

The invisible man - an invisible epidemic

Masculinities¹, (homo)sexualities², vulnerabilities, and HIV risk in South Asia

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It is my aspiration that health will finally be seen not as a blessing to be wished for, but as a human right to be fought for.

United Nations Secretary General, Kofi Anan³

Realisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS

Booklet of the Declaration of Commitment on HIV/AIDS: United Nations General Assembly, P24, Special Session on HIV/AIDS, 25-27 June 2001, United Nations

Sexual health is the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love.

WHO, Education and Treatment in Human Sexuality: The Training of Health professionals, p6, 1975

In the state of Uttar Pradesh in India, with a population of 140 million, only 693 men who have “Mapping of Population Groups Vulnerable to HIV/AIDS in Uttar Pradesh” (a state in India), submitted to Uttar Pradesh State AIDS Control Society, compiled by ORG Centre for Social Research, New Delhi, Oct. 2003

Glimpses through a dark window

After South Africa, India has the second largest estimated number of people living with HIV/AIDS in the world. According to the India National AIDS Control Organisation (NACO), as of 30th November 2003, the cumulative total for AIDS cases in India was 57,781, while the estimated numbers with HIV infection was almost 5.1 million⁴ although the true figure could likely be much higher. It was also estimated that 85% of HIV transmission is sexual.⁵

While the role of male to male sex in the pandemic has been almost unrecognized in the region, and more often than not, ignored, denied, if not “invisiblized,” there is significant anecdotal and other information to indicate that there are substantive levels of males involved in male-to-male sex, and very low HIV anti-body testing levels of males who have sex with males.⁶ In addition, identifying persons as a “homosexual” is very problematic with the level of knowledge of MSM behaviors, identities and contexts very limited. We get only hints, glimpses, as if looking through a dark window at a blurry and shadowed inner world.

Naz Foundation International⁷ (NFI), in conducting situational assessments among MSM⁸ in seventeen cities in South Asia found significant levels of male-to-male sexual behaviors within a gendered context (i.e. **not** based on sexual orientation), high levels of multiple partners, low condom usage, significant levels of symptoms of sexually transmitted infections, low levels of knowledge regarding HIV transmission, and the possible spread of HIV/AIDS into the general population. Other sources have found similar results.

So what do we mean by the now commonly used term “men who have sex with men”? Who are these “men who have sex with men”? And why did NFI begin to use the phrase male-to-male sex, or males who have sex with males instead of the generally accepted “men who have sex with men”?

For many donors, governments, and NGOs, the phrase “men who have sex with men” has unfortunately become synonymous with the terms “homosexuals”, or “gay” men, an equation that has no bearing on reality. At the same time, it is often signified within the context of discussions of “vulnerable groups,” or “target groups.” In other words a small group of exclusive “homosexuals” who are isolated from the general population and, therefore, at risk only to itself.

This type of reductionist thinking along with its associated beliefs, make it problematic to be fully aware of the extent of male-to-male sexualities and behaviors along with HIV vulnerability and risk. This faulty thinking is adopted not only by those who are engaged in these behaviors, but the wider general population as well as those decision-makers who are responsible for the investment and management of HIV/AIDS interventions.

We see what we want to see, what we have learnt to see, and what we choose to see is often a reflection of our own beliefs and constructs. In our education systems we are taught of a binary, hierarchal and oppositional system of sexuality, gender, and behavior. Thus we have man/woman, heterosexual/homosexual, straight/gay, and white/black. When we look through this prism of either/or, we see an obscured world.

In an attempt to avoid such binary thinking in the field of HIV/AIDS interventions, the term “men who have sex with men” was created as a way to address those who do not identify themselves as gay and their sexual health needs. But in a cross-cultural framework a significant problem has plagued the use of the word “men” in this term, and creates a universal category of MAN that ignores cultural and social constructions of manhood, masculinity and manliness. The key question here would be “What is a MAN?”

In South Asian cultures, manhood (and adulthood) is defined more by specific responsibilities, duties and obligations, along with certain behaviors and practices, than by a biological age. Marriage and the production of children (particularly male children) are cornerstones in this socio-cultural definition of manhood.

Another issue that is rarely recognized (except in the negative and moralistic sense of denial) is that adolescence (also a social construct⁹) and youth (an undefined term) does not preclude sexual activity of all kinds, and such activities may well be consensual.

A third concern would be regarding those “men” who do not conform to normative socio-cultural definitions of masculinity and are not deemed men by their male sexual partners (and often do not perceive themselves as such) although they are biological males.¹⁰

Finally of course, questions such as what desire is, how desire is constructed, why men have sex, why males have sex with each other, and for that matter with females, are rarely asked. It is often assumed that recreational sex, that is sex for pleasure and discharge, is constrained by reproductive necessity. Questions are rarely asked whether sexual acts arise from opportunity, immediate availability, curiosity, or for “the heck of it” because it is available. Thus the meaning and significance of sex acts become invisible, further compounded when those that specifically desire sex with a person of the same gender do so because they are deemed to be “homosexual” where this is seen as not “normal”.

With these concerns in mind Naz Foundation International (NFI) began to use terms such as “male-to-male sex” and “males who have sex with males.” While this may not appear to be of any great significance in the larger debate it does have an impact upon what we are addressing when we discuss masculinities, sexualities, vulnerable populations, and HIV/AIDS programmatic interventions. It is also central to the discourses that reflect a rights-based approach to sexual orientation and sexual health.

South Asian societies tend to be highly male (masculine) dominated societies, where social and public spaces are primarily “owned” by men. However, as homo-social and homo-affectualist¹¹ societies, it is possible for socio-cultural barriers on male-to-male sex to be

crossed in appropriate spaces and sexualized contexts, i.e. sharing of beds and all male private spaces. Further, significant numbers of males perform gendered roles as feminized males and can be accessed by those deemed as “real men”. The NFI surveys indicate that male-to-male sexual behaviors do exist in South Asian countries at substantial levels.

