HIV PREVENTION AMONG MEN WHO HAVE SEX WITH MEN (MSM) IN INDIA: REVIEW OF CURRENT SCENARIO AND RECOMMENDATIONS

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CONTENTS

ABBREVIATIONS AND ACRONYMS USED

ABVA - AIDS Bhedbhav Virodhi Andolan
AIDS - Acquired Immune Deficiency Syndrome
CBOs - Community-Based Organizations
CSWs - Commercial Sex Workers
GLBT - Gays, Lesbians, Bisexuals and Transgendered/Transsexual persons
HIV - Human Immunodeficiency Virus
KABP - Knowledge, Attitude, Behavior and Practices
MSM - 'Men who have Sex with Men' or 'Males who have Sex with Males'
MSMW - Men who have Sex with Men and Women
NACO - National AIDS Control Organization [India]
NGOs - NonGovernmental Organizations
STDs - Sexually Transmitted Diseases
TSM - Transgender(ed) persons who have sex with men
UNAIDS - Joint United Nations program on HIV/AIDS

DEFINITIONS OF THE TERMS USED IN THIS PAPER

"How we use language shapes how we think"

The definitions of the words given below are *not standardized* and are used differently by different individuals and in different parts of the world. The meanings of words also change over time. Concepts and attitudes toward gender identity and sexual identity are changing in the society as a whole, as well as within the sexual minority communities. Therefore, the meanings of these words will continue to change as well. (Most of the 'definitions' are modified/adapted from the websites - www.siecus.org, www.biresource.org and www.gendertalk.com)

Male: An individual's biological status as male or female. A label used to signify a "human sex," the biological designation based on genitalia. Can also be a socio-political term, used by an individual to label their gender identity. (Note: In this paper, the term 'male' used to denote individuals who are born with male genitalia, irrespective of the gender identity)

Man: A term referring to someone who identifies as such, who may often exhibit masculine or male characteristics (see *masculine* and *male*). Popularly understood within a binary gender system to refer to someone who is male-bodied. (Note: In this paper, the term 'man' is used to denote the gender and 'male' to denote individual's biological status)

Masculine: An often ambiguous term that refers to self-expression, performance, actions, behaviors, dress, grooming, adornment, and speech popularly associated with someone who is male-bodied within a binary gender system. People of all genders can self-identify as masculine or as having masculine characteristics.

Feminine: An often ambiguous term that refers to self-expression, performance, actions, behaviors, dress, grooming, adornment and speech popularly associated with someone who is female-bodied within a binary gender system. People of all genders can self-identify as feminine or as having feminine characteristics.

Men who have Sex with Men (MSM): This term is used to denote all those men who have sex with other men regardless of their sexual identity. This is because a man may have sex with other men but still consider himself to be a heterosexual or may not have any specific sexual identity at all. This means one has to concentrate on behavior, in addition to the sexual categories, in the area of HIV/STD prevention.

Males who have sex with Males (MSM): This is used as an umbrella term under which all biological males who have sex with other males are included, regardless of their sexual/gender identity. Thus literally it also includes transgender/transsexual (male to

female) persons since they are actually biological males.
[Note: Some transgendered/transsexual persons (male to female) don't want themselves to be included under this term, even though this term mainly serves as a working definition. To denote such persons, recently, the term "*Transgender persons who have Sex with Men*" (TSM) has been introduced.]

Men who have sex with Men and Women (MSMW): This denotes those men who have sex with men as well as women regardless of their sexual identity. This too, denotes just their behavior.

Gay: One who has significant (to oneself) sexual or romantic attractions primarily to members of the same gender or sex, or who identifies as a member of the gay community. One may identify as gay without identifying as a member of the gay community and vice versa. Though 'gay' is a common term for male and female homosexual persons, these days it is mainly used to denote homosexual man. Self-identified gay men do not necessarily have sex only with men, but occasionally may engage in sex with women.
(Note: In this paper, 'gay' refers to "any person (man) who is *conscious* of his erotic attractions/sexual behavior towards persons of same gender/sex (i.e., other men)". Thus, the term 'gay' need not necessarily indicates 'gay identity' in this paper).

Lesbian/Lesbian woman: A girl or woman who has significant (to oneself) sexual or romantic attractions primarily to members of the same gender or sex, or who identifies as a member of the lesbian community. In India, this term is used to indicate bisexual women also.

Heterosexual (n., adj.): 1. Sexual or romantic behavior between a member of one sex and a member of another gender or sex. 2. One whose significant (to oneself) sexual or romantic attractions are primarily to members of another gender or sex.
(Note: Heterosexual persons are sometimes referred to as "straight". In this paper, most often the term 'heterosexual' is used as an adjective rather than as a noun).

Homosexual (n., adj.): Individual with a primary sexual and affectional orientation or emotional attraction toward persons of the same sex. Male homosexuals are often referred to as 'gay', where as female homosexuals are referred to as 'lesbians'. A term often viewed as negative, overly clinical, or disempowering by members of GLBT/Sexual minority community.
(Note: The word 'homosexual' is most often used as a label and it may not be an identity. Also, this term is sometimes considered derogatory and not preferred by persons with same-sex behavior. In this paper, mostly it is used as an adjective rather than as a noun).

Bisexual adj., n.: One who has significant (to oneself) sexual or romantic attractions to members of both the same gender and/or sex and another gender and/or sex, or who identifies as a member of the bisexual community. People who are attracted to members of both genders or sexes may be monogamous, polyfidelitous or nonmonogamous. (Note: In this paper, mostly the term 'bisexual' is used as an adjective rather than as a noun)

Gay community: The group of people who are conscious of their erotic attractions/sexual behavior towards persons of same gender/sex or who identify as members of the gay community. One may identify as gay without identifying as a member of the gay community and vice versa. Lesbians and bisexual men and women often do not feel included by this term.
These days, the terms *'**Gay communities***' or '***Gay populations***' are used to stress that, like the people they comprise, these communities or populations are diverse.

Bi(sexual) community n.: The group of people who are conscious of their erotic attractions/sexual behavior towards persons of either gender/sex or who identify as members of the bisexual community. One may identify as bisexual without identifying with the bisexual community or vice versa.
These days, the terms *'**Bisexual communities***' or '***Bisexual populations***' are used to stress that, like the people they comprise, these communities or populations are diverse.

LesBiGay: Short form for **Les**bians, **Bi**sexuals and **Gay** people.

MSM community/population: This term is used to denote the population of men who have sex with men who may or may not have 'gay, bisexual or any other identity'. Though they are fragmented and isolated in the general population because of their commonalties they form a 'community'.
These days, the terms *'**MSM communities***' or '***MSM populations***' are used to stress that, like the people they comprise, these communities or populations are diverse.

GLBT community: This represents the community of **G**ays, **L**esbians, **B**isexuals and **T**ransgendered/transsexual persons. These groups often jointly fight against discrimination and stigmatization based on one's sexual orientation and/or gender identity and thus identify as a common community. Also used as a term to denote the entire community of sexual minorities irrespective of identities (Note: In this paper, the term 'GLBT community' is used interchangeably with the term 'sexual minorities' or 'sexual minority community').
These days, the terms '***GLBT communities***' or '***GLBT populations***' are used to stress that, like the people they comprise, these communities or populations are diverse.

Sex: 1. A term used historically and within the medical field to identify genetic/biological/hormonal/physical characteristics, including genitalia, which are used to classify an individual as female, male, or intersexed person. 2. A person's biological or anatomical identity as male, female or intersexed person. 3. Activity engaged in by oneself, with another, or others to express attractions and/or arousal. (also see *sexuality*, *sexual behavior*)

Sexuality: Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. Its dimensions include the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles and personality; thoughts, feelings, and relationships. The expression of sexuality is influenced by ethical,

spiritual, cultural, and moral concerns.

Same-sex sexuality: Currently, this term is being used as an alternative to the term 'homosexuality' (though some would like to use only this term instead of the term 'homosexuality'). Similarly, the term 'homosexual behavior' is being replaced by the terms - same-sex behavior, same-sex sexual behavior, same-gender sexual behavior. (Note: In this document the terms 'homosexuality' and 'homosexual behavior' are used because of their 'familiarity' and without any negative connotations).

Sexual Orientation. One's erotic, romantic, and affectional attraction. It could be to people of the same sex, to the opposite sex, or to both sexes.

- ***Heterosexuality.*** Erotic, romantic, and affectional attraction to people of the opposite sex.

- ***Bisexuality.*** Erotic, romantic, and affectional attraction to people of both sexes.

- ***Homosexuality*****.** Erotic, romantic, and affectional attraction to people of the same sex.

[Neither the term heterosexuality nor the term homosexuality existed before 1890. The terms 'homosexual' and 'homosexuality' may have the connotation that same gender attractions are a mental disorder (medical term: homophilia), and are therefore distasteful to some people. Also see - *Same-sex sexuality*]

Prejudice: A negative prejudgement of a group and its individual members.

Stigma: experience of others' negative attitudes.

Discrimination ("enacted" stigma): Unjustifiable negative behavior toward a group or its members.

Homophobia (n.): [Gr. homo (man) + phobia (fear).] 1. An irrational hatred and fear of lesbian and gay people that is produced by institutionalized biases in a society or culture. 2. A term for all aspects of the oppression of LesBiGays. (See *heterosexism, biphobia*.)

Biphobia (n): The oppression or mistreatment of bisexuals, either by heterosexuals (often called homophobia if it does not target bisexuals separately from lesbians and gay men), or by lesbians or gay men.

Internalized homophobia/biphobia (n.): The internalized oppression of LesBiGay people. This includes the often-conflicting feelings that we are bad at the core; that the entire world is unsafe, that we can only trust other members of our own group; that members of our group are untrustworthy; that for safety we must stay in hiding; that for safety we must come out everywhere, all the time, that our love is bad, or is not the same

as other people's love.

Transphobia (**also genderphobia**): The irrational fear or hatred of those who are perceived to break or blur stereotypical gender roles. Expressed as negative feelings, attitudes, actions, and institutional discrimination. Often directed at those perceived as expressing or presenting their gender in a transgressive way, defying stereotypical gender norms, or who are perceived to exhibit "non-heterosexual" characteristics - regardless of individuals' actual gender identity or sexual orientation. (Also see - *homophobia*.)

Sexism: 1) an individual's prejudicial attitudes and discriminatory behavior toward people of a given sex, or 2) institutional practices (even if not motivated by prejudice) that subordinate people of a given sex.

Heterosexism/ist (n): The oppression of LesBiGay people. The assumptions that identifying as heterosexual and having sexual and romantic attractions only to members of another gender or sex is good and desirable, that other sexual identities and attractions are bad and unacceptable, and that anyone whose sexual identity is not known is heterosexual. Usually coupled with both unconscious and willful "blindness" to the existence and concerns of LesBiGay people (Also see - *homophobia, biphobia*). A heterosexist is one who practices heterosexism.

Stereotype: A belief about the personal attributes of a group of people. Stereotypes can be overgeneralized, inaccurate and resistant to new information.

Identity: How one thinks of oneself, as opposed to what others observe or think about one.

Sexual Identity: An inner sense of oneself as a sexual being, including how one identifies in terms of gender identity and sexual orientation. Some believe that sexual identities should never be assigned or ascribed, but only self-reported, with meanings determined by the person assuming that identity.

Gender n.: One's personal, social, and/or legal status as a male or female. Words that describe gender are feminine and masculine.

Gender role: It is how one appears/behaves in relation to social/cultural expectations or perceptions of how a man or woman should look/behave (i.e., how "masculine" or "feminine" an individual acts.) Society commonly has norms regarding how men and women should behave, although the argument is made that dominant normative behavior is a dynamic, often evolving, process (Also see - *Gender-variant*).

Gender-variant: Displaying gender traits that are normatively more typical of the opposite biological sex, within a given. "Feminine" behavior or appearance in men is gender-variant as is "masculine" behavior or appearance in women. Gender-variant behavior is culturally specific (Also see - *Gender role*).

Gender expression or Gender statement: The public expression/statement of one's gender identity. Gender expression/statement is external or socially perceived. It refers to all of the external characteristics and behaviors that are socially defined as either masculine or feminine, such as dress, mannerisms, speech patterns and social interactions.

Gender identity n.: Person's internal, deeply felt sense of being either man or woman, or something other or in between. Gender identity does not always match biological sex; for example, a person may be born biologically male yet identify as a woman. Because gender identity is internal and personally defined, it is not visible to others. In contrast, a person's "gender expression" is external and socially perceived.

Transgender(ed) person: A term used to describe those who transgress social gender norms; often used as an umbrella term to mean those who defy rigid, binary gender constructions, and who express or present a breaking and/or blurring of culturally prevalent/stereotypical gender roles. Transgendered persons usually live full or part time in the gender role opposite to the one in which they were born. In contemporary usage, "transgender" has become an umbrella term that is used to describe a wide range of identities and experiences, including but not limited to: pre-operative, post-operative and non-operative transsexual people; male and female cross-dressers (sometimes referred to as "transvestites", "drag queens", or "drag kings"); intersexed individuals; and men and women, regardless of sexual orientation, whose appearance or characteristics are perceived to be gender atypical.
(A male-to-female transgendered person is referred to as '*transgender woman*' and a female-to-male transgendered person is referred to as '*transgender man*').

Transsexual: Individual whose gender identity is that of the opposite gender (sex). There are male-to-female and female-to-male transsexuals. A transsexual may or may not have had sex reassignment surgery and thus could be 'pre-operative' transsexual, 'post-operative' transsexual and 'non-operative' transsexual. (A male-to-female transsexual person is referred to as '*transsexual woman*' and a female-to-male transsexual person is referred to as '*transsexual man'*).

Intersex(ed) persons: Persons who have the characteristics of both male and female biological organs and/or genitalia. (Formerly called as '*hermaphrodites*').

Eunuchs: In India, this term is commonly used to denote Alis/Hijras (who come under transgender/transsexual category). Originally, this term is supposed to have referred to males who have undergone emasculation not by choice, but by accident, coercion or as a punishment. E.g., In ancient times, some males were emasculated to serve as guards in royal harems.

Sexual minorities or Sexual minority community: Refers to lesbian, gay, bisexual and transgendered/transsexual persons as well as persons with other identities (such as Kothis and Alis/Hijras) as a minority group in a predominantly heterosexual total population. (Sometimes referred to as '***sexuality minorities***').

These days, the *terms '**Sexual minority communities**'* or '***Sexual minority populations***' are used to stress that, like the people they comprise, these communities or populations are diverse.
(Note: In this paper, the term 'GLBT community' is used interchangeably with the term 'sexual minorities' or 'sexual minority community').

"Come out"(of the closet): 1. To disclose one's own sexual identity to another person. [I came out to my mother] 2. (come out to oneself) To discover that one's own sexual identity is different than one previously assumed. [I came out to myself three months ago.] 3. To be open about and deal with one's own and others' reactions to the discovery or disclosure of one's sexual identity. [I am out to my mother.] [I am out at work.] 4. (come out for) To disclose another person's sexual identity to a third person with the second person's permission or at their request. [I asked my mother to come out to my grandparents for me.] 5. May be generalized to disclosure of any information about oneself, not just one's sexual identity.

Important point:
Though it may seem logical to equate **Men who have Sex with Men** *(*MSM) with gay men and **Men who have Sex with Men and Women** (MSMW) with bisexual men, strictly speaking it is not so. ***In this paper, the term 'MSM' is used to include MSMW also, unless otherwise specified.***

INTRODUCTION

India has the second largest number of persons living with HIV/AIDS in the world after South Africa. India has an estimated number of 3.7 million (2.1 to 4.3 million) HIV-infected people at the end of 1999 (UNAIDS, 2000), and 3.86 million at the end of 2000 (NACO: http://naco.nic.in/vsnaco/indianscene/update.htm: accessed on 23rd September 2001). In India, national statistics shows that HIV spread is mainly through heterosexual transmission (NACO, 1999)**.** As a result, awareness campaigns and prevention programs of Govt. of India have been focused on the general heterosexual population. Since HIV education for the public emphasizes only heterosexual transmission, men may be largely ignorant of the risks of man-to-man sex, or consider that the risks don't apply to them; therefore they may not protect themselves and their male and female partners from HIV infection. Since national statistics show a very low percentage of man-to-man transmission of HIV (NACO, 1999), men who have sex with men (**MSM**) have been almost completely neglected from the HIV prevention programs of the Govt. of India**.** Since male-to-male sex is a criminal offence in India, and MSM are a marginalized and largely invisible population, MSM may be at high risk for HIV infection.

It has been estimated that a substantial number of men in India have same-sex/bisexual behavior (Ashok Row Kavi, 1999). Despite the relative invisibility of MSM in India, limited research suggests that a substantial number of MSM may engage in high-risk behaviors with both men and women (The Humsafar Trust, 2000a, Venkatesan C et al, 2000a, 2000b, 2001). Since almost all MSM eventually get married, this means the spread of HIV infection is not only to other men but also to their female partners and their unborn children. This larger transmission mandates the need to immediately initiate HIV prevention programs for MSM.

