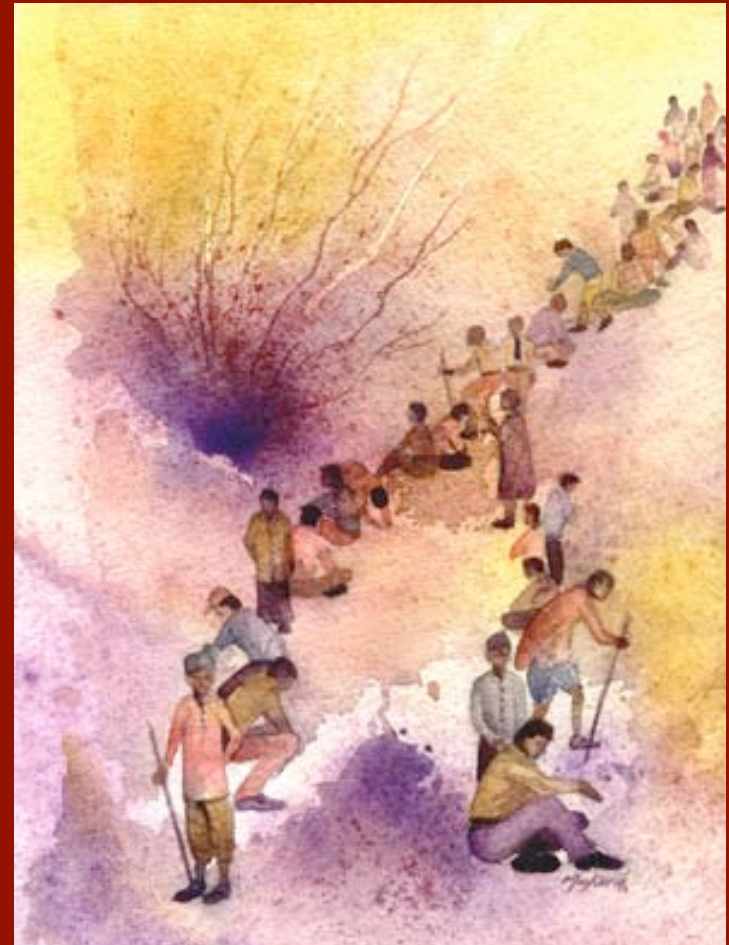


Masculinities, (homo)sexualities and HIV vulnerability

*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!



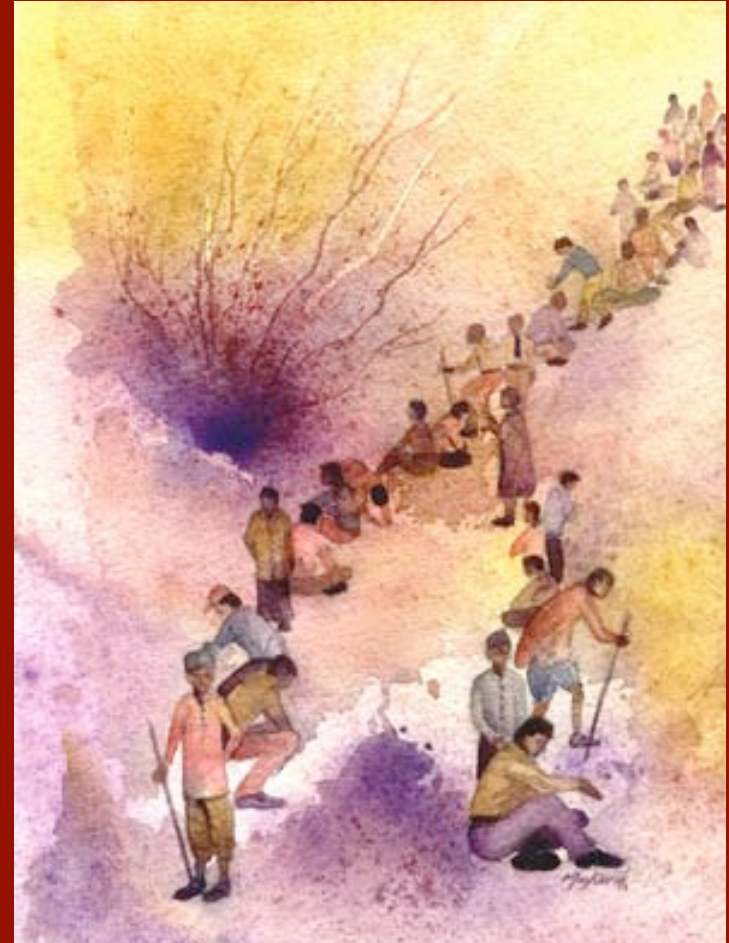
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Second Session

A way forward?

