

## **MSM Advocacy Project**

**Enhance the capacity to the National MSM and AIDS Human rights, policy and advocacy Task Force to enable it to train, establish, monitor and coordinate the activities of 13 Local Policy and Advocacy Units in MSM Projects in 13 cities of India over a period of 1 year**

**PMO/CASP/005**

**Executive Summary**

**April 2007**

## Acknowledgements

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## Acronyms

AIDS	Acquired Immune-Deficiency Syndrome
CBO	Community-based organisations – in this context organisations developed by MSM for MSM
DfID	Department for International Development, UK
FCO	Foreign and Commonwealth Office, UK
HIV	Human Immunodeficiency Virus
INFOSEM	Indian National Forum for Sexual Minorities
INGO	International non-government organisation
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersexed and Queer
MOU	Memorandum of Understanding
MSM	Males/men who have sex with males/men: NFI prefers the term biological term 'male' rather than the socially constructed word 'man' in the South Asia context
MSW	Male sex workers – specifically refers to those males whose sole source of income is from sex work
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NFI	Naz Foundation International
NGO	Non-government organisation
SACS	State AIDS Control Society
STI	Sexually transmitted infection
TI	Targeted interventions
UK	United Kingdom
UNAIDS	United Nations Joint Programme on AIDS

## Why we should work with males who have sex with males

Why we should work with male-to-male sex and HIV prevention, care and support?

Because:

- It is the right thing to do on humanitarian grounds.
- It is the right thing to do epidemiologically.
- It is the right thing to do from a public health perspective.

Males who have sex with males (MSM) whether their self-identity is linked to their same sex behaviour or not, have:

- The right to be free from violence and harassment;
- The right to be treated with dignity and respect;
- The right to be treated as full citizens in their country;
- The right to be free from HIV/AIDS;

MSM who are already infected with HIV have the right to access appropriate care and treatment equally with everyone else, regardless of how the virus was transmitted to them.

## Sexual health

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

*World Health Organisation  
Draft working definition, October 2002*

## Executive Summary

HIV/AIDS is a growing issue of concern in India, where currently the government states that 5.10 (or more) million people are infected, but with some estimates indicating that the country could have some 20 million HIV positive people by 2020 if the current lack of prevention work continues.

The issue of male-to-male sex as a contributing factor to the rapid rise in the number of HIV infections in India has not been significantly acknowledged for a variety of reasons. Apart from a lack of data, these reasons include a range of socio-cultural factors, such as denial, invisibility, and a construction of male sexualities based on a western frame of gay sexualities, which has led to a supposition that there is a low prevalence of male-to-male sex in the country. However, much of the sexual behaviour between males in India is, in reality, based on constructions of gender, not on sexual orientation.

In terms of the dynamics of differing frameworks of MSM, NFI and its partners have focused on those who are socially excluded, the marginalised and stigmatised, economically disadvantaged, and those who are the most vulnerable to infection and have least access to services. These are the most visible of MSM, the ones who construct their sense of being within a gendered framework of feminised behaviours and sex roles.

In this context, MSM is a highly stigmatised and vulnerable population with regard to HIV infections, and there is growing evidence to indicate the HIV prevalence rates among this population is increasing, whereas the HIV prevention, care and support service coverage across the country is very low.

A significant part of the denial of MSM and HIV concerns is the fact of their social exclusion and discrimination, and the range of social, legal and judicial impediments in developing appropriate HIV services for MSM, as well as accessing those services.

Social exclusion has a personal and social history that lead to negative impacts on educational and employment opportunities, which, of course, increases poverty and which increases an already low self-esteem and self-worth because of femininity and preferred sexual practice, and leads to the potential for sex as a source of income for self and family and a survival strategy. This leads to a denial of social justice and human rights.

In other words, social justice and human rights issues for MSM are a complex matrix of issues, concerns, and needs that reflect 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. It is a vicious circle that constantly reinforces itself.

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 individuals. The protection of the basic human rights of MSM should therefore grounded in a human rights framework, that all people are worthy of equal respect and dignity whatever their situation.