If same-sex/bisexual behavior is not addressed in the safer sex messages and if HIV prevention programs for MSM are not initiated immediately, then the nation would miss this timely window of opportunity to control the spread of HIV and to avoid so many preventable deaths.

PART - 1: GLBT/SEXUALITY MINORITY COMMUNITIES IN INDIA

1. GAY MEN IN INDIA

In this section, the issues faced by gay men in their day-to-day life are briefly discussed. The scientific studies on their high-risk behavior and risk of HIV transmission are discussed in the second part of this paper.

BEING A GAY IN INDIA

"Gay people, like non-gay people, vary enormously in shape, size, appearance, occupation, view point and self-perception. There cannot be said to be any single [defining characteristic of] homosexuality, as gay men and lesbians are not a coherent, easily definable group. Differences in region (including rural/urban ones), religion, and economic class make for widely divergent experiences and attitudes regarding marriage, same-sex eroticism and individual identity. There is, therefore, no such thing as a [single] "gay" certainly. Also, there are vast differences between gay men and lesbians in the way they experience and think about their sexuality"(AIDS Bhedbhav Virodhi Andolan, ABVA, 1991)

Beginning of attraction and reactions to it

Often the attraction towards the same sex persons is recognized in the adolescent period or even much earlier. While narrating his early childhood experiences a gay man says, "…I was getting more interested in boys. I must have been about 10 years old then. I would love to touch a boy and whenever a boy brushed himself against me, or touched me, my whole body would quiver for no reason. I don't know what was happening to me. Neither had I any knowledge of sex then…"(*Sangha Mitra*, Feb. 1999). At first, these persons are confused about their feelings and try to avoid them. They lack any kind of information on sexuality issues, since talking about sex is a taboo in India. Some may feel that they are passing through a phase and will soon get over it. For some it *could* be a 'passing' phase but for others it is *not so*. Some may try hard to project themselves as heterosexual - by eve-teasing, by developing a 'steady' relation with a girl, or even to the extent of visiting female sex workers along with their friends.

No one to support

While a few persons accept their sexuality, the majority think that the feelings they have and what they are doing are abnormal and immoral. They may develop guilty feelings, become isolated from others and may suffer from bouts of depression. They cannot share their feelings even with their close friends, let alone their parents. This is because they simply don't have the courage to discuss this matter for fear of rejection and disapproval. Those who do reveal their feelings to their non-gay friends may lose their friendship

forever. Also, some may feel that by revealing their feelings they may make their family members suffer unnecessarily.

"Coming out" to parents

Some do inform their parents, especially their mothers, either in a preplanned way or in a sudden burst of emotions. Some parents may accept their son for what he is, but most times parents are stunned by their son's "coming out". For many parents, this is something they have never given thought to, or anticipated, or have come across only in media as happening to someone else. They cannot accept that it is happening right in their own house and may react by denying the significance of the disclosure. Often the first reaction is to assume that their son is just passing through a phase or he is just in a state of confusion. Some think he is psychologically upset and needs to be treated by a psychiatrist. Still others may feel guilty assuming that they have brought up their son in a wrong manner. They may develop concerns about how to face relatives, friends, acquaintances, how to develop marriage alliances for the other family members, etc. A mother of a gay man said this when her son came out to her, "My first reaction was - 'what will happen to my gold bangles'…"(ABVA, 1991). [Note: If a man "comes out" as a gay in India it may mean - no marriage and therefore no *dowry! - Dowry refers to the money/'gifts' given by the bride's family to the bridegroom to facilitate marriage in India]*

Marriage [heterosexual] as a cultural norm

In India, marriage is considered a duty and obligation to one's family. Questioning the marriage arranged by the parents or expressing unwillingness in getting married makes parents think that their son is not obeying them and/or has no love for them. There is a very strong social pressure to marry and to father children to continue one's lineage. The desire of a person to get married [to a female] is often of little or no consequence and may not be considered at all. Probably, the highly interdependent nature of relationships in India as compared to the individualistic culture in western countries like United States is one of the root causes.

Since marriage is the social norm and everyone else around them is getting married, most of the gay men/MSM don't want to question the meaning of such marriage even when they are not interested sexually in the wife to be. If a man does not want to get married (to a woman), the society suspects his 'masculinity' and rumors may spread that he is 'impotent' or can't father a child. To avoid such stigmas, a gay man is compelled to marry. Some may willingly get married *not* because they desire sex with a woman but simply for a 'life-long companion and a friend'. But what about the woman who gets married to a gay man - will she be happy? Most of the time wives of the gay men don't know about the hidden sexual longings or same-sex sexual behavior of their husbands. Many may sense that something is not right, but cannot identify the cause and often blame themselves or their behavior for the lack of warmth. Some gay men, while not loving their wives, may still willingly perform their [sexual] 'duty'.

Even gays who are out to their parents are very often forced to get married to a woman since their parents, as well as they themselves, may see marriage as the only "solution" to 'getting rid of this *unnatural habit*'. A gay man said, 'When I came out to my parents

they told me -"You can behave according to your own wishes but we need a grand-son"…'

Another gay man said, "As I see things now most gay men in India get married off and fool themselves (besides their wives) then try to give the impression of living happily ever after. Then they advise their bachelor friends to marry. No wonder, more than half the gays who cruise in my area are married. I know of at least four who married less than a year ago and are back on the cruising scene, almost every night. Seriously, no laughing matter, at least for the wives… In the west you call them married, bisexual men who lead secret, double lives. Over here they are called Indian married men..." (ABVA, 1991).

A cross-cultural study (Kumar and Ross, 1990) conducted on 44 North Indian homosexual men found that most men had had bisexual experiences in the past 2 months and half were [heterosexually] married. The authors stressed the significance attached to marriage and lack of a distinct homosexual subculture in India (Kumar and Ross, 1991).

Monogamous relationship

In India, where arranged marriage is the cultural norm and where there is much opposition even to heterosexual love (note: arranged marriage is the rule in India), one can very well imagine the level of unacceptance towards 'gay marriage', let alone understanding homosexuality. Many Indian gay men find the concept of 'gay marriage' ridiculous and a western concept. While a few public lesbian 'marriages' have been reported (discussed elsewhere) and a few cases of friendship agreement *('Maitri Karar'*) between women have been documented, till date a public 'gay marriage' between two men in India is yet to be announced (though cohabitation of a few gay couples have been reported in newspapers). While some gay men may choose to be 'monogamous', many have sex with steady as well as casual partners. Many persons don't want to have a committed long-term relationship because it would be disastrous for them in term of their family and their social standing.

Those persons who are in a steady monogamous relationship are often possessive in nature. They may tolerate their partner mingling freely with opposite sex friends but not with the same-sex friends. If one of the partners come to know that what he considered as "mutually" monogamous relationship is in fact not so, that relationship often breaks up. Some persons may follow 'serial monogamy'. If one of the persons in a 'monogamous relationship' gets married to a woman, the relationship may end. A gay man narrates, "…I had a close physical friend. We loved each other at many levels. …he could not avoid an arranged marriage. The end result of it is that he has a life that is crushing him mentally. His wife, who is a great person, feels the strain and does not understand why. He never drank, until yesterday…I got over our break up and adjusted. About the only joy I see on his face is when he comes to visit me and sees that I am happy. Hard, cruel realities...What are we going to do to help others escape from the same trap?…"(in *Trikone*, Nov-Dec, 1989). Some times even after marriage some persons may continue their relationship in a secret way, living a typical closeted life.

Gay scene

In larger cities, especially in Metros, one can see a lot of 'gay scene'. There will be many cruising areas in these cities that can serve both as pick-up areas and also as areas where they can have sex. Cruising areas are frequented not only by gays but also by *other* men who have sex with men but who resist any 'gay label'. "…I find many cruisers insisting that they are "men" (giving the impression of being heterosexual) who would prefer to shove their hands behind their backs or in their pockets, and expects you to do the rest. But the fact that he prefers male sexual delights is something he will never admit..." - a gay man in a communication to ABVA, 1991.

Police harassment

In many cruising places, especially public toilets and beaches, gays encounter a lot of harassment from policemen. The main aim of the police is to extort money from these gays and in some cases also force these gays to have sex with them. It has been reported that policemen lure gay men by pretending to have interest in them. "…The policemen had taken my address from an identity card in my pocket. What if they came to my house and threatened me, asking for more money? What if my parents found out that I was a gay and looking for sex in public places? But where else could I look for it?…" asks a gay man (ABVA, 1991).

A gay man summed it up thus: "We won't make it criminal for you to have sex or build stable relationships, just refuse to acknowledge you exist, close down all the places where you can meet each other, threaten to throw you out of your job, your home, the country if we can catch you, watch you die and tell you deserve it, steal your books, your children, reject you as friends, drag you into court, into hospital, into prisons, into asylums…Then when you come whining to us that you are badly treated, we'll tell you there's something unstable, sick and abnormal about you, that we have other priorities and you're lucky to have any rights at all"(ABVA, 1991).

"COMING OUT" IN INDIA

Only when there is a self-conscious gay identity, one can 'come out'. In India, where there is near lack of gay identity, one cannot talk about "coming out" at all. However, as mentioned earlier gay-identified youth do come out but that too in very small numbers. Even this small number attracts the attention of the media because of its rarity. Kyodo News Service (Feb 5, 2000) reported - "An increasing number of middle-class Indian gays are 'coming out of the closet,' much to the disapproval and consternation of their families" and it credited the growth of gay life, in part, to satellite television and the Internet (From International news #304 - Feb 21, 2000, (c) Rex Wockner).

The marriage of Lila and Urmila

"In December, 1987, police women Lila Namdeo and Urmila Srivastava of the 23rd battalion stationed in the outskirts of Bhopal, caped their year long friendship by marrying each other…"(Trikone, March 1988). Their act provoked a sensational stir as

the nation struggled to grasp the implications of a public lesbian marriage. On police record, Lila and Urmila have been discharged from the police force for unauthorized absence from duty. However, it seems that the real reason for their removal from the police service is the fact that they were lesbians and announced that they married each other (ABVA, 1991).

Some role models

Ashok Row Kavi is an openly gay journalist and who is the editor of "Bombay Dost", a gay magazine from Mumbai. He, together with two other gay men, founded the Humsafar Trust in Mumbai, which was registered in March 1994. Ashok represents the Trust in government bodies and official organizations like the National AIDS Control Organization (NACO), India.

Sekar Balasubramaniam is the first person in India to come out as an HIV-positive gay man in 1994. He strongly felt that gay men should be educated to protect themselves from HIV infection. Hence he along with a group of gay men started Social Welfare Association for Men (SWAM), a community-based organization for MSM in Chennai. SWAM strives to create awareness and inculcate safer sex behaviors among MSM in Chennai.

Saleem Kidwai is a quiet and very vigorous research worker. He is a lecturer in history and has co-authored an excellent book on the history of homosexuality in India - "Same Sex Love in India - Readings from history and literature". He is a powerful builder of support systems for gay men in India and one of the trustees of 'Humrahi', a gay group in Delhi.

There are many persons in the Indian sexuality minority communities who are doing excellent work in different fields - like Owais Khan, who made use of the internet to build queer activism and started the LGBT e-group (LGBT-India) for the first time and Pawan Dhall, Integration, who has run the first long lasting and sustained magazine on gay issues in eastern India (Naya Pravartak) and initiated Network East.

An Indian gay men's view on "coming out"

A 30 year-old Indian gay man in a communication to ABVA says, "Being a gay and being publicly gay in India are two different things. The latter entails social and professional retribution which I was not prepared to with stand…"(ABVA, 1991).

Except for a handful of persons, there are few positive images or role models in India which may encourage gay Indians to 'come out'. However it should be understood that "coming out" is a complex phenomenon and the need to come out and the possible consequences of coming out may mean different things to different people in different settings.

2. LESBIANS AND BISEXUAL WOMEN IN INDIA

The existence of lesbians has been vigorously denied in India let alone the denial of homosexuality in general. Many centuries ago, Vatsyayana, in *KamaSutra*, mentions about women who have sex with women (as *"**svairini**"*). It is only in recent years that Indians have come to know about lesbianism after the sensational lesbian marriage of Lila and Urmila (discussed previously) in 1987, occasional newspapers reports on "woman killed herself due to exposure of *lesbian* relationship" and the recent controversial film, "*Fire*" (which portrayed sexual relationship between two married Indian women).

View of Indian women's organizations on lesbianism

In spite of the 25-year-old women's movement, lesbianism is not even considered a legitimate issue to be commented upon by the women's organizations in India. Some women's groups are even hostile to lesbianism. Only a very few women's organizations in India have nonjudgemental attitude towards lesbianism. In a communication to AIDS Bhedbhav Virodhi Andolan (ABVA, 1991), "There is a basic difference between female and male homosexuality", says a lawyer and activist of Forum Against the Oppression of Women (FAOW), Bombay, "Lesbianism is an integral part of the women's movement for liberation. It constitutes an important area of their struggle against the exploitative principles and institutions of patriarchy. Lesbianism questions and threatens the existing male-dominated social order in a way that male homosexuality does not" (ABVA, 1991).

Among women's groups, lesbianism was first brought up at the Calicut conference in 1990, during the session on single women. The efforts of a few lesbian activists enabled a separate session on this issue in the 1994 Tirupati conference where the attempt to claim space was met with severe hostility from some participants. Recently it was also discussed at the 1996 Ranchi conference, where there was a workshop on lesbianism open to all women, attended by more than seventy women, and a closed evening get-together only for "women who love women" (CALERI, 1999).

Support groups, magazines and helplines

Not much is known about the existence of lesbian support groups or activist groups in India prior to 1980s. ***Anamika***, a South Asian lesbian magazine ran for a few years starting May 1985 but then become defunct. ***Shamakami***, a newsletter for South Asian "feminist lesbian-identified women" made its debut from the US in June 1990. In July 1991, ***Sakhi*** was announced as a lesbian network coordinated from Delhi. Many other lesbian networks do exist in informal ways. ***Sangini*** is the first telephone help line and counseling service that is available for "women who are attracted to other women". This was launched in October 1997 with the help of Naz foundation, India. Sangini also organizes support group meetings for these women on a regular basis. ***Aanchal*** is another helpline for lesbian and bisexual women in Mumbai. ***Stree Sangam*** is a collective of lesbian and bisexual women in Mumbai. A group called ***Sappho*** provides support and counseling services for lesbian and bisexual women in Calcutta. ***Women's Network*** is a

group of lesbian and bisexual women in New Delhi. ***CALERI*** (Campaign for Lesbian Rights) is a collective of individual lesbian activists and many groups which work in the area of human rights and democratic rights (CALERI, 1999).

Being a lesbian in India

"Lack of space for discussion of alternate sexuality (or sexuality period), and social denial of lesbian existence creates a situation wherein women are compelled to remain silent about their sexual orientation. Marriage is the norm and majority are married by the age of 29. Not only does these lead to problematic heterosexual bonds, it is a social imperative that imposes enormous constraints on the formation of the non-heterosexual identity. Thus many lesbian and bisexual women marry men due to family pressure, caste stricture, force, lack of alternative, or fear of facing the non-acceptance and also the loneliness that staying single might entail. Such homophobic social conditions contribute to psychological, emotional and sometimes physical distress" (Sangini, undated, ?2000*)*.

In India, once a woman recognizes attraction towards another woman, she may be confused about her feelings and starts thinking that she is abnormal. She can not share her feelings with her parents or even with her close friends. Many are caught in a sense of isolation and guilt. Since they lack even basic information on sexuality, they don't know how to deal with their feelings. In India, where arranged marriage is the norm and strict obedience to parents and conformity to social expectation are central to cultural identity, these women have little choice. Loyalty to the family or fear of making a stand block women from asserting their right to independent life styles. Sometimes these women may try hard to change, deny or erase their feelings in a variety of ways: some may get married thinking that their 'obsession with these feelings' will disappear after the marriage but only to discover later that it is not so; some may consider secret escape or even consider suicide as a release from these pressures; some educated urban women may also think of sex change operation for the sake of their partner or to escape social stigma. Not ironically, one may come across messages like "A 30 year-old gay man looking for a marriage of convenience with a lesbian" in the classifieds section of Indian gay magazines.

Lesbian women also find it difficult to meet female partners and to find a safe place to discuss intimate matters with them. Apart from the societal isolation, lesbian and bisexual women are also detached from eachother, as they are a fragmented and invisible community. Only in the Metropolitan cities, small informal communities of middle or upper class lesbian women exist, most invisible to the public eye.

Some women discover that they are lesbians or bisexual women only after marriage. They may be confused about "new" feelings of attraction to women, the possibilities of sex between women, concerns about the sexual transmission of HIV between women and other sexual health/hygiene concerns. But do these women consider divorce?. Very rarely, since they are economically (and possibly emotionally) dependent on their husbands. Also, their family may not accept them once divorce occurs. "The general opinion [i]s it [i]s important to maintain the 'social facade' of marriage and that being involved with a woman should not affect the functioning of marriage" (Sangini, undated,

?2000). While this view may not be widespread, the sad truth is lesbians in India don't have the economic independence and social support to resist marriage or to live with their female partner.