Most of these male-to-male sexual frameworks do not exist within a socio-sexual context of a heterosexual/homosexual oppositional binary¹² and as exclusive categories. Rather, there appears to be an inclusive behavior that involves a substantial level of males operating within a wide variety of categories and/or networks. These frameworks can consist of gendered self-identities, or a perceived ‘body heat’ leading to a perceived urgent need for semen discharge, perhaps ready and easy accessibility to male sexual partners, along with the social contexts of gender segregation, social policing of females, delayed marriage, and concepts of masculinity and femininity. Along with these frameworks are those with specific sexual identities/orientations that are defined by class and economic purchasing power.

What we therefore see is a polymorphous sexual behavior within constructs of gendered/sexual identities and behavior that generate an invisibility of behaviors and risks. In other words we have the invisible male along with a varied range of homosexualities and practices.

The invisible mirror

We see what we want to see or have learnt to see. When we look at the world, we face an invisible mirror, one that reflects our own beliefs and ideas of the world. The rest is ignored, denied and invisibilized.

Well-educated and married with a young son, 26-year-old Prem works in a large family business in Calcutta, India, where his family is prominent. He has fond memories of his first sexual experience with another boy at the age of 13. He continues to have sex with other men, even after his marriage, albeit less frequently for lack of opportunities. His sexual interactions with other men have always been fleeting “pick-ups.” He has never wanted to form a relationship with another man because this would increase the risks of exposure. Any disclosure of these desires would be disastrous for him in terms of his family and his social standing. He would prefer not to be married. He does not love his wife, but feels he performs his husbandly duties adequately. He identifies himself as a homosexual, but not as a gay man.

Islam is an auto-rickshaw driver in Dhaka, Bangladesh, and he lives in one of the small shanty clusters in the city. He is married with four children. He says that sometimes he just has to go out and finds a *kothi*¹³ or a *hijra*¹⁴ to have sex with, although he is happy with his wife. However, he enjoys anal and oral sex, but he cannot ask his wife to do these activities as this would shame her. This usually happens about once every two months, and he feels that he cannot control his desire for this. He finds men at the many contact points around the city. He does not call himself a homosexual; without access to English he does not understand the word gay. Nor does he see anything wrong in what he does. He is just “playing about.” For him this is not sex – that is what he does with his wife. He remembers his first sexual experience with his uncle back in his home village. He was 14 when he was asked to penetrate him. He states that he is happily married to his wife.

19-year-old Arjit is a student in New Delhi University studying English literature and is from a well-to-do family in the Diplomatic Service. He calls himself gay and would like to “come out” to his family, but he is deeply concerned about their possible reaction and rejection of him. They might cut him out of the family and he would lose everything! He has always been aware of his homosexuality; ever since he can remember he was always attracted to other boys. His first experience with another boy was when he was 11. Now he visits the various “gay” haunts around New Delhi where he can find “plenty of action.”

Mohammed is a 21-year-old self-identified *zenana*¹⁵ in Lahore, Pakistan. He feels he was born this way. He loves having sex with “real men.” While he has a regular masculine partner

whom he calls "husband," he also has sex with other men he meets on the street. He says it is easy to pick up these men anyway. They like him because he is so feminine and beautiful. Most times these men will give him small gifts and sometimes money.

Ranjan, a 16-year-old male sex worker, from a poor family, plies his "business" in Chennai near the railway station. He has done this since he was 13, when he had to run away from home because of his father's beatings. He never wants to go back home. He says that he enjoys his "work" because it gives him a lot of money, even though his clients are sometimes rough. He is saving money to buy a small business. He does not call himself a homosexual, even though he enjoys the sex. It is only business.

Mohammed, 42, is married with three children and works in a hotel in Pune. He visits a local female prostitute once a month after payday. He also has sex with some of the male guests and other staff at the hotel. He says, "I am always hot. I want a girl, but they're too expensive. So when I am hot and I don't have enough money, then I know several men who I can have *maasti*¹⁶ with. A lot of my friends do this."

Arun lives with his lover Kamal near a railway station in Mumbai. They have lived together as partners for the last five years. Both work as municipal sweepers. That is how they met. Both have had sex with other men prior to their meeting. They say they want to stay together as lovers. They do not consider themselves as different. They know many men who enjoy sex with other men/males. They don't play husband and wife roles, thinking it rather silly as both are men. They both left school at 13. However, both are under pressure to get married now from their families. Both expect that they will get married sooner rather than later. They intend to continue seeing each other for sex after their marriages.

Where do these men fit in the binary construct of homosexual/heterosexual? The risk of categorization is to invisibilize behavioral choices.

Sexual or gendered identities, masculinities and sexualities take shape within psychosocial and historical processes, which in turn are contextualized by religion, culture and language. Euro-American understandings and discourses on "gay identities," heterosexuality, homosexuality, bisexuality, or even the use of the term "sexual minorities" can be misleading, and can invisibilize to a significant extent the range and level of male-to-male sexual activities and those involved in them.

South Asian cultures are supremely patriarchal, gendered and hierarchal, so the word MAN is defined not so much by biological age, but by gender roles and performance, religious rituals along with family/marital duties and obligations. In such phallo-centric patriarchal cultures, the word sex and its meaningfulness is usually defined within a reproductive paradigm, while masculinity is defined by the act of sexual penetration and gendered roles, not by "sexual orientation." Those who are sexually penetrated would thus be perceived as less manly, hence less worthy, feminized, as a sort of debased male, and would be highly stigmatized leading to a range of violence and abuse, as well as sexual accessibility, without diminishing the masculinity of the penetrator. As such the male penetrator would usually not be considered a "deviant" but is a part of the general male population. To a great extent this invisibilizes him in terms of his sexual practices.

It is the penetrated male that is subjected to the perception of deviancy and thus of abuse. This perception is further reinforced by the socio-cultural realities of invisibilization of sexual behaviors, gender segregation, social policing of women, an acceptability of male homosociability and homo-affectionalism, masculine dominance over public spaces and discourse, a culture of shame where family, community respect and honor hold sway, compulsory and arranged marriage, the social pressure for reproduction (particularly of male children), understanding of sex only in its reproductive sense, joint and extended families, and the negation of the self before the community/family.

