

# The invisible epidemic

*Male-to-male sex and HIV/AIDS in South Asia*

An appropriate response

Naz Foundation International

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2. **What is an appropriate response to the problem?**
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# Frameworks of male-to-male sex in South Asia

Sexual diversity and polymorphous behaviour includes:

- Gendered framework and performative identities, sexual practices, and sex roles
- Sexual identity/orientation
- Discharge, institutional, situational, economic
- Accessibility

Class, education and poverty frame practices and Identities.

# Frameworks of male-to-male sex in South Asia

- Most male-to-male sexual behaviours are invisible and not gay/homosexual identified
- Man males involved in male-to-male sex will also often have sex with wives/other women
- Male-to-male sex is substantive and involves males across the economic and social spectrum

# Frameworks of male-to-male sex in South Asia

**A homosocial and homoaffectional culture with:**

- Gender segregation and social control of females
- Overcrowding and male only spaces
- A gendered construction of male-to-male sex
- Poverty, unemployment and low income encourage male-to-male sex work
- Males are easier to access than females
- Sex practice defined by behaviour/acts rather than identities

# Who are males-who-have sex-with males (MSM)?

- MSM is not an exclusive category or “target group”
- MSM does include those males with specific sexual identities, such as gay men, as well as those with gendered identities such as *kothis/zenanas* (defined later)
- It involves any male who has (or had) sex with another male, irregularly or regularly
- But not all MSM are at risk of HIV infection - this would depend upon their specific sexual practices

# Who are males-who-have sex-with males (MSM)?

- Based on evidence, male-to-male sex in South Asia appears to be primarily structured around sex and gender roles - the penetrated and the penetrator
- Here the penetrator perceives himself involved in a manly activity - he does not perceive himself, nor is he perceived, as a homosexual
- His penetrated partner is perceived (and most often perceives himself) as “NOT-MAN”
- Neither perceive themselves as “men having sex with men”

# Indigenous identities

- *kothis/zenanas/metis*
  - a self-identified label used by feminised males who have sex with males, and use their feminised behaviours in public spaces to attract “real men” for sex. They are usually sexually penetrated.
  - However, many *kothis* will also be married with children in a culture of “compulsory heterosexuality”
  - They are primarily from low income populations

# Indigenous identities

- **Hijras**

- A self-identified term used by males who do not define themselves as “men”, or “women”, but as a “third gender”. Hijras cross-dress publicly and privately, and form part of a social, religious and cultural community. Ritual castration is often a part of the hijra identity. Sex with males, often for reward is common. They also have their own language, known as “Ulti”.

# Gay identity in South Asia

- Gay-identified men tend to come from educated and upper-income urban areas
- They tend to find partners who are also gay-identified
- Do not socialise or access low-income *kothi*-identified males
- Might access non-identified “real men”
- Male-to-male sex frameworks are bounded not only by gender roles or sexual orientation, but also class, education and income

# Indigenous labelling

- *Panthis/giriyas*
  - The *kothi* name give to “real men”
- *Pariks*
  - The *kothi* name given to the ‘husband’ of a *kothi* - a regular partner of a *kothi*

# Indigenous labelling

- ***Do-parathas/double-deckers, AC/DC***
  - *Kothi* terms for those men who penetrate and are penetrated, which is disparaging
- ***Chapati-chapati***
  - A *kothi* term for *kothis* who have sex with other *kothis*. Though of a shameful, and sometimes called “lesbian sex” by *kothis*

*“Why do men have sex with men? This is not normal. We kothis are here for them.”*

*“I don’t mind if my panthi 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.”*

From interviews with kothi-identified males

# Appropriate terms

In terms of HIV prevention, bipolar categories of:

- “Man” / “woman”
- “Homosexual” / “heterosexual”
- “Gay” / “straight”

do not work to address HIV concerns. Hence the category “men who have sex with men” has been used, but the term “men” can be problematic since this is also socially constructed.

## “Male” v “Men”

In South Asia much of male-to-male sex is based on gender, sex, and, or, age roles.

