

WORKING WITH MSM IN SOUTH ASIA

A Framework For Good Practice

The NFI Experience
January 2004

Introduction

Since 1996, Naz Foundation International (NFI), based on its knowledge and experience of working with males who have sex with males (MSM) frameworks and networks, has provided technical assistance and support to develop some 28 CBO MSM sexual health projects in the South Asia region, 15 of them in India.

Experience had shown that the countries of South Asia, such as India, Nepal and Bangladesh, have common frameworks of male-to-male behavioural dynamics, shared terminologies and gendered frameworks, and the same significances and meanings placed on sexual behaviours, gendered identities and social constructions of masculinities.

Based on this experience NFI has developed a range of replicable development tools and resources that support local CBO MSM sexual interventions. The model of service delivery by Bharosa in Lucknow, India is the same as that used by Bandhu Social Welfare Society in Bangladesh, Blue Diamond Society in Kathmandu, Nepal, and Vision in Lahore, Pakistan, as are the management and programme tools and resources that they use.

What follows in terms of good practice below is based on NFI experience since 1996 of its model of MSM sexual health interventions.

The context

South Asian countries are male dominated societies, where the social and public spaces are primarily male owned. As homosocial and homoaffectionalist societies, sexual boundaries between males can often be easily crossed in appropriate spaces and become sexualised acts. Further, significant numbers of males perform gendered roles as feminised males and can be accessed by those deemed as “real men”. Experience indicates that male-to- male sexual behaviours does exist in India at substantial levels.

Most of these male-to-male sexual behaviours do not exist within a socio-sexual context of a heterosexual/homosexual oppositional binary and as exclusive categories. Rather there appears to be an inclusive behaviour which involves a substantial level of men/males operating within a wide variety of categories and/or networks, which involves at times, gendered self-identities, a perceived ‘body heat’ leading to a perceived urgent need for semen discharge, ready and easy accessibility to male sexual partners, and the social contexts of gender segregation, social policing of females, delayed marriage, and concepts of masculinity and femininity.

The frameworks of male-to-male sex, often substantially divergent, involve males who self-identify primarily as *kothis*¹ and are usually penetrated; males/men who take on the penetrating role in male to male sex (known as *giryas/panthis*² by *kothis*) accessing *kothis*; *hijras*³ also access by normative males, and at times, adolescent males. These males are usually perceived by *giryas/panthis* as feminised males/females, which enables the *giryal/panthi* to maintain his sense

¹ *Kothi* - A self-identifying label for those males who feminise their behaviours (either to attract “manly” male sexual partners and/or as part of their own gender construction and usually in specific situations and contexts), and who state that they prefer to be sexually penetrated anally and/or orally. *Kothi* behaviours have a highly performative quality in social spaces. Self-identified *Kothis* use this term for males who are sexually penetrated, even when their performative behaviour is not feminised. This is the primary and most visible framework of MSM behaviours. *Kothis* state that they do not have sex with others like themselves, only “real men”. However many *may* also be married to women as a family obligation. Also called *metis* in Nepal and *zenanas* in Pakistan.

² *Giryal/Panthis* - A *kothi* label for any “manly male.” A *panthi/giryal* is by definition a man who penetrates, whether it is a woman and/or another male. *Panthis/Giryas* would most likely also be married to women and/or access other females. Their occupations vary across the social class spectrum from rickshaw drivers to businessmen.

³ *Hijras* - A self-identified term used by males who define themselves as “not men/not women” but as a “third gender.” *Hijras* cross-dress publicly and privately and are a part of a strong social, religious, and cultural community. Ritual castration may be part of the *hijra* identity, but not all *hijras* are castrated. Sex with men is common, and like men who have sex with *kothis*, such men would see themselves as ‘real men’ and not homosexuals.

of manliness and be seen as a part of the normative male society. Other dynamics include males who access other 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 have sex with friends for mutual pleasure, and males in all male institutions. Along side these indigenous forms of labelling, gay-identified males, primarily among English speaking, middle and upper classes also exist with their own networks.

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

The most visible of these networks are those involving *kothis* and *hijras* because of their public performative role, which is a part of their self-identification. In some cities in South Asia there are also *male massage networks* and other normative masculine males working as male-to-male sex workers.

This, if course, does not tell the whole story of male-to-male sexual behaviours in these countries.

Male-to-male sex work is a significant factor in many South Asian cities and towns (and perhaps villages also). A broad range of frameworks also exists here. *Hijras*, *kothis*, massage boys/men, male youth, and other males/men will sell sex to men because of poverty and unemployment. Without a welfare system, and with significant levels of unemployment or low level incomes, male sex work can be a way out in terms of supporting the self and family. This is not to imply that males involved in sex work do not enjoy the sex with other males. Often they will also have a regular male or female partner.