Between 2003 and 2005, Naz Foundation International conducted a study into the violence, abuse and discrimination faced by MSM, which was published under the title *From the Frontline* (for a copy of the report please NFI website [www.nfi.net](http://www.nfi.net)). This study was supported by the British Foreign and Commonwealth Office and it provided empirical evidence that there was significant levels of abuse, violence and rape of MSM, and that the social, legal and judicial environment was having a detrimental impact on sexual health interventions, where even staff of MSM agencies were being harassed, abused and violated. It was clearly demonstrated that these impediments led directly to disempowerment and increased vulnerability of MSM, where violence and the violation of

human rights obstructed redress of grievances, and created an atmosphere of fear where implementation of sustained HIV risk reduction was very difficult, if not impossible.

Beyond this study, NFI also established the the National MSM Human Rights Policy and Advocacy Task Force (the Task Force for short), along with advocacy cells set up in 5 partner projects through providing training in legal literacy and rights, along with documentation and monitoring skills.

The present project, supported by the DfID India Office, was developed to sustain the achievements of the FCO supported project, by continuing to support the existent advocacy cells, support and extend the scope of the Task Force, and support the development of new MSM advocacy cells. The study on the socio-cultural, judicial and legal impediments to sexual health promotion among MSM was also extended to include these additional areas where the new advocacy cells were to be established which would provide a more comprehensive report on human rights violations among this highly stigmatised and at-risk population.

The project period was between April 2006 and March 2007.

## Activities

The main activities undertaken were:

- MOU developed with the National MSM and AIDS Task Force to implement the project, and funding support provided to continue its activities.
- 8 Training workshops conducted in 8 cities for MSM CBOs to develop local policy and advocacy cells and staff recruited.
- Funding support provided through the National MSM and AIDS Task Force to these 8 policy and advocacy units to conduct their project activities (documentation and crisis interventions). MOUs were developed with each of the local projects.
- Funding support provided to the 5 policy and advocacy units already developed to maintain their activities and their MOUs extended for the project period.
- 11 Training workshops conducted with 11 of the policy and advocacy units to develop peer educators for the dissemination on legal literacy and human rights.
- Recruitment of consultant for the development of the documentation process and production of the book on *kothis*.
- Workshop conducted for project partners on documentation methodologies and photography as a documentation tool.
- Documentation by project partners in terms of 2 case studies per partner of human rights violations, along with photographs, and theoretical background paper developed for the advocacy book.
- Advocacy book on *kothis* produced.
- Regular documentation of human rights violations by each local policy and advocacy cell, reporting to the National MSM and AIDS Task Force.
- Monitoring visits to the local policy and advocacy units conducted by the Task Force
- Monitoring visits to the Task Force conducted by NFI.
- Regular activities and financial reports produced.

## Amendments to the original work plan

Amendments were agreed in December 2006, which included:

- Planned national workshops with secondary stakeholders were halted with the rationale that organising just 3 workshops at the national level would not be the most effective way of addressing the advocacy concerns of MSM at this level, and therefore these workshops may not be the most effective use of the available resources. It was further understood that the low key regular but sustained advocacy that the National Task Force was already conducting at the

national level was a much more effective way of creating change. Funds allocated for this activity was used to develop an additional 2 more policy and advocacy units.

- The activity of monthly stakeholder meetings as was being conducted by the local policy and advocacy units were discontinued after the month of October 2006, for the same reasons as stated above, namely that it was realised that one off meeting with one groups of stakeholders was not the best utilisation of the available resources, and that a sustained low key intervention with advocacy tools with local government officials and other stakeholders was a much more effective method.
- An additional activity of creating a document by involving the project partners, on the lives of *kothis*, so that a better understanding of *kothi* issues and needs can be achieved with the general public, was included in the list of activities. This inclusion resulted in the creation of the book *My Body Is Not Mine – Stories of violence and tales of hope – Voices from the kothi Community in India*.

## Achievements

### Output 1

*National MSM AIDS Task force supported for project period.*

Trainings conducted, funds disbursed to all 13 units, BCC resource produced, *kothi* book produced, activities coordinated with local advocacy units. 11 monitoring visits conducted:

The project already has had an impact on the development of NACP III planning, as project partners were a part of the process whose inputs were taken on board, as well as a part of the pre-consultation meeting process of *Risks and Responsibilities Male Sexual Health and HIV in Asia and the Pacific International Consultation Meeting*, and were therefore involved in developing the Principles of Good Practice and the Delhi Declaration of Collaboration documents.

### Output 2

*Eight new policy and advocacy units developed and supported during project period, with training provided on human rights of MSM, procedures for documentation of abuse and violence, and legal literacy dissemination.*

Training on legal literacy, human rights framework, advocacy methodologies, policy strategies, documentation etc.