The penetrating partner often sees himself as a “man”, while the penetrated partner tends to be perceived, and perceives himself as not a “man”.

Thus in both cases, the term “men who have sex with men” becomes problematic.

# Male-to-male sex prevalence

- 25% of medical students at Patna Medical College in a 1992 survey revealed that they had same-sex relationships (Wyatt, 1993)
- Of the 1500 men who replied to a questionnaire in an English men's magazine in India, Debonair, 29.5% stated that had sex with another man before the age of 20 years (Roy Chan, et al. 1998)

# Male-to-male sex prevalence

- A survey of 527 truck drivers in northeast India revealing that 15% had sex with men (Ahmed, 1993)
- In Bangladesh, a study conducted by the International Centre for Diarrhoea Diseases Research, Bangladesh in 2002 indicated that over 22% of rickshaw pullers had sex with other males.

# Male-to-male sex prevalence

In Pakistan, the July 1996 edition of AIDS Analysis Asia reported 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

# Male-to-male sex prevalence

City	City population	Sample size (kothi identified males)	Number of sex sites	Number of reported sex partners in proceeding month
Hyderabad, India	5 million	200	102+	8100
Sylhet, Bangladesh	1 million	200	28+	8800

**Who is involved in male to male  
sex?**

*A kothi response?*

“All men”

# Why do males have sex with males?

- Desire for other males
- Desire for specific acts
- Pleasure from discharge – “body heat”
- Wives (and at times other women) do not do anal or oral sex
- Males are easier to access – shared beds and spaces
- Anus is tighter than vagina and gives more pleasure

- No one is suspicious when males mix with other males
- Females are more socially policed and more difficult to access
- For play and curiosity
- A girl's virginity should be protected
- No marriage involvement
- Making money
- Maintaining chastity

# Stigma and Discrimination

In a gendered sexual environment, feminised males who have sex with men are doubly stigmatised because of:

- Their gendered social/sexual behaviours
- The perceived knowledge that they are anally penetrated
- Gay-identified men are at times also perceived as feminised males

# Stigma and Discrimination

- Such stigmatisation leads to male violence, social exclusion and a denial of services
- As males growing up in a patriarchal society, such feminised males are also self-stigmatised because of their gendered identities, social exclusion and sense of worthlessness
- And of course stigmatisation is greatly reinforced when living with HIV/AIDS

# Violence and abuse

In a 2002 study conducted in Bangladesh with feminine-identified males (N=124):

- 33% reported sexual assault or rape by their “friends”
- 48% reported being sexually assaulted or raped by local police
- 64% reported being harassed by police

# Violence and abuse

- 71% reported being sexually harassed by local hooligans
- 87% stated that they have been sexually assaulted because they were effeminate
- 41% stated that their harassment by police was because they were effeminate
- Reports from elsewhere in South Asia indicate similar levels of violence, sexual assault and rape on feminised MSM.

# Why work with male-to-male sexual behaviours and HIV?

- The contribution of MSM behaviours to the HIV/AIDS epidemic in India was officially set at 1% in 2001
- However, there are serious under-estimations of behaviour
- Most males involved in male-to-male sex will not identify their behaviours
- The reliability of HIV data is also suspect

# Why work with male-to-male sexual behaviours and HIV?

- There is a lack of knowledge about MSM and prevalence
- In Bangladesh, syphilis rates for *kothi*-identified MSM vary between 4%-10%
- In Mumbai a 2003 study indicated an HIV prevalence rate of 20%
- In Chennai, a 2000 study indicated a 4% rate of HIV infection
- We know that male-to-male sexual behaviours are substantive

# Why work with male-to-male sexual behaviours and HIV?

- Very few interventions in a region of over 1.5 billion people.
- Self-identified MSM, such as *kothis*, gay men and *hijras* are socially excluded.
- Highly vulnerable to human rights abuses and sexual violence
- Low access to sexual health services
- Multiple partners, low condom use, and very little access to water-based lubricant

