the sense of incapability of dealing with the regular harassment and abuses that *kothis* face. This is exacerbated as one grows older, because the *kothi* begins to correlate their own sexuality with the obstructions and lack of progress of their various ambitions. This results in a pattern of self-blame, which manifests itself as self-hate. “I wish I was never born” said a FGD participant in Dhaka “then my family would not have to be ashamed of me. I cannot even earn enough for them”.
- Frustration with the harassment and abuse also manifests itself for some as a desire to change and become ‘normal’. This ‘desire to change’ is understood as changing

their sexual preferences and becoming 'non-MSM', 'non-*kothi*', or 'non-homosexual'. However, when in spite of attempts they are not able to change their desires or behaviours, they perceive this as a weakness of their self. This also erodes the value that they accord themselves.

- *Kothis* feel that they are not respected by society in general. A common refrain is "society does not accept us" or "society does not respect us". They see the various harassment and abuses as a manifestation of this lack of respect. Often this lack of respect is also internalised and reflected in self-destructive behaviour. One person in Chittagong admitted that he attempted suicide because he felt unloved and worthless.
- For some *kothis* economic disempowerment also leads to an eroded sense of self-worth.
- For some *kothis*, the fact that they had to sell sex in order to survive is a reason for great shame and trauma, and being sex workers who are often not in control of either their economic or their physical circumstances; they regard themselves as dirty and unworthy.

33% of the respondents reported that they have either thought of or tried to commit suicide at some point in their lives.

With a view to demonstrate the rate of harassment and obtain an indication on how many of those who have not been interviewed through the questionnaires also face the kind of harassment that the respondents may be reporting, or in the alternative how many of the respondents who report that they have not faced any harassment of any kind are aware of others who face such harassments, a question was posed 'Even if you have not been harassed, do you know of others who have been so harassed?' 77% [96 out of 124] of the respondents stated that they know of others who have also faced such harassment. Of this 96 who admitted to knowing such other persons, 46 stated that they know of less than 5 such persons, 33 stated that they knew between 5 to 10 such other persons, and 17 stated that they knew of more than 10 such persons.

It is also clear from the study that local constabulary often target outreach workers of MSM sexual health projects too with extortion demands, and if such demands are not met the work of outreach is obstructed. This has a direct impact on vulnerability and risk of

HIV.

Many times local constabulary make arbitrary arrests under the laws related to powers of detention on suspicion. This is a law that is abused with impunity to target outreach staff and MSM in the field. This law is also used as an excuse to justify any detention of MSM.

RECOMMENDATIONS:

In light of the above-mentioned findings, the following recommendations are made to address the issues that have come out in the findings of the study:

- 1) Since local police harassment and rape is a major obstruction to sexual health promotion, intensive sensitisation and training needs to be done with the police at all levels. This sensitisation should be two tiered and should be conducted separately.
 - a) The first tier should target police officials who are often not aware of the types of harassment that are committed by local police, nor are they sensitised to the issues of the human rights of MSM and the national policy framework on HIV/AIDS under which the intervention work is conducted. It is therefore necessary to target them with training and sensitization programmes so as to generate an appropriate human rights environment with law enforcement agencies.
 - b) The second tier should target the local police. It is more often these local police that are responsible for the various harassment and abuses of MSM. It is also they who often obstruct outreach work. Training with local police should involve, not only sensitization, but also developing with their participation, appropriate and actionable mechanisms that addresses such abuse and violations as and when they occur.
 - c) There may well be resistance to any such training process. But one way of overcoming this would be to involve the state agencies responsible for implementing HIV/AIDS prevention programmes to organise the training process with the involvement of police officials. In this way HIV prevention agencies can be utilised to train police at both levels.
- 2) It would not be viable to attempt to directly intervene with *mastaans* with sensitisation. But the effect of their abuses can be minimised by intervening with the police. If the police can be sensitised to the kinds of abuse and harassment that MSM in general and intervention agencies in particular face in the field from *mastaans*, and

if they can be urged to take appropriate and prompt action against them, then it is likely that such harassment will reduce to a large extent. Such sensitisation can be a part of the training package that is developed for the police.

- 3) As a first step it may be suggested that the police sensitisation be taken up in all the cities in which MSM HIV intervention projects are operational.
- 4) To minimise the incidence of rape and sexual assault, legislative changes need to be introduced that provide for effective remedy against male-on-male rape. This can be done by either introducing male rape provisions in the penal code, or by amending the sodomy law (Section 377 of the Bangladesh Penal Code) so that it covers all male-to-male non-consensual sexual acts while not criminalising consensual acts. This would make it possible for MSM who are victims of rape to seek legal remedy without criminalising themselves in the process. This can be done either by involving the National AIDS Programme in advocacy efforts targeted at legislative change, or it can be done by bringing about a constitutional challenge to the present definition and usage of the sodomy law in the court of law.