Total of 60 MSM trained  
8 training workshops conducted

Locations and people reached:

Ahmedabad	666
Baroda	N/A
Cochin	534
Goa	200+
New Delhi	987
Pondicherry	1067
Thiruchirapalli	665
Vishakapatnam	983

Advocacy meetings held with local stakeholders: 66 meetings

Targets for legal literacy have been achieved as a result of the legal training workshops with partners and community members

Documentation and interventions in crises situations have ensured that specific issues are identified and addressed.

The National Task force and members of the local policy and advocacy units have informed and influenced the debate on the NACP III strategy formulation, and also the MSM strategy document thereby affecting directly the policy regimen. Participation in the court challenge to Section 377 has been positive and is likely to result in overturning the law in the foreseeable future. Local advocacy with the media, the police and the bureaucracy has created a positive environment where MSM interventions can take place.

There has been an actual increase in the reporting of the number of abuse, harassment and violence. This is actually a positive trend and a result of increased awareness and the availability of a support structure to address these incidents. The taking on board of these higher reported incidents and intervention to mitigate them is assured to actually bring down the number of cases in the future.

### Output 3

*Photo-book produced on case studies of human rights abuse on MSM along with the theoretical framework on violence and discrimination against MSM.*

Consultants recruited, and training held with community leaders on documentation methodologies and use of photography for documentation on rights abuse.

*13 participants*

Photo-book produced:

*My Body Is Not Mine: Stories of Violence and Tales of Hope – voices from the kothi community*

### Output 4

*Support provided to the 5 already existing local policy and advocacy units during project period.*

Locations and people reached:

Chennai	2120
Hyderabad	5430
Kolkata	1022
Lucknow	4312
Mumbai	3478

### Output 5

*Training workshops for MSM as peer educators conducted in six cities to develop skills on legal literacy and human rights, along with the production of a booklet Know Your Rights in five vernacular languages (Bengali, Malayalam, Tamil, Telegu, and Gujarati).*

11 Workshops conducted: 73 MSM trained as peer educators on legal literacy. Workshops held in Ahmedabad, Chennai, Cochin, Goa, Hyderabad, Kolkata, Lucknow, Mumbai, Pondicherry, Trichy, and Vizag.

BCC resource produced *Know Your Rights* in Bengali, Gujarati, Malayalam, Tamil and Telegu.

## Output 6

Human rights violations, abuse, discrimination and violence against MSM documented in 13 cities where policy and advocacy units had been developed.

City	Family Violence	Police Violence	Police/Other Rape	Murder	Discrimination (medical, job, etc)	Other
Kolkata	28	8	2	1	29	7
Lucknow	31	4	2	0	13	3
New Delhi	16	23	5	0	8	13
Baroda	NA	NA	NA	NA	NA	NA
Ahmedabad	16	1	0	0	4	9
Bombay	44	15	11	7	12	9
Goa	3	2	0	0	0	10
Cochin	26	17	1	0	4	1
Chennai	17	6	3	3	11	11
Trichy	37	17	1	1	2	18
Pondicherry	11	8	2	0	4	3
Hyderabad	45	21	7	0	34	2
Vizag	9	15	2	0	22	3

The projected output for a reduction of incidents of human rights abuse of MSM arising from the activities of the local policy and advocacy cells was not achieved. Rather, there has been an increase in the reporting of such incidents. However, it is clear, however, that this is the consequence of MSM having access to a reporting mechanism, where prior to the development of such policy and advocacy units, no such mechanism existed. This can thus be seen as a positive trend where more people are aware and therefore willing to report such abuse and violence. While this can be perceived as a success achieved within the project period, this also entails that such work must be sustained and strategies must be developed with all stakeholders to address these instances of abuse and violence, so as to reduce their occurrence and mitigate their impact in the future.

## Partner organisations

Organisations existing at the time of the commencement of the project that were supported through this project	Organisations that were developed as part of this project
1] Bharosa Trust, Lucknow	1] Parma, Ahmedabad
2] Pratyay Gender Trust, Kolkata	2] Lakshya Trust, Baroda
3] Mithrudu, Hyderabad	3] Humsafar Trust, Goa
4] Sahodaran, Chennai	4] FIRM Anasooya, Cochin
5] Udaan Trust, Mumbai	5] Sahodaran, Pondicherry
	6] Snegyitham, Thiruchirapalli
	7] Sahara Trust, Vishakhapatnam
	8] Mitr Trust, Delhi

## Key study findings

The study interviewed 50 respondents in each of the 6 cities originally targeted for developing the new MSM policy and advocacy units, giving a total of 300 respondents. The cities involved were Ahmedabad, Cochin, Panjim, Pondicherry, Thiruchirapalli, and Vishakhapatnam.