# Why work with male-to-male sexual behaviours and HIV?

- Low self-esteem and disempowerment
- Most male-to-male sexual behaviours are invisible
- Bridging populations to spread HIV into the general population, particularly women
- Many are married and/or have sex with other females

# Vulnerability and risk

- Power inequalities and disempowerment
- Low self-esteem
- Violence and abuse
- Rape, blackmail and illegality
- For low-income feminised males this is reinforced by:
  - Poverty
  - Low levels of literacy

# Vulnerability and risk

This leads to social exclusion exacerbated by fear of discovery, which leads to:

- Low condom usage
- Multiple partners
- Lack of sexually transmitted infection treatment

Higher vulnerability leads to  
Higher risk behaviours

# Addressing social exclusion and vulnerability

Unless we address the social, cultural, judicial and legal impediments to effective HIV/AIDS and sexual health interventions among males who have sex with males, and deal effectively with stigma, discrimination, male violence and social exclusion, the “fight against AIDS” could be lost.

# Sexual Health

A WHO definition from 1975:

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

**We argue that all people have the right to sexual health.**

# Issues that must be addressed

- **Advocacy and policy**
  - Repeal of legislation and training of law enforcement agencies, judiciary and media
- **Identity-based self-help interventions**
  - *kothi*, *hijra* and gay self-help groups helped in community building and mobilisation, along with recognition of gender variance and diversity
- **Anal sex as a mainstream behaviour**
  - Partners of feminised males are from the general male population, many of whom also have anal sex with women

# Issues that must be addressed

- **Capacity and skills building**
  - With low income populations there are a lack of skills, knowledge and capacity. They will require on-going technical support.
- **Promote sexual responsibility**
  - The majority of males who have sex with males will become married. Female partners are at risk also.

# Issues that must be addressed

We must also address the social construction of masculinity that allows *genderphobia* to be a part of that construction, that enables violence against feminised males (and females) to be socially permissible, and that socially excludes such males, and say they are less than human.

# Naz Foundation International

- Formed in August 1996 as a UK registered charity specifically to work with MSM networks in South Asia, to develop their own sexual health services through:
  - Community building and empowerment
  - Where the beneficiaries are also the service providers
  - Advocacy on sexualities, alternate masculinities, HIV status
  - Promoting sexual responsibility towards ALL sex partners

# Naz Foundation International

- Vision
  - We believe in a world where all people can live with dignity, social justice and well-being
- Mission
  - To empower socially excluded and disadvantaged males, their partners and families, to secure for themselves social justice, equity, health and well-being, through advocacy, policy development, along with technical, institutional and financial support