South Asian frameworks of male-to-male sex are substantive, divergent and broadly inclusive,

involving not only the more visible gendered males who identify themselves as *zenanas/kothis/metis* and are usually penetrated, but also their more invisible males/men partners who take on the penetrating role (known as *giryas/panthis/ta*¹⁷ by *zenanas/kothis/metis*) accessing *zenanas/kothis/metis*, *hijras*, and at times, adolescent males.

However, not all male-to-male sexual encounters in South Asia fall into the *kothi/panthi* dichotomy. Other constructs, desires, and patterns of sexual encounters exist, framing a complex, open-ended, and extremely porous 'group,' or 'networks' of MSM. In fact the word 'group' is highly suspect; it does not fully frame the actual behavioral practices of males across South Asian societies. The word 'group' implies an exclusive practice of a number of men/males, but this is not the reality. While *hijras* and "public" *kothis* may be considered a group in which their shared behavioral characteristics make them significantly visible, their partners and others are not, and can be defined as a part of the general male population whose public behavior is 'manly' according to the socio-cultural definitions in South Asia. Other dynamics also include normative males who access other normative males for discharge and/or desire to be penetrated, males who desire male-to-male sex and do not gender themselves and usually indulge in mutual sexual activity - 'giving and taking,' friends who have sex with friends for mutual pleasure, and males in all-male institutions. Among the educated and urban elite, a Western gay sensibility and community is also emerging in parallel to these activities.

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

Furthermore male-to-male sex work is also a significant factor of vulnerability in South Asian cities. *Hijras*, *zenanas/kothis/metis*, *malishias*, male youth, and other males will sell sex to men usually because of poverty and unemployment. Without a welfare system, and with significant levels of unemployment or low level incomes, male-to-male sex work can be a survival strategy in terms of supporting the self and family. This is not to imply that males involved in sex work do not enjoy sex with other males. Some will also have a regular partner - a *pucca dost/parik*,¹⁸ or even a female.

Male-to-male sex then includes those who identify with the same-sex sexual desire, often through gendered sex roles, as well as those who do not. It involves biologically adult males, as well as adolescent males. If we only speak of homosexuality, a framework based on identity/sexual orientation, then what happens to those males whose sexual behaviors with other males are outside the purview of such frameworks because they do not see themselves as possessing a sexual orientation other than a normative masculinity as men?¹⁹

What is clearly seen is that language, behavior, and identity are, to a significant extent gendered, within a hidden context of polymorphous behaviors, and that gendered behavior and sexual practice are more significant markers for the majority of males involved in male-to-male sex than a specific sexual identity. In a way it could be said that there are limited numbers of MSM with specific gay/homosexual identities, but significant levels with a gendered identity or with perceived masculine "body needs" that shape their sexual practices. We can thus say that what seems to exist is a range of masculinities and gendered behaviors with differing contextualization of gendered roles, sexual practices, sex partner choices, perceived sexual needs, pleasures and desires. In other words, MSM phenomena are highly complex and cannot be reduced simply to a "target group."

Contemporary research on sexualities and genders have clearly shown that bipolar categories such as 'man' or 'woman' or 'heterosexual' or 'homosexual,' are not useful to describe the range of identities, desires and practices" existing in South Asia.²⁰ The terms "gay" or "homosexual" are too contextualized by a specific history, geography, language, and culture

to have any significant usefulness in a different culture from their source. As such, we need to be talking more about sexualities, genders, homosexualities and heterosexualities, as well as about behavioural constructions. Where many will speak of behaviorally homosexual persons in certain situations, we can also talk about behaviorally heterosexual in the South Asian context.

The frameworks of male to male sex are substantially divergent and inclusive. It includes normative males whose desire to penetrate is the only signifier not the sex of the person who they are penetrating, feminised males (*kothis*), along with *hijras*, who desire to be penetrated by other males, and adolescent and other males who do *maasti* together for fun, to experiment, or just to enjoy. Males are often easier to access for sex than females, while male sex workers are usually cheaper than female sex workers. Such same-sex behaviors occur in neighborhoods, all male institutions such as prisons, between male friends who seek release from “body heat” and semen discharge. It also includes self-identified gay men, primarily among the urban, English speaking elite and middle classes.

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

While there are substantial networks of visible *kothis* of all gradations in urban centers - from the very feminized and cross-dressing type to those who have moustaches and dress in shirt and trousers - their sexual partners could well be any masculine male who tend to be invisible. Sexually accessing these masculine sexual partners by *kothis/hijras* is not considered difficult. All urban areas appear to have sexualized spaces, such as parks, toilets, railway and bus stations, specific bazaars, streets, and other public areas where *kothis* and *hijras* would go to meet potential *giryas/panthis*, often marketing their sexual availability through their feminized social behaviors. Many ‘real men’ also go to these sites, not only to meet such accessible males, but often for quite legitimate purposes, where they can get caught up “in the heat of the moment” and access *kothis* and *hijras* there at the time.

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

Numerical perversity

Counting numbers is the name of the game for donors, policy makers, and government institutions in the field of HIV/AIDS programming and funding. How many? What do they do? Where? However this approach requires a Linnaeus approach to categorization, classification and reduction to the lowest common denominator, particularly when it is bound within a binary system of sexuality based on this or that. If it does not fit then it does not exist. A form of numerical perversity exists and HIV/AIDS triage rules the stage.

As discussed above male-to-male sex as a category is highly complex, diverse, and for many significantly gendered which makes it extremely difficult to make any effective size estimations. Simplifying this complex scenario, it is composed of two or more populations; those that are relatively visible, i.e. *public kothis and hijras*, and those invisibilized because such males are a part of the normative male population, i.e. non-public *kothis*, males in all male institutions, neighborhood encounters, and so on. And of course this population would need to include gay-identified men as well.