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

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

While there were substantial networks of *kothis* of all gradations in urban centres - from the very feminised and cross-dressing type to those who have moustaches and dress in shirt and trousers - their sexual partners could well be any masculine male. Similarly there are significant levels of *hijras* communities in major urban centres.

Massage boys/men and other similar male sex workers are not only being accessed by men for masturbation and discharge as part of the massage process, they were also being accessed by males across the economic and class spectrum for penetrative sex. Women may also access many of these massage boys/men for sex.

There are other networks of male-to-male sex, not only in a range of male only institutions, such as prisons, hostels, orphanages, or between young male friends in neighbourhoods, but also between older men and adolescent boys. Such frameworks can be seen within contexts of

- a. Desire for a specific sexual act, i.e. anal sex and oral sex ("Wives/women don't do this")
- b. 'Body heat' that requires discharge ("When my body gets hot, I just can't control myself")
- c. Mutual desire for male-to-male sex
- d. Desire for adolescent boys known in the historical literature as "beardless youths" ("Boys are like women, soft:)

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

What is clearly seen in many of the MSM sexual networks is that language, behaviour, and identity are to a large extent

gendered, within a invisible context of polymorphous behaviours, and that behaviour and actual 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 (either feminised or masculinised) or with perceived masculine 'body needs' which shaped sexual practices.

One more point needs to be made. Relationships between the various networks (I use this term advisedly rather than groups) are often self-stigmatising, tense and sometimes abusive because of the social construct of penetration being seen as equivalent to feminising. Gender 'politics' and relationships come to the fore. Thus masculine male sex workers may abuse *kothi* sex workers because of their feminisation; *kothis* will abuse male sex workers and gay-identified men because they also are penetrated, *giryas/panthis* abuse *kothis*, and substantial tensions exist between *hijras* and *kothis*, since most *kothis* are not castrated nor want to be. These tensions can explode into verbal and physical abuse at times.

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, are married or going to be married, even those who self-identified as *kothis*. Many manly sex partners from the general male population would also be married or going to be married and may well have other females as sexual partners.

Such MSM frameworks and structures thus require parallel strategies to address HIV/AIDS and sexual health concerns and needs:

- a. Focused interventions addressing the specific needs of *kothis*, who do have a framework for community building and mobilising based on shared feminised sensibilities, sexual practices and visibility.
- b. Focused interventions for gay-identified men with shared sexual identity being the community framework.
- c. Similar interventions among *hijras*.
- d. Education, awareness and STI service delivery that ensures that knowledge of anal sex as a risky practice is a part of any intervention with the general male population.

Note: based on NFI experience the psychosocial needs of *kothis*, *hijras* and gay-identified men are often very different and it may be more appropriate to have different interventions for each of these networks.

Along with this, needs to be the recognition that the majority of males involved in male-to-male sexual behaviours also access women as wives and/or as sexual partners. This means that to a significant extent the pattern of infection could well be male-to-male-to-female. Thus all MSM sexual health programmes must include risks to female partners, and that STI service delivery must also address the concerns of female partners of MSM.

While Naz Foundation International has primarily worked with focused interventions with feminised males (*kothi*-identified), it has encouraged the resultant CBOs to work with female sexual health programmes, and with those working with specific groups of vulnerable males from the general male population, including truck-drivers, clients of female sex workers, IDU projects and so on. It has also encouraged its partner agencies to provide assistance to *hijra* and gay-identified networks wherever possible, along with male sex worker networks and other dynamics of male-to-male sex.

There are only 2 main strategies for promoting sexual health

- THE MORAL STRATEGY – *DON'T DO IT*
- THE PRAGMATIC STRATEGY – *DO IT SAFELY*

Which strategy would be most effective in reducing the spread of HIV/AIDS?

It therefore needs to be clearly stated here that behaviour change does **not** mean promoting abstinence or changing the male-to-male sexual behaviours and gendered identities to male-to-female behaviours, both of which are unrealistic and arise from a moralistic approach to HIV prevention. It means empowering MSM to reduce their own risks to STI/HIV infection through changing their risky behaviours to less risky behaviours and creating an empowering environment where this becomes possible. It is a risk reduction strategy that NFI promotes.

Key signifiers for good practice

As far as NFI knows, no legitimate and independent study has been done on best practices for MSM sexual health interventions in South Asia (although we believe that one is being conducted in Bangladesh with Bandhu Social Welfare Society at the time of this writing). Nor, as far as can be determined, any national impact study been done in regard to sustained changes of levels of risk reduction or consistent condom use among MSM accessing sexual health services, either NGO or CBO led.