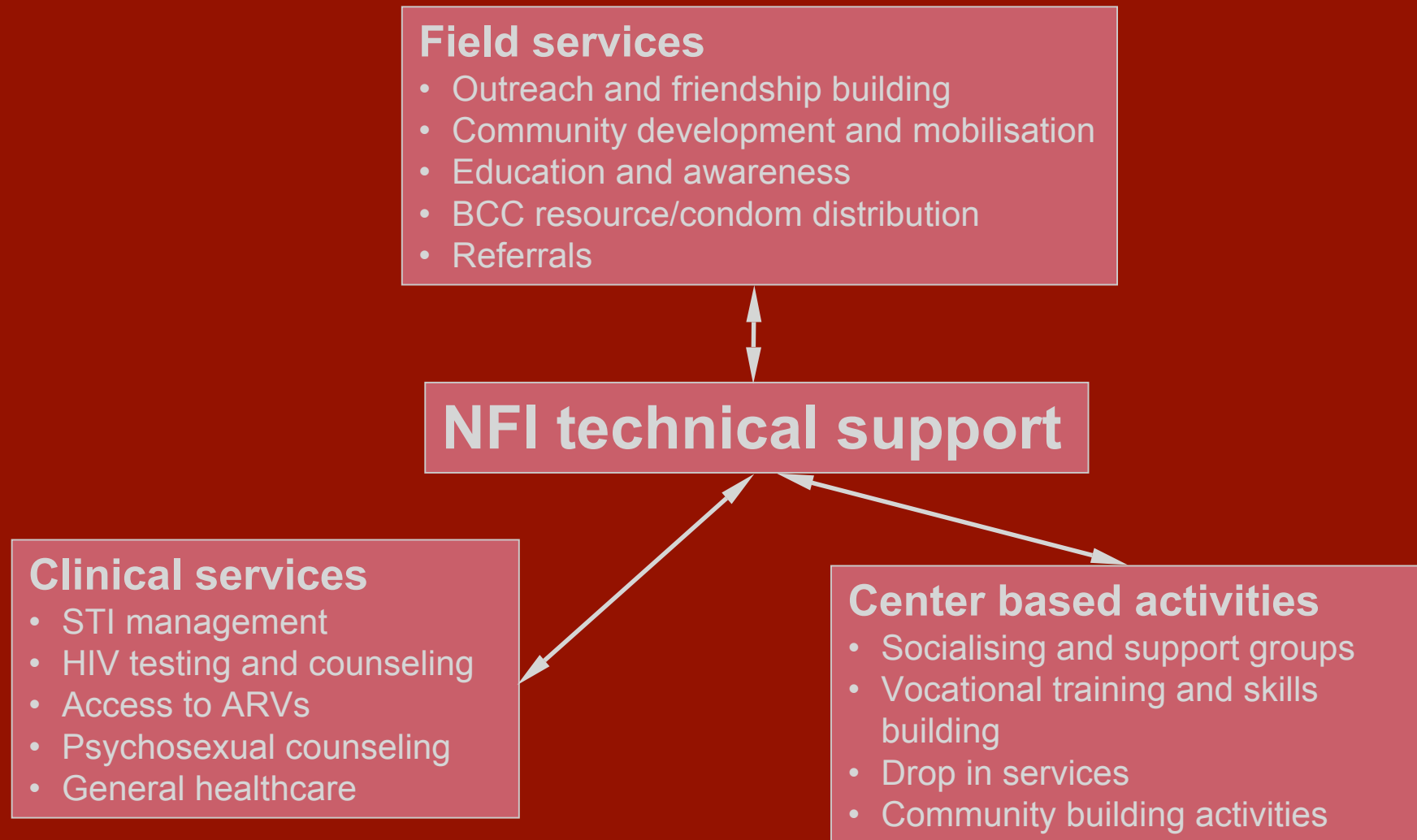
# What have we done?

- 25 MSM community based organisations (CBOs) developed across South Asia, reaching over 500,000 *kothi*-identified males and their partners
- Regional MSM trainers network developed
- 25 MSM CBOs receiving on-going technical assistance and support
- A range of behaviour change communication resources, training manuals and briefing papers developed
- Situational assessments conducted in 12 cities across the region

# What have we done?

- Human rights study conducted in Bangladesh, now being replicated in India
- Masculinities and sexualities study conducted in Bangladesh among young men
- Information and Resource Centre developed in Lucknow, India
- Regional Office established in Lucknow, India
- Strategic development plan for scaling up response across the region
- Significant advocacy work done nationally, regionally and internationally

# Services framework



# A strategic response to MSM and HIV/AIDS

- **Objectives**

- To develop and disseminate replicable, scalable and cost-effective prevention, care and treatment interventions relevant to MSM behaviour and sexual health needs
- To build and support a network of state-level linking organisations in India and similar national-level organisations in other South Asian countries, which have the capacity to provide on-going assistance to grass-roots organisations working directly with MSM populations.

# A strategic response to MSM and HIV/AIDS

- **Objectives**

- To improve the understanding of MSM behaviours and cultures in South Asia, among decision makers, opinion leaders, donors and other influential constituencies, particularly related to HIV/AIDS, social stigma and discrimination, gender and sexual violence
- To advocate for policies that recognise the fundamental human rights of MSM, and create a political and social environment conducive to working with these males and their partners.
- To secure stable, long-term financial and technical support for appropriate HIV and AIDS related interventions among MSM populations in South Asia.

