The invisible epidemic

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

The situation, and our response

Naz Foundation International

Aims

1. Outline differing male sexualities and gender identities in South Asia
2. Explain major issues of concern
3. Detail our response so far
4. Explain how to find more information and get involved
5. Opportunity to ask questions

Objectives

1. Presentation (45 minutes)
2. Question and answer session (15 minutes)
3. Follow-up

Frameworks of male-to-male sex in South Asia

Sexual and gender identity and behaviour framed by:

- Gendered framework with “performative” behavior
- Sexual practices and sex roles
- Chosen identities
- Beliefs around sexual behaviour, and need for “discharge”
- Situation - location, accessibility of women, etc.,
- Economic need
- Class/cast, education and poverty
- A homosocial and homoaffectional culture

Frameworks of male-to-male sex in South Asia

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

Indigenous identities

- ***kothis/zenanas/metis***
  - a self-identified label used by feminised males who have sex with males, and who use 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.

Indigenous identities

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”

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, prerogative

- ***Chapati-chapati***
  - A *kothi* term for *kothis* who have sex with other *kothis*. Though of a shameful, and sometimes called “lesbian sex” by *kothis*

Quotes from *kothi*-identified males

“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 (“husband”) beats me, I feel as helpless as a woman. Since I want to be a woman, it actually makes me feel good.”

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.

Therefore we use the term “males who have sex with males”.

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

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 other women) do not do anal or oral sex
- Males are easier to access – shared beds and spaces
- Anus is thought to be tighter than vagina and giving 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 curiousity
- 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 and 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?

- There is a lack of knowledge about MSM and HIV 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 behaviour is common

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
- MSM are 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

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 help 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 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, which enables violence against feminised males (and females) to be socially permissible, in a society that socially excludes such males, and says 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

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

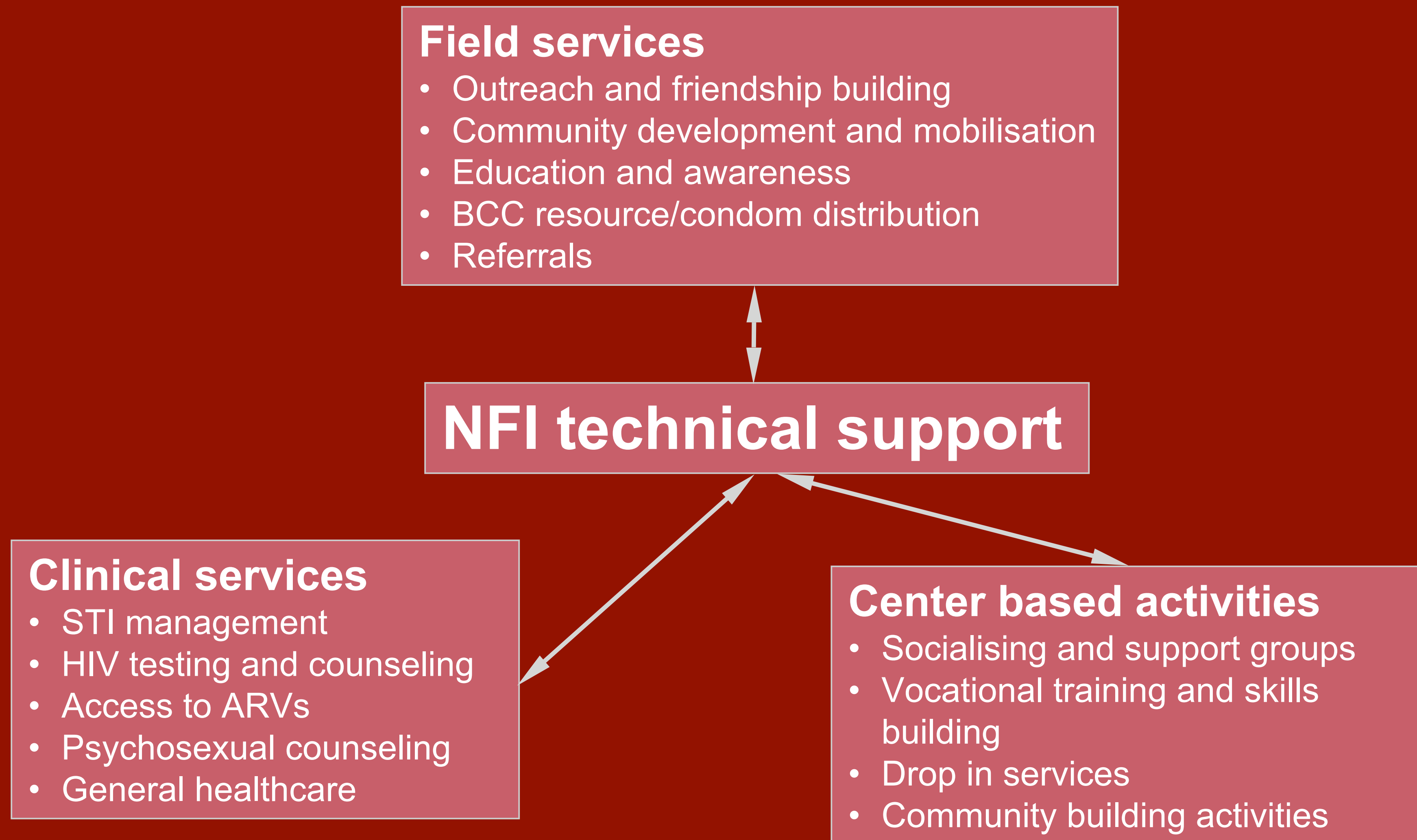
What have we done?

- 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 behaviours 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.

Bangkok AIDS Conference 2004

Leadership statement
Bangkok AIDS Conference 2004

"We must acknowledge the threat to, and suffering, of all vulnerable people, including children, young people, women, sex workers, people who inject drugs, **males who have sex with males** and migrant and displaced persons – and commit to reducing their vulnerability to HIV infection."

As presented at the XV International AIDS Conference by Ms. Graca Machel, Patron of the Leadership Programme, on July 16, 2004 in Bangkok.

More information and to get involved

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Thank you!

Advocacy, policy and support on male sexualities

Naz Foundation International

Some questions

Shouldn't you be promoting a gay identity?

What can I do to help?

What is the situation elsewhere in Asia?

What is the situation in other developing countries?

What are you doing for lesbians?

What are you doing for women in general?

How did you personally get involved in this work?