In India, due to socio-cultural-religious pressures and obligations, the majority of MSM, whether feminised or not, get married. For many such MSM, duty obliges them to carry on an active sexual life with their spouse even as they also have sex outside of the marriage with other male partners.

This means that many MSM can act as a bridge population for the spread of STI and HIV. The study reported that almost two thirds of the respondents got married because of family pressure. However, almost half of the respondents stated that their wives are unaware of their male-to-male sexual activities.

In fact even in those cases where the wives had knowledge of the male-to-male sexual activities of the respondents, almost half of them reported that had accepted it, either reluctantly or willingly. This is possibly reflective of the status of women in society, where the shame and stigma associated with divorce often compels many to meekly accept their husbands' activities without protest. Moreover almost 5% of the respondents have stated that they had regular female sexual partners other than their wives.

Almost 25% of the respondents stated that their parents knew about their male-to-male sexual activities. Almost one third of these respondent stated that these persons came to know of their same sex behaviour because they were effeminate or non-masculine. Also significantly the threat of blackmail by masculine sexual partners of *kothis* mean that many a time these sexual partner themselves tell the relatives of the *kothis* that they had sex with him. 41% had their sexual identity exposed by those that they have had sex with.

This finding validates two postulates. First that it is gender role and gender identity that is conflated with sexual behaviour and therefore if one is feminised, it is presumed that one would also be same sex attracted. Second, the shame and sometime stigma is attached only to the feminised partner and they are the ones open to violence and blackmail, since its getting penetrated in the sexual act, the perceived sexual role that feminised partners are supposed to sexually play out, which is stigmatising. The masculine partners do not face any such social sanction, their masculinity is not affected, simply because they are the penetrating partner in the sexual act. They can therefore act with enough impunity to even be able to disclose the fact of the male-to-male sexual behaviour of the penetrated partner to their families without stigma attaching to themselves.

Almost half the respondents state that their earning capacity has been affected because of their male-to-male sexual activity.

MSM who self-identify as *kothis* are usually under-educated and economically from poorer sections of the general population. This is the result of many factors including to some extent the harassment that many *kothis* face in educational institutions, which mean that they do not finish their education. Almost half the respondents earn only between 1000 and 3000 rupees a month.

One of the positive results of the legal literacy work that has been carried out is that almost 76% of the MSM accessed for this study were aware that that is a criminality imposed by the law on same sex sexual activities. It was also evident from peer interviews that many MSM were willing to be part of any mobilising effort to ensure that the law is overturned and repealed. Many were also aware that it is the law that created the situation where they could be targeted and harassed by the law enforcement officials. Almost half of the respondents stated that they had, at some point, been harassed by the police because they had sex with other males.

The nature of harassment from the police is wide ranging. The primary motivation of the police appears to be to extort money. In a way we can say that the problem is not of an illegal act, nor is it of law and order. Often other forms of violence are applied by the police when the demands for money are either not met, or are not met as per their expectations. Many times the police also demand sexual gratitude in lieu of monetary payments. This is coercive in those instances where the person is both unwilling to pay and to have sex with the police. In these situations the police become overly aggressive and violent, and there have been reported instances where MSM have been picked up from public areas and thereafter gang raped in police barracks.

Other than the police, a significant number of respondents have stated that they have been harassed by *goondas* (local bullies). The nature of harassment and violence by *goondas* is almost the same as that of the police. In fact, often the *goondas* collaborate with the beat police and share their extortion take with the police. This means that the police effectively protect these *goondas* and

therefore are unwilling to take any action against them even if there is a complaint against the *goonda*. This gives a lot of impunity to the *goonda* to continue with their violent actions.

A significant finding is that in both the case of police harassment and *goonda* harassment, almost half the respondents have stated that they were targeted simply because they were effeminate. This fact again goes on to establish that most of the violence against MSM in India is gender based and is not necessarily dependent on the sexuality of the person.