Section 377 Bangladesh Penal Code: Whoever voluntary has carnal intercourse against the order of nature with man, woman, or animal, shall be punished with imprisonment of either description which may extend to life, or up to 10 years, and shall also be liable to fine.

Explanation: Penetration is sufficient to constitute the offence as described in this section.

- 5) If the option of a legal challenge is chosen for bringing about the necessary changes in the sodomy laws, then adequate funding need to be provided for the same.
- 6) Sensitisation of the police should make issues around gender a main focus of activity. This is necessary to arrest the incidences of harassment and abuse caused by insensitivity to gender issues.
- 6) There should be provision of resources to conduct advocacy programmes with the education department to make gender sensitisation in the higher educational

institutions, especially institutions that are all male, a regular part of the education curricula. This would help in reducing the harassment of 'effeminate' and 'not-masculine' males.

- 8) One of the immediate needs of *kothis* is economic empowerment. This can be brought about by the following:
 - a) By the formulation of appropriate micro-credit and income-generation schemes.
 - b) By the institution of vocational and other non-formal education for MSM as they are often forced to leave formal education early, leading to erosion of economic capabilities.
- 9) The existing projects conducting HIV intervention programmes with MSM should be given the resources and training to develop their skills to start providing psychological and psychiatric help to those who have repressed trauma due to violence and sexual assault that they have faced. Appropriate mental health strategies need to be developed to address this.
- 10) Each city that has operational projects on MSM HIV intervention should be given the resources to train and sensitise a group of local lawyers on the jurisprudence of human rights development on MSM, so that they can form a core team whose services can be accessed whenever there is a violation of any right of MSM.

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For managing the diverse logistics of the study and keeping the stopwatch in place so that all activities of the study gets done in right time, thanks also needs to be given to AHM Azizul Haque, Paritosh Kumar Deb, Mahbubul Islam, and AHM Jamal Uddin, the project managers of Dhaka, Sylhet, Mymensingh, and Chittagong projects of Bandhu. Special Thanks to everyone at IDHRB, whose valuable inputs, total dedicated participation, and

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While this Briefing Paper arises from a specific study in Bangladesh, evidence from other south Asian countries strongly demonstrate similar dynamics and concerns.

Aditya Bondyopadhyay and Shivananda Khan

Briefing Paper No. 8

The context of social constructions of masculinities in South Asia and the *kothi* framework

October 2002

This paper arises from studies Aditya Bondyopadhyay has conducted in Bangladesh and India, along with the work of NFI.

It is important to locate the issues of sexual health of males who have sex with males in a theoretical framework around the construction of masculinities in south Asia. This is necessary to contextually conceptualize the dynamics which give rise to the violations and violence against MSM in conservative and discriminatory settings as found in south Asia.

Sexual Identities take shape within psychosocial and historical processes, which in turn are contextualised by culture and language. Therefore one finds that different cultures often translate similar words and phenomena into different meanings with inherent subtleties typical of that culture. Therefore at the very beginning it is important to understand that eurocentric perceptions and values gives a definition to heterosexual, homosexual and bisexual identities quite different from how these phenomena are understood in south Asia.

In south Asian cultures, the behaviour and experience of the male is affected by socio-cultural realities such as the invisibilisation of sexual behaviours, segregation of the genders, acceptability of male homo-sociability and homo-affectionalism, male dominance over public space and discourse, a culture of shame where family and community respect and honour holds sway, compulsory and arranged marriage, pressure of reproduction, understanding of sex only in a reproductive sense, joint families, and the negation of the self before the community and family. This behaviour is further defined by gender roles attributed to males and females within society, especially when important defining events in life such as the assumption of adulthood, are defined by such gender roles.

The fact that medicalisation of sexuality and sexual behaviours in the 19th century, largely in Western cultures, has given rise to a whole new discourse and understanding of gender, sexuality and sexual behaviour. This was based on who one has sex with, rather than on behaviour itself, giving rise to a new 'species' – the homosexual. But such a construction often has little relevance in the social and cultural context of much of south Asia. Therefore, to say that homosexuality is when a man expresses sexual attraction for another man may not be exactly appropriate in the context of this region. This is so because in South Asia, dichotomised and oppositional structures of gender roles are the defining characteristic. A man who has sex with another man is defined as a homosexual in the Western understanding whereas in South Asia, a more appropriate way of expressing the same would be to talk in terms of a male who has sex with another male. In other words in South Asia one has to talk in terms of sex between biological males, for often it is found that one of the partners in the sexual act would not describe himself as a man, or would not be recognized as man by his male sexual partner.

It is not surprising that the term homosexual does not have a direct equivalent in South Asian languages. This fact also underlines the history of tolerance of same-sex behaviour that has existed in the entire South Asian region, but only for the penetrating male. For the penetrated male, the issue of stigmatisation was focused on crossing perceived gender roles. It is only with the advent of criminalisation of sodomy imposed by the colonial powers in the sub-continent that the notion of right and wrong, and normal and 'abnormal' sexual behaviour became a reality in public discourse. However this discourse has developed in the gendered context of South Asia and therefore the abhorrence and discrimination that has been a result of such criminalisation has also grown similarly.