Absence of self-conscious lesbian identity in most women means their identity will remain 'invisible' in the society. Also, the social taboo is so strong that most of these women detest being called lesbians. This has hindered the formation of lesbian support groups and activist groups. Even lesbian-identified women may not be willing to come to support groups because they may find the idea of attending a support group as an alien or western concept. Also, there are some practical problems like time constraints due to domestic work, and attending a support group means they have to leave the house without informing their family.

Relevance of bisexual behavior of Indian women in the context of HIV transmission

"Disclosing one's orientation to counsel[ors], medic[al] and legal service providers is difficult with most assuming heterosexuality and having homophobic opinions. This results in the severe neglect of lesbian and bisexual women's mental and sexual health needs. That many women commit suicide, experience suicidal feelings and encounter frequent bouts of depression demonstrates this" (Sangini, undated, ?2000).

A woman who describes herself, as 'lesbian' should not be thought of as having low risk of HIV infection. Most of the Indian lesbians are behaviorally bisexual (since many get married) whether they like it or not. That means there is considerable risk of HIV transmission due to their bisexual behavior, and through certain sexual practices like cunnilingus with their female partners during menstrual period and sharing of sexual toys which can produce trauma. Also, once they get pregnant the risk of transmission to the unborn baby also exists. These issues need to be addressed in any comprehensive HIV prevention and care programs for women.

Research studies on Lesbians in India:

Few scientific studies are conducted on the sexual health of lesbians in India. And there is a very large gap in understanding about the prevalence of lesbian/bisexual behavior of Indian women and their relevance in the context of HIV spread.

The first author of this paper came across an abstract, "*A comprehensive study on lesbianism and sexual behavior among women*, BOSS & CIPCA Organization, India", in the abstract book of Fifth International congress on AIDS in Asia and the Pacific, Kuala Lumpur, 1999 (554/PSCD035, p42). The abstract reads, "A two year study has been conducted by BOSS & CIPCA Organization with a project coordinator (w) and 7 health counselors (w) in nearly 4 universities, and 22 degree college women's hostels, and eight working women's hostels in the southern province in India. A total of 20,902 women aged between 14 - 24 years were selected for personal talks regarding their sexual practices and awareness about HIV/AIDS. It is found that 33% of the women are accustomed to self-satisfying procedures, while only 9% have sex with male partners and *11% of them are lesbians*. The others are controlling their sexual desires with the help of meditation and concentrating on their studies and other activities. We educated them

through awareness campaigns in their hostels and provided them essential IEC". Surely this painstaking study needs appreciation until you see, " [We] Identified 211 women who are prone to lesbian sex and educated them about the HIV/AIDS and safer sexual practices and ***provided them behavior therapy to avoid lesbian sex***. Most of the lesbians responded well to our awareness campaigns. 121 women have changed their behavior, *the remaining who are addicted to lesbianism are unable to leave it*, but are following safer sexual practices. *We are still trying our best to bring about behavior change in them*". The entire focus of this study was thus shifted from providing "sex education relating to HIV/AIDS and safer sexual practices" to hunting for lesbians and 'fixing' them. Also this study gives the term "behavior change" a *new* meaning. Is it not ironic that a women-only-team conducted this study?. Would they give "behavior therapy" to those women who have sex with men since the risk of man-to-woman transmission of HIV is much greater then woman-to-woman transmission?! This study reflects the Indian society's attitude in general to homosexuality as "a disease to be cured, an abnormality to set right, and a crime to be punished".

3. "INDIAN" IDENTITIES, LABELS AND SEXUAL BEHAVIOR

The following description of 'identities'/'labels' are based on informal discussions and in-depth interviews with individual persons with different identities, and informal group discussions with persons with different identities (especially those in Chennai) by the first author. Thus, the following discussion represents the current views on some of the "Indian identities". If any person feels that a particular identity has been misrepresented or vital things of that identity are not expressed adequately, that is not intentional.

Language and terminology in the area of sexuality can be problematic. People's self-perceptions and self-identifications can vary widely from culture to culture, as well as within each culture.

Many women and men whose principal emotional-sexual attraction or conduct is towards people of the same sex will, for many reasons, not necessarily identify as "lesbian" or "gay". Some may identify with other analogous terms which are more meaningful in their particular cultural context. Others may not see their sexuality as a basis on which to construct an identity, or may find it difficult to apply a fixed label to their sexuality (Amnesty International, AI-index: ACT 79/003/1999).

Western typologies (in sexuality) are often not considered to be relevant in developing countries. Though no attempt has been made to 'box' an Indian identity into one of the 'western identities', occasionally however similarities and differences between certain 'Indian identities' and 'western identities' have been noted below.

HIJRAS/ALIS ("EUNUCHS")

(**Note:** The term 'Hijra' is used in North India, while the term 'Ali' is used in Tamil Nadu. Many NGOs/CBOs as well as health care providers commonly use the term 'Eunuch' to denote Hijras/Alis. Almost all Hijras/Alis call themselves only as Kothis.)

Hijras have been in India for centuries. In the ancient times, they occupied high political posts in the royal courts. They are believed to have special powers to bless or curse. They are organized into small visible communities (with their '*Guru*' [spiritual leader or master] and other *Chelas* [disciples]) but they may live alone or with their male partners. Their traditional way of livelihood is by singing and dancing in festival occasions, marriages, birth of a male heir, etc. Also, sometimes they go for begging by clapping (*"Thali"*) at market places and shops. Because of the gradual decline of income in these 'jobs' some are forced to enter into sex work.

Hijras are born as biological/anatomical males who reject their 'masculine' identity in due course of time to identify either as women, or not-men, or in-between man and woman, or neither man nor woman. There are no valid data to state how many intersexed persons

('hermaphrodites') are living in the Hijra community but they are likely to be extremely rare. According to *Transpal Sentinel,* a magazine for Indian crossdressers and transsexuals, intersexed persons may constitute a disproportionately small number, as small as one for 20 thousand or more. Hijras were regarded previously as cross-dressed homosexuals by some authors (cited by Serena Nanda, 1999) but Hijras are equivalent to the transgendered/transsexual persons.

Those persons who identify themselves with women often leave their birth families at a very young age and join the Hijra/Ali community. Lack of education, lack of other job opportunities and lack of economic/emotional support from their birth families compel many to enter into sex work for survival. Thus, Hijra/Ali community has mainly persons belonging to the lower socioeconomic status. There is no information about cross-gender identified males who belong to middle and upper class families. It is possible that such persons don't want to join the Hijra/Ali community because of various reasons (Transpal Sentinel, 1998).

Subgroups among Hijras:

The following classification is a slightly modified version from an article that appeared in a transgender magazine (Transpal Sentinel, 1998) in India.

1. ***Nirvan (Nirvan Kothi):*** Those who had undergone "*Nirvana*" (Salvation - as castration is known) i.e., removal of both testes and penis (voluntarily/willingly) and who are in woman's attire. These persons are usually known as "***Nirvan Kothi(s)***" or simply as "***Nirvan(s)***" with in the Hijra/Ali community. Traditionally, emasculation is done by a senior Hijra/Ali called *'Daima'* (Hindi) or *'Thai Amma'* (Tamil) which literally means 'mid-wife'. These days, many Hijras/Alis undergo emasculation operation by quack doctors (fake medical personnel).

2. ***Aquwa (Aquwa/Ackwa Kothi)***: Those who wear women's or men's attire, but who have not yet undergone castration but may or may not want to undergo castration in the future. Many live as women under a Guru, while training in singing, dancing and other rites of the community, as they wait to attain *Nirvana*. Some of them are under "*Gurus"* who teach them about female mannerisms such as how to speak, sit and make gestures like woman. [This is equivalent to the 'real-life' experience/test in the western countries, during which the person who wish to have sex reassignment surgery has to live as a woman for about one or two years]

3. ***Zenana***: Here even though they think of themselves as woman, these persons don't want to undergo 'castration' because they don't want to meddle with nature (i.e., mutilate themselves). These persons may be in men's or women's attire. (Currently this term is not in common use with in the Hijra/Ali community. These days, these persons also come under *Aquwa Kothis*)

(**Note:**

- The term "castration" is used here to mean removal of the penis as well as the testicles, even though it usually means removal of testicles only. The term 'emasculation' can also be used to mean the same.
- The above classification is a simplified one and the description given for the subgroups may not be accepted universally by the Hijra/Kothi community.)

Some Hijras who are yet to be castrated or don't want to get castrated may be in the men's dress. These persons are more likely to be confused with feminine homo/bisexual males (see later). Also this led to the prior misconception that "pure passive" *homosexuals* exist, since these transgendered persons practiced only or mainly receptive anal/oral intercourse. i.e., there was (and is) confusion in differentiating between uncastrated transgendered persons (uncastrated Hijras) and feminine homo/bisexual males.

(Thus, if we have to say in western terminology, Hijras/Alis are a heterogeneous group which include, but are not limited to, pre-operative transsexuals (in male or female dress), transsexuals in transition [under hormonal therapy], post-operative transsexuals and non-operative transsexuals)

It must be understood that even the Hijra community often considers the terms "Hijra/Hizda/Hijde" (or the term 'Ali' in Tamil) as derogatory and demeaning. That term is used here only for discussion purposes and should not be attached any other connotation. **Hijras/Alis usually refer to themselves as "Kothi" only** (both in North and South India) and refer to their [Hijra] community as "*Kothi lowg*" (means 'Kothi community' in Hindi). The term 'Hijra/Ali' itself is considered to be derogatory by many Hijras/Alis (Kamal Dhalla and Ruth Lor Malloy, 1997). **Thus the terms ""*Hijra/Hizda/*Hijdes" and "*Ali*" are gradually becoming more of labels than identities.** However, within their community certain derogatory words like - '*Pottai (*Tamil language*)*', '*Ombodhu (*Tamil language*)*', and even masculine pronouns are freely used to refer to other 'Alis'. Recently, some Ali activists in Tamil Nadu has coined the term "***Aravani***" to replace the term "***Ali***" (though the term "*Aravani*" is not widely known or used).

Though Hijras can be asexual, many do have sex with men. Some Hijras engage in commercial sex work for lack of other options and are willing to leave this work if they are given alternative jobs (Timothy et al, 1999). Those earning their living as commercial sex workers do practice high-risk sexual behavior with their clients, casual and steady partners (since they practice receptive anal and oral intercourse) (Venkatesan C et al, 1999a). Some Hijras get "married" to a man and cohabit with him. Hijras call that man (or any man who only penetrates) as "***Panthi***", which (according to them) means 'real man'. A Hijra remarked, "We call those men as 'Panthi' who penetrate us. If we came to know that he is being penetrated by others, we don't like him and don't want to have sex with him…because one day or other he will also become like us". They don't seem to know the fact that a man can penetrate as well as get penetrated but still regard himself as no lesser than other men. This may be due to the conventional 'Indian way' of thinking, i.e. viewing the penetrator as "man" and those who get penetrated as either female or those who have feminine tendencies. This also reflects the tendency to view the

penetrated person as 'inferior'. This follows the simple "heterosexist logic": woman is inferior woman gets penetrated by man any man who is penetrated by other man = feminine nature predominates in the penetrated man anything feminine is inferior = penetrated man is inferior.

Some Hijras get married to a female before joining the Hijra/Ali community and may also have children from that marriage.

The emphasis of the sexual role - 'penetrator and person who gets penetrated' - is more likely only to reaffirm their gender identity as woman. It is also very likely that for the same reason Hijras tend to have multiple male (*man*) sexual partners. Thus getting into sex work serves a double purpose - not only does it solve the problem of money but it also gives Hijras a psychological satisfaction since Hijras feel that *men* are coming to them since these men consider them [Hijras] as *women*.

If you think that since Hijras think of themselves as woman they don't penetrate, you could be wrong!. Ashok Row Kavi says, "We came to know that in some parts of Mumbai Hijras in sex work are getting more money from truck drivers than the female sex workers. On enquiry, much to our surprise, we found that these [uncastrated] Hijras penetrate [the anus of] the truck drivers and that is why they are given more money". If Hijras identify themselves with females and only consider those who penetrate as 'real man', then how come that they penetrate other 'man'!. Vatsyayana, in *KamaSutra*, while describing the virile behavior in women [*purushayita*], notes that certain women mount their male partner [*upasripta*] and sodomizes him [*purushapasripta*] (Alain Danielou, 1994). If women can penetrate and still regard themselves as woman, then there is no surprise if Hijras penetrate but still regard themselves as 'woman".

Bairupi or Bairupiya ('Fake Hijras')
In North India, some males mimic Hijras by wearing female dress and go for begging by clapping (so as to make easy money). Hijras claim that these fake Hijras (Bairupi), by their indecent behavior in public spaces and trains, spoil the name of Hijras.

KOTHIS

Kothis are a heterogeneous group. It is unrealistic to expect that a single 'definition' of Kothi-identity will fit everyone with that identity. The meanings attached to Kothi-identity vary according to the region, language, age group, socioeconomic status, educational status, degree of involvement in Kothi community and even from one Kothi-identified person to another. Having said this, one can justify the diverse opinions held by different individuals and CBOs on Kothi-identity.

Traditionally, the 'definition' for 'Kothi' is - "males who show obvious feminine mannerisms and who involve mainly, if not only, in receptive anal/receptive oral intercourse with *men*". However, most of these feminine homo/bisexual males who identify themselves as 'Kothis' get penetrated as well as penetrate (Note: Sometimes the term '***Khada Kothi***' is used in North India to denote some Kothi-identified feminine

homo/bisexual persons who cross-dress and penetrate their male partners). Also, a significant proportion of them have bisexual behavior and many also eventually get married to a woman.

Most of the Kothi-identified males show varying degree of feminine mannerisms/behavior and also cross-dress occasionally. These persons are akin to "queens"/"drag queens" in western countries. If Kothis do have "feelings of a woman" and female mannerisms/behaviors, why don't they consider themselves as Hijras/Alis? This is a complex issue and may have more than one possible answer. This could be because the degree to which they identify themselves with woman may not be sufficient to warrant the 'Hijra'/'Ali' label.

As mentioned earlier, most (if not all) Hijras/Alis prefer to call themselves only as 'Kothi'. Thus there are two groups which share the Kothi-identity. One group is persons with Kothi-identity but those who don't think of themselves as Hijras/Alis. For the purpose of discussion, let us call these persons as 'simple' Kothis. Another group is the Hijra/Ali community, whose members identify themselves only as 'Kothis'.

The 'simple' Kothis don't cross-dress publicly except when soliciting sex work or in the Kootandavar festival in Tamil Nadu (But they are careful not to let their birth families know that they cross-dress). Many don't have an urge to undergo emasculation even though they cross-dress. But some do undergo emasculation and later may cross-dress part-time or full time. They are more likely to be living with their birth families or living with their wives. Some 'simple' Kothis don't socialize well with the Hijras/alis while some may mingle freely with them. Some of these 'simple' Kothis also consider themselves as 'Aquwa Kothi' since they are not emasculated (or don't want emasculation). Some do take female hormones for breast development though they don't want emasculation. In Tamil Nadu, 'simple' Kothis differentiate themselves from the Alis by saying -*"Avanga romba patchaiya irupanga"* (which means - "there are more *patchai*". Note: In Tamil language, the term "*patchai*" literally means 'green'). What they actually want to convey is - Alis are those persons who show obvious feminine mannerisms, puts on female make-up, are in women's dress most of the time, and who may or may not be castrated.

(Thus, in western terminology, 'simple' Kothis include, but are not limited to, 'drag queens', feminine gay/bisexual men [who might never cross-dress], male-to-female transgendered persons, pre-operative transsexuals, non-operative transsexuals and male-to-female transsexuals in transition, i.e., taking female hormones)

In contrast, Hijras/Alis are more likely to be in female dress almost all time, and more likely to have either undergone emasculation or have resolved to undergo in the near future. They are more likely to have left their birth families (or left their wives, if married prior to joining Hijra community) and living with other Hijras/Alis. Most Hijras/Alis consider 'simple' Kothis as "Aquwa Kothis in male dress and/or Kothis who don't want to undergo emasculation".

Some educated feminine homo/bisexual males who have "Kothi' identity ***also*** identify themselves as "gay". They have learnt this English term through the organizations that work for Kothis and Hijras, or through their friends. Likewise, some self-identified gay men prefer mainly (if not *only*) getting penetrated. Some proportion of them, who socialize with Kothis, thus ***also*** identify themselves as "Kothis" because of their *behavior.* Thus one can see "dual identities" in India.