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Issues of need and concern

- **Understanding dynamics of male-to-male sex behaviours**

The need to have more knowledge and better understanding of masculinities, male sexualities and male to male behaviours through anthropological and formative research. Class, gender variance, and identity concerns. Inadequate knowledge has led to a denial of need and services.

- **Population estimations**

Poor research methodologies and understanding, as well as not partnering with MSM networks, has led to considerable population underestimates, further reinforcing denial of need and services. Also bridging population

- **Levels of HIV infection and impact on general population**

There are only 3 sentinel sites for MSM in the country. Inadequate surveillance

Issues of concern

- **Inadequate STI treatment**

Medical professionals inadequately trained in terms of anal STI and related problems.

- **Access to prevention services**

Very few MSM sexual health programmes. Issues in terms of NGO-led services or self-help community-based organising.

- **HIV treatment, support and care**

Low priority, differing issues, no appropriate counselling, and poverty.

Issues of concern

- **Female and male sexual health**

Sociocultural issues determine high rates of marriage among self-identified MSM, as well as other MSM. Along with this concepts of masculinity also increase numbers of female partners among MSM. Anal sex behaviours exist among the general male population, as well as between males and females.

- **Funding**

Inadequate funding and poor funding guidelines. Thus new CBOs find it difficult to access funding, and funding based on numbers accessed. Government model based on “closed area” and “exclusive groups.”

- **State policies**

There is a major conflict between the Health Ministry and Home Ministry policies, because of IPC Section 377 which leads to possible illegality of any MSM HIV/AIDS intervention as abetting this law.

Issues of concern

- **Models of service delivery**

Two primary models for working with self-identified MSM. NGOs working for MSM, or MSM self-help organising for service provision. How does one build sustainability for risk reduction? And what about non-identified MSM?

- **Resources, skills, and sexual health products**

Inadequate training provided for developing CBOs, insufficient condoms and expensive lubricant if at all available.

- **Understanding**

What does behaviour change for MSM mean? For many it has meant stopping their behaviour or “converting them to heterosexual behaviour”.

Government response

- **New targeted intervention plan**

Increases funding for MSM interventions, and includes better condom supply and adds lubricant as a key sexual health tool. This is a step in the right direction. However problems from the previous plan still exist.

- **Advocacy and policy**

Inadequate advocacy and policy development, both at central and state level. Thus many SACS will not support MSM HIV/AIDS interventions. Further little interaction between Health and Home ministries in regard to legislative barriers to HIV/AIDS interventions. A national advocacy strategy needs to be developed and supported by donors. Policy development should include affected populations.

- **Training and sensitisation**

Inadequate sensitisation and training on issues and needs. A training strategy needs to be developed

- **National strategy**

There is no national or state strategy developed for scaling up coverage of MSM sexual health services.

Key Questions

- **How many “targeted interventions” and where?**
- **What is the cost?**
- **Who will implement?**
- **Where will they get the skills?**
- **Who will conduct monitoring and evaluation?**
- **What model of interventions will be primary?**
- **How to build sustainability - both financial and behavioural**

NFI response

- **A strategic plan**

A five year strategic plan for enhancing responses to HIV and MSM in India and the rest of South Asia, following eight years of working on MSM issues in the region. This is centred on a self-help model of service delivery which would establish State MSM nodal agencies providing technical support to district level MSM CBOs.

- **Advocacy and policy**

NFI has evolved a national strategy to address advocacy and policy concerns. This involves advocacy at state and central levels along with developing a national MSM AIDS Task Force. Involvement in policy-making.

- **Skills building**

Training programmes and skills building workshop designed for MSM networks and MSM self-help organisations towards skilling up for programme management and development.

- **Knowledge generation and management**

Dissemination of current knowledge and generating new knowledge through research.