In the phallo-centric patriarchy that dominates social life in South Asia, sex is understood in a reproductive sense and masculine power is defined by the act of sexual penetration. In this scheme anyone who does not penetrate loses the claim to be defined as a man. The penetrator always remains "the man" but the one penetrated becomes "not man enough" and therefore somehow of a lower status and standing as compared to "the man". Again given the fact of accepted male superiority, such

penetrated persons are also considered to be degraded and thus often abusively addressed as *maiga, chakka, hijra, kothi, gotian, gandu* and so on.

The superior status of “the man” is enforced by the gender segregation of social spaces and of labour, both these spheres being dominated by men. The perception of the male child as family capital, along with strictly defined gender roles both in social duties and obligations as well as in terms of liberties enjoyed, often translates into severe punishment and retribution against the male who transgresses his role and thus devalues his status. All this also means every male has severe societal and familial pressures to marry and reproduce (preferably male children) so as to reassert his claim be “the man” in the penetrator oriented phallo-centric society that recognizes and legitimises only reproductive sex.

In other words it is marriage that makes “the man” a proper man, which institution effectively defines his becoming an adult. Thus, no marriage implies that a biological male has yet not become a MAN (an adult) and this perception affects one personally and how one is understood in society irrespective of his age. In a sexual context, the only way to deal with all of the above complexities even while preserving a semblance of the gender superiority of the man is to invisibilise sexual behaviour. Of course South Asia does have a way out of this dilemma. An unmarried male could be defined as a brahmachariya, a sanyasin, a person of religious persuasion who “sacrifices” his “manliness” for the greater good.

This invisibilisation helps preserving the fiction of reproductive sex only within marriage and complete absence of sex outside. It helps reinstate the reproductive logic of sex. And, most importantly, it sweeps the possibility of all sexual acts and behaviors outside the bounds of the above under the proverbial carpet by rejecting public discourse on the subject. It further helps in inculcating a sense of superiority vis-à-vis all traditions that are expressive of sexual diversities, which are seen as dirty and perverted. This is a huge psychological apple cart, which is toppled by males who participate as the penetrated sexual partner in the sexual act. They challenge all the accepted and ingrained notions and therefore are punished. The punishment takes the form of demasculinisation, dehumanization and deprivation of their various rights.

Sexual behavior takes the place of sexuality. Male sexual desire becomes self absorbed and is reduced to one of discharge, rather than based upon a desire for another person. The silencing and denial associated with this leads to an exile like situation, where, closeted and schizophrenic states of mind easily emerge and subsumes the person, wherein every expression of an alternate sexual desire has to be mired in shame and silence. All this has two significant fallouts, both curiously attached to the need of “the man”. The first is that sex is often seen as a means of releasing tension. That is why one hears terms like “I did sex to release body heat” or “I needed to release body tension”. The other is that sex takes the form of fun and play, where the stigma attached to it is sought to be reduced by defining it in a frivolous light. Terms like *masti* are used that are associated with sex. The term *masti* can be defined as fun or play or both. It is not serious enough to be sex, it just happens as if a game.

We arrive at a state where sexual preference and sexual behavior is not a matter of identity. It takes place in hushed circumstances and is propelled by opportunity, accessibility and the need of discharge. It is almost negated by giving it the appellation of play and fun.

One needs to take this understanding into the detailed analyses of the *kothi* construct. *Kothi* is a term that has existed for a long time in the popular discourse of the sub-continent. It was especially a part of the various dialects that was spoken by the *hijras* of south Asia. It did not define an identity, but rather a behavior. In the gendered world of South Asia, a male person who acted in a feminised manner was called a *kothi*. The term was derogatory and abusive in nature, and was intended to stigmatise. There was always the hidden implication that because the person is female-like, he would be penetrated by a MAN in the sexual act. But such feminised males gradually adopted the term so that often in their communication amongst themselves they called themselves *kothis*. It however still continued to describe a type of male and not a self-defining identity.

The “man” in this scenario can be anyone and he is in fact everywhere. He need not hide or be ashamed, for he is penetrating in the act of sex, therefore he is doing what men do. He is not doing anything deviant in so much as he is having sex with those who are women-like. Also he can disappear into the mainstream of male life in society

and therefore cannot be identified. He therefore cannot be targeted specifically either. And since usually his entire sexual act is in secret and is never spoken of or acknowledged in the public, he can safely hide behind the security that anonymity and lack of knowledge provides. He can also violate the rights of those who do not conform to the gendered roles of society with impunity and get away with it, for he himself cannot be targeted or shamed. He has been given the term *Panthi*, *Giria*, *Parikh*, etc. by the *kothis*. However it should be kept in mind that the *panthi* does not call himself such. He need not, for he is the regular man in society. It is only *kothis* who call him such, in counter-distinction to themselves. As said in the first line of this paragraph, he can be anyone and he is in fact everywhere.