# Stakeholder analysis

- **Primary beneficiaries**
  - *kothis*, other self-identified MSM, males sex workers
- **Secondary beneficiaries**
  - Their male and female partners
- **Linking agencies**
  - state and country CBOs
  - Local grassroots CBOs, networks
- **Enablers**
  - Donors, policy makers, judiciary, state enforcement agencies

# Implementation

- **Strengthening operations in India**
  - Re-organisation of NFI operations and structure
  - Policy Office in New Delhi established
  - Enhanced relationships with existing state-linking organisations
  - Scaling up operations of existing state-linking organisations
  - Development of new grass roots CBOs in each state
  - Development of new state linking organisations

# Implementation

- **Strengthening operations in South Asia**
  - Enhanced relationships with existing national-linking organisations
  - Scaling up operations with existing national-linking organisations
  - New national-linking organisations developed

# Tools and Models

Adaptable and replicable

- Documentation
  - re-formatting CBO development and management handbooks as user friendly and in local languages
- Training manuals
  - Reformatting as user friendly and in local languages
- Development of new components
  - Counseling: pre-post test, psychosexual
  - Appropriate care and support
  - Management of a VTC centre
  - Developing self-help PLHA support groups
- Communication materials

# Knowledge and Research capacity

- Knowledge Management
  - NFI knowledge system development
- Information Technologies
  - Internet/intranet development
- Research Partnerships
  - Partnerships with national/international academic and research institution
  - Development of an NFI Research Advisory Council
  - Development of a research agenda
  - Epidemiological, behavioral, ethnographic and anthropological research
- Fund-raising
  - Multilateral, bilateral and private
  - International and local
- Advocacy
  - Regional Policy Office in New Delhi

# Strengths

- Credibility
  - Proven track record
- Knowledge and experience
- Models of replicability and scaling up developed
- Existing partnerships

# Previously identified weaknesses

- Funding
- Human Resources
- More reactive/less proactive
- Need to formalise more partner relations