It must be understand that even though feminine homo/bisexual males may call themselves "Kothis" many persons are quick to point out that they are *not* "Hijras/Alis". Also, the very act of including "Kothis" under the transgender umbrella is resisted quickly by some educated feminine homo/bisexual males, as they don't consider themselves as 'transgender' (English term). On the other hand, many Hijras/Alis consider the term "Hijras/hizdas (or Alis)" as synonymous with "Kothis" even though they mostly prefer to call themselves "Kothis". These days, those Hijras who have access to NGOs/CBOs working with GLBT communities know the English term "transgender" and proudly call themselves "transgender" even though they might not have fully understood the meaning of that term.

NGOs/CBOs that work with MSM reach mainly "Kothis' and "Hijras" since they can be easily identified and approached in the community. Thus these organizations are 'missing' the majority of "*men* who have sex with *men*" who look "normal" ('straight-looking'), those who don't have a self-conscious identity, and those who don't cruise. Thus a major segment of MSM remains invisible and hard to reach.

Kothi/Kowdi bashai **(Tamil) or** ***Kothi/Kowdi basha*** **(Hindi)**
This refers to the code language that is used by the Kothis to refer to certain things (mainly sexual acts). Actually this is not a 'language' as such since only certain things are given code words. These code words have been developed so that exchange of information can occur freely in the public spaces without other persons understanding. Usually the code words that are used by 'simple' Kothis are essentially the same as that used by Hijras/Alis (who also call themselves Kothis). These code words vary from state to state in India.

PANTHIS

The term 'Panthis' is used by Kothis/Hijras to refer to those persons who are 'real men' - in the sense those who only penetrate. Though it may also refer to rough and tough appearing men, a man who shows subtle feminine mannerisms may still be regarded as 'Panthi' if he only penetrates. These days, the term Panthi is used more loosely by Kothis/Hijras to denote heterosexual persons as well as any man who is masculine and who also has sex with women. This term is also used to denote the steady person (or 'special boy friend') of a Hijra/Kothi or the 'husband' of the Hijra. Some times the 'husband' or the steady partner is referred to simply as '(your) *mard*' [means man, in Hindi].

The sexual orientation of 'Panthis' is usually believed to be 'heterosexual' in orientation but fluid enough to have sex with Kothis/Hijras. There is a belief that 'Panthis' basically get attracted only to the feminine nature of Kothis/Alis and they don't have a homosexual orientation. But it is also possible that Panthis have homo/bisexual orientation but feel intimidated to have sex with other masculine males and thus prefer to have sex with Kothis/Alis who are feminine.

'Panthi' is more of a label than an identity since 'Panthis' came to know of that term only through Kothis/Hijras and they themselves don't take that term seriously. Some times calling oneself 'Panthi' is a matter of prestige since those who are penetrated are considered inferior. While it is possible that Panthi is only a penetrator because he is "lacking interest in experimenting in reciprocal sexual activities" as suggested by some authors (Asthana and Oostvogels, 2001), it is more likely due to the stigma attached to being a receptive partner. Some times a self-conscious homosexual (who might penetrate as well as receive) prefers the term 'Panthi' rather than the term 'Kothi'. Thus for sexual role playing some body has to take the Panthi role (penetrator) and somebody has to take the Kothi role (penetratee). Even a self-identified 'gay' man who socializes with Kothis has to say he is a 'Panthi' if he wants to have sex with a Kothi-identified person.

Panthis are either married to a female or eventually will get married to a female. Some of these 'Panthis' also have sex with other men (of any sexual identity) and may also penetrate as well as get penetrated (oral or anal). Though there is a general assumption that Kothis/Hijras may not accept their 'Panthis' if they know that their Panthis get penetrated as well, in reality as long as he behaves in a 'masculine' manner with Hijras/Kothis they are not rejected (however, this is not always the case).

Some Hijras/Kothis get 'married' to 'Panthi' even though that Panthi might have been already married to a female. Some may get 'married' to a Panthi and may also accept these Panthis wanting to get married to a female while other Hijras/Kothis may be possessive and may not easily be willing to 'share' their husbands).

Thus, in general, a combination of the following things can be used to find out whether a person is Panthi or not. Kothis/Alis generally believe that: A Panthi -

- is masculine in appearance.
- only inserts and never becomes a receptive partner to any one.
- does not even touch the male genitalia (if not emasculated) of the Kothi/Ali.
- only gets attracted to Kothis/Alis and not to other masculine males.
- mainly gets attracted to females and thus has every right to have sex with females and to get married to a female (though some Kothis/Alis are very possessive).

[Note: Previously, the 'real man who only penetrates' used to be called '***Kowriya'*** or '***Giriya'*** in the 'simple' Kothi language and 'Panthi' in the Hijra language. These days, mainly the term 'Panthi' is used by Kothis/Hijras though the term "Kowriya" is still in usage in North India]

DANGA (this term is used mainly in Chennai, Tamil Nadu)

The term Danga is used mainly by the NGOs/CBOs to refer to Kothi. Even some researchers (Asthana and Oostvogels, 2001) have used the term 'Danga' rather then the term 'Kothi' while describing the different *identities* in Tamil Nadu. But 'Danga' is actually more of a label than an identity. Only a few Kothis (especially those who work in NGOs/CBOs) know that the term 'Danga' is used to mean 'Kothi'. Some mistakenly believe that 'Danga' is the English translation for 'Kothi' or *officially* Kothi is known as 'Danga'. A related term 'Saree Clad Danga' is also used by the NGOs/CBOs in Tamil Nadu to refer to Kothis who crossdress as well as to Aquwa Kothis (Alis) who cross-dress. The term Danga is not widely used or known to the Kothi community.

"DOUBLE-DECKER" (the exact term used by Kothis/Hijras)

This refers to persons who get penetrated as well as penetrate, and those who may also have sex with women. It is because these persons get penetrated as well as penetrate other, Kothis classify these persons as a separate category - "Double-deckers". Since the term being a 'English' one, it means that this term has been only recently coined by the Kothi/Hijra community. The feminine mannerisms in Double-deckers are often overlooked, as they may be very subtle even though in some it would be obvious to any body. Some of these persons usually identify themselves only as 'Kothis' rather than 'Double-deckers' even though they 'accept' that they are 'Double-deckers' if questioned directly (Like - "Yes, that is how sometimes *other* Kothis call me"). Thus Kothi and Double-decker may not necessarily be mutually exclusive categories. It also may mean that sometimes 'Double-decker' is more of a label than an identity but it could be regarded as a subcategory of 'Kothis'. However, some may not call themselves as 'Kothis' but still accept the label 'Double-decker' (probably because they might think that calling themselves as 'Double-decker' is more prestigious than calling themselves as 'Kothi', since the latter means 'effeminate and being passive'). Almost all Double-deckers eventually get married to a female.

'INDIANIZED' GAY IDENTITY

The term 'gay' essentially has the same meanings as that in Western countries for the educated self-identified homosexual males belonging to the middle and upper class. But for some self-identified homosexual males the meaning attached to the word 'gay' may be sometimes quite different.

While some well-educated persons, regardless of their sexual orientation, may have never heard the term 'gay', other well-educated self-identified homosexual persons eventually do find a name to identify with - the English term 'gay'. They learn this term either while searching the library to find more information about their 'condition' or through other

'gay' friends. Thus the term 'gay' is not a familiar term even for well-educated persons, whereas the terms 'homosexuals', 'homosex' and 'homo' are usually very familiar. Even these terms may be sometimes confused with different things (The first author had personally heard a male patient saying - "I had homosex". Only after some time was it recognized that he was actually referring to masturbation as 'homosex').

The less-educated self-identified homosexual persons, who have access to NGOs/CBOs that serve MSM, eventually and inevitably come to know about the English terms - "Gay, Bisexual and Transgender". As these terms are not properly explained to them, these terms are used by these persons with their own personal definitions and they also experiment in equating the western identities with the Indian identities. For example: - the term 'gay' is used to mean all persons who are attracted to same-sex partners regardless of the gender identity of the persons. Thus eventually almost all the Indian identities like - Kothis, Hijra, Panthi, Double-decker, etc. comes under this term 'gay'. However the Hijras (especially those who are always in woman's dress irrespective of the castration status) are usually given the label 'transgender' (English term). Kothi-identified feminine homo/bisexual males are, however, quick to protest that they are not "Transgender". This is not because they fully understand this term but because it has become synonymous *only* with Hijras. The English term 'gay' has been 'translated' by some as "English Kothi"! (Some persons call English-speaking Kothi-identified persons as 'English Kothis'). Or alternatively some times 'translation' of Kothi results in 'Gay'. A Kothi-identified person said, "So what do you call 'Kothi' in English - Gay!".

(Note: In some CBOs, where gay-identified persons may socialize with Kothi-identified persons, gay-identified persons may say that they are 'Panthis' since these 'gays' don't want the Kothis to call them 'Kothis'.)

WHY IS THERE ALWAYS CONSIDERABLE CONTROVERSY OVER THE DESCRIPTION OF CERTAIN "INDIAN IDENTITIES"?

Unlike the western identities like 'Gay, Lesbian, Bisexual' that have some 'standard' definitions, there are no pre-existing definitions for the "Indian identities". Consequently, whatever a person thinks about his/her identity becomes the true essence of that identity to that person and whatever any other persons have to say about that identity becomes wrong. In other words, everybody (researchers as well as the community members) thinks that they are correct and others are wrong.

Many researchers/authors think in their own ways and their description of "Indian identities" is likely to be influenced by many factors like -

- Through whom and by what methods have the information about various identities been collected (Eg: Whether the researcher really had discussions with persons with different identities or was the information collected through 'key informants'? Or whether the respondents were recruited through 'snowballing' method? - since that means persons are more likely to identify with others sharing similar views about that

identity [*not necessarily*] and thus the sample is more likely to be 'homogeneous')

- The conscious or sub-conscious influence of the knowledge the researcher has about western identities.
- The censorship (by the researcher or the community members) of certain issues which may pose certain risks to both the community members with a particular identity as well as the researcher.
- The meanings attached to the Indian identities, like any other field, changes over time. This means description of 'Indian identities' this year may be 'outdated' a few years later. Even if one thinks that identities are immutable, the meanings attached to those identities are not.

IDENTITIES Vs. BEHAVIOR:

Sexual health outreach should attempt as far as possible, to respect the identities chosen by individuals and not attempt to force upon them western constructs such as gay or transgender. These days, the term ***"males who have sex with males"*** is used to indicate those biological males who have sex with other biological males. Then, in a strict sense, it includes Hijras (uncastrated and castrated), Kothis and other "*men* who have sex with *men*". Working definitions such as 'males who have sex with males' are appropriate for outreach as long as these are treated as behavioral categories which may include people with any of the above identities, males who don't identify as any of the above, as well as males who may subscribe to constructs such as gay and bisexual. However, due respect should be given to the sexual identity assumed by any male who has sex with other males.

4. SEXUAL NETWORKS BETWEEN PERSONS WITH DIFFERENT IDENTITIES: IMPLICATIONS FOR HIV TRANSMISSION AND ACQUISITION IN INDIA

The sexual networks between persons with different 'Indian' identities and those with 'western' identities are illustrated in the diagram. One can see that there is a great potential of transmission of HIV/STDs among these different groups and also to their female partners and future children.

- Persons with 'Kothi' identity mainly act as receptive partner, but many penetrate also (with different partners or on different occasions with the same partner). They have sex with Panthis, 'Double-deckers', 'Gays', 'Bisexuals' and persons with no self-conscious sexual identity. Kothi-identified persons usually don't have sex with other Kothi-identified persons, however many also have sex with females and a significant fraction of these eventually get married.

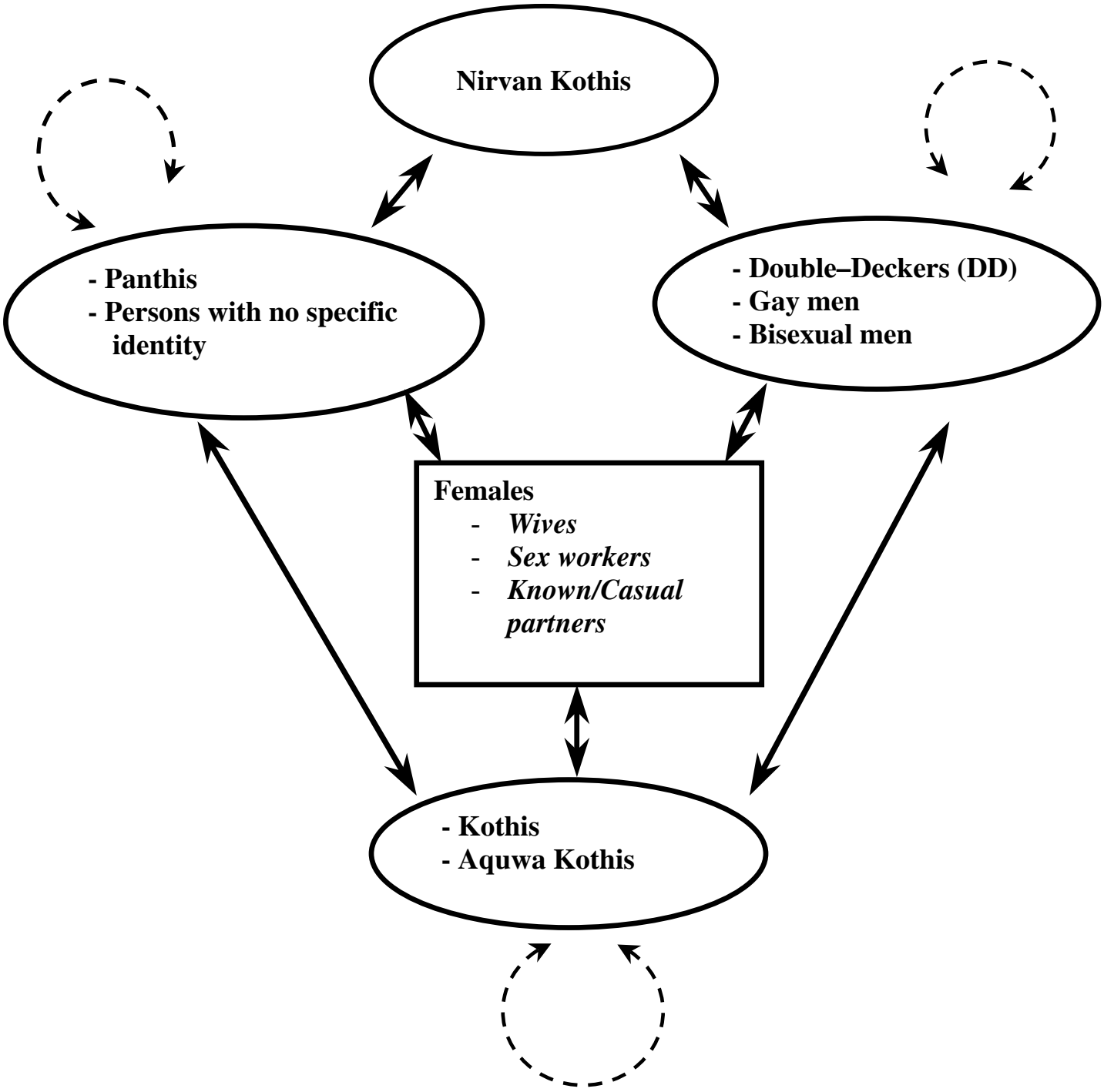
- 'Panthi' is only a label. It is the Kothis who call their masculine male partners as Panthis. Thus, very few (if any) persons will call themselves 'Panthi'. Consequently most 'Panthis' also will come under the category of persons who don't have a self-conscious sexual identity. These persons, though believed to be only penetrators by the Kothis, also may act as a receptive partner with other 'Panthis' or 'gays'. Almost all Panthis have sex with females and eventually get married to a female. If the Panthis don't want to use condoms, then Kothis might have unprotected sex with them since if they insist on condom use they might loose these potential sex partners (Panthis).

- 'Double-deckers' too, like 'Panthi', is only a label given by Kothis to those persons who insert as well as receive. Thus, some Kothis themselves are 'Double-deckers'. If a Kothi has sex with a person and that person penetrates as well as receives, then, according to the Kothi, that partner is a 'Double-decker'. But that person's identity may be 'gay', 'bisexual', 'Kothi' or may have no specific identity. Most 'Double-deckers' have sex with females or eventually get married to a female.

- 'Alis/Hijras' who have not undergone emasculation and wear male or female clothes (*Aquwa Kothis*) are usually attracted toward and want to have sex with masculine-looking males whom they call 'Panthi'. But, whether that person is 'Panthi' or not can be decided only after a sexual encounter with those masculine-looking males. A masculine-looking male is expected only to penetrate, and if he also wants to be a receptive partner then he is shunned. This emphasis of the receptive role being the very basis for the Kothi identity means Kothis are at high risk for HIV infection. (Note: 'Double-deckers' may have sex with 'Alis' who have not undergone emasculation, but they have to play only the 'insertor' role while having sex with 'Alis').

- 'Alis/Hijras' who have undergone emasculation (*Nirvan Kothis*), needless to say, act only as receptive partners. They have sex with masculine-looking males whom they call 'Panthi'. 'Double-deckers' may also have sex with 'Nirvan Kothis'.