Society at large, however, has all the reason to target and abuse a *kothi*. He is not a penetrator; therefore he is not man enough to enjoy the privileges of men. He is less than man, but still being a biological male, he is available and more accessible in the social domain than females. Therefore he can be accessed by the 'men' to fulfill their play, fun, and need of discharge. He is a cause of shame to the family and therefore is abused by it. He does not qualify and fulfill the gender roles, and therefore has to be policed, often with violence. Most importantly, he is perverted because he does sex for reasons that could not be reproductive, and therefore poses a threat to the social order.

It is with the advent of community building efforts as a part of HIV/AIDS intervention that the term *kothi* has been appropriated, and it has also become a matter of personal identity. The appropriation has actually reduced the stigma attached to the term and is seen to be gradually becoming a term of pride and community solidarity amongst *kothis*. It is a positive development, which may overturn or end the oppression of the society at some future date.

The self that is so negated by society, and which negation is deeply internalized by *kothis* themselves is responsible for the lack of self-worth and self-esteem of the *kothi*. The *kothi* is made vulnerable by the actions of society at large and he increases his vulnerability by defining his self in the stereotype of the gender role of an oppressed female in a traditional society. Being told that he is not a man or less than a man, and feeling uncomfortable with the roles and responsibilities that men have appropriated for themselves, a *kothi* begins to identify as a female. But this identification is not in

the image of an empowered woman. It is an exaggerated parody of the vulnerable woman. Therefore in the traditional societal structures, a *kothi* does not find the moorings of empowerment. He continues to languish in the self-defined and society determined disempowered role.

It is often observed that this sense of disempowerment translates into the *kothi* accepting the abuse and violations of his rights and bodily integrity as his due in society. He rarely fights back and he deals with the trauma of all the abuse by either turning on himself in self-destructive ways, or by suffering in silence. Psychological dysfunction is also observed in a lot of cases.

It also has economic ramifications. A *kothi* is hounded in educational institutions, so he cannot study. His lack of literacy compels him into economic disadvantage. He is very often denied inheritance and is forced into sex work. Employers discriminate and harass at the workplace, compelling them to leave the job market or seek jobs that under-employ them.

In any HIV prevention intervention one has to take into account the above realities. In the contemporary world where it is widely believed that the real antidote to the HIV and AIDS pandemic is by securing, protecting and promoting the rights of those most vulnerable, it becomes imperative that we approach the work of intervening with *kothis* keeping these social factors in mind so that appropriate advocacy and other tools can be developed that empowers *kothis* to take on the role of protecting themselves, even as they enhance their self-worth and self-esteem and get nearer to becoming equal partners and participants in social life.

Aditya Bondyopadhyay and Shivananda Khan

Briefing Paper No. 9

Know Your Rights

Are You a 'Man Who Has Sex With other Men [MSM]'?

Do you know your Rights?

October 2002

Do you know that in India it is a crime for two men to have sex with each other: Well that's what section 377 of the Indian Penal Code says. This section punishes 'Carnal intercourse against the order of nature' with up to life imprisonment. Although it is not defined what 'against the order of nature' means, the courts have ruled that this includes anal sex and oral sex. The question is how valid is this law, and is it implemented?

This law was made in 1860, and was based on the English anti sodomy laws. In England the anti sodomy laws have been undone. But this law remains in force in India. But with the change in understanding and attitude towards homosexuality, there is growing demand for a repeal of this law even in India. The Law Commission of India has recommended that this law should be repealed. Also this law is against the fundamental rights guaranteed to all citizens including MSM.

This law is rarely applied. But it is an excuse that the police and other law enforcement agencies use to harass, blackmail, and extort money from MSM. Raids in cruising areas are an example of such harassment that you often face. Also as long as this law exists, proper HIV/AIDS intervention work amongst MSM cannot take place. Distribution of condoms amongst MSM or giving information about safe sex may be seen as an abetment to the crime given in this law. Other rights of MSM, including their human and fundamental rights also suffer and cannot be protected and promoted.

The High Court or the Supreme Court can declare this law null and void. But no such judgement exists as yet. Currently it is under challenge in the High Court of Delhi.

But.....

Does that mean that you have no rights?

Well no. You do have certain rights that no law can take away. These are the **Fundamental Rights**, which is given in the constitution. These are the most basic of all the rights of the citizens, and the High Courts or the Supreme Court can declare void any law that is against the fundamental rights. Some of the important Fundamental rights that you should be aware of are:

§ **Right to equality [Article 14]:** This means that all citizens, be they MSM or not, have to be treated equally and given equal protection under the law. This article forbids the state [state means the government or agencies of the government like the police etc.] from acting with discrimination against anybody. For you as a MSM it becomes important since MSM have been additionally discriminated against.