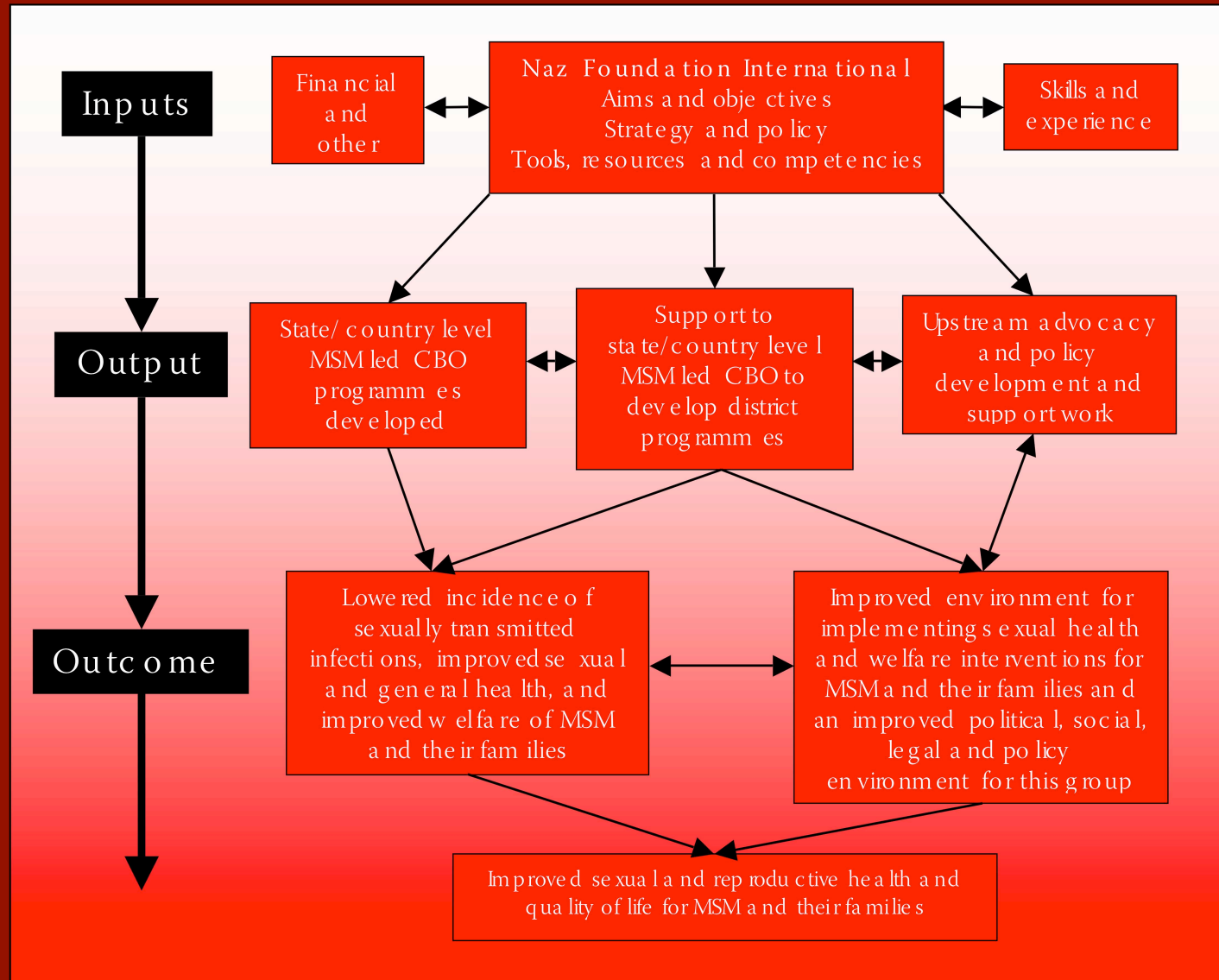
# Opportunities

- Increasing coverage of MSM sexual health services
- New services
  - *Care and support*
  - *Adolescent male sexual health*
- New sexual health resources
  - *Development*
  - *Distribution*
- Advocacy

# Threats

- Stigma and discrimination
- Politics
- Harassment
- Funding

# Process model



# Poverty reduction perspective

- Work focuses on low-income males who have sex with males, their partners and families
- HIV/AIDS and STI reduction of MSM (and their partners, including reproductive health for female partners) improves their health and ability to work and earn
- Advocacy helps to reduce stigma associated with MSM behavior, leading to better educational and job prospects
- Projects can provide work related training and employment opportunities

# Gender equality perspective

- Work addressing stigmatisation and discrimination against feminised MSM tackles broader gender issues in society
- Work with MSM to improve their responsibilities to their female sexual partners, in terms of sexual health, welfare and human rights
- Work closely with organisations working on gender issues, to enable them to better respond to the health, welfare and human rights issues that MSM behaviour, stigma and discrimination raises

# SIDA's potential role

- Partner with NFI, to support the implementation of it's strategic development plan, to improve the health, welfare and human rights of MSM, their partners and families
- To provide finance to NFI's strategic development plan budget to enable it to better implement this plan
- Advocate with others, to ensure that the issues of MSM, their partners and families in South Asia are appropriately addressed

# Conclusion

- Demonstrated that there is a clear and immediate problem for MSM, their partners and families, in terms of discrimination, stigma, and heightened vulnerability to HIV, other STIs, and human rights abuses
- Demonstrated that NFI has developed a strategic response to these issues, in terms of scaling-up client-level interventions in South Asia, enhancing policy and advocacy work, and improving the sustainability of this
- Demonstrated a potential role for SIDA to become a partner in this work, provide financial assistance, and advocate on relevant issues

# Human rights - sexual rights for all



# Thank you!



*Advocacy, policy and support on male sexualities*

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**Naz Foundation  
International**