We are therefore hesitant to discuss best practice models in this context in this paper. What we have done is to therefore identify key elements in the NFI model of service delivery for marginalised MSM that have been successfully replicated in a number of different localities where NFI has provided technical support for locally-based MSM sexual health community-based organisations to be developed, and suggested that these be defined as Good Practice.

A study had been undertaken by Tim Mackay, consultant to the Department for International Development, UK, which looked at Bandhu Social Welfare Society in Bangladesh and Sahodaran based in Chennai, India, where both these agencies had accessed NFI technical expertise to develop MSM-led sexual health interventions. Both had utilised NFI's training and development manuals, key monitoring tools and financial management, as well as service delivery models. The study was conducted in 1999⁴.

From the report

A major result of the work undertaken so far has been the testing of a number of key strategies and service delivery components that make up a response to the sexual health needs of males who have sex with males and their female partners in South Asian countries. These strategies can be characterised as an integrated, flexible “framework” or “model” that can be adapted and used in different locations and circumstances.

In the work reviewed the “framework” has demonstrated a strong value. There are observable weaknesses but these relate more to quality of implementation and circumstances beyond the control of the projects than any inherent fault in the concept. The framework is not rigid or static and will evolve as further work is undertaken.

While the results to date are impressive there remain enormous challenges if the full potential of the organisations, and the main goal of the work, is to be realised.

And...

Conclusion

The framework or model, which has been generated by NFI, Bandhu and Sahodaran to respond to the needs of males who have sex with males is sound, has proved to be adaptable and has produced exciting results so far. It can be used as a starting point for individuals and agencies in other locations in South Asia to create their own responses to their specific needs.

Most key stakeholders (international, national and local), including UNAIDS, based on their global experience, now recognise that for an effective, appropriate, and sustainable, HIV/AIDS prevention programme that focuses on any marginalised and socially excluded population, certain key indicators are required. These are:

✓ **Focused participatory interventions**

Strategic focusing of participatory prevention programmes for populations most at risk.

✓ **Ownership of the issue**

Those most at risk will also need to acknowledge their own risk and own the issues involved.

⁴ Centre for Sexual and Reproductive Health: *Sexual Health of Males who have Sex with Males in South Asia – an evaluation of the work of Naz Foundation International and two of its partner projects- Bandhu Social Welfare Society, Dhaka and Sahodaran, Chennai*, November 1999 - Tim Mackay. Undertaken by JSI (UK) on behalf of the Department for International Development, UK.

✓ ***Beneficiaries as service providers***

For a sustainable programme on risk reduction, those most at risk must be directly involved in developing, implementing, and providing prevention services for their peers.

✓ ***Self-help community-based organising***

To ensure involvement of, and management by, beneficiaries, key individuals within marginalised populations should be recruited, provided training and skills building, and empowered to develop their own service organisation.

✓ ***Access to appropriate and affordable STI treatment services***

It is essential that clinicians providing STI treatment services are sensitised to the specific sexual health needs of vulnerable MSM, which includes providing STI management in regard to anal STIs and symptoms. Such services should be confidential, not only around STI status, but also with regard to sexuality and behavioural choices.

✓ ***Access to appropriate HIV voluntary testing and counselling***

Ensuring that confidential testing along with pre-test and post-test counselling appropriate and sympathetic to the needs of MSM is essential.

✓ ***Access to appropriate treatment, care and support services***

Many MSM living with HIV/AIDS are not only stigmatised by the positive status, but also by the route of infection and their feminised sensibilities. Treatment, care and support programmes need to be sensitised to these different frameworks of stigmatisation and address them appropriately.

✓ ***Access to affordable appropriate condoms and water-based lubricants***

Reducing the risks of STI/HIV infection is central to any effective HIV/AIDS prevention programme. The most significant risk is through anal sex, both for the penetrated as well as for the penetrator. Regular use of condoms for anal sex is an essential component for any risk reduction strategy. However, in addition to this, ready access to appropriately packaged water-based lubricant is also an essential component of this, since anal sex by its nature increases the stress on condoms itself as well as reduces rectal damage.

✓ ***Access to appropriate IEC materials***

These materials need to be appropriate to the issues and concerns of MSM in languages, terminologies and imagery that are meaningful and understandable to them.

✓ ***Long-term technical and financial support***

It is most likely that the level of technical knowledge to develop, implement and manage an HIV/AIDS prevention and care programme for peer beneficiaries will be low if existent at all. Developing these skills and knowledge will require a sustained effort to share such information with those developing the service. At the same time, these self-help initiatives must also be ensured of appropriate levels of funding over a sustained period of time in order to develop these skills and continuity of service provision.