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

Behavioral surveillance studies are often problematic, inadequate and poorly designed. These studies are plagued by procedural and ethical issues such as where inappropriate questioning is the norm, poor formatting of studies, lack of confidentiality, stigmatization by researchers, or no mention of same-sex relations. This paucity in information and knowledge is further compounded by a lack of understanding of the dynamics and frameworks of same-sex behaviors in a South Asia context.

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

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

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

Quantitative studies conducted in India include:

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

In Bangladesh, in a study conducted by the International Centre for Diarrhoea Diseases Research, Bangladesh (ICDDR,B) in 2002 indicated that over 22% rickshaw pullers had sex with other males.²¹

In Pakistan, AIDS Analysis Asia, reported in July 1996²² that:

- 20% of men in one rural area have male-to-male sex
- 40% of men living in a Karachi squatter settlement had male-to-male sex
- 72% of truck drivers in central Karachi had sex with other males, while 76% had sex with female sex workers

NFI has conducted a number of surveys among MSM in a range of cities across Asia, where in each site 200 *kothi*-identified males were interviewed. From these situational assessment reports (which can be accessed on NFI's website, www.nfi.net) the number of "real" men partners accessed in one month were:

| | |
|--------------------|------|
| Sylhet, Bangladesh | 8800 |
| Hyderabad, India | 8100 |

Similar levels were reported in other cities.

It is very clear that the Org Centre for Social Research's *Mapping of Population Groups Vulnerable to HIV/AIDS in Uttar Pradesh* (October 2003) and similar studies are dramatically misleading. They only estimate an MSM population of 693 in a state of 140 million of which 262 were supposed to be from Lucknow alone. Bharosa, a male sexual health project working with MSM in Lucknow, in its initial assessment in 1997 was able to access 400 *kothis* for interviews without any difficulty, and since then has accessed well over 5000 such males, not including their sexual partners.

The Kinsey study titled '*Sexual Behavior of the American Male*' (otherwise known as The Kinsey Report, 1948 - number questioned: 5,300 white Americans) is one of the most thorough studies of sexual behavior. It was basically a study of white Anglo-Saxon population, but it did procure some baseline data regarding homosexual behaviors. Its main result was the famous Kinsey graph where number 6 on the scale was 'permanent practicing homosexual' and number 0 on the scale was "permanent practicing heterosexual.'

The report states that:

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

- 18 per cent of the males have at least as much of the homosexual as the heterosexual experience in their histories for at least three years between the ages of 16 and 55.
- 13 per cent of the male population has more of the homosexual than heterosexual experience for at least three years between the ages of 16 and 55.
- 10 per cent of the males are more or less exclusively homosexual for at least three years between the ages of 16 and 55.
- 8 per cent of the males are exclusively homosexual for at least three years between the ages of 16 and 55.
- 4 per cent of the white males are exclusively homosexual throughout their lives, after the onset of adolescence.
- 46 per cent of the male population has engaged in both heterosexual and homosexual activities to the point of orgasm throughout their adult lives.

From this it is clear that male sexual behaviors are not divided into exclusive categories of “heterosexual” or “homosexual.” Instead, while there were some males with an exclusive behavioral choice, there were more who move between these categories of behavior in varying degrees.

While the Kinsey study has been faulted in its methodologies, its basic data has been validated in a range of multi-cultural studies around the world. There is therefore no reason to believe that Kinsey’s benchmark of about 5% of the sexually active male population forms a core exclusive homosexual population in South Asia, and that there are many more that are “part-timers” so to speak. But this is of course complicated by the fact that in South Asia, marriage is socially compulsory. Such estimations do not take into account patterns of male-to-male sex encounters outside of this “homosexual” dynamic.

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

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

While it would be pragmatic to stay close to the Kinsey estimates, the data suggests otherwise. Factors such as the non-recognition of same-sex behaviors that are not being classified as ‘sex,’ the declining female-male ratios in the country, and distortions arising from rural-urban migrations, all point to higher male-male sexual transactions in South Asia.²³

Thus, direct evidence and anecdotal reports from across South Asia suggest that male-to-male sex is common and substantive, and that there are a broad range of reasons for this, including gender segregation, social policing of women, delayed marriage, difficulties

accessing females, over-crowding, poverty, unemployment amongst unmarried males, as well of course, desire for specific sex acts, as much as desire to have sex with another male.

Silence equals death

The contribution of MSM to the HIV/AIDS epidemic in India was officially set at 1 percent in 2001.²⁴ But these estimates seriously underestimate the significance of MSM behaviors to the epidemic in India, especially since global estimates suggest that 5 percent to 10 percent of HIV prevalence is attributable to sexual transmission between men.²⁵ Truck drivers are a group known to have higher levels of male-to-male sexual behavior than the general public.²⁶ Therefore, the high rates of HIV infection among truck drivers may be an indicator of the importance of male-to-male transmission in the India epidemic.

While data on MSM and HIV does not appear to be available from Nepal or Pakistan, with regards to Bangladesh, the fourth round of a national sero-surveillance reports that HIV is below 1% among MSM, while syphilis rates vary between 4% - 10%.²⁷

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

As a report produced by Solidarity and Action Against The HIV Infection in India (SAATHI)²⁸ stated, "There is no nation-wide data on the prevalence of HIV infection among MSM in India." The National AIDS Control Organization (NACO) of India says, "On HIV among MSM groups, little reliable data is available. Informal estimates suggest rapid increases may be taking place in this particularly vulnerable community" (NACO, 2000). Only a few studies from Mumbai have reported HIV prevalence among MSM. The prevalence of HIV infection among gay-identified men attending STD clinics in Mumbai metro was studied by the National Institute of Virology over a 6-month period in 1992 in collaboration with Bombay Dost (India's first gay newsletter). HIV prevalence was found to be 20.67%, which was very high given the fact that this studied cohort was of an educated middle class and hence had the means and materials to be adequately aware of the transmission routes of HIV. It could imply that HIV prevalence amongst MSM without a conscious self-identity of their sexual orientation would be higher (Ashok Row Kavi, 1999).²⁹

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

Data from the National AIDS Control Organization (NACO) in India (2000) of 232 HIV sentinel sero-surveillance sites across India, 2 of which targeted MSM, suggested HIV seroprevalence rates among MSM of 23.94% in Mumbai (in Maharashtra State) and 4% in Tamil Nadu State (in Chennai).³⁰ These figures can be taken as indicators of the increasing risk of HIV infection among MSM across the region as the above comments are equally valid for Bangladesh, Nepal, and Pakistan.