- **Resource Development**

A range of IEC materials, training manuals, management and monitoring tool-kits and other resources developed and being developed in a range of Indian languages.

Key Recommendations

- Legal, legislative, socio-cultural and judicial impediments to MSM sexual health interventions need to be removed.

At the very least, this means that there needs to be a positive dialogue between the Health and Home Ministries in regard to support for marginalised populations in the fight against AIDS.

Along with this, is required concerted advocacy to repeal Section 377 of the India Penal Code.

Key Recommendations

- Address human rights abuses, and reduce the levels of sexual violence, harassment and abuse of MSM and the staff of MSM sexual health service providers through:
 - Appropriate sensitisation and training of law enforcement personnel at all levels, the judiciary, and the legal profession
 - Ensure that laws against male-on-male rape and sexual abuse are on the statute books, and that these laws are adequately implemented with appropriate sanctions
 - That the constructions of masculinity that support gender violence are challenged through appropriate education and awareness

Key Recommendations

- Empower local networks of self-identified MSM networks to develop their own self-help HIV/AIDS service provision including support and care.

This means ensuring that:

- Appropriate skills training, management support and safe spaces to meet are readily available
- Adequate levels of on-going funding are provided
- Appropriate resources and tools, such as low-cost condoms and lubricant, education materials, STI treatment, and ARVs are easily accessible

Key Recommendations

- Ensure that any enabling strategy includes key indicators that can be measured in terms of impact assessment.
 - This will also mean that sanctions will need to be in place to ensure compliance by key stakeholders.

Key Recommendations

- Central involvement of MSM in policy making, advocacy, and HIV/AIDS interventions at national, state and local level.
 - This means that appropriately skilled MSM should be part of decision making processes on policy and advocacy, through direct involvement and consultation.

Key Recommendations

- National, state and local HIV/AIDS agencies, both governmental and non-governmental, as well as the general community, should be sensitised to the specific issues, concerns and needs of MSM.
 - This means education and training programmes targeted at specific organisations, groups and individuals, utilising a broad range of resources and the media.
 - Anal sex should be ‘mainstreamed’ and included in all HIV/AIDS and sexual health programmes.

Key Recommendations

- Staff of sexually transmitted infection treatment centres and voluntary testing and counselling centres should be provided with skills training to ensure that their services are appropriate, empowering and accessible to MSM.
 - This means that such staff should understand the relevant issues, concerns and needs of MSM, to ensure that they provide appropriate services.

Masculinities, (homo)sexualities and HIV vulnerability

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Third Session



Naz Foundation International

- Formed in August 1996 as a UK registered charity specifically to work with males-who-have-sex-with-males (MSM) networks in South Asia, to empower them to develop their own sexual health services through:
 - Providing technical assistance and support to local groups and networks to develop their own community based organisations (CBOs) as self-help groups
 - Providing access to range of training, management and monitoring and evaluation tools and behaviour change communication (BCC) resources
 - Conducting situational assessments and other studies on male-to-male sexualities, behaviours and health issues
 - Advocating on funding and appropriate intervention strategies
 - Promoting sexual responsibility towards all sex partners