§ **Rights to various Freedoms [Article 19]:** This article guarantees certain freedoms, which are:

- **Freedom of speech and expression:** This means that if you are a *kothi* and want to dress up like women or put on make up, then it is your personal expression and you cannot be targeted or harassed for that. You can also seek police protection against such harassment. If police are the ones who are doing the harassment, then complaint can be lodged against them, or they can be hauled to the courts. It also means that you can air your concerns and views without fear.
- **Freedom to assembly peaceably and without arms:** This means that you and other MSM have the right to visit public cruising areas as long as you are not doing anything un-peaceful, or any other act that may be obscene or create problems to others. You can also hold meetings and gatherings in these areas. It also means that in the absence of any prohibitory orders, the police cannot harass or target you in cruising areas.

- **Freedom to form Associations or Unions:** This freedom implies that you have the right to form support groups and NGOs who work for your concerns. As long as there is no illegal activity going on in these support groups, they are protected from any form of interference and harassment by the government or the police.
- **Freedom to move freely throughout the territory of India:** This freedom guarantees that you can travel in any part of India without any obstruction. On a smaller scale, no public space like parks etc. that you or other MSM may access for cruising or socialisation, can be closed specifically to you. If you are a Male Sex Worker, you cannot be removed from public spaces, nor can any restriction be put on your movement. However in the public space, if you indulge in an actual sexual act, you may be booked under the obscenity laws or for lewd conduct. For actual sexual acts or for soliciting in public you may also be booked under the “Immoral Traffics Prevention Act”.
- **Freedom to reside or settle in any part of the territory of India:** This means that you cannot be denied residence in any part of India. If you are a legal resident of a premise, then the state cannot evict you for being MSM. You can also file a police complaint against any harassment or obstruction caused to you in any such residence.
- **Freedom to practice any profession, or carry out any occupation trade or business:** This freedom is extremely important for you, especially if you are a Male Sex Worker. Sex work is an occupation, and you have a right to carry on with it. Although Section 377 of IPC makes anal and oral sex illegal, the “Immoral Traffic Prevention Act”, which is the law relating to sex work does not make sex work illegal by itself, even for Male Sex Workers. This means that unless the state can prove that the sex work involves anal or oral sex, it cannot stop you from doing sex work.

Note: The above freedoms are not absolute. The state can put restrictions on their enjoyment on the grounds of public order, decency, morality etc. But since no such specific restriction with regards to MSM has been put as yet, you can enjoy these freedoms as though they are absolute.

§ **Right against illegal punishment [Article 20(1)]:** This right guarantees that no person can be punished arbitrarily for anything that is not a crime.

Although technically anal and oral sex is a crime under Section 377, but it has to be proved in a court by conducting a trial, before anyone can be punished for it. Effectively however, it is seen that anal or oral sex is very difficult to prove.

§ **Right to life and personal liberty [Article 21]:** This is probably the most important fundamental right and implies that the state cannot only not take away your life, it can also not do anything that affects your standard or quality of life. Also the State cannot hurt your dignity in any way, or take away your liberty to act as you please, as long as you do nothing illegal. Since male-to-male sex is fundamental to your existence, happiness, and quality of life, it can be said that this article provides you with protection against harassment or criminalisation for such sex. But this would have to be confirmed by a judgement of the court, which is not there as yet.

§ **Protection against detention and arrest in certain cases [Article 22]:** This article becomes important since the police often pick up MSM from cruising areas. As per this article, the police are bound at the earliest to disclose to the person arrested, the ground for such arrest. If you are arrested, you have to be produced before a magistrate within 24 hours of your arrest. You also have the right to be represented by a lawyer of your choice. We shall deal with your rights on arrest in details later.

Are these the only rights that you have?

Actually you have various other rights under **civil** and **criminal** law.

Civil rights means that you cannot be denied your right to property, or the right to participate in civil activities like voting, travelling by public transport, inherit property, going to school or college, getting married, adopt children [if allowed under your personal law], etc. simply because you are MSM. Under civil law you can also sue for compensation for any damages or injury that you may have suffered at the hands of any person.

Criminal Law provides protection to you against any form of mental harassment or bodily harm, and punishes the offender. In this regard it is important to know that all forms of threat and/or violence is a criminal offence. So if you are a MSM and are faced with any of the following situations:

- You are either being threatened with physical violence, or being subjected to such violence.
- You are being wrongfully restrained or confined [for e.g. you are being locked up] by your family or by anybody else.
- Somebody is causing you hurt and injury to either extort money from you or extracting a confession from you.
- Somebody is forcefully having sex with you when you do not want to have sex with him.
- Somebody is blackmailing you or threatening you with exposure.
- Somebody is otherwise harassing you.

You can take legal action against such person and can have him criminally prosecuted. Such prosecution depends on whether the crime committed by the person is cognisable or non-cognisable.