NFI conducted Social Assessments among MSM in Bangalore, Hyderabad, and Poncherry in 2000.³¹ One of the questions in the study was about HIV+ve status, where 200 MSM in each city were interviewed.

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

The paucity of information and knowledge about the prevalence of both behavior and HIV infection means that adequate funds are not channeled for appropriate sexual health interventions to reduce risk of infection, nor treat those already infected. Thus, silence does equal death.

What risk?

From all the studies that NFI has conducted it is clear that for certain MSM populations, anal sex is the common practice, along with multiple partners, low self-risk assessment, and significant levels of STI symptoms.

For example, in a 2000 study in India and Bangladesh, where NFI conducted social and risk assessments of MSM in a range of urban settings within networks of the most publicly visible of MSM, i.e. Bangalore, Hyderabad, Pondicherry, Sylhet³² where 200 males were interviewed in each city through convenience sampling by peers:

Multiple partners in previous month

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

Anal sex in previous month

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|--------------|-----------|-----------|-------------|--------|
| Insertive | 24% | 35% | 23% | 22% |
| Receptive | 76% | 65% | 77% | 78% |
| Total number | 7029 | 3754 | 2182 | 6692 |

Condom used

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|----------------|-----------|-----------|-------------|--------|
| Insertive acts | 35% | 45% | 34% | 33% |
| Receptive acts | 29% | 45% | 36% | 31% |

Reported symptoms

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|--------------------------|-----------|-----------|-------------|--------|
| Pus/discharge in stools | 7% | 0% | 0% | 16% |
| Penile pus/discharge | 13% | 2% | 0% | 4% |
| Genital sores | 16% | 1% | 9% | 6% |
| Oral sores/blisters | 16% | 3% | 3% | 1% |
| Bleeding when defecating | 22% | 2% | 16% | 16% |
| Rash on genitals | 25% | 5% | 13% | 11% |
| Pain when defecating | 28% | 7% | 0% | 20% |
| Pain while urinating | 29% | 10% | 31% | 54% |
| Rectal | 30% | 9% | 28% | 51% |

| | | | | |
|-----------------|--|--|--|--|
| itching/burning | | | | |
|-----------------|--|--|--|--|

Treatment

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|-----------------|-----------|-----------|-------------|--------|
| Nothing | 40% | 62% | 30% | 22% |
| Pharmacy | 20% | 1% | 7% | 42% |
| Private doctors | 20% | 7% | 35% | 9% |
| Hospitals | 27% | 27% | 28% | 31% |
| Others | 24% | 3% | 0% | 7% |

Knowledge and awareness

| | Hyderabad | Bangalore | Pondicherry | Sylhet |
|---------------------------------|-----------|-----------|-------------|--------|
| <u>Have you heard of AIDS?</u> | | | | |
| Yes | 71% | 85% | 57% | 69% |
| No | 29% | 15% | 43% | 31% |
| <u>What have you heard?</u> | | | | |
| An STD | 5% | 5% | 3% | 14% |
| Multiple partners | 7% | 2% | 0% | 0% |
| Sex with an FSW | 7% | 15% | 10% | 0% |
| Not using condom | 10% | 38% | 3% | 4% |
| No idea | 14% | 7% | 36% | 30% |
| Dangerous disease | 57% | 30% | 42% | 36% |
| Bad sexual relations | - | 3% | 6% | 0% |
| <u>Personal risk assessment</u> | | | | |
| Large | 47% | 3% | 54% | 0% |
| Small to medium | 7% | 39% | 7% | 19% |
| Don't know | 46% | 58% | 39% | 81% |

From similar Situational Assessments conducted in other cities in South Asia, it is clear that there are similar tales. Little or no investment, ignorance, denial and invisibility, inappropriate information and so on ensures that silence continues to equals death over twenty years into the pandemic.

But this is not the end of the story.

Men will be men

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

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

In other words, social justice and rights for MSM are a complex matrix of issues, concerns, and needs that reflect personal psycho-sexual histories, economics, poverty, gendered roles, social-cultural polices and attitudes, as well as legal concerns. These issues create a troubling

environment for MSM individuals, but particularly for feminized males, of low-esteem, disempowerment, and marginalization that leads to further abuse, violence and social exclusion. It is a vicious circle that constantly reinforces itself.

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

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

Those who are meant to be protected sustain abuse and violence. Many *zenanas/kothis/metis* not only face harassment, sexual violence and rape from law enforcement agents, but also from those whom they have called friends in schools and colleges, from those in positions of trust such as relatives, neighborhood elders, elder friends, and teachers. Gang rape is not uncommon. Such forced sex is always unsafe and often results in serious physical injury such as a ruptured rectum, internal haemorrhage and so on.

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

It is this belief that leads to the notion that those who are feminized can be exploited and abused, that being feminized somehow weakens the person, a notion often harbored by the *zenanas/kothis/metis* themselves.

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

“When my parik 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 *zenanas/kothis/metis* to abuse and assault and to a refusal of service provision. The fact that *zenanas/kothis/metis* themselves have internalized these notions so strongly means that specific tools will need to be developed for *zenanas/kothis/metis* in order to empower them to start valuing their lives and enhancing their self-respect.

In a study conducted in 2002 by NFI consultant Aditya Bondyopadhyay with Bandhu Social Welfare Society in Bangladesh,³³ significant findings included:

- 33% reported assault of a sexual nature,³⁴ or rape at the hands of friends, i.e. those who the respondent knew and trusted, which followed only to the incidence of sexual assault or rape at the hands of *mastaan/goonda* (traditional terms for hoodlums or bullies) and the police.

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

Rape and sexual assault also results when *kothis* or male sex workers refuse to pay the extortion demands of “hoodlums” or police. It may be noted that all the male sex workers in this study were self-identified *kothis*.