SEXUAL NETWORK AMONG PERSONS WITH DIFFERENT IDENTITIES/BEHAVIOR



- 'Gay' men have sex with other 'gay' men, Kothis, 'bisexual men' and persons who have no sexual identity. Some 'gay' men don't prefer to have sex with feminine-looking/acting males thus avoiding Kothis and 'Alis'.

- Persons with 'bisexual' identity are very rare. They may have sex with other 'bisexual' men, 'gays', Kothis, 'Double-deckers', 'Alis' and persons with no self-conscious sexual identity. Almost all the 'bisexual' men have sex with females and eventually get married to a female.

Thus, it is important to note that there is considerable bisexual behavior among persons with any identity (except possibly 'Alis', even though some 'Alis' might already be married to a female before joining the Hijra/Ali community, or before emasculation). Also, many get married to women. They can not use condoms with their wives since the wife will then become suspicious of their husband's behavior. Also, it might be difficult to explain why they are using condoms if their wives have already undergone tubectomy (in India, many women undergo tubectomy after having two children).

Note: It is the Kothis/Hijras who have coined the terms 'Panthi' and 'Double-decker' to classify their male partners according to whether they only insert or also receive. Consequently, male partners of Kothis/Hijras will be labeled as 'Panthi' and 'Double-decker' (by Kothis/Hijras) according to their sexual role. Thus these male partners of Kothis/Hijras don't have any *"identity"* like 'Panthi' or 'Double-decker'. Some times, Kothi-identified persons who receive as well as penetrate might say, "I'm Kothi. But sometimes I *behave* like Double-decker". Some Kothi-identified persons may have sex with other Kothi-identified persons by not exhibiting their feminine mannerisms. A Kothi-identified person says, "When I saw a Kothi to whom I get attracted very much, I act like a 'Panthi' [means - in a masculine manner] and have sex with that Kothi" [implying being the penetrator].

To summarize,

- Identities may or may not have correlation with behavior/sexual practices, even though the basis of certain identities itself is having particular behavior/sexual practices. More research is required in this important area.
- Complex sexual network among persons with different identities means rapid transmission/acquisition of HIV/STD from one group to another.
- The complexity and magnitude of the sexual networks among persons with different identities makes it difficult to distinguish which group is *actually* the 'bridge' group.

5. 'INDIAN' AND WESTERN IDENTITIES: IMPLICATIONS FOR HIV PREVENTION

The presence of different identities (both indigenous and western) poses many challenges in bringing together the sexual minority community in India and uniting in the fight against HIV/AIDS for the following reasons.

- In western countries persons with 'gay' or 'bisexual' identities have sex with one another (i.e., with persons having the same identity) and are organized on that common ground. In India, persons with identities like Kothis or Alis/Hijras do not have sex with one another but are organized on the common ground of their sexual role (being a receptive partner) and having feminine mannerisms. This means persons with these identities are relatively at high risk of HIV infection than those males who only penetrate (e.g., Panthis). Community outreach, peer education, and condom distribution should be useful strategies to educate Kothis about HIV/AIDS and safer sex, since Kothis mingle freely with each other and identify as a community.

- In Ali/Hijra community, 'Chelas' [disciples] are under the control of 'Guru' [master]. Thus, there has been a suggestion that the 'Guru' can play a significant role in establishing and enforcing codes of safer sex behavior (Asthana and Oostvogels, 2001). While such a strategy sounds good, it is not without problems. For example, one *Ali* asked "How can an *Amma* (mother) give condoms to her own *Ponnu* (daughter)?" Note: In Tamil Nadu, '*Guru*' is also called '*Amma*' (mother) and *Chela* is also called '*Ponnu*' (daughter). Community outreach, peer education and condom distribution can be useful strategies.

- 'Panthis' and 'Double-deckers', as mentioned earlier, are only labels. Hence, it may not be possible to identity these persons and teach them about safer sex. They can be reached through mass media by broadcasting HIV prevention messages which talk about risk of unprotected sex between males. Also, the Kothis/Alis can be taught condom negotiation skills so that they have safer sex with their male partners.

- 'Gay' (and 'bisexual') identity is present mainly in the middle and upper class educated men. Persons with 'gay' identity don't mingle with one another freely. Since 'coming out' is very rare and marriage is a cultural norm almost every one with 'gay' or 'bisexual' identity gets married. The stigma attached to homosexuality, not feeling the need to come out, the fear of being considered 'impotent' if not married to a female and the social pressure to get married all prevent a the gay-identified person from resisting marriage. Thus gay-identified persons don't find any valid reason why they should come out and fight for their 'rights'. Thus, while the 'individualistic culture' of the west helped in organizing the gays in western countries, the 'interdependent culture' of India prevents 'gays' from getting organized since they are unable to resist their family and social pressure. Gay-identified persons can be reached through CBOs as well as through appropriate mass media HIV prevention

messages which the gay men can identify with.

- Gay/bisexual-identified men may not want to mingle with persons with indigenous identities (like Kothis or Alis/Hijras) because of differences in socioeconomic status, educational status and presence of feminine mannerisms in Kothis/Alis. This means it will be difficult to bring together persons with different identities to jointly fight against HIV/AIDS.

- Since many persons with any identity (except possibly Alis/Hijras) have bisexual behavior and also don't use condoms consistently with male or female partners, there is a high risk of transmission to their male and female partners (including wives) and future children.

- Since identities may or may not have correlation with behavior/sexual practices, no presumptions should be made about the sexual behavior/practices of persons with a particular identity. This is especially important in the preparation of HIV prevention education messages and in designing HIV prevention intervention programs for MSM with different identities.

6. NEAR LACK OF GAY AND BISEXUAL (MALE) IDENTITY IN INDIA

NEAR LACK OF 'GAY' IDENTITY IN INDIA

A research study was conducted in West Bengal, India in 1999, to study the sexual orientation and sexual identity of men who have sex with men. 52 MSM were asked to rate their preference on a 7-point (Kinsey type) scale on 6 variables, which distinctly describe the sexual orientation (Joseph Sherry, 1999). The composite score for sexual orientation showed that 55.8% are predominantly homosexual, 36.5% are predominantly bisexual and a small percent of 7% are predominantly heterosexual. When asked about how they wished to be known in their society, 44% did not have a name to be identified, 20% preferred to be known as bisexual, 18% as gay/homosexual and 9% as heterosexual. Moreover, 7.7% wished to be known as 'MSM' [a new 'identity'] and 2% as Dhurani [may come under transgender category]. This study shows the inconsistency between sexual orientation and sexual identity as shown by studies conducted in other countries.

Most often persons who have same-sex behavior used to say - "I *like* homosex" or "I have *interest* in homosex" (Or if some persons are questioned whether they ever have had sex with a man might say, "I'm *not interested* in homosex"). Some may say "I learnt this habit from my friend" or "This *line* [which means behavior or activity] was introduced to me by one of my relatives". For some persons 'homosex' is thus an *activity*, for some it is a '*habit*', and for some it is a matter of whether one has *interest* in that or not.

The first author of this paper has come across hundreds of MSM in the STD clinic of Govt. General Hospital, Chennai, Tamil Nadu, where he got trained. Unlike in Western countries, here one cannot ask the patient whether he/she is a heterosexual, homosexual or bisexual. This is simply because there are no terms for them in Indian languages (though there are many derogatory terms to denote feminine males in almost all languages). In Tamil Nadu, a Tamil technical term has been coined to denote homosexual men, which is not widely used and unknown to many lay people; in Tamil newspapers the term 'lesbians' is used as such in Tamil language. Hence, here physicians used to ask -"whether you have sex with woman, man or both"? In this setting, MSM (belonging to low socioeconomic status) were asked about how they see their same-sex behavior. The following responses were obtained.

- "I *also* have sex with women"
- "*They* [other men] only approach me [to have sex]"
- "I *only* penetrate"
- "It is only an outlet to release my tension"
- "*Other* men seduce me *quite often*"
- "We just *help* each other"
- "It is just for a fun"
- "*That* man told oral sex will relieve the itching sensation in his throat"
- "This will be over once I get married"
- "I'm married but only occasionally I have sex with men"

- "My wife doesn't allow me to do certain [sexual] acts. That is why I approach men"
- "My wife's vagina has become loose. Hence I have anal sex with men"
- "I'm happy with my wife but sometimes I just have to go out and find a man to have sex with".

All these excuses, denial of attraction towards men, blaming others for one's behavior, etc. are mainly due to the fear of social disapproval, rejection and discrimination. Not paradoxically, those men who are aware of the sexual attraction to other men feel very guilty about their behavior and even ask for converting them to "normal". 'Gay identity' is present mainly in urban, educated (middle and upper class) persons since they came to know of these English terminologies and have access to information.

To summarize, in general, the near lack of 'gay identity' in India is due to:

- Homosexuality is never discussed openly.
- Lack of specific terms in Indian languages for gays and lesbians.
- Ignorance of the concept of sexual orientation and sexual identity.
- Perceived homophobia in the community.
- Internalized homophobia.

NEAR LACK OF 'BISEXUAL' (MALE) IDENTITY IN INDIA:

Bisexual identity is virtually absent in India mainly because (as discussed earlier) the concept of sexual orientation and identity is not known or understood by even people with alternative sexualities. Also, the English term 'bisexual' is not known or familiar even among well-educated persons. Often doctors themselves mistake this term to mean inter-sexed persons (formerly 'hermaphrodites').

If a person has bisexual behavior or attractions, he may simply ignore the same-sexual behavior /attractions as he is attracted to woman also. This is incontrast to a person with a predominant same-sex behavior/attractions since here this person may feel different because he may feel he is not having *enough* attraction to woman. Consequently he tries to find a 'label' for his condition and eventually finds one like - Gay, Kothi, etc. However in Indian men who are erotically attracted to both genders, the need to get a label or for that matter even to feel 'different' may not arise since they are also getting attracted to women.

Among these persons with bisexual behavior/attractions, some may be conscious about their attractions to either gender. These persons, who might think of themselves as 'bisexual' if they were in US, eventually get married. However it seems that no one uses the term "[heterosexually] *married bisexual men*" but only the term "[heterosexually] *married gay men*" (Note: Some MSM who don't have any self-conscious sexual identity and who may get married can be simply referred to as "[heterosexually] Married MSM"). Thus it is also likely that these persons are not actually 'forced' into heterosexual

marriage but may willingly get into heterosexual marriage life.

Thus the term "married gay men" may or may not mean the following things: Some are *actually* "bisexual men" who don't regard themselves as 'gay' or 'bisexual'; some are actually not 'forced' into heterosexual marriage; some of these are actually 'gay' men who may or may not like having entered into a heterosexual marriage life.

As discussed earlier, the term 'Double-deckers' is used to specifically indicate those who penetrate as well as get penetrated. This criterion may be stressed by some as essential to this identity. Sometimes, persons those who have sex with both men and women are also called 'Double-deckers'. Thus using the first criterion, some authors (Asthana and Oostvogels, 2001) have suggested that 'Double-deckers' are coming closer to the western *identity* 'gay'. If the second criterion is used, then 'Double-deckers' may come close to the western *identity* 'bisexual (man)'.

Persons who have access to CBOs working with MSM also came to know the term 'bisexual' and sometimes prefer this term to gay or Kothi (One person says, "I would rather call myself a 'Panthi or bisexual' than as 'Kothi or gay'". Note: Here this person doesn't like the term Kothi because it implies 'being passive' and also he doesn't want the label 'gay' since he thinks it is synonymous with 'Kothi'. This also may indicate he is not quite serious about the bisexual *identity*).

Persons with true bisexual identity are yet to come out but surely the acknowledgement of such identity is on the rise which is indicated by the inclusion of 'bisexual' in the agenda of 'Gay' organizations as well as in the emergence of many GL**B**T organizations.

7. LEGAL STATUS OF HOMOSEXUALITY IN INDIA: IMPLICATIONS FOR HIV PREVENTION

Indian culture tolerated same sex eroticism for centuries. But the former British rulers found this repulsive, and declared it a crime in the Indian Penal Code (IPC), which was enacted in 1861. IPC section-377, originally drafted by Lord Maculy in the early 1830s, reads:
"*Unnatural offences*: Whoever voluntarily has carnal intercourse against the order of nature with either any man, women or animal shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to 10 years, and shall also be liable to fine.
Explanation - Penetration is sufficient to constitute the carnal intercourse necessary to the offence described in this section" (ABVA, 1991, Lawyers collective, 2000).

The exact scope of this vague definition - "Carnal intercourse against the order of nature" -has generally been interpreted to include acts of anal sex as well as oral sex between males. The possibility of this definition being extended into heterosexual acts of anal or oral sex also exists but has not been tested. Consent of the other party is completely irrelevant for conviction but it may be a relevant consideration while fixing the quantum of punishment. It must be pointed out that homosexuality *per se* is not an offence, and an "act" of unnatural intercourse has to be proved. Though the law makes only anal (and possibly oral) intercourse between two males a crime, in practice and in effect it criminalizes homosexuality.

The legal status of homosexuality in the Indian Armed Forces follows the model set by section 377. Section 46 of Chapter VI Offences, of the Army Act, 1950 states: "Any person subject to this act who is guilty of any of the following offences, that is to say - a) is guilty of any disgraceful conduct of a crude, indecent or unnatural kind - shall on conviction by court-martial, be liable to suffer imprisonment for a term which may extend to seven years or such less punishment as is in this Act mentioned." Similar provisions exist in the Air Force Act, 1950 (ABVA, 1991).

Sec.377, which criminalizes homosexual behavior, is today responsible for the denial of various fundamental rights like life and liberty, health, privacy, speech, movement, etc., to the sexual minorities. The denial of these fundamental rights to sexual minorities lead to their enhanced vulnerability to HIV/AIDS by making them highly invisible and unreachable for HIV prevention education and for providing sexual health related services. It has also resulted in low self-esteem (which indirectly decreases condom use and increases risky sexual behavior), discrimination in employment, vilification, threats of physical violence, extortion of money from police, etc.

It is now an accepted postulate that the only way of protecting vulnerable populations from HIV/AIDS is by protection and promoting their rights, so that they are in an empowered position to protect themselves. However, due to S.377 IPC, effective

interventions are rendered impossible because dissemination of information on anal and oral sex, distribution of condoms, etc. could be construed as abetment of a criminal act.

Many countries including the United Kingdom have decriminalized adult consensual homosexual acts. In India, however the same old British law is being followed blindly with out any inclination to reexamine it. Recently, the Law commission of India (LCI) has examined this issue while reviewing 'rape laws' and recommended changes to the existing laws. The LCI 172nd report has included in its recommendation the repeal of section 377 and has expanded the term 'rape' i.e., penetration of the vagina, anus or mouth with the penis, to any other part of the body. This report is a mere beginning and has not comprehensively dealt with this issue. Many human rights groups, GLBT groups, Child rights groups, and Women's groups are debating upon the LCI deliberations. They are trying to find out inadequacies in the LCI recommendations and to propose necessary changes.

Elimination of sodomy laws and legalization of marriage among gay men and lesbians are considered as one of the environmental structural interventions in HIV prevention (Kim M Blankenship et al, 2000). Hence it is high time that all discriminatory legislations on homosexual behavior be repealed in India in line with many European countries.

8. GROUP ACTION OF GLBT/SEXUAL MINORITY COMMUNITIES IN INDIA

Near lack of self-conscious sexual identity in India has prevented the MSM community from organizing themselves for a long time. Many attempts have been made since the late 1970s to start support groups for gays and lesbians and to communicate with gays through newsletters discussing issues relevant to gays in India, but only a few have stood the test of time.

As early as 1978, a gay newsletter called "***Gay scene***" was started from Calcutta. It ran monthly until it folded in 1980. In May 1985, Anamika, a newsletter for South Asian lesbian and bisexual women came out. The publication in 1986 of ***Trikone***, a newsletter for South Asian gay men and lesbians brought out by two Indian graduates from California, USA, was considered as a major event for gay people in India who can read English. (Now it also addresses the rights of bisexual men/women and transgendered persons). Sympathetic coverage in Indian magazines like - *Society* and *India Today* brought its address to hundreds of people in the cities and small towns across the country.

In June 1988, ***Shakthi*****,** a South Asian lesbian and gay network, was formed in London. ***Shakthi kabar***, the newsletter of a South Asian lesbian and gay network, a few years later from London and like Trikone, was circulated free of charge in India. In June 1990, ***Shamakami***, the newsletter for South Asian Lesbian and bisexual women, came out. ***Freedom***, an "*Indian Gay Newsletter*" was launched from Gulbarga, Karnataka in August 1990 and was published monthly. The *Golden club city* of Bangalore was formed in March 1991 "to provide a nonjudgemental forum of like-minded people to meet and also to work for an amendment to the Indian constitution which is at present hostile to us". There were also other transient groups (e.g. *Gentlemen's club of Calcutta*, 1989), which vanished as soon as they formed (ABVA, 1991).