What are Cognisable and Non-Cognisable offences and how can you act in each case?

Well **cognisable** offences are those that the police can investigate on their own accord and can arrest a person if they find him guilty. Therefore if you have been subjected to a cognisable offence, you have to file a complaint and insist with the police that a FIR

has been registered. A FIR is the first step to a prosecution. Thereafter the police shall on their own accord investigate and prosecute the person. If however the police refuse to file a FIR, you can have your complaint sent over to the Superintendent of Police by a registered letter, and that suffices as a FIR. If the police still do not act, you can file a writ petition against them in the High Court, and ask for a direction compelling them to act on the FIR.

A **non-cognisable** offence is one where the police needs the permission of a magistrate before they can investigate the crime. They also need an arrest warrant before they can arrest the person. Therefore in such cases, you can file a complaint in the general diary of the police station. The Station I/C will most probably then direct you to a magistrate for permission to prosecute the person. But you can also directly go to a magistrate, file a complaint before him, and ask for prosecution of the person. Going directly to the magistrate is a better idea if the person involved is a policeman.

Often you can ask the police station to tell you whether the crime is cognisable or non-cognisable. It is also a good idea to consult a lawyer, for he can assist you in the whole proceeding.

Other than the above provisions, you can also ask the Executive Magistrate to make the person involved sign a bond for keeping the peace. He can thereafter be punished if this bond is broken. If the persons involved are police personnel, you can make a police complaint and can ask for departmental inquiry against them. You can also file a writ petition against the police in the High Court. Now days, you can also approach the National or the State Human Rights Commission for violation of your rights by the Police.

Remember that the police have no right to harass you. The police cannot violate the law, nor are they above the law. Harassment or extortion by the police amounts to misconduct and action may be taken against them for this. They may also be suspended if a complaint is filed against them. For specific crimes they may be punished under the Indian Penal Code.

So what are your rights if the police arrest you and what can you do?

§ You have the following rights when you are arrested:

- To be informed of the **reason for your arrest**.
- You also have the right to inform at least one friend, acquaintance, or relative, of the fact of your arrest and where you are being held.
- You have a right to consult a lawyer, and be represented by the lawyer.
- If you cannot afford a lawyer, you have the right to ask for **free legal aid**. Ask the magistrate when you are produced before him for being provided with such legal aid.
- You cannot be **handcuffed**. However necessary force may be used against you or to restrain you, if you resist arrest.
- You have to be produced before a magistrate within 24 hours of your arrest. You may insist on this if you are not so produced.
- If you are charged with a bailable offence, you have the right to be released on bail.
- You have the right to apply for bail before the magistrate/court, if you are charged with an offence that is non-bailable.
- You have the right to be examined by a doctor at the time of your arrest and any injury marks on your body must be recorded.
- You also have the right to be examined by a doctor every 48 hours of your detention.
- You have the right to meet your lawyer during interrogation.
- The police cannot force you to give evidence against yourself. Therefore you may keep quite and not answer any question during interrogation.
- It is important to understand that anything that you tell the police cannot be used as evidence against you.
- The police cannot use force or third degree measures against you.

§ These are some of the things you may do in case you are arrested:

- It is always best to keep the telephone number of either a reliable lawyer, or such person who can get you a lawyer always with you, and insist on calling that person after you are arrested.

- If you anticipate an arrest, it is advisable to apply for and obtain an order of anticipatory bail.
- When you are being arrested, there is no point in resisting arrest. It is best to seek legal help afterwards.
- Feel confident to tell the police that you are aware of your rights and that some of their actions are illegal.

Are there any other rights that you, as an MSM, should be aware of?

Well certainly! You must also be aware of your **Health Rights** and **Sexual Rights**.

§ **Health Rights** arise from right to life, which has been described above. No person can interfere with your body unless you give free, specific, and fully informed consent for the same.

Fully informed consent means a doctor cannot treat you in any manner that he thinks fit, unless he has informed you of the possible adverse consequences of the treatment, and you have thereafter agreed to be treated. A doctor or anybody else cannot test you for HIV either, unless you have been counselled and have agreed to be tested. Your consent also has to be free, which means that nobody can force or coerce you to agree to anything. If you have been tested for HIV against your will, or if you have been subjected to any treatment that you did not agree to undergo, you can seek legal remedy against the doctor or the medical institution.

You also have a right that the confidentiality of any treatment that you undergo be maintained. If your confidentiality has been breached, you can take legal action.

If you are HIV positive, you need not be afraid to take legal action for fear of your status being disclosed in the court. Now, you can sue under a false name [*this is called suppression of identity*], without revealing your identity.

You also have the right to seek medical treatment from any state run medical establishment without discrimination on the ground that you are MSM. In fact a state run medical establishment cannot deny you treatment on any ground. If they do you can take legal action against them and seek compensation.

