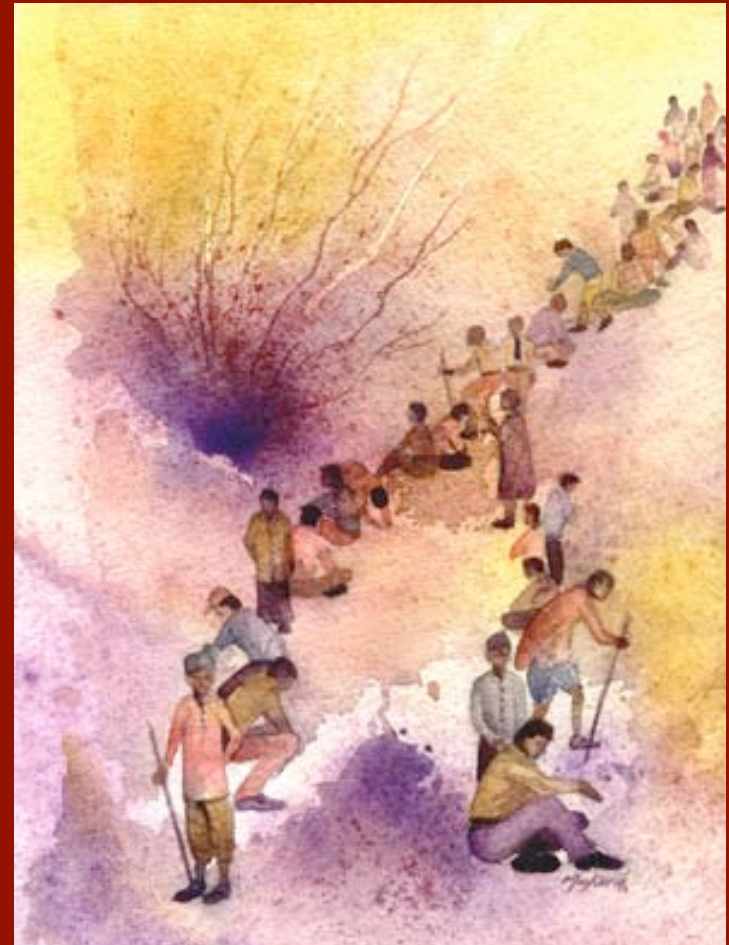


# Masculinities, (homo)sexualities and HIV vulnerability

*Working with males who have sex with  
males in India*

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# Male-to-male sex in India

- 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)
- A survey of 527 truck drivers in northeast India revealed that 15% had sex with men (Ahmed, 1993)

- 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 behaviours in the Indian male population ranges from 8% to over 50% (Neil McKenna, 1996)
- In a study of sexual behaviour 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.

*Just in case you may think male-to-male sex is an urban phenomena:*

A cross sectional survey of 2910 rural Indian men aged 18-40 years from five rural districts in five different states (including Rajasthan) revealed that nearly 10% of single and 3% of married men had had unprotected anal sex with a man in the past year. Homosexually active men are not a separate sexual category, and report extensive mixing with female partners. They have more female partners than other men, and they practiced anal intercourse in 11% of their heterosexual contacts.

**Homosexual activity among rural Indian men  
Ravi Verma and Martine Collumbien  
Research Letters, AIDS 2004, 18: 1845-1847**

# ***An error of omission and commission***

*From 'Mapping of Population Groups Vulnerable to HIV/AIDS in Uttar Pradesh', compiled by ORG Centre for Social Research, New Delhi, October 2003*

**Uttar Pradesh with a male population of 84 million was reported to have only 693+ MSM!!**

**Lucknow with a male population of some 1 million males was supposed to only have 273 MSM!!**



## BUT:

In 1997, in an NFI supported situational assessment conducted by Bharosa - our local partner -- interviewed 400 kothi-identified MSM in Lucknow alone. Since then this small community based organisation (CBO) has already met over 5000 kothi-identified males. This does not include their “manly” sexual partners!

This sort of significant disparity between official documentation, and that being provided by local based MSM CBOs is dangerous, since it generates under-reporting and thus under-funding. We find this across India.

# Male-to-male sexual context in India

There appears to be two main frameworks of MSM, with an emergent third in major urban areas; among the upper middle classes:

- **Gendered framework**

- Male to male desire based on feminised gendered roles and identification - sexual acts are based on gender roles, i.e. man/not-man: primarily *kothis* and *hijras*.

- **Discharge framework**

- Male to male sexual behaviours arising from immediate access, opportunity, and “body heat”. They involve males/boys/men from the general male population who will access feminised males, or boys.

- **Emergent gay framework**

- Male to male desire framed by sexual orientation. Primarily used by middle and upper classes. Such gay identified men usually seek other gay identified men as sex partners.

# Male-to-male sexual context in India

Many males from the general male population will also access feminised-identified males (*kothis/hijras*) or boys for anal/oral sex . These males do not see themselves as “homosexuals”, or even their behaviour as “homosexual”, since they take on the “manly” penetrating role in male to male sex. Nor do their partners see themselves as homosexuals because they either see themselves as “not men”, or they are involved in “play”, and not “sex”.