The family is the other setting where a lot of violence takes place. The family is usually accepting of same sex behaviour if nobody comes to know of it and if the family is not shamed. However if the family is shamed, then the usual way of regaining honour is by being violence on the person that causes the shame. *Kothis*, being highly visible, are usually stigmatised and this brings shame to the family. Hence there tends to be significant levels of familial violence against *kothis*.

53% of the respondents report that they have been sexually harassed or abused in the past one year simply because they were effeminate. Of these, almost 12% say that such incidents have been more than 10 such incidents in the past year, while 8% report that it has been so frequent that they have lost count

172 out of 298 respondent stated that they have been sexually assaulted or raped in the past one year.

One third of all respondents reported harassment at the school or educational institution. They claim that this has affected their education and many left their studies mid way. About 40 say that if they had not faced any harassment, they would have been better educated and would have better employment prospects. Many respondents have stated that they are in sex work because of their incomplete education that has made it difficult to find good employment. This of course, would have an impact of many low-income MSM becoming involved in sex work.

## Issues of concern

### 1. Continuing support for the MSM policy and advocacy units

A project or a programme that aims to address the human rights and social justice concerns of any marginalised and socially excluded population needs sustained support, as any break in the advocacy work due to lack of funding support means that the momentum that is generated is lost and that ground has to be regained again. It also creates a crisis of credibility with the client population with which one works with, since they perceive any discontinuation of services and support as an abandonment of their issues and concerns, and its cause.

With the delays in NACP III implementation, all these advocacy units that have been developed to respond to the serious human rights abuses that prevail in their lives, along with the National MSM and AIDS Task Force that coordinates their local activities, provide technical assistance, and advocates on a national level will most likely cease to function until funds once again become available. This gap in advocacy work and local service provision will have serious consequences on the lives of many MSM.

It is therefore extremely important that the work of this nature should be supported for at least a medium term of 3-5 years and not in single year cycles.

### 2. Up-streaming advocacy work

It is vital that the policy and advocacy work that is being undertaken in regard to MSM and sexual health is up-streamed to include stakeholders at the highest policy-making levels, as well as the judiciary (High Courts and the Supreme Court), national advocates, law enforcement agencies, the Home and Health ministries, and so on. At the same time, advocacy work needs down-streaming at the local level with the government bureaucrats, local police and magistrate courts. Further, such policy and advocacy also needs to be linked with regional initiatives as well, created an enabling environment for sustained change towards improving the lives of MSM where they can feel safe and

access appropriate services for their sexual health needs. Such work requires donor support and leverage, as well as their active participation in such advocacy work.

### **3. Litigations**

One of the concerns that had been raised by this Advocacy Project, along with evidence to support this concern, is that there needs to be litigation support that is built into the service provision of policy and advocacy units at the local level and for mass action suits and Public Interest Litigations at the Task force level so that actions can be taken to reduce the levels of human rights violations of MSM by both state and private actors.

It is recommended therefore that the targeted interventions budget and/or the budget for the local units should have a provision for retaining a lawyer, and adequate funding should be provided to the Task Force for training and sensitising such lawyers to the social and legal needs of at-risk MSM.

### **4. Scaling up**

While the work of developing the MSM policy and advocacy units has been carried out in only 13 cities so far, the Task Force estimates that there needs to be a minimum of 40 such units developed across India to adequately cover the social justice issues of MSM in the country. Such a scaling up of service provision needs to be a part of any future plan for the development of the Task Force and its programme.

## **Comments and lessons learnt**

Developing 8 new MSM advocacy and policy units, coordinating these activities, along with the 5 such units previously developed, conducting the study on social, judicial and legal impediments to MSM sexual health services, while enhancing and strengthening the National MSM and AIDS Task Force, clearly indicates the capacity to replicate such developments across India.

At the same time, while these MSM advocacy units have registered a rise in reported cases of human rights violations of MSM, this itself is an indication of the success of these units, clearly demonstrating, not only the urgent need for MSM populations to have access to appropriate mechanisms to address their social justice concerns and needs, but also the need for support to find appropriate mechanisms through the courts to reduce these levels of abuse. Without such mechanisms of addressal, the lives of MSM continue to be at risk from continuing high levels of abuse and violence, as well as from HIV and AIDS, itself impacting on the country's ability to reduce the level of HIV infections mitigating the economic impact that rising HIV infections would have.