In July 1991, ***Sakhi***, a lesbian group, was formed in New Delhi. In November 1991, the groundbreaking report (on Indian homosexuality) by AIDS Bhedbhav Virodhi Andolan (ABVA), *Less than gay*, came out from New Delhi. In December 1991, ***Pravartak***, a gay magazine from Calcutta, came out. In August 1993, Counsel club, was formed in Calcutta. ***Sangini***, a telephone help line and counseling service that is available for "women who are attracted to other women" was launched in October 1997 with the help of Naz foundation, India.

Perhaps the most momentous gay event of 1990 was the appearance of ***Bombay Dost***, a gay magazine edited by Ashok Row Kavi, an openly gay journalist. *Dost* received widespread sympathetic coverage in Indian media. It is brought out simultaneously in English and Hindi. Ashok Row Kavi together with two other gay men founded the ***Humsafar trust***, which was subsequently registered as a public charity in Mumbai metro in 1994. The Humsafar Trust has four components: community work, street outreach, advocacy and research. The Trust educates men on STD and HIV/AIDS through its

outreach programs as well as through its sister publication *Bombay Dost*. The Humsafar Trust has many credits to it in the area of sexual health of sexual minorities in India. It conducted the first HIV awareness survey among self-identified gay men and results were published in 1991. A rapid needs assessment with a participatory approach was conducted which led to the beginning of a skeletal street outreach and condom distribution network in 1992. The trust is responsible for organizing the first gay men's conference in the subcontinent after consulting all the gay groups in India, the objective of which was to network with peer leaders from the emerging gay groups in South Asia. The trust networks not only with other gay groups in India's larger metros but has taken upon itself the task of helping set up gay groups in smaller towns of India. In May 2000, the Humsafar trust organized the three-day conference called "Looking into the Next Millennium." (supported by : India Fund, UNAIDS, DFID & SIDA). One hundred ten gay and lesbian activists from around India attended this conference (international news #316 - May 15, 2000 (c) Rex Wockner). The conference was an effort to build a NGO network of sexual minorities and initiate sexual health interventions among them. As a result of this, '*Network India*", which is the network of almost all the existing sexual minority community groups in India has been formed.

Many support groups of sexual minorities are being formed throughout various parts of India. The Kyodo News Service reported Feb. 5. that "[Indian] Authorities are registering one new gay activist group about every six months…" (From international news #304 - Feb 21, 2000, (c) Rex Wockner). Some of these support groups also have their own newsletters, which also provide information on HIV/AIDS and safer-sex practices. Also, access to the Internet has lead to '***Internet activism***', and many informal Internet based gay groups like - *Gay Bombay*, *Gay Calcutta*, *Gay Delhi*, *BiIndia*, etc are being formed.

One can now see the emergence of 'GLBT' groups in India which fight together for their rights. These include organizations like- ***Sangama*** in Bangalore, ***Sambhavna*** in Mumbai and groups supported by ***Naz (India) Foundation Trust (HumNawaz, HumRahi, HumJoli)*** in Delhi. Other CBOs and NGOs which work with/for sexual minorities include ***Dai Welfare society*** in Mumbai, ***AIDS Bhedbhav Virodhi Andolan*** (ABVA) and ***Siddhartha Gautam Trust*** in New Delhi, ***Mitrudu***, ***Expressions*** and ***Saathi*** in Hyderabad, ***Prajak***, ***Sapphire creation***, ***Pratyay***, ***Integration*** and ***Counsel Club*** in Calcutta, ***Udaan*** in Mumbai, ***Good as You*** (GAY), ***Jagruti Gelaya***, ***Swabhav***, ***Snehashraya*** and ***Sabrang*** in Bangalore, ***Mansa*** in Orissa, ***Social Welfare Association for Men*** (SWAM), ***Sahodaran***, ***Sahodaran Prakriti***, ***Chennai Mitra*** and ***South Indian AIDS Action Program*** (SIAAP), ***Trichi innovative AIDS action program*** in Tamil Nadu, ***Aravani*** in Kerala, ***Bharosa*** and ***Friends India*** in Lucknow, ***Aasra*** in Patna, ***Samantar*** in Pune, and ***Lakshya*** in Gujarat.

The reasons for the formation of support groups are many. Though the need to organize themselves has been mainly due to social and political reasons, some gay organizations are started mainly to create HIV/AIDS awareness among the gay community and to educate them about the safer sex practices. But it has been commented that "Self-identified groups [a]re being manipulated into wholly HIV based work and marginalized through some clever calculation" (Humsafar Trust, 2000b). While the formation of many

groups may be welcome news for the gay activists, it has also has introduced new problems. “Strange tensions [a]re now evident in the emerging gay networks. Whereas just a decade ago, there was little politics within the networks, a new war ha[s] now erupted between ‘Kothis’ and gay-identified gay men. Suffice to say something strange [i]s happening” (Humsafar Trust, 2000b). It must be noted that this ‘politics’ in the sexual minority communities is seen only among the various self-organized groups and it is not applicable to the sexual minority communities who don’t belong to or don’t have access to these support groups/organizations. Understandably, the need for these various groups to work together is the top priority at this crucial time. Only when there is solidarity among these groups will the common goal of fighting against discrimination and stigmatization on the basis of sexual orientation and gender identity become successful.

PART - 2: EPIDEMIOLOGY AND DEMOGRAPHY

1. EPIDEMIOLOGY OF HIV/AIDS IN INDIA (in relation to MSM)

India is one of the countries worst affected by HIV/AIDS with an estimated 3.86 million persons living with HIV/AIDS (year 2000). In numbers it is second only to South Africa. The estimated HIV infection rate among adult population between 15-49 years of age is 0.7% (National AIDS Control Organization, NACO, India: http://naco.nic.in/vsnaco/indianscene/update.htm: accessed on 23rd September 2001). The first case of HIV infection was reported from Chennai (formerly Madras) in 1986.

The epidemiology of HIV/AIDS in India as reported by NACO, India, is given below. (NACO: http://naco.nic.in/vsnaco/indianscene/overv.htm: accessed on 23rd September 2001)

AIDS Cases Reported in India [to NACO]
(Period of Reporting - 1986 to August 2001)

Cumulative no. of AIDS cases reported till August 2001	
Males	19719
Females	6177
Total	**25896**

[**Note**: The male:female ratio is 3:1]

Risk/Transmission Categories [Among Reported AIDS Cases]

Modes of transmission	**No. of cases**	**Percentage**
Sexual	21554	83.23
Perinatal transmission	520	2.01
Blood and blood products	944	3.65
Injecting Drug Users	986	3.81
History not available	1892	7.31
	25896	**100.00**

No split up of sexual modes of transmission is given in the recent reports of NACO. This is probably because the Govt. of India has recognized that it has no reliable or valid data on the different sexual (hetero/homo/bi-sexual) transmission modes of HIV/AIDS. Asthana and Oostvogels states "Recognising the difficulties of using the term 'homosexual' in the Indian context, the National AIDS Control Organization now groups

both of these categories under 'sexual activity'…" (Asthana and Oostvogels, 2001). However, one can still find statements like "The predominant mode of transmission of infection in the AIDS patients is through heterosexual contact…" in NACO's website (NACO: http://naco.nic.in/vsnaco/indianscene/ trend.htm: accessed on 23rd September 2001)

HIV serosurveillance (until April 30, 2000)

	Cumulative
Number of persons screened	3643825
Number of persons seropositive	96694
Seropositivity rate (per thousand)	26.54

Break-up of seropositivity in HIV serosurveillance (until April 30, 2000)

Route of Transmission	**Seropositive**	**Percentage**
Sexual	47163	**48.78**
Through blood and blood products	6478	6.70
Through infected syringes and needles	3787	3.92
Perinatal transmission	314	0.32
Others (including suspected ARC/AIDS)	**38952**	**40.28**

From the above data given by NACO one can very well see the lacuna with regard to the modes of transmission of HIV in India.

1. In serosurveillance, sexual transmission is mentioned as only 48.78%. How many of these are due to heterosexual, homosexual or bisexual behavior?
2. In serosurveillance, what does the category "Others" stand for? Does it mean the exact mode of transmission is unknown? Also what does it mean by stating that - "*Others* (*including suspected ARC/AIDS*)" - when we are only talking about the mode of transmission and not the clinical stage of the disease?
3. In AIDS case surveillance, sexual transmission is mentioned as 83.23%? How many of these are due to heterosexual, homosexual or bisexual behavior?
4. How can it be claimed that HIV transmission in India is 'predominantly heterosexual'
    - when the HIV serosurveillance report identifies sexual transmission as only 48.78% and split up is not known?
    - the 'others' category in the HIV serosurveillance report is 40.28%?
    - when men are predominantly affected (men:women ratio is nearly 3:1), given the fact that the efficacy of man-to-woman transmission is greater than woman-to-man transmission?

- when the reliability of sexual history taking in these serosurveillance centers is questionable?

Accepting the lack of reliability in the data from the serosurveillance centers, NACO has recently *"withdrawn"* all the data from the serosurveillance centers (NACO: http://naco.nic.in/ vsnaco /indianscene/overv.htm: accessed on 23rd September 2001).

In the **1998** data of NACO, it was stated that *among the 5204 AIDS cases reported* until March 1998, ***heterosexual transmission*** constituted ***74.15%*** and ***homosexual transmission*** constituted ***0.58%***, Recipients of blood constituted 7.05%, injecting drug users - 7.3% and "others" - 10.92% (NACO, 1999). Thus according to the NACO, homosexual transmission contributed to only 0.58% *among the reported AIDS cases* until 1998. Data on AIDS cases provide a picture of HIV infection approximately ten years old. We contend that in order to estimate recent trends in HIV infection, NACO must rely on data on HIV testing, HIV prevalence and incidence reports, and risk behavior among men who have sex with men from centers that deal with MSM. Unfortunately, there is little reliable data on these.

Other factors that may influence the reliability of data on HIV infection are: (i) many MSM don't have a self-conscious sexual identity; (ii) they may not consider telling about same-sex behavior especially if not asked about it; (iii) even amongst persons who are conscious of their same-sex attraction and behavior (and those who have 'western' or 'Indian' identities), many are reluctant to identify themselves as such and to disclose their same-sex behavior or sexual orientation to health care providers, fearing stigma and discrimination.

HIV prevalence among MSM in India

Ignorance about same-sex behavior and discrimination against MSM affects the extent and reliability of data on HIV infection in this population, contributing to the paucity of studies among MSM and almost no funding, until recently, for HIV prevention programs for MSM.

There is no nation-wide data on the prevalence of HIV infection among MSM in India. National AIDS Control Organization (NACO) of India says "On HIV among MSM groups, little reliable data is available. Informal estimates suggest rapid increases may be taking place in this particularly vulnerable community" (NACO, 2000). Only a few studies from Mumbai have reported HIV seroprevalence among MSM. The prevalence of HIV infection among gay-identified men attending STD clinics in Mumbai metro was studied by the National Institute of Virology over a 6-month period in 1992 in collaboration with *Bombay Dost* (India's first gay newsletter). HIV prevalence was found to be 20.67%, which was very high given the fact that this studied cohort was of educated middle class and hence had the means and material to be adequately aware of the transmission routes of HIV. It therefore implies that HIV prevalence amongst MSM without a conscious self-identity of their sexual orientation would be higher (Ashok Row Kavi, 1999).

Another study from Mumbai published in 1994 showed that about 16% (among 63 blood samples) of MSM attending STD clinics of Mumbai were seropositive for HIV (Nandi et al, 1994). HIV prevalence of 15% among MSM in Mumbai has been reported recently from the STD clinic of a non-governmental organization (Humsafar Trust) working with MSM (Maninder Setia et al, 2000).

Recent data from NACO (2000) of 232 HIV sentinel serosurveillance sites across India, 2 of which targeted MSM, suggest HIV seroprevalence rates among MSM of 23.94% in Mumbai (in Maharashtra State) and 4% in Tamil Nadu State [in Chennai]. (NACO: http://naco.nic.in/ vsnaco/indianscene/overv.htm: accessed on 23rd September 2001)

STD prevalence among MSM in India

Only limited data are available about STD prevalence among MSM in India. A preliminary analysis of STDs among 85 MSM attending an STD clinic in Mumbai gives the following information: 4 had clinical rectal gonorrhea (among these 2 were culture-positive and remaining 2 were smear-positive), 4 had perianal warts, 3 had gonococcal urethritis, one case each of secondary syphilis, genital molluscum contagiosum and genital scabies. The point prevalence of HIV in this population was 15% and VDRL reactivity was 16% (Maninder Setia et al, 2000).

In a recent study from Chennai, analysis of 51 MSM who attended a community-based clinic over a period of three months showed the following. Thirteen (26%) MSM were clinically diagnosed to have one or more STDs. Clinically the following pattern of STDs was found: Perianal warts - 4 (8%), Genital Herpes - 4 (8%), Perianal herpes - 1 (2%), Secondary syphilis - 1 (2%), Gonococcal urethritis - 1 (2%), Molluscum contagiosum - 1 (2%), Proctitis - 2 (4%), Scabies - 1 (2%) and Prostatitis - 1 (2%). Genital dermatoses like Candidal intertrigo - 4 (8%), Candidal balanoposthitis - 1 (2%), Perianal candidiasis - 1 (2%) and Tinea cruris were also found. Serological testing for syphilis (VDRL) was not routinely conducted due to financial constraints. Seven (14%) self-reported as HIV-positive (Venkatesan C and Sekar B, 2001).

2. ESTIMATION OF MSM IN INDIA

India being a multi-linguistic country, gay/bisexual men cross all demographic boundaries. Thus they can be of any linguistic group, class, age, occupation, marital status, ability or religion. Also, we cannot neatly compartmentalize human sexuality and many men who have sex with men who do not regard themselves as gay or bisexual men.

Behavior Surveillance Studies (BSS) in India
In India, there have been no nation-wide BSS studies. State-wise, local BSS studies were both inadequate and badly designed. They ranged from 1.8% of the male population studied in Maharashtra by Dr.Meera Savara and Dr.Sridhar to 11% of the population surveyed in Kerala through a pre-selected procedure. There were many procedural problems in most surveys done in India. They ranged from inappropriate questioning (same-sex relations not defined adequately) to no mention of same-sex relations at all (The Humsafar Trust, 2000c).

Other quantification studies conducted in India
Quantifying the number of gay men in a given population depends very much on the sensitivity of the methodology used.

Quantitative studies conducted in India include:

- A survey at Patna medical college in India in 1992 revealing that 25% of male medical students and doctors had had same-sex relationships (H V Wyatt, 1993).

- A postal survey of the readership of 'Debonair', an Indian English language magazine from Mumbai revealing that of 1500 men who replied, 29.5% had sex with another man, and in 80% of the cases before the age of 20 years (Roy Chan et al, 1998).

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

- A major study conducted in Pune city, where only 1.2% of men interviewed said they had homosexual relations although the authors did add, "we do feel it is extremely difficult to get an accurate estimation of homosexual experience in a general survey like we did". The researchers agree that a completely different kind of questionnaire has to be designed to get more information on the prevalence of homosexual behavior (Roy Chan et al, 1998).

- A postal survey of rural and semi-rural men in the Indian state of Tamil Nadu to which 1200 men replied found that 8% had had sex with other men (Shreehar Jaya, 1994).

- A survey of gay-identified men performed by *Bombay Dost* where a noticeable proportion of men [surveyed] indicated that they were coupled to 'both a male

and a female' (The Bombay Male Sexual Health Information Project, June 1992) (Roy Chan et al, 1998).

- According to a report on MSM in developing countries, the prevalence of MSM in the Indian male population range from 8 to over 50% (Neil McKenna, 1996).

- In a recent Naz Foundation Report (2000), "guesstimates" of males who have sex with males in different cities of India were given as:

  Hyderabad: 120,000 plus in a population of 4 million plus
  Bangalore: 120,000 plus in a population of 4 million plus
  Pondicherrry:35,000 plus in a population of 700,000 plus

  These figures appear consistent with general research that places levels of "homosexuality" in a majority of populations at between 3-7 %. (www.jsiuk.com/resources/publications/issues papers: accessed on 15th September 2001)

- In a study of sexual behavior among about 1600 college students in Chennai, India, (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.

The danger of studies that underestimate the prevalence of homosexual behaviour is that they may lead to insufficient resources being made available to prevent the transmission of HIV infection among MSM.

Estimation of Indian MSM based on Kinsey study (Ashok Row Kavi, 1999)

The Kinsey study titled '*Sexual Behavior of the American Male*' is one of the most thorough studies on sexual behavior. It is basically a study of white Anglo-Saxon population, but it does procure some baseline data regarding homosexual/bisexual behaviors. Its main result was the famous Kinsey graph where number 6 on the scale was 'permanent practicing homosexual' and number 0 on the scale was ''permanent practicing heterosexual'. It was assumed that a significant proportion of American males fell somewhere between these two extremes though it is not clear whether the scale could 'shift' according to the circumstances. For example, would a person who is number 2 on the scale (mostly heterosexual) ever shift to number 5 (mostly homosexual) in a predominantly single sex environments like those in prisons, remand homes and defense establishments?