§ **Sexual Rights** arise from the fact that you are the absolute master of your body and no one can interfere with it against your will. Therefore no one can force you to have sex with him or her. Also if you have agreed to have only safer sex, then no one can forcefully have unsafe sex with you. Such acts tantamount to sexual assault, and criminal action may be taken against the person who does this. Such a person can also be sued in a civil court for compensation.

Often, the local MSM sexual health agency can help you if you are facing any kind of problem or if your rights are being violated. These agencies also can assist you in seeking legal help. It is therefore best to keep the contact number of these agencies with you and to call them for help when you need it. Unless you know your rights and start exercising them, others will continue to violate them.

Aditya Bondyopadhyay

Briefing Paper No. 10

A rights based framework for preventing the transmission of HIV among men who have sex with men

Paper prepared by Miriam Maluwaⁱ, UNAIDSⁱⁱ Law and Human Rights Adviser

Presented at an Inter-Agency meetingⁱⁱⁱ on “Working with Men who have Sex with Men for HIV/AIDS Prevention and Care, 1 November 2002, Room C102, World Health Organisation, Geneva Switzerland

I. The Framework

International human rights law protects all persons equally, without distinction or discrimination. The broad range of human rights- civil, political, economic, social and cultural- should be equally enjoyed by all groups of individuals. The protection of the basic human rights of men who have sex with men is therefore, grounded in a human rights framework that all people are worthy of equal respect and dignity whatever their situation.

The core international human rights Treaties and Conventions adopted by the General Assembly, *inter-alia*, the Universal Declaration on Human Rights,^{iv} Convention Against Torture, Inhuman and Degrading Treatment,^v International Covenant on Civil and Political Rights,^{vi} the International Covenant on Economic, Social and Cultural Rights,^{vii}, the International Convention on Elimination of All Forms of Discrimination Against Women^{viii}, and the Convention on the Rights of the Child^{ix} guarantee all human beings freedom from discrimination on many grounds, including sex, colour, language, religion, political opinion, birth, national or social origin, property, civil, political and social or other status.

The principle of non- discrimination has also been adopted in regional human rights instruments such as the African Charter on Human and People’s Rights,^x the American Convention on Human Rights^{xi}, and the European Convention on Human rights^{xii},

In the context of HIV/AIDS, the United Nations Commission on Human Rights has resolved that “...discrimination on the basis of AIDS or HIV status, actual or presumed, is prohibited by existing international human rights standards, and that the term “or other status” in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS.”^{xiii}

Thus, no one should be discriminated against on the basis of their HIV status or suspicion of it. In reality, however, members of populations perceived to be at higher risk of HIV infection, such as men who have sex with men or their families and associates are “presumed” infected and, thus discriminated against.

The United Nations human rights treaty bodies that monitor’ compliance of States, at national level, with their obligations to ensure respect, protection and fulfillment of human rights of all persons provide (i) an important avenue for raising HIV-related human rights issues, (ii) elaborating how principles of international human rights law apply to HIV/AIDS, including on issues of men who have sex with men and (iii) helping States better to understand and comply with their obligations as they apply to HIV/AIDS.

The Human Rights Committee, which monitors the implementation of the International Covenant on Civil and Political Rights, has, for example, addressed the issue of the right to privacy, noting that Article 17^{xiv} of the International Covenant on Civil and Political Rights is violated by laws which criminalize private homosexual acts between consenting adults.^{xv}

Specifically in the context of HIV/AIDS, the Committee has found that the “criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS ... by driving underground many of the people at risk of infection ... [it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention.”^{xvi}

Further, the Committee has also resolved that the term “sex” in article 26 of the Covenant on Civil and Political Rights, which prohibits discrimination on various grounds,^{xvii} includes sexual orientation.^{xviii} Furthermore, the Human Rights Committee has also confirmed that the prohibition against discrimination requires States to review and, if necessary, repeal or amend their laws, policies and practices to proscribe differential treatment that is based on arbitrary HIV-related criteria.^{xix}

II. Vulnerability of all

Discrimination against men who have sex with men and other disadvantaged groups^{xx} increases such person's vulnerability to the risk of HIV infection, as well as the likelihood that they will be targeted for coercive measures, such as mandatory testing, arbitrary arrest, segregation, detention and deportation.^{xxi}

Such discrimination also compromises the health of the general population as those affected actively avoid detection and contact with health and social services. The result is that those most needing information and, education and counseling are driven underground.

Safeguarding human rights in the context of HIV/AIDS is, therefore, not only vital in itself as a principle, but it is also pragmatic. Its aim is to encourage those who are infected to cooperate with the authorities so as to slow down the epidemic. This can be achieved only if people have assurances that their rights will be respected.