Reported gang rape by policemen was significant, 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 haemorrhage etc. It is also generates risks for the police officers.

The other factor that contributes to the abridgement of the basic safety of MSM and *kothis* in public areas is that *mastaans* often collude with the beat policemen. *Kothis* therefore do not receive any protection from the police when any harassment or assaults by the *mastaans* are actually reported.

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 other forms 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 are effeminate. This is of course an indication of the whole issue of feminized males and gender, which is dealt with hereafter, but is also indicative of the high percentage of MSM who suffer sexual assault and rape.
- 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 feminized behaviors. 55% of those who had faced harassment from *mastaans* also reported that the *mastaans* guessed they were MSM from their feminized behavior.

Cases of victimization by family members were not uncommon. Of the 25 respondents whose near relatives were aware of their sexual behavior, only 19 said that they had not accepted it. Their families 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 fourth standard or less, thirteen up to secondary level, and five up to higher secondary level. All those who had gone to university reported sexual harassment in either school or college.

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

Such regular experiences along with the fact that such feminized males live in culture which constantly validates normative masculinity creates internalized pain, shame and trauma along with deep sense of failure as men. This usually leads to self-blame, a lack of hope, and self-destructive behavior.

- 33% of the respondents reported that they have either thought of or tried to commit suicide at some point in their lives.
- 77% [ninety-six out of one hundred and twenty four] of the respondents stated that they know of others who have also faced such harassment. Of this ninety-six who admitted to knowing such other persons, forty-six stated that they know of less than five such persons, thirty-three stated that they knew between five to ten such other persons, and seventeen stated that they knew of more than ten such persons.

It was also clear from the study that beat constabulary often target outreach workers of sexual health projects too with extortion demands, and if such demands are not met the work of outreach is obstructed.

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

Sufficient evidence exists, and regularly reported to NFI from its partner agencies, that similar levels of abuse occur in the other countries of the South Asian region.

It is clear that legal, judicial, political and social advocacy is urgently needed not only concerning those living with HIV/AIDS, but also social justice and human rights for MSM. Advocacy will need to include challenges to the 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 *zenanas/kothis/metis*.

A range of international and national agencies working in the field of HIV/AIDS have recognized that for effective and sustainable strategies to prevent the spread of HIV/AIDS and to control emergent epidemics in a range of localities, countries and regions, MSM should be seen as a vulnerable “group” or “population,” and their sexual health concerns need to be addressed in ways that enable “community-based” responses. Papers, documents, and policies have all been written about empowerment, creating and enabling environment, community-based strategies that may lead towards risk reduction, along with the tools to produce such a change. However, without addressing the day-to-day violations that confront so many MSM, vulnerability to HIV/AIDS will remain high.

It is a largely excepted premise that the fights against HIV/AIDS must be allied with addressing human rights concerns of the most vulnerable, along with protecting the rights of those affected and/or infected by the virus.

Governmental policies for combating the HIV pandemic are often in conflict with the penal laws of the countries within the region. Therefore we find that on the one hand the health policy of the government seeks to address male-to-male sexual behaviors for HIV intervention. But on the other hand we also find that the continuing criminalization of such behaviors discourages those in need of information and services to seek the services provided by those policies. It therefore means that the delivery of services cannot be optimized. Furthermore, the outreach staff of intervention agencies and the targeted audiences are susceptible to police excesses because the criminal laws are in direct conflict with HIV policies. Staff are open to

abuse without the protection of the law, and they are deterred from seeking any remedy. This directly impedes HIV outreach.

In Bangladesh, India and Pakistan, legislation left over from British colonial times impedes effective and appropriate HIV interventions amongst MSM, where in several cases outreach staff and others have been harassed and/or arrested and charged with “corrupting society,” “aiding and abetting the commission of a crime” (the act of sodomy), and publication of obscene literature (use of materials for education purposes).

The particular legislation in question is the infamous Section 377 of the Bangladesh/Indian/Pakistan Penal Code, which states:

“Anyone who voluntarily 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 to ten years and shall also be liable to fine”

The explanation appended to the sections states “Penetration is sufficient to constitute the offence as described in this section”.

In India, the meaning of criminal penetration under anti-sodomy laws has been broadened to include oral sex, mutual masturbation and inter-femoral (thigh) sex; this broadening of the definition has been created through a range of court judgements over the last 50 years or so.

The existence of this so-called anti-sodomy law has a range of adverse consequences:

- Proper intervention efforts cannot be organized since such interventions can be construed as an abetment of a criminal act.
- It helps in the further marginalization of an already vulnerable “community” – MSM, afraid of attracting criminal sanction, do not come forward to access care, help and information.
- Most importantly, it is now not only a moral or legal issue. It is a tool of harassment and extortion in the hands of public authorities and is therefore also a corruption issue.
- It is very difficult to prove, but easy to charge with, which is the reason it is abused more often than it is used properly. This abuse in turn forces MSM to go underground and not access information and help, thereby increasing vulnerability to HIV/AIDS.
- It violates the privacy of the individual and is based on premises that have been scientifically established as false and untenable, yet it remains in the statute books and continues to be an impediment to intervention efforts.
- Unless it is repealed there can be no effective advancement of the other rights of the MSM population such as recognition of common law partnerships, inheritance, adoption and maintenance rights.

Another concern is that any effective intervention efforts amongst MSM also face the Obscenity laws, and laws pertaining to loitering and public indecencies/nuisance, and abetment.

These laws are often invoked to impede the intervention process and the process of disseminating safer sex and health information. They are also used to target MSM in public spaces of socialization, which are used by intervention agencies for dissemination of information. Most importantly, the laws on abetment are vague enough to attract sanction against intervention agencies as abettors of a criminal offence.