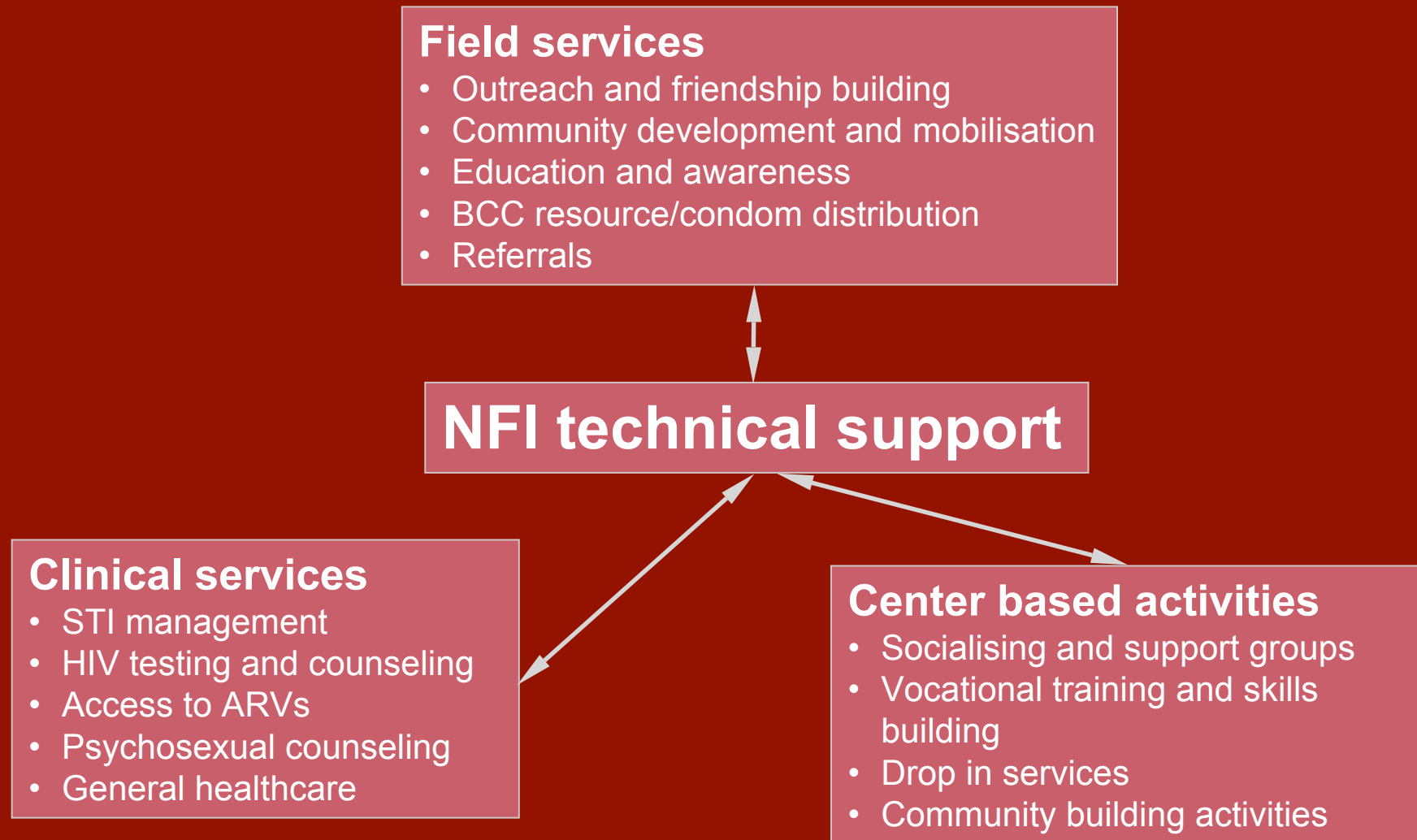
What have we done so far?

- Supported the development of 25 MSM CBOs developed across South Asia -, (16 in India, 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 BCC resources, training manuals and briefing papers developed
- Situational assessments conducted in 12 cities across the region (nine in India)

What have we done so far?

- Resource and Training Centre developed in Lucknow, India
- Regional Liaison Programme Office established in Lucknow, India
- Strategic development plan for scaling up response across the region
- Significant advocacy work done nationally, regionally and internationally