The Kinsey surveys have been challenged, criticized, lampooned and dissected. However, the baseline 'five percent' that are number 6 on the scale seem to be a figure that is constant for the human species, independent of race, religion and political system. Sexual behavioral surveys usually hover around this baseline benchmark for 'permanent

practicing homosexuals' in any studied population. There is no reason to believe that this benchmark is not applicable to the Indian society. Five percent of the sexually active male population comes to a core homosexual population of 13.5 million homosexual males in India. This figure was obtained from the 1991 census, by calculating the sexually active male population as 60% of the population (males falling between the ages of 15 and 60 years) and then computing five percent of that figure. Another 37.5 million males fell in the ranges between number 3 to number 5 on the Kinsey scale. These males eroticised other males at some time or other in their lives and had occasional sex with them, when they could. Some of these males are behaviorally bisexual and moved up or down the Kinsey scale according to the circumstances. However, the final figure of Indian males practicing homosexual behavior was found to be nearly 50 million by adding up these figures, which is quite considerable.

Sexual behavioral studies in India have classified homosexual men as anything from 1% of the sexually active male population to nearly 28% of the 'occasionally behaviorally homosexual males'. It would be pragmatic to stay close to the Kinsey estimates even if the data suggests otherwise. Factors like, nonrecognition of same sex behaviors being classified as 'sex', the declining female-male ratios in the country further distorted by rural-urban migrations, all point to higher male-male sexual behaviors in India.

PART - 3: HIGH-RISK SEXUAL BEHAVIORS AMONG MSM IN INDIA: POTENTIAL FOR HIV TRANSMISSION AND ACQUISITION

1. CONCEPTS OF RISK GROUPS AND RISK BEHAVIOUR IN INDIA

According to official statistics, "The predominant mode of transmission of infection in the AIDS patients is through heterosexual contact…" (National AIDS Control Organization, NACO. http://naco.nic.in/vsnaco/indianscene/trend.htm, accessed on 23rd September 2001). Though this has somewhat prevented the scapegoating of gay men in India, it has also led to not involving MSM in HIV prevention programs of Govt. of India.

In India while majority of people infected with HIV belong to the 'general population', some groups are mentioned as "groups at highest risk" which include commercial sex workers, truck drivers, injecting drug users, migrant laborers and men having sex with men (Note: Until recently the term "homosexuals" was used by Govt. officials and NGOs). Usually MSM is typically listed last even in the list of "groups at highest risk" (see http://naco.nic.in/ vsnaco/nacp/phase2.htm: accessed on 23rd September 2001) or even conveniently ignored.

The following discussion on "risk groups" has been adapted and modified from Michael Rooney and Peter Scott (Rooney and Scott, 1993).

The notion of the risk groups has, in general, fed into preexisting prejudice against the groups mentioned above, and to deny the risk by the general public. The way in which the term "risk group" is understood is different for different people. In India, if the general public knows about the term 'risk-group' at all they usually think of [female] sex workers, clients of the [female] sex workers and truck drivers.

The concerns in using the term "risk group" are as follows.

- HIV transmission or acquisition is by risk behavior such as unprotected penetrative sex. AIDS does not occur as a result of belonging to a particular group [for e.g., sex workers, truck drivers]. This message is very important to make people who do not come under the "risk group" (i.e., heterosexual men and women) to understand that it is the sexual behavior which determines a person's risk. Sexual identity, by itself, neither increases nor decreases the risk of acquisition of HIV infection.

- It might be wrongly believed that HIV is somewhat intrinsic to and contained within the risk groups. People outside the risk groups may believe that there are moral, geographic, demographic, or social barriers between themselves and so-called risk groups.

- Health promotion workers are especially wary of using the term 'risk groups' since

they are keen to avoid any suggestion of blaming the victim which may be inherent in using that term.

- The term 'risk group' fails to acknowledge the diversity of behaviors in any particular group. All MSM and all injecting drug users do not have identical behavior or levels of risk.

The above concerns would be easily dismissed as 'being overly sensitive' in the use of language. However, it must be understand that language has a powerful influence over the way people conceptualize and the way people behave.

Since same-sex behavior is not even mentioned as a way of HIV transmission and acquisition in India, the major concern right now is not about whether the term "risk group" should be used or not, but to make the policy makers understand that same-sex behavior does occur throughout India and may be contributing to significant proportion of HIV transmission and acquisition. After a long period of silence and denial, National AIDS Control Organization (NACO) of India has acknowledged "…though highly covert, homosexual behavior has its sure presence in all the [Indian] cities" (NACO, 1997) but "little is known about MSM behavior [in India]" (NACO, 2000).

2. HIV RISK BEHAVIORS AMONG MSM IN INDIA - A BRIEF REVIEW

Information about HIV infections due to male-male transmission is difficult to attain from STD clinics, sero-surveillance centers or in voluntary counseling and testing centers. It is either under-reported or missed out completely when a sexual history is taken. Inaccurate Sexual History taking has been reported at the ARCON-IADVL (Indian Association of Dermatologists and Venereologists Laboratory) Clinic in South Mumbai (Roy Chan et al, 1998). The questionnaire given to potential blood testees does not mention homosexuality at all. Whether this is because asking questions about stigmatized behavior is disallowed for the fear of it being a criminal sexual activity is not known.

The Humsafar Trust's rapid survey of sexual behaviors among 100 self-identified homosexual men who visited the Humsafar drop-in center in January 1996 revealed that:

- 40% practiced anal sex without condoms.
- 45% had sex with more than five partners in the last 6 months.
- 40% never used condoms
- Of those who used condoms, 40% said they were 'uncomfortable' wearing condoms (Roy Chan et al, 1998)

In Chennai, a study on the sexual behavior of MSM (96 persons) recruited in the cruising areas was conducted recently (Venkatesan C et al 2000b). The respondents were mainly middle-class and educated. Among these 96 MSM, 26% were married and more than 60% had had sex with a woman at least once in their lifetime. The mean number of male and female partners in the last year was 51.5 and 1.4 respectively. Common penetrative sexual practices were insertive and receptive anal/oral sex. Most used condoms only occasionally or never. Condom use was greater with sex workers and casual partners compared to steady partners. Condom use with female partners was lower than with male partners.

Another recent study from Chennai conducted among MSM attending a community-based clinic showed the following sexual risk behavior pattern (Venkatesan C and Sekar B, 2001). Among 51 MSM enrolled over a period of three months, majority (64%) have had sex with females. All the married MSM reported never using condoms with their wives and inconsistent use of condoms with other female partners. Unmarried MSM with bisexual behavior also reported inconsistent condom use with their female partners. About 60% of the MS reported penetrative (insertive and/or receptive) anal intercourse with another male in the past 3 months; 40% used condoms at the most recent anal intercourse.

Recent UNAIDS report (2000) states that, "In one study of truck drivers in India - men who spend long hours together on the road - almost a quarter reported oral or anal sex with a man, and all of those said they also had sex with women. A study of men attending a clinic for Sexually Transmitted Infections in the Southern Indian city Pune showed that men reporting receptive anal sex with men were 2-6 times more likely to be infected than men who reported no anal sex, even after taking into account other risk factors" (UNAIDS, 2000).

A baseline study of Knowledge, Attitude, and Behavior among 174 MSM in selected sites in Mumbai was conducted by the Humsafar Trust recently (The Humsafar Trust, 2000a). It gives the following information.

Sexual Behavior

- More than half (53%) of the respondents reported having been receptive partners in anal sex. Of these, 19% (n=17) reported having been engaged frequently in receptive anal sex. 50% of the respondents reported that their sex partner used a condom.
- A majority of respondents (67%) reported having been engaged in insertive anal sex in the last month. Of these 18% reported having been frequently engaged in insertive anal sex. 58% reported having used condoms during insertion. Of these 34% always used condoms during insertion, 55% used it sometimes.
- A total of 64% respondents had been involved in peno-oral sex. Condom use was very low in both oro-insertive and oro-receptive intercourse.
- Almost half of the respondents reported having sex with a female partner in the last month. Half of these frequently had sex with a female sex partner. During these sexual encounters 66% of the respondents did not use condoms. Of those who used condoms, half of them always used them.
- Commercial sex: Almost one fifth reported having engaged in sex in exchange for cash or in kind.

Substance abuse

On substance abuse, 37% respondents reported that they consumed alcohol before sex. Of these, 26% always consumed alcohol before sex. Half of those who consumed alcohol before sex usually consumed a quarter of a bottle (about 100 ml of alcohol) or more.

Knowledge and Attitudes of Indian MSM toward HIV/AIDS

The following information is taken from a recent baseline study of Knowledge, Attitude, and Behavior among 174 MSM in selected sites in Mumbai that was conducted by the Humsafar Trust (The Humsafar Trust, 2000a).

- One fourth of the respondent did not know or were unable to say what HIV is. Only one fifth were aware that it is a microorganism causing AIDS.
- A majority of the respondents (>90%) replied in affirmative to 'transmission through sex with out condoms' and 'transmission using the same toilets used by HIV-positive person.
- All responded in affirmative to 'transmission in hugging a person'.
- A majority (86%) said that using condoms during sex could prevent HIV.
- About 50% said using sterilized needles, syringes and skin-piercing instruments could prevent HIV.
- Two-fifths said avoiding pregnancy if a woman is discovered to be HIV-positive could prevent HIV.

- Almost three-fourths replied in affirmative to whether HIV means death.
- About 60% said that there was no cure for HIV.
- A majority (88%) had correct knowledge of what is AIDS
- About 90% replied in affirmative to whether AIDS means death.
- More than three-fourths said that there was no cure for AIDS.
- Around 32% said they would break off the relationship if their friend were detected to be HIV-positive.
- Around 38% said they would continue friendship but would not have sex.
- Around 32% perceived HIV-positive person to be an immoral person. One fifth of the respondent perceived HIV-positive person to be a curse of god and 90% perceived HIV-positive person to be a bad person.

Thus, the available studies indicate that

- Indian MSM have low levels of HIV/AIDS knowledge and negative attitude toward persons with HIV/AIDS.
- MSM are engaged in high-risk behaviors (e.g., unprotected anal intercourse).
- Many don't use condoms on a regular basis with their male partners.
- A significant proportion of MSM also have sex with female partners without regular use of condoms.
- Indian MSM have high HIV seroprevalance rates (4% - 24%).

Male Sex workers (other than Hijras/Alis):

There remains strong denial of the existence of male sex workers (other than Hijras/Alis [male-to-female transgender/transsexual persons]) in India. However, limited evidence points not only to their presence but also high-risk sexual behaviors among this population (Asthana and Oostvogels, 2001, Venkatesan C et al, 1999b).

The male sex industry in Chennai operates in an underground manner and there are different groups of persons involved in this work like - 'family boys', independent sex workers, callboys, and hotel boys. Many of these persons may not have a self-conscious sexual identity and most get married eventually. Though the clients of these persons are almost always MSM (mostly self-identified gay men), a few also serve women clients who are usually the female partners of their male clients. Condom use among these male sex workers is very poor (Venkatesan C et al, 1999b), although in a recent study from Chennai, MSM recruited from cruising areas were more likely to use condoms regularly with casual partners and commercial sex partners than with steady partners (Venkatesan C et al, 2000b). More research is needed to find out the extent of males in sex work, high-risk sexual behavior among this group, and to develop appropriate intervention programs for this high-risk subpopulation of MSM. Male sex workers are not reached by intervention programs for Hijras in sex work or for female sex workers.

3. MALES WHO HAVE SEX WITH MALES (MSM): DIFFERENT SCENARIOS, DIFFERENT NEEDS, DIFFERENT SOLUTIONS

N*ote: In this section, MSM refers to Males who have Sex with Males.*

(A considerable portion of the following has been adapted and modified from Michael Rooney and Peter Scott, in "Working where the risks are: Health promotion interventions for men who have sex with men, in the second decade of HIV epidemic") (Rooney and Scott, 1993)

MSM are a heterogeneous group and their needs can be different depending upon many things like their age, presence of self-conscious sexual identity, socioeconomic status, literacy level, sexual role playing, sexual communication skills and negotiation skills. In what follows, some of the different needs are expressed by showing different scenarios. They are not mutually exclusive but serve to illustrate the heterogeneity of the MSM population and thus the need for different solutions.

One can 'discover' different groups of MSM as shown below whose needs may vary widely. Though some solutions have been proposed below to meet the different needs, they are by no means comprehensive and clearly not the only solution(s). Only the specific solution(s) to that group or scenario is given below. The first step is to identify these different groups, the second step is to find out their specific needs, the third step is to find out appropriate ways to meet their needs, the fourth step is to implement them and the final step will be to evaluate the whole process based on the feedback and to continuously enhance and improve the whole process to make it more effective.

- Groups of behaviorally homosexual or bisexual males, single or married, who lack self-conscious sexual identity and who unpredictably and opportunistically have sex with other males.
  Possible solution: They can be reached through mass or local media which addresses issues of homo/bisexual behavior and the risk of HIV/AIDS in a frank manner.

- MSM who are aware of their attraction towards other males, who tend to have sex more often with males and are often seen in cruising areas.
  Possible solution: They may be reached through peer educators and field staff of NGOs/CBOs.

- MSM who engage in sex work either as a part-time job or as a way to recruit male partners or for both.
  Possible solution: May be reached through mass media or by peer-educators.

- MSM who may believe that it is safe to have sex with males but not with females and thereby use condoms only with female sex workers or casual female partners.
  Possible solution: Messages which say clearly that condoms should be used regardless of the gender/sex of the partners and types of sexual partners should be conveyed.

- MSM who use condoms inconsistently with males but don't use any condoms while having sex with their wives or other female partners.
  Possible solution: Awareness through messages which clarify that condoms should be used regardless of the gender of the partners and types of sexual partners.

- Married MSM who also have sexual relations with males and are unable to negotiate or practice safer sex with their wives because using condoms with wife may arouse suspicion especially if the wife has already undergone tubectomy.
  Possible solution: Teaching sexual communication skills and condom-negotiation skills.

- MSM who are monogamous (may not be mutually monogamous) or who follow serial monogamy and who may or may not know about HIV/AIDS/STD and safer sex information.
  Possible solution: Concept of 'negotiated safety' can be taught. Sexual communication skills and condom-negotiation skills should be taught.

- MSM who know about safer sex and carry condoms with them but unable to negotiate condom use with their partners and finally end up in having unprotected sex.
  Possible solution: Self-efficacy/personal management skills, sexual communication skills and condom-negotiation skills should be taught.

- MSM who always carry condoms with them but are unable to use them since they give in to their partners preferences.
  Possible solution: Self-efficacy skills should be taught.

- MSM who have been practicing safer sex but are experiencing difficulty sustaining it.
  Possible solution: The need to maintain safer sex practices must be periodically stressed/reinforced.

- MSM who think it is safe to have sex with whom they 'choose carefully' or who 'appear to be unpromiscuous' or 'decent' even though they know about safer sex methods.
  Possible solution: Messages which clearly convey that one can not find out whether a person is HIV-infected or not by appearance alone must be given. Condom use should be stressed regardless of the appearance of the partner.

- Adolescent males who have sex with other males in apparently closed groups such as school, colleges, etc. They mistakenly believe that the closed nature of the group protects them from infection and thus may or may not use condoms even if they have information about safer sex.
  Possible solution: School/college students should be reached and taught about sexuality issues, safer sex practices and AIDS education programs.

- MSM who have been told that they must give up sex and who, as a result, are unable to practice safer sex when they do have sex.
  Possible solution: Health care providers should be trained in sexuality issues and in giving competent care to MSM patients. Rather than moralistic messages, pertinent sexual options should be given so that MSM can choose one that is suitable to them.

- MSM who may never use condoms while having sex with their steady partners (male or female) and may use condoms inconsistently with casual partners (male or female).
  Possible solution: Messages should state clearly that condoms should be used regardless of the gender or types of the sexual partners.

- MSM who consume alcohol or who use illicit drugs and are unlikely to practice safer sex under the influence of alcohol or drugs.
  Possible solution: Alcohol and substance abuse programs should work in co-operation with HIV prevention programs among MSM.

- MSM who exchange sex for drugs or alcohol and who may not be in a position to negotiate condom use with their partners.
  Possible solution: Alcohol and substance abuse programs should work in co-operation with HIV prevention programs among MSM.

- MSM who are unwaged, poor or homeless and who cannot afford condoms.
  Possible solution: Safer sex information and free condoms should be made available through outreach programs for this group.

- In males-only-environment like prisons, some males may have sex with other males either with or without consent. Lack of information about risks involved in unprotected sex between males, non-availability of condoms, and traumatic nature of coercive sex all increase the risk of HIV infection among prison inmates.
  Possible solution: Information about STD/HIV/AIDS and risks involved in unprotected sex between men must be given. Condoms should be freely available to those who might need them.