However, it needs to be recognised that the extremely short time frame of the implementation schedule, the complexity of the project, a range of constraints produced by financial regulatory mechanisms, along with what was eventually determined as the inadequate framework for ongoing financial support from government and other donor agencies post the end of the project, creates a range of difficulties that include maintaining the motivation of local advocacy units at the end of this project. With no security being guaranteed for continued funding support, or where there would be a significant gap in funding support for these newly developed MSM advocacy units, there will be a serious gap in service delivery. Potentially, a great deal of energy and resources are at risk of going to waste. Both NFI and DFID, along with the relevant State AIDS Control/Prevention Societies, should have taken this issue on board a great deal earlier and ensured an effective exit strategy for the project and for on-going funding support. While it had been anticipated that the NACO NACP Phase III would have begun implementation by the end of this project, its delay will have a significant impact on service continuity. This possibility should have been taken on board and a resolution developed. As a consequence, it cannot be guaranteed that some of the developed units can continue, and would now require additional technical support when funding does arrive as a priming mechanism.

The project has demonstrated that policy and advocacy initiatives that directly involve the affected populations can produce the most effective local impact in reducing social exclusion. However such initiatives need the support of a range of institutions to reinforce this impact, from the donors itself to NACO, SACS, and other stakeholders. While much was achieved at these levels, more work needs to be done with the judiciary, the Home Ministries (at state and national levels), and certain SACS. Where NACO has taken on board a range of key health concerns of MSM through the consultation process for the planning of NACP III and the direct involvement of these advocacy units, these gains need to be institutionalised, rather than being dependent upon individuals who have been willing to take on board these concerns.

Unless, social exclusion, marginalisation, stigma, violence, discrimination against MSM are not addressed institutionally, at the most, all we can expect to achieve are reactive approaches to advocacy, localised amelioration on a temporary basis based on individuals, and no long-lasting impact upon society and MSM themselves. HIV will continue to rise amongst this highly vulnerable population, and there is a strong likelihood that HIV prevalence among MSM could easily reach those that are being experience in Thailand and Myanmar (28% HIV prevalence in Bangkok among MSM, and nearly 40% in Yangon, Myanmar).

An old saying from HIV awareness programmes in America stated “silence = death”. This continues to be valid for MSM.

## Concluding statement

Males who have sex with males, particularly those with feminised identities, are highly stigmatised, not only because of their sexual practices, but also because of their gendered status. Add HIV infection to this, and what we have is a population socially excluded and who experience a significant degree of human rights violations, including discrimination, harassment, violence, and rape. These males are not only highly vulnerable to HIV, they are also experiencing a heavy burden from the significant levels of HIV prevalence among them. Adding to this burden is the lack of HIV prevention, care and support services that could address their needs, with a lack of appropriate advocacy to develop an enabling and empowering environment that would help reduce their risks and vulnerabilities.

There is a need to have a strategic response to these needs that can address the need to create such an environment that would empower MSM to address their sexual health needs safely. This project was based on a belief, that for effective advocacy and policy development work, it requires efforts at both local and national levels, while engaging representatives from MSM networks, groups and organisations to adequately document human rights violations, presenting this information as evidence of the social, legal and judicial impediments for HIV prevention, care and support services for this population.

For India to successfully address the challenge of the growing HIV epidemic among its marginalised and socially excluded populations, of which MSM is one, more attention must be paid to this issue, and effective means developed to challenge these impediments, and address them appropriately.

The mechanisms developed by the project include a national coordinating body (the Task Force) that would address issues of concern at national levels, along with the development of local policy and advocacy units which would act as documenting agents, provide crisis interventions, and work at policy development at local levels. The local level work involves including the local wisdom in meeting local needs, but informed by the policy and human rights standards and goals that are universal. This freedom to address local problems is the key to the success of such local policy initiatives and interventions in crises situations.

An increasingly strengthened relationship has evolved with many bureaucrats and policy implementation agencies during this project period. The National Task Force had played a crucial role in informing the debate and development of NACP Phase III and the National MSM Targeted

Intervention Strategy. Local bodies have developed relationships with their respective SACS, the local police, media, political groupings, local human rights NGOs, and so on. All of these relationships, if they are sustained, contribute to the creation of an enabling environment where HIV prevention, care and support services focusing on the sexual health needs of MSM can take place without hindrance and where MSM can access these service without fear. It also works to empower individual MSM to adopt safer behaviours and sustain such change in behaviours.