It has been recognized and articulated by UNAIDS and others that for building sustainable risk reduction strategies in the context of HIV/AIDS prevention and care, community ownership, mobilizing and active participation of those most at risk, are central for success. For vulnerable networks such as varieties of MSM, the lack of safe spaces and space for socialization is a fallout of Section 377. Criminalization also gives the state the authority to break up or disallow any such interaction. Further, this lack of safe spaces in turn also gives rise to incidents of violence, blackmail, extortion and threats, which closets the population and discourages the spread of safer sex information and prevention efforts, and increases vulnerability to HIV/AIDS.

Lack of support structures is also the fallout of discriminatory laws and the lack of safe spaces. This leads to an isolation of individual MSM and causes psychological and other distress. It also opens up the MSM to abuse and does not allow him to have proper access to legal/medical redress when abused or hurt.

Further systemic and sustained interventions are a casualty, and this affects the entire population by making them vulnerable to HIV/AIDS and other STIs. Thus most MSM, particularly those with feminized identities and/or anal problems, usually cannot access care and health facilities as knowledge of their sexual behavior may attract criminal sanction. Existing laws therefore violate the right to health, which is a guaranteed fundamental right under Article 21 of the Indian Constitution, along with similar articles in the Constitutions of the other countries in the region.

A paper prepared by Miriam Maluwa, Law and Human Rights Advisor to UNAIDS³⁵ argued that current international human rights treaties and conventions, along with those dealing with HIV/AIDS created “the human rights framework which 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 programs, including those addressing men who have sex with men.”³⁶

However, this author believes that there is an inherent weakness in this, in that the discourse is being taken to mean sexual orientation. While this of course is extremely important, it is inadequate in addressing many of the concerns highlighted above. Ignored These are the human rights and sexual health concerns for the range of gender variant males amongst MSM that reflect stigma, discrimination and social exclusion, and the abuses that arise based on non-conformity to normative masculinity.

Another concern this author has is that a human rights-based approach singularly focused on sexual orientation (or even gender variance) and which argues that “sexual minorities” such as lesbians, gay men, transgendered persons and *hijras* (and other gendered identities) should have the same rights as any other minority rights that are often embedded within their Constitutions, would still be inadequate to address all the human rights concerns of MSM. However, such an argument does not address the behavioral choices of those who do not identify themselves as a “sexual minority”.

In Sonia Katyal’s essay “Exporting Identity,”³⁷ the argument for the rights to privacy, gender choice, the right to form associations, to meet, and behavioral practices where consensuality is involved, may be a broader and more inclusive approach to begin to address the identified concerns above.

It is suggested that any rights-based approach to the sexual health needs of MSM should not only take into account the World Health Organization’s 1975 definition of sexual health as a cornerstone, but also must address the rights to privacy and freedom of association, along with repealing all laws, regulations, and policies that impede the right to sexual health for all.

From a range of reports, conversations and direct experience and discussions with MSM in a number of South-East Asian countries, similar experiences to that described above have occurred. Sexual health interventions often suffer the same short-sightedness, where feminized males are targeted for condom promotion, but their masculine sexual partners are invisibilized under “occupational groups” who are only offered advice and knowledge about condom use and vaginal partners because they are invisible as MSM.

The issue of female sexual health is also highly pertinent among MSM. Cultural tradition makes marriage socially compulsory. Many MSM, of whatever framework or gender identification and/or orientation, are married or going to be married, even those who perform feminized roles. Many manly sex partners from the general male population would also be married or will be married and may well have other females as sexual partners. This means that the sexual transmission of HIV from males to males, and then on to females may be quite

common (and even female-to-male-to male), especially as most males tend not to practice safer sex with each other, and most females are either ignorant of their male partners other sexual behavior, or unable to demand protection.

To truly address the concerns expressed in this paper, we must not only gain more knowledge about the dynamics of the range of homosexualities and male-to-male sex in Asia using anthropological, sociological, historical, and behavioral studies, we must also deconstruct the concept of masculinity as being expressed as normative, looking at masculine violence against difference and femininity. We must work directly with MSM populations, involving them as partners in such studies, as partners in any sexual health and HIV/AIDS interventions, as partners in civil society.

The time for action is now. Concerted efforts must be made to ensure that all peoples, and within the context of this paper, all varieties of MSM have the rights to “life, liberty and the pursuit of happiness” that is often talked about, but with no meaningful action being taken. Silence is not golden.

¹ Masculinity is interpreted as the predominant and “hegemonic” framework, which defines how a man should behave and act personally, sexually, socially, and culturally. However, it is also recognized that there are different constructions of masculinity that vary across cultures, age groups, sexual orientations, sexual preferences, actual behaviors, gender identifications, economic classes, and religions, and thus we should speak of masculinities.

² “Sexuality” refers to all aspects of people’s sexual lives: their sexual desires, their sexual behaviors and their sexual/gendered identities. It is important to focus on sexuality in HIV prevention work because it is important to understand people’s risk behaviors in the context of their sexual desires and sexual identities.

However, contemporary researchers have been discussing the concept of a range of sexualities, expressing the enormous diversity of cultural interpretations, meanings and significance placed upon sexuality. Similarly there would be a range of homosexualities and not some monolithic construction of one homosexuality.

³ From 25 Questions and Answers on Health and Human Rights, Health and Human Rights Publication Series, Issue No. 1, July 2002, World Health Organization.

⁴ From the Indian National AIDS Control Organization’s website (<http://www.nacoonline.org/gacts.htm>), accessed on 14th September 2004.

⁵ Website: <http://naco.nic.in/vsnaco/indiascene/update.htm>. Accessed on 23rd September 2001.

⁶ See NFI situational assessments for a range of South Asian cities where questions on HIV anti-body testing were asked available on www.nfi.net.

⁷ Naz Foundation International (NFI) is a non-governmental agency registered in the UK but working exclusively with male-to-male sex and sexual health concerns in South Asia by providing advocacy, policy development and technical support to empower local networks of males who have sex with males to develop their own community-based HIV/AIDS and sexual health service provision. Since 1996, NFI has assisted in the development of 28 such community-based HIV/AIDS service providers in South Asia. See NFI website, www.nfi.net.

⁸ I will use the acronym MSM in this text, but where I do it specifically means males who have sex with males. In other case I will use the phrase male-to-male sex.