- MSM who are illiterate or unaccustomed to reading and thus largely untouched by health promotion messages (including HIV/AIDS/STD) to date.
  Possible solution: MSM should be reached through other forms of media and other ways e.g., through peer outreach.

- MSM who are behaviorally bisexual with very low self-esteem as a result of being 'in the closet'. Their low self-esteem and occasional access to sex makes it harder for them to be concerned about protecting themselves.
  Possible solution: Programs which boost self-esteem and self-confidence should be conducted.

- MSM who have remain uninfected despite having unprotected sex for a very long time strongly believe they do not need to use condoms since they are 'resistant' to

STD/HIV infection.
Possible solution: Explaining to them that HIV transmission per sex act is low, but each new partner adds to the risk.

- MSM who are in their forties or fifties and who think there is no point in using condoms since they are going to die in a decade or so and have already 'enjoyed' many things in life.
  Possible solution: Explain to them their role in stopping the spread of the disease.

- Street male youth because of poverty and alcohol or drug use, may have sex with other males for money and may not have safer sex information or negotiating skills.
  Possible solution: Provision for information, teaching negotiation skills, survival skills, and condom negotiation skills, enrolling in alcohol and substance abuse programs.

- Some MSM have their identity based on sexual roles. Thus, some MSM who are likely to be mainly, if not only, receptive partners are at a higher risk. For example, MSM who practice mainly (if not only) receptive anal or oral sex (e.g., Kothi, Hijra/Ali) are at a higher risk of getting HIV infection than those MSM who mainly (if not only) insert (e.g., Panthi).
  Possible solution: The identity of Kothis is based on being a receptive partner, so it may be difficult to ask them to practice alternative sexual practices, i.e., other than receptive anal sex, or to ask them to use condoms since they may not feel empowered to do so. Nevertheless they should be advised to use condoms every time and with all partners.

- Some MSM with HIV infection might have been told that they must give up sex (during counseling and medical information) and hence may not be able to practice safer sex when they do have sex.
  Possible solution: Other than abstinence, alternative options like safer sex practices should be explained to HIV-infected persons.

- Some MSM have the belief that ingestion of semen (during oral sex) gives them energy. Thus to them the idea of using condoms for oral sex may seem too restrictive.
  Possible solution: Emphasis must be given to the fact that risk associated with unprotected oral sex is low but not nil. They must be asked to assess for themselves the risk they are willing to take.

- Some MSM strongly believe that they must release the semen into the mouth or the anus of their partners since they think that only then will the "heat" in their bodies get reduced. Thus they may not be willing to use condoms since condoms 'prevent' the emission of 'heat'.
  Possible solution: Risks associated with unprotected sex should be explained. Their misunderstanding about "heat release" should be clarified.

- Some males, by the nature of their occupation, may have sex with other males for

money (e.g., masseurs/*maalishwaalas*). These persons may not regard themselves as 'homosexual' men and may not follow safer sex practices.
Possible solution: *Maalishwaalas* may not be willing to talk about safer sex practices or HIV/AIDS with outreach workers who are self-identified homosexual males. Peer education using other *maalishwaalas* should be tried.

It is important not to feel overwhelmed by the range of different needs. Many of them are overlapping needs that may be addressed by actions that fulfil several functions simultaneously. The above long list of possible scenarios and groups has been given for the purpose of illustrating how inadequate a method based upon assuming a single health promotion action, such as leaflet or condom distribution by outreach workers, would be for the majority of those at risk. ***On the other hand explaining the need for using a condom during any and all sex to protect oneself from STD/HIV infection is at the core of all intervention work.***

4. LIMITATIONS OF RESEARCH DATA ON MSM IN RELATION TO HIV/AIDS IN INDIA

There remains a large gap in actual information on sexual behavior, especially among MSM and gay-identified men. This sector is most difficult to reach stigma and denial attached to these behaviors has pushed it underground. Whatever little material exists indicates strongly the need for intervention among MSM.

Bhushan Kumar and Michael W Ross state that 'Very little systematic research is published on homosexual behavior in the Indian subcontinent in terms of actual practices and associated HIV transmission risks" (Kumar and Ross, 1991). NACO too acknowledges "…little is known about MSM behavior [in India]" (NACO, 2000).

McKenna says, "This absence of enquiry - this failure of research - is in one sense self-perpetuating: if no information exists on sex between men, then sex between men must either not exist or be so rare that it is statistically insignificant in any consideration of HIV and AIDS" (Neil McKenna, 1996).

In a review of HIV prevention interventions in developing countries, Merson *et al* note, "It is evident from our review that there are three high-risk populations for which there is a dearth of evaluated prevention interventions in developing countries - men who have sex with men, youth and IDUs [injecting drug users]. Notably absent from our review were scientific evaluations of programs that focused on men who have sex with men. These populations are often difficult to reach in many countries because of the stigma associated with homosexuality, but are urgently needed in view of the high-risk of HIV infection among gay men" (M H Merson et al, 2000).

Regarding the reasons for the lack of HIV prevention intervention research in developing countries, Merson *et al* say, "…One of the most important reasons for the small number of scientific evaluation of HIV prevention interventions in developing countries has been the limited number of researchers in these countries with appropriate training…A fundamental step in improving prevention research in low and middle-income countries must be to expand the training of social scientists and epidemiologists, so that more of them are able to conduct the much needed prevention intervention research" (M H Merson et al, 2000).

Whether the first decade of this new millennium will also be characterized by remarkable lack of attention devoted to the situation of MSM in India remains to be seen.

PART - 4: REASONS FOR THE LACK OF ATTENTION TOWARDS MSM COMMUNITY IN INDIA IN THE AREA OF HIV PREVENTION

By the Government of India:

There are a number of reasons why there are only a very few, if not total absence of, HIV prevention programs for MSM community. Some of the possible reasons are enumerated below:

1. The assumption that homosexuality does not exist in India. Those who agree with the presence of homosexuality in India think that MSM population in India is insignificant (in numbers) to pay it sufficient attention.

2. Lack of understanding of the multiple forms of male-to-male sexual behaviors that take place in Indian society.

3. Lack of research data on the sexual behavior in general, and same-sex behavior in particular, of the Indian people.

4. The official data presented on the modes of transmission of HIV in India indicate that the mode of HIV transmission is 'predominantly heterosexual' in India. The small percentage quoted as due to homosexual transmission do not alert the policymakers to formulate HIV prevention programs for MSM population.

5. The assumption that HIV prevention programs for MSM are the responsibility of NGOs/CBOs and Govt. can only 'assist' them in their work (that too with limited funding).

6. In India, anal intercourse between two consenting adult men even in privacy is a criminal offense. Thus for the Govt. of India it may be a dilemma - to condemn homosexual acts on the one hand and on the other hand to actively encourage MSM to utilize HIV prevention services.

7. Inattention towards the call for repeal of section 377 of Indian penal code, which criminalizes homosexual acts since it might be believed that giving importance to this issue may only bring trouble to the ruling party. Consequently, gay/bisexual men will be suspicious and unwilling to utilize the services of Govt. of India.

8. Another potential problem the Govt. of India may have to face, because of homophobia, is opposition to HIV prevention programs for MSM both from within the ruling party and from the opposition parties.

9. Lack of political will to address the health of gay, lesbian, bisexual and transgendered persons in the Indian society, as they are not visible in the first

place and also they are not a strong, united, influential, political force (and hence the assumption that their votes may not make any difference).

By NGOs:

On the part of NGOs, the probable reasons for not becoming involved in HIV prevention programs for MSM are:

1. Denial of homo/bisexual behavior in the locality where the NGO works.

2. The perception that the necessary work needs to be done by gay and bisexual men within their organizations, or by some other NGOs, or it can be done only by gay voluntary organizations.

3. The perception that 'it is too difficult to work with the gay, bisexual and MSM communities'.

4. Lack of skills and infrastructure to work with the MSM community.

5. Lack of interest in dealing with MSM issues may very well be due to covert or overt homophobia. This homophobia can result in all manner of direct or indirect resistance to work effectively with gay, bisexual and MSM communities.

6. Funding for HIV prevention programs for MSM is often very limited and with minimal or no explicit government endorsement. This makes it difficult for the NGOs to start or sustain programs for MSM.

7. Lack of interest among the donor agencies in supporting and sustaining prevention programs for MSM, which makes NGOs concentrate on some other projects on HIV/AIDS.

By the Health care providers/Researchers:

1. Lack of sexuality education among health care providers has led to prejudices and misconceptions about certain issues on sexuality. This may very well affect the way physicians or counselors ask sexual history or the way they take care of persons belonging to different sexual orientation or gender identity.

2. Only few persons carry out research on behavioral sciences, especially sexual behavior. Though this may be due to lack of interest on this subject, or due to lack of skills in conducting a sexual behavioral research study, it may very well also be due to discomfort in entering this area. In addition, researchers may think behavioral research does not warrant much attention, or it has no relation with the clinical area, and hence it is not worthwhile to enter this field. It may also be

because of fear of being stigmatized if one works in the area of sexual behavior, especially with MSM.

3. Failure to understand that homosexuality is not a psychiatric disorder but a normal variation of human sexuality. Many Indian doctors still think of homosexuality as a 'sexual perversion' and believe that gay men need 'treatment'. If this is the attitude of the Health care providers, then one can very well imagine the attitude of the general public.

   [Note: This is in spite of the fact that homosexuality is no longer considered a mental disorder and was removed from the list of psychiatric disorders by **A**merican **P**sychiatric **A**ssociation (APA) in 1973 and from the **I**nternational **C**lassification of **D**iseases (ICD-10) by World Health Organization (WHO) in 1993. But the WHO's ICD-10 still retains a diagnosis of "ego-dystonic homosexuality", a condition in which the patient suffers from anxiety or discomfort about his or her sexuality.)

Part - 4: RECOMMENDATIONS TO THE GOVT. OF INDIA AND NGOs/CBOs FOR PREVENTION OF HIV/STDS AMONG MSM COMMUNITY

1. RECOMMENDATIONS TO THE GOVERNMENT OF INDIA

HIV/STD preventive intervention programs for MSM:

Since available studies show that a significant proportion of men in India has same-sex/bisexual behavior and also practice high-risk sexual behaviors with both male and female partners, it is strongly recommended that programs of HIV prevention among MSM must begin immediately throughout India.

- Culturally appropriate HIV/STD prevention outreach programs and peer education for MSM population in collaboration with CBOs/NGOs need to be started immediately and evaluated for effectiveness.

- Govt. of India (National AIDS Control Organization, NACO) as well as NGOs/CBOs working in HIV/AIDS should include culturally appropriate and linguistically accessible HIV prevention messages that address the risks of unprotected sex between men and promoting the use of condoms and water-based lubricants in their mass media campaigns. This is especially important since this may be the only way to reach certain subgroups of MSM (like those who don't have self-conscious sexual identity or those who don't cruise) and make them aware of their risk behaviors since they may not be approached even by the community outreach programs. Also, airing the subject of male-to-male sex in public can also help reduce stigmatization.

- HIV/AIDS educational materials of Govt. of India (NACO) as well as NGOs/CBOs should provide accurate and uncensored information about the risks involved in any kind of sexual behavior (hetero, homo, or bisexual behavior) and any kind of sexual practices (vaginal, oral, and ano-rectal).

- There is a need for co-operation and collaboration among various HIV/AIDS prevention intervention projects that concentrate on different subgroups or risk behaviors. MSM are characterized by considerable diversity. MSM could also be sex workers, truck drivers, street youth, injecting drug users (IDUs), migrants, prisoners, or any combination of these and all these groups come under 'high-risk' groups by themselves. Collaborations and interactions among different projects that address different risk behaviors are necessary. Such interactions may result in screening a population for all kinds of risk behaviors rather than concentrating only upon one risk behavior and could more be effective.

- High-quality condoms, which are suitable for use during anal intercourse, should be made available, accessible and affordable. Water-based lubricants, which are at present inaccessible and unaffordable, should be made available widely at an affordable cost.

Education and Training for the health care providers in HIV/AIDS and sexuality issues:

Taking into consideration that health care providers' attitude towards and knowledge about MSM may affect the quality of care provided to this population and thus ultimately influence the effectiveness of the HIV/STD prevention and care programs of the Govt. of India, the following recommendations are made to the Govt. of India as well as to the health care providers.

- Training programs for health care providers on sexuality issues should be developed and evaluated for effectiveness. Also, all health care providers should be provided with adequate training and skills on how to work with sexual minorities. These programs should be an integral part of the STD/HIV/AIDS training programs for health care providers. Sexuality education for the physicians and other allied health-care personnel (e.g. counselors) will enable them to ask sexual history in a comfortable manner and to take care of the patient regardless of his/her sexual orientation or gender identity. It is crucial that staff in STD clinics be educated to overcome ignorance and prejudices about MSM and to be sensitized to the need for examining patients for oral and ano-rectal STDs.

- Models for training health-care providers in MSM-sensitive care need to be developed.

- All health care professionals who encounter MSM in their clinical practice should be able to counsel these persons (or refer them to appropriate specialized settings like STD clinics, voluntary counseling and testing centers, CBOs/NGOs) regarding the risks of HIV/STDs and methods for reducing or preventing high-risk behaviors.

- Health care providers (of any specialty) need to acquire basic knowledge of GLBT/Sexual minority community (through medical academic curricula, inservice programs, or other educational opportunities) and their health needs so that they are comfortable and competent in providing services to them.

- Continuing education for health care providers who come in contact with MSM population in clinical settings should be available through professional organizations, continuing medical education programs, etc. to increase understanding and sensitivity.

- Professional organizations of health care providers (like STD/HIV physicians, DermatoVenereologists, Urologists, Psychiatrists, Clinical psychologists) should address sexual orientation and gender identity concerns in continuing medical education courses, clinical guidelines, risk assessment, and screening policies.

Research among MSM population in relation to STD/HIV/AIDS:

There is very little scientific data about the HIV-risk behaviors among MSM population in India. Since information about the MSM population in India is important and necessary to design specific interventions and to provide appropriate services, the following recommendations are made.

- Research is required to find out the incidence and prevalence of HIV/STD among MSM population, how they identify themselves, and to identify which sexual practices increase the risk of specific STDs.

- Baseline studies on the Knowledge, Attitude, Behavior and Practices (in relation to HIV/AIDS) of MSM in different parts of the country need to be conducted.

- Studies are needed to identify appropriate and effective HIV preventive interventions for MSM in India.

- The quality of epidemiological records, reporting and data analysis should be improved in order to gain a more accurate view of the HIV epidemic in India, while at the same time ensuring respect for human rights.

- Studies are needed to find out how 'minority stress', stigma and marginalization make them more vulnerable to STD/HIV.

- Research is needed to determine the most appropriate health communication strategies for MSM populations including those who don't have a self-conscious sexual identity.

- Support should be given for research to study how different ways of asking questions about sexual orientation, same-sex/bisexual behavior, attraction, and gender identity affect response rates and the validity of responses so as to develop "Sexual history" risk assessment tools that are culturally and linguistically appropriate.

- Research is needed to determine if access to MSM-specific information improves health-seeking behaviors, increases access to health care, enhances knowledge and yields better health outcomes.

- Research is needed to determine the barriers to accessing health care by the MSM population.

- Research is needed to determine the causes of, as well as the resolutions to, homophobia within the health care system.

- Research is needed to test different ways to transfer effective behavior intervention programs to prevention agencies (Govt. and NGOs/CBOs).

Formulating Policies that address issues related to MSM population and repealing discriminatory legislations:

At present there are no national policies that address issues related to MSM population in India. Since having explicit policies usually precede any action, and often are required to substantiate the actions that are being undertaken or have to be undertaken in the future, the following recommendations are made.

- To repeal all discriminatory legislations that criminalizes same-sex sexual behaviors between consenting adults in privacy, which include section 377 of the Indian Penal Code (with suitable provisions/modifications in other statutes/laws to take into account the child sexual abuse and adult same-gender sexual assault), and the relevant sections of the Army, Navy and Air Force Acts, 1950. Decriminalization of homosexual acts and legalization of adult consensual homosexual acts will boost the self-esteem of MSM and also allow them to access/utilize HIV/STD services.

- Serious consideration should be given to introducing anti-discrimination and protective laws to reduce human rights violations against MSM, including those relating to HIV/AIDS.

- There is a need for national HIV/STD prevention strategy for MSM population, the population at great risk for HIV infection. Such strategy should reflect the cultural, linguistic, educational and socioeconomic status and age diversity among MSM population.

- State AIDS Control Societies (SACS), District AIDS Control Societies, and health departments need to form alliances with CBOs/NGOs to address the epidemic at the local level by conducting needs assessment and funding community-based prevention and treatment strategies.

- All central and state government health departments and ministries should adopt a policy of accessibility to care and services for sexual minority community.

- Local health departments, with the assistance of State AIDS Control Societies (SACS)/ District AIDS Control Societies, should consult with GLBT/Sexual minority community organizations in determining how to provide high-quality, comprehensive STD/HIV-related clinical services to MSM population.

- Effective strategies to bridge the gap between the worlds