But more work needs to be done to institutionalise such policy and advocacy at government, donor, HIV service providers, and others, if sustainability of an enabling and empowerment environment for MSM is to be fully achieved.

This project demonstrates a way forward, and requires funding support for this critical work to be maintained, scaled up and up-streamed. The challenge lies before us.

## Stigma and discrimination

Naz Foundation International has been involved in providing technical, financial and institutional support to MSM collectivities in India (and elsewhere in South Asia) since 1996. Since then we have assisted in the development of 70 such projects, which between them have reached nearly a million MSM.

In terms of the dynamics of differing frameworks of MSM, NFI and its partners have focused on those who are socially excluded, the marginalised and stigmatised, economically disadvantaged, and those who are the most vulnerable to infection and have least access to services. These are the most visible of MSM, the ones who construct their sense of being within a gendered framework of feminised behaviours and sex roles.

They are self-labelled *kothis* in India, while their sexual partners who are perceived as “real men” and are labelled *panthis* or *giryas*. Such men are not seen, nor for they see themselves as homosexuals. They are “real men” because they penetrate.

*Kothis* are therefore doubly stigmatised because as biological males they are sexually penetrated – and thus not perceived as men. And their feminisation, their crossing of the gender roles and barriers accepted as social norms reinforces the stigmatisation, leading to exclusion and denial of access to services and to the social compact.

And they are vulnerable because of the sexual and gender roles they play within male sexual practices which often leads to significant levels of manly sex partners, sexual abuse, violence, rape, and harassment, often from an early age.

Evidence from research in India clearly shows that the process of stigmatisation and thus vulnerability arise from concepts of masculinity in these cultures, which lead to marginalisation, social exclusion and abuse of the most vulnerable of MSM – those with feminised identities.

Social exclusion has a personal and social history that lead to negative impacts on educational and employment opportunities, which, of course, increases poverty and which increases an already low self-esteem and self-worth because of femininity, and leads to the potential for sex as a source of income for self and family and a survival strategy. This leads to a denial of social justice and human rights.

In other words, social justice and human rights issues for MSM are a complex matrix of issues, concerns, and needs that reflect personal psycho-sexual histories, economics, social-cultural policies 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. It is a vicious circle that constantly reinforces itself.

On the other hand, the partners of *kothis* can easily melt into the manly social background, their sense of masculinity maintained because they are the penetrators, not of other men, but of not-men.

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

Without addressing these psychosocial concerns appropriately and with urgency, sexual health promotion programmes targeting *kothis* and their *panthi/girya* partners would not be able to

adequately develop sustainability in behaviour change towards risk reduction.

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 AIDS programme may recognise the need to address the HIV/AIDS concerns of male-to-male sexual behaviours, but on the other, the continuation of the criminalization and social stigmatisation of such behaviours often leads to threats of blackmail, sexual abuse, and violence, if not arrest and imprisonment (where if course much male-to-male sex and male-on-male sexual violence occurs). 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.

Those who are meant to protect, sustain abuse and violence. Many *kothis* face harassment, sexual violence and rape from law enforcement staff, from those whom they have called friends in schools and colleges, from those in positions of trust such as relatives, neighbourhood elders, elder friends, and teachers. Gang rape is not uncommon. And of course such forced sex is always unsafe and often results in serious physical injury like a ruptured rectum, internal haemorrhage etc.

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

“I don’t mind if my *panthi* beats me up. It only shows how manly and powerful he is.”

“When my *panthis* beats me, I feel as helpless as a woman. Since I want to be a woman, it actually makes me feel good”.

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

And is clear that legal, judicial, political and social advocacy is urgently needed that is not only about living with the virus or with AIDS. It is not only about social justice and human rights for MSM. It should include challenging accepted notions of masculinity and femininity so that discrimination and stigmatization, social exclusion and marginalization can be effectively challenged as they confront the daily lives of *kothis*. It is only then that we can hope for a time when *kothis* can live in dignity and wellbeing, with social justice and human rights.