Services model for MSM CBOs



Stakeholder analysis

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

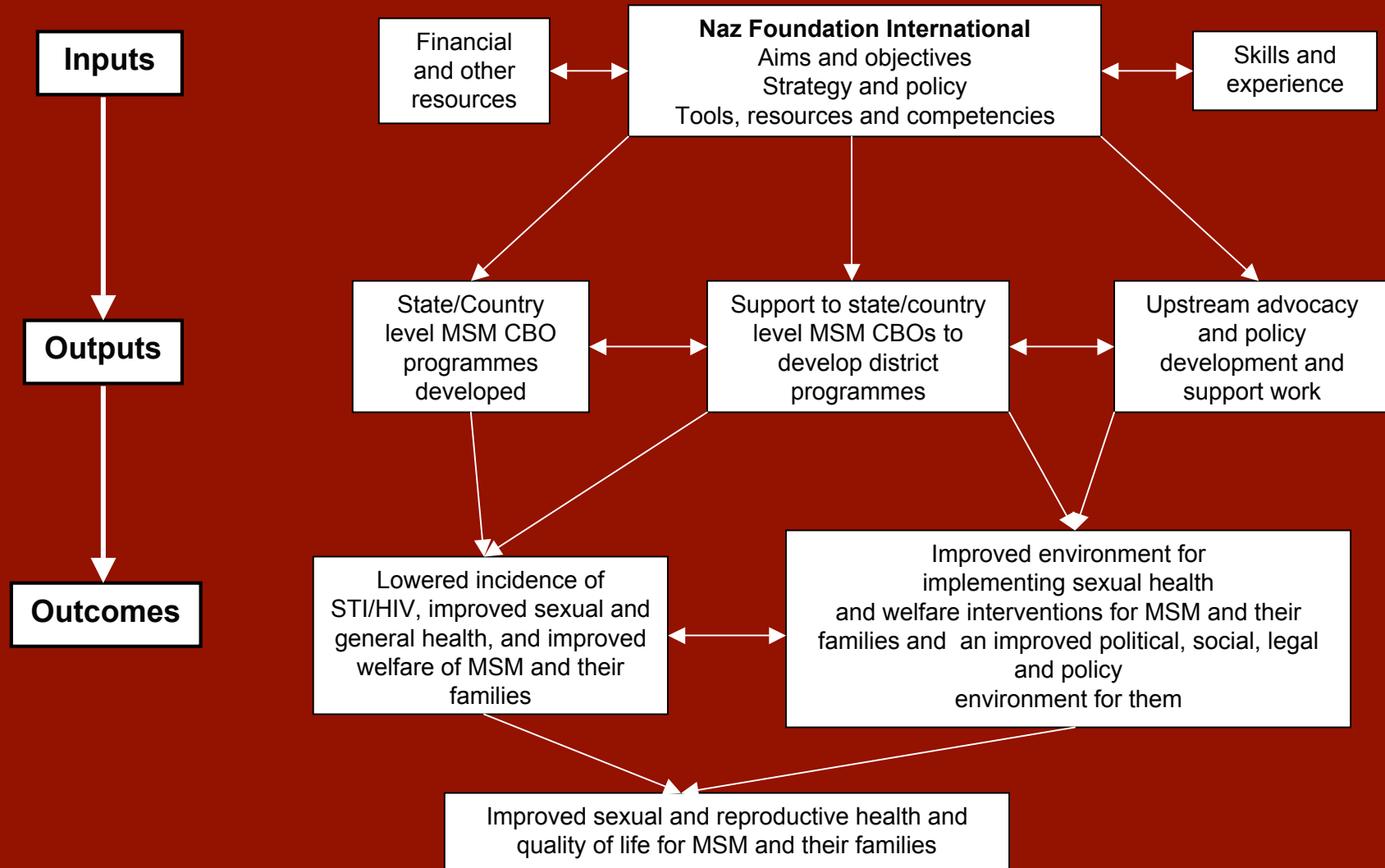
Tools and Models

- 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 voluntary testing and counselling centre
 - Developing self-help HIV+ support groups
- BCC materials
- NFI Partners Network: a tool for sharing skills and information

Strengths

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

The role of NFI



What can NFI offer?

- Grass roots knowledge and a decade of experience working in the field of MSM and sexual health in South Asia
- A range to replicable service provision and management tools for MSM sexual health CBOs
- Experience in training and capacity-building of MSM CBOs with the necessary tools to achieve this
- Experience in training for peer-led situational assessments

What can NFI offer?

- A study centre with over 2500 books and documents on HIV/AIDS, masculinities, sexualities, genders and male-to-male sex – a developed Knowledge Management Plan
- A range of briefing papers, essays and articles on masculinities, sexualities, male-to-male sexual behaviours and sexual health
- Advocacy and policy experience
- An existent network of MSM sexual health projects:
ARMAN – Asia Region MSM AIDS Network

What can NFI offer?

- Skills in organising and managing regional workshops, meetings and conferences
- Research into masculinities, sexualities and male-to-male sexual behaviours
- Access to a network of international experts in the field

What can NFI offer?

- A broad range of BCC templates specific to the needs of MSM already tested and replicated in local languages in South Asia
- A Regional Training Centre in Lucknow, India
- Mentoring and technical support
- An MSM CBO service provider model
- A process model
- Cost-effectiveness