⁹ The theory, which underlies this study, is based on the principle of social constructionism, which holds that masculinities, sexualities, and sexual behaviours (if not sexual desires themselves) are socially constructed through social and sexual scripting processes.

¹⁰ See NFI reports on a number of Situational and Social Assessments on MSM in a range of cities in South Asia accessible on its website www.nfi.net.

¹¹ In South Asian countries, gender segregation of social spaces is a strong form of social policing of gender relationships. Primary relations are between the same gender (homosocial). Homoaffectionalism in the sense that the term is used in this text means social acceptance of the public display of male-to-male or female-to-female affection. For example, it is common in Bangladesh to see two males holding hands or arms wrapped around each other as they walk. Often male friends will also share beds when sleeping, wrapping themselves around each other. (See Hardman: 1993; Also Khan: 1996, where he points out that the boundary between homoaffectionalism and homosexual behaviours is very “thin” particularly in shared spaces and “under the blanket.”)

¹² Hierarchical and oppositional binary: I use this phrase in the specific context of gender(ed) relationships between males and between males and females, or masculinity and femininity, where these genders and their qualities are seen as a hierarchical and in opposition to each other. In other words, maleness is superior to femaleness and in opposition to it.

¹³ *Kothi* - A self-identifying label used by those males who feminize their behaviors (either to attract “manly” male sexual partners and/or as part of their own gendered construction and usually in specific situations and contexts), and who state that they prefer to be sexually penetrated anally and/or orally. *Kothi* behaviors have a highly performative quality in social spaces. Self-identified *kothis* use this term for males who are sexually penetrated, even when their behavior is not feminized. This is the primary and most visible framework of MSM behaviors. *Kothis* state that they do not have sex with other *kothis*; however, they may also be married to women. The term *kothi* tends to be used in India and Bangladesh, *zenana* in Pakistan and *meti* in Nepal.

¹⁴ *Hijra* - A self-identified term used by biological males who define themselves as “not men/not women” but as a “third gender.” *Hijras* cross-dress publicly and privately and are a part of a social, religious, and cultural community.

Ritual castration is a part of the *hijra* identity, but not all *hijras* are castrated. Anal and oral sex with masculine men is common.

¹⁵ The term used in Pakistan and means the same as *kothi* (see note 13).

¹⁶ *Maasti* is a Hindi word meaning mischief.

¹⁷ *Panthis/Giriyas/Tas* - a *zenanalkothi/meti* label for any “manly male.” A *panthi/giriya* is by definition a man who penetrates, whether it is a woman and/or another male. *Panthis/Giriyas* may also be married to women and/or sexually access other females. Their occupations vary across the social class spectrum from rickshaw drivers to businessmen.

¹⁸ *Pariks/Pucca Dost* - a *zenanalkothi/meti* label for the “husband” of a *kothi*. The *parik/pucca dost* could also be married to a woman and have sex with other women as well as males.

¹⁹ See: *The risks of categorization*, Shivananda Khan, *Pukaar*, Issue 21 April 1998; *Varieties of homosexuality in Bangladesh*, paper presented by Dr. Carol Jenkins at the 12th World AIDS Conference, Geneva, June 28-July 3, 1998, *Pukaar*, Issue 24, January 1999; *Men and HIV: socio-cultural constructions of male sexual behaviors in South Asia*, Shivananda Khan, *Pukaar*, Issue 28, January 2000; *Males who have sex with males in South Asia – a kothi framework*, *Pukaar*, Issue 31, October 2000. *Pukaar* is the quarterly journal of Naz Foundation International and available on its website www.nfi.net as pdfs.

²⁰ Personal discussion with Dr. Carol Jenkins, Care Bangladesh, 1999.

²¹ Presentation by ICDDR,B at the 2nd National Male Sexual and Reproductive Health Consultation Meeting organised by Bandhu Social Welfare Society, Bangladesh, August 2003.

²² Reported in AIDS Analysis, Asia, July 1996, Focus on Pakistan, page 6.

²³ *HIV Prevention Among Men Who Have Sex With Men (MSM) In India: A Review Of Current Scenario and Recommendations* – background paper prepared by SAATHII (Solidarity and Action Against The HIV Infection In India) Working Group on ‘HIV prevention and care among Indian GLBT/Sexual Minority Communities, revised drafted, April 2002, pp 56.

²⁴ Government of India, Ministry of Health and Family Welfare, National AIDS Control Organisation, *Estimation of HIV Infection among Adult Population* (New Delhi, India: Ministry of Health and Family Welfare, 2001).

²⁵ *AIDS and Men Who Have Sex With Men (UNAIDS Point of View)* (Geneva, Switzerland: UNAIDS, 1998).

²⁶ A.D. Bryan, J.D. Fisher, and T.J. Benziger, *HIV Prevention Information, Motivation, Behavioural Skills and Behaviour among Truck Drivers in Chennai, India*, *AIDS* 14, no. 6(14th April 2000):756-8.

²⁷ Background document on the dissemination of the fourth round (2002) of national HIV and behavioural surveillance, National AIDS/STD Program, Bangladesh, June 2003.

²⁸ See note 23.

²⁹ Ibid.

³⁰ National AIDS Control Organisation of India’s website (<http://naco.nic.in/vsnaco/indianscene/overv.htm>). Accessed on 23rd September 2001).

³¹ www.nfi.net, Situational Assessments among MSM in South Asia.

³² See *Situational Assessments among MSM in four cities in South Asia*, 2000: Bangalore, Hyderabad, Pondicherry and Sylhet, an NFI study for Family Health International.

³³ See study report *Against the Odds*, 2002, 2004, www.nfi.net.

³⁴ 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.

³⁵ Presented at the special UNAIDS convened Inter-Agency meeting on Working with Men who have sex with men for HIV/AIDS Prevention and Care, 1st November 2002.

³⁶ See NFI Briefing Paper No. 10, statement by Miriam Maluwa.

³⁷ *Exporting Identity*, published in *Yale Journal of Law and Feminism*, Volume 14, Number 1, 2002.