## The framework of sexuality and rights

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 individuals. The protection of the basic human rights of MSM should therefore be 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,<sup>1</sup> Convention Against Torture, Inhuman and Degrading Treatment,<sup>2</sup> International Covenant on Civil and Political Rights,<sup>3</sup> the International Covenant on Economic, Social and Cultural Rights<sup>4</sup>, the International Convention on Elimination of All Forms of Discrimination Against Women<sup>5</sup>, and the Convention on the Rights of the Child<sup>6</sup> 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,<sup>7</sup> the American Convention on Human Rights<sup>8</sup>, and the European Convention on Human rights.<sup>9</sup>

Further, the Human Rights Committee, which monitors the implementation of the International Covenant on Civil and Political Rights, has addressed the issue of the right to privacy, noting that Article 17<sup>10</sup> of the International Covenant on Civil and Political Rights is violated by laws which criminalise private homosexual acts between consenting adults.<sup>11</sup>

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,<sup>12</sup> includes sexual orientation.<sup>13</sup> 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.<sup>14</sup>

<sup>1</sup> Adopted by the General Assembly on 10<sup>th</sup> December 1948 under Resolution 217 A (III)

<sup>2</sup> Adopted by the General Assembly on 10<sup>th</sup> December 1984 under Resolution 39/46 of December 1984. Entered into force on the 26<sup>th</sup> June 1987.

<sup>3</sup> Adopted by the General Assembly under G.A resolution 2200 (XXI), UN GAOR, 21<sup>st</sup> session, Supplement No. 16, UN Doc. A/6316 (1966). Entered into force 23 March 1976.

<sup>4</sup> Adopted by the General Assembly on 16 December 1966 under G.A. Res. 2200 (XXI); UN GAOR, 21<sup>st</sup> Session, Supplement No. 16 at 49, UN Doc. A/6316 (1966).

<sup>5</sup> Adopted by the General Assembly under GA Resolution 34/180 of 18 December 1979. Entered into force 3<sup>rd</sup> September 1981

<sup>6</sup> Adopted by the General assembly under GA res. 4/25 of 20<sup>th</sup> November 1989. Entered into force 2<sup>nd</sup> September 1990

<sup>7</sup> Adopted on 26<sup>th</sup> June 1981. Entered into force 21<sup>st</sup> October 1986

<sup>8</sup> Adopted 22<sup>nd</sup> November 1969. Entered into force 18<sup>th</sup> July 1978

<sup>9</sup> Adopted 4<sup>th</sup> November 1950. Entered into force 3<sup>rd</sup> September 1953

<sup>10</sup> 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.

<sup>11</sup> Communication No. 488/1992, *Nicholas Toonen V Australia*, (Views adopted on 31<sup>st</sup> March 1994, fiftieth session). See Report of the Human Rights Committee Volume II General Assembly Official Record Forty-ninth session (Geneva, 18<sup>th</sup> October to 5<sup>th</sup> November 1993); Fiftieth session (United Nations Headquarters, 21<sup>st</sup> March to 8<sup>th</sup> April 1994) Fifty-first session (Geneva, 4<sup>th</sup> to 29<sup>th</sup> July 1994), (A/49/40). <http://www.unhcr.ch/tbs/doc.nsf> Pages 226-237, paragraph 8.2

<sup>12</sup> "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status"

<sup>13</sup> *ibid*, paragraph 8.7

<sup>14</sup> *ibid*, paragraph 11

Discrimination against men who have sex with men and other disadvantaged groups<sup>15</sup> 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.<sup>16</sup>

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 counselling are driven underground. Here, specifically in the context of HIV/AIDS, the Human Rights Committee has found that the "criminalisation 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." <sup>17</sup>

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 only be achieved if people have assurances that their rights will be respected.

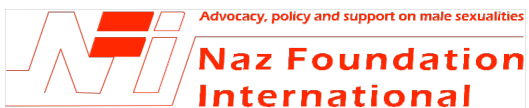
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<sup>15</sup> Such groups may also include women, children, minorities and indigenous populations, those living in poverty, migrants and other aliens and injecting drug users.

<sup>16</sup> 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>

<sup>17</sup> Communication No. 488/1992, *Nicholas Toonen V Australia*, (Views adopted on 31<sup>st</sup> March 1994, fiftieth session). See Report of the Human Rights Committee Volume II General Assembly Official Record Forty-ninth session (Geneva, 18<sup>th</sup> October to 5<sup>th</sup> November 1993); Fiftieth session (United Nations Headquarters, 21<sup>st</sup> March to 8<sup>th</sup> April 1994) Fifty-first session (Geneva, 4<sup>th</sup> to 29<sup>th</sup> July 1994), (A/49/40) . <http://www.unhchr.ch/tbs/doc.nsf> Pages 226-237, paragraph 8.5





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