And of course not to forget males/men in all male institutions, such as prisons, the uniformed forces, colleges, universities, schools, religious institutions, and just places where males congregate.

MSM then is not an exclusive category or “group,” but reflects a behaviour which appears to be relatively common, within which are self-identified MSM as well as those for whom this is just another sexual behaviour.

# Indigenous identities/sexualities

- **Self-identified *kothis***
  - Males who feminise themselves performatively as a means to attract “real men” – primarily from low income populations – a penetrative identity.
- ***Hijras* and transgenders**
  - Males who perceive themselves as not-men/not-women. A sociocultural Identity.
- **Gay-identified men**
  - Primarily from upper middle class who define themselves as gay – sexual orientation.
- **Men/Male Youth**
  - Do not have a sexual identity, but experience male-to-male sex for a range of reasons.

Also in India, some male-to-male sexual relationships are defined by age – “beardless youths”.

- “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”.



Such beliefs reflect a range of gender identities and masculinities.

# Sociocultural frameworks of male-to-male sexual availability in India

- Patriarchal social structures within a culture that is homosocial and homoaffectionalist
- Public domain as a male space
- Gender segregation, where females are socially policed and often difficult to sexually access
- Poverty and personal survival strategies

# Sociocultural frameworks of male-to-male sexual availability in India

- Mass male migration and shared spaces
- A dominant masculinity which sees a “man” as the penetrating male, a “man” who can maintain his “manliness”, even when he penetrates another male
- A gendered construction where males who are sexually penetrated are constructed as “not-men”
- Non-vaginal sex not seen as “sex”, but as “play” - *masti*, discharge

# Appropriate terminology

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. NFI thus uses the term “males”.



# Why do males have sex with males?

- Desire for other males – gender/orientation
- Desire for specific acts – anal/oral
- Pleasure and enjoyment from discharge – “body heat” – also “play” and curiosity
- Wives do not do anal or oral sex – ashamed to ask



- Males are easier to access – shared beds and spaces, while females are more socially policed, and more difficult to access
- Protecting a girls virginity – maintaining chastity
- For money, employment, and favours



# Why do males have sex with males?

- No one is suspicious when males mix with other males
- The anus is tighter than vagina, and gives more pleasure
- No marriage involvement
- Maintaining chastity
- Its not “real sex”



# Violence and abuse

**From a study conducted by NFI in Bangladesh with feminised males who have sex with males:**

- 71% faced with harassment from goondas
- 87% stated that they were subjected to sexual assault or rape because they were effeminate
- 64% stated that they faced police harassment because they were effeminate
- 33% reported sexual assault or rape by “friends”
- 48% reported sexual assault by police

**This level of violence and abuse exists across India for the same reasons.**

# Vulnerability and risk

- Invisibility and denial
- Stigma, discrimination and social exclusion
- Violence and abuse
- Low levels of self-esteem
- Lack of safe spaces
- Disempowerment
- Lack of resources and skills

- Poverty
- Genderphobia
- Illegality
- Denial of human rights
- Conflict in state policies
- Low service delivery



For MSM living with HIV/AIDS, particularly those who are feminised; stigma, discrimination, and social exclusion are greatly reinforced.

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

- Low condom usage
- Multiple partners; both male and female
- Lack of sexually transmitted infection treatment
- Low access to services

Higher vulnerability leads to higher risk behaviours.

# A disempowering environment

- Stigma, discrimination and social exclusion affects the ability of vulnerable populations to protect themselves from HIV/AIDS
- It disempowers them from getting support and care
- It disenfranchises them from accessing what services may be available
- It reduces opportunities to develop appropriate services

**Abuse follows infection follows abuse**

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

- MSM is not an exclusive group isolated from the general population
- It involves males from the general male population along with males with specific gender/sexual orientations
- Male-to-male sex is a bridging behaviour for HIV and other sexually transmitted infections:

Transmission routes:

male-to-male-to-female

female-to-male-to-male

# 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 and STI/HIV sero-status
- Most males involved in male-to-male sex will not identify their behaviours, nor access services
- In Mumbai a 2003 study indicated an HIV prevalence rate of 20%
- In Chennai, a 2000 study indicated a 4% rate of HIV infection

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

- We know that male-to-male sexual behaviours are common
- Self-identified MSM, such as *kothis*, gay men and *hijras* are marginalised and 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?

- Significant levels of male sex work
- Bridging populations to spread HIV into the general population - particularly to women
- Many are married and/or have sex with other females
- Poverty and low levels of literacy
- Very few appropriate services exist

# 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
- **Access to resources**
  - Easily available condoms, lubricant, appropriate IEC materials, information, knowledge and skills

# Issues that must be addressed

- **Increasing coverage**
  - There are very few HIV/AIDS self-help interventions in the country. Scaling up coverage is urgently required.
- **Capacity and skills building**
  - With low income populations, there is often a lack of skills, knowledge and capacity. People 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 a 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.



# Developing an enabling environment: What does this involve?

- To empower affected and infected populations to develop and deliver their own self-help services.
- To increase the technical skills and knowledge of MSM service providers.
- To ensure appropriate resources are easily and readily available.
- To reduce stigma, discrimination and violence.



# Thank you!