✓ ***Advocacy on legal, judicial and social impediments to promoting HIV/AIDS prevention and sexual health***

Along with advocacy on the above signifiers, advocacy on addressing the legal, judicial and social impediments to HIV/AIDS prevention and care programmes focusing on MSM is an essential requirement towards developing an empowering environment so that affected populations can reduce their risks to HIV/STI infections and modify their sexual practices in order to achieve this.

In addition to the above it needs to be remembered that many MSM have no gendered or sexual identities and that primarily they perceive themselves as normative males who penetrate non-men. Such men are invisible within the general male population. It will therefore be essential to ensure that education, awareness and STI treatment programmes for occupational groups and the general male populations along with condom promotion should also address anal sex as a risky sexual behaviour.

Why not use an existent non-government agency to implement an MSM HIV/AIDS intervention?

The difficulty for donors, where private or government, is that very few community-based MSM service providers exist. In such an environment, where the epidemic is growing and spreading and an urgent response is required, and where other non-government agencies exist, the tendency has been to fund these NGOs to deliver HIV/AIDS prevention services to

MSM populations.

However, such a strategy tends to utilise a “top-down” approach, which does not lead to ownership or empowerment of the beneficiaries towards maintaining safer sex behaviours.

One approach, if non-MSM NGOs are to be used, is that these NGOs should work with specific groups/networks of MSM towards building up self-help organising through technical support, and empowering such self-help groups to develop their own community-based response through promoting community-based organising/organisations.

This is the NFI approach.

However, many NGOs are involved in HIV prevention and sexual health programmes for other risk populations as well as the general male population. Such NGOs should be sensitised in regard to male-to-male sexual behaviours and include issues of risk and risk reduction in their programmes. After all MSM as a category and behaviour crosses all risk populations.

Key components in developing any intervention focused on self-identified MSM

- Identifying key MSM individuals and MSM networks within the specific target city/area
- Provide such individuals with appropriate skills building and on-going technical support
- Map and network within the focused city/area
- Form a self-help groups and build their knowledge and management skills towards developing their own CBO
- Identify safe spaces for group meetings, education programmes and socializing activities towards community-building
- Ensure adequate supplies of condoms and water-based lubricant
- Ensure ready access to appropriate STI clinical services
- Provide adequate long term funding
- Address legal, judicial and social impediments

There are four primary components in such an MSM-led HIV/AIDS prevention and care programme:

➤ **Field Services, which should include**

- Outreach and friendship building
- Community development and mobilising
- Education and awareness
- Advice and information
- IEC materials distribution
- Condom/lubricant distribution
- Referrals to drop-in centre, STI treatment, counselling and HIV testing

➤ **Centre-based services, which should include**

- Drop-in services;
- Social group meetings
- Skills-building vocational classes,
- Sexual health awareness-raising and condom and lubricant distribution;
- Counselling;
- Telephone helpline;
- Recreational activities
- Community-based research

➤ **Health Services, which should include**

- STI treatment and management
- HIV testing and counselling
- Access to treatment for opportunistic infections and ARVs
- Psychosexual counselling
- General health care

➤ **Technical Assistance, which should include**

- On-going accessibility to technical support when requested
- Training and skills building
- Access to a range of BCC and training resources
- Research
- Advocacy
- Participation in policy development
- Networking and developing partnerships

While the above signifiers and components of an MSM sexual health intervention are believed to be crucial to build a sustainable, effective and an appropriate programme that is MSM-led, without an effective sero-and behavioural surveillance programme conducted by external evaluators, impact and outcomes for such a programme cannot be measured. Appropriate monitoring and evaluation at all levels are essential, in terms of process, management, finance, service delivery, and change. Such M & E is not just data collection of how much condoms are distributed, and so on, but includes qualitative evaluation of process and outcome. An annual sero and behavioural surveillance programme significantly adds to this by providing an effective tool to measure the impact of such interventions.

Conclusion

To ensure that MSM who are at risk from STI/HIV infections have access to appropriate sexual health services and that risk reduction strategies can be implemented effectively requires knowledge, understanding and openness by key stakeholders to the realities of the sexual lives of so many males. It requires a strong commitment and leadership from donors and policy-makers to invest adequate funds to protect the lives of so many people. It requires creating an enabling and empowering legal, judicial and social environment in which positive actions can be taken, and that networks of MSM can take charge of their own lives and well-being. It can be done. It should be done. It must be done.

ANNEX 1

NFI Sexual Health Promotion Service Model