III. Accountability of States

As members of the United Nations and as States Parties to the said international human rights instruments, States have obligations to *respect protect* and *fulfil* human rights.^{xxii}

The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of human rights.^{xxiii} The obligation to *protect* requires States to take measures that prevent third parties from interfering with human rights^{xxiv} and the obligation to *fulfil* requires States to adopt appropriate legislative, budgetary, judicial, promotional and other measures for the full realisation of human rights.^{xxv}

States have also willingly made political commitment to implementing human rights in the context of HIV/AIDS.^{xxvi} States must be held accountable for these legal and political commitments.

IV. Conclusion

The human rights framework gives access to existing procedural, institutional and other accountability and monitoring mechanisms which can be used to monitor and

advance a rights based approach to HIV programmes, including those addressing men who have sex with men.

Given the magnitude of the HIV epidemics, “human rights for all” should not be rhetoric. The fundamental human rights principle of non-discrimination should lay the foundation for effective responses to the global HIV epidemic, and hopefully to the protection of the right to health for all, equally, irrespective of status.

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ⁱⁱ The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the main advocate for global action on HIV/AIDS, leading, strengthening, and supporting an expanded response to prevent the transmission of HIV and alleviating the impact of the epidemic. UNAIDS is a unique joint venture between UNICEF, UNDP, UNDCP, UNFPA, UNESCO, WHO, ILO and the World Bank to bring together expertise in sectors ranging from health to economic development.

ⁱⁱⁱ Convened by UNAIDS Secretariat and WHO.

^{iv} Adopted by the General Assembly on 10th December 1948 under Resolution 217 A (III)

^v Adopted by the General Assembly on 10th December 1984 under Resolution 39/46 of December 1984. Entered into force on the 26th June 1987.

^{vi} Adopted by the General Assembly under G.A resolution 2200 (XXI), UN GAOR, 21st session, Supplement No. 16, UN Doc. A/6316 (1966). Entered into force 23 March 1976.

^{vii} Adopted by the General Assembly on 16 December 1966 under G.A. Res. 2200 (XXI); UN GAOR, 21st Session, Supplement No. 16 at 49, UN Doc. A/6316 (1966).

^{viii} Adopted by the General Assembly under GA Resolution 34/180 of 18 December 1979. Entered into force 3 September 1981

^{ix} Adopted by the General assembly under GA res. 4/25 of 20 November 1989. Entered into force 2 september 1990

^x Adopted on 26 June 1981. Entered into force 21 October 1986

^{xi} Adopted 22 November 1969. Entered into force 18 July 1978

^{xii} Adopted 4 November 1950. Entered into force 3 September 1953.

^{xiii} Commission on Human Rights Resolutions 1995/44; 1996/43, 1999/49; 2001/51 and Sub-Commission Resolution 1995/21

^{xiv} Article 17 states (i) “No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. And (ii) Everyone has the right to the protection of the law against such interference or attacks.

^{xv} Communication No. 488/1992, *Nicholas Toonen V Australia*, (Views adopted on 31 March 1994, fiftieth session). See Report of the Human Rights Committee Volume II General Assembly Official Record Forty-ninth session (Geneva, 18 October to 5 November 1993); Fiftieth session (United Nations Headquarters, 21 March to 8 April 1994) Fifty-first session (Geneva, 4 to 29 July 1994), (A/49/40) . <http://www.unhchr.ch/tbs/doc.nsf/Pages/226-237>, paragraph 8.2

^{xvi} *ibid*, paragraph 8.5

^{xvii} “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”

^{xviii} *ibid*, paragraph 8.7

^{xix} *ibid*, paragraph 11

^{xx} Such groups may also include women, children, minorities and indigenous populations, those living in poverty, migrants and other aliens and injecting drug users.

^{xxi} See examples of HIV/AIDS related litigation <http://www.tac.org.za/>; Carrasco E (2000); and Access to Treatment as a Right to Life and Health. Canadian HIV and AIDS Policy Law Review; 5:4. Available at: <http://www.aidslaw.ca/maincontent/otherdocs/Newsletter/vol5no42000/carrascodurban.htm>

^{xxii} See Committee on Economic Social and Cultural Rights *General comment 14. The right to the highest attainable standard of health adopted* 11 August 2000.. E/C.12/2000/4, paragraphs 34-37

See also <http://www.unhchr.ch/html/menu2/6/cescr.htm>

^{xxiii} For example, refraining from identifying or limiting equal access of all persons, including men who have sex with men, preventive and curative HIV/AIDS health services and care or abstaining from enforcing discriminatory practices as State policy.

^{xxiv} For example, adopting of legislation to ensure the equal access to health care and health related services provided by third parties; to control the marketing of medicines and medical equipment and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.

^{xxv} For example, adoption of a national health policy with a detailed plan; promotion of HIV/AIDS education, as well as information campaigns and vaccine research

^{xxvi} For example, recent relevant political commitments have been made in the United Nations Millennium Declaration (2001), the UN General Assembly Special Session Declaration on HIV/AIDS (2002), The Declaration and Program of Action of the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance (2001) and The Declaration from the World Summit for Social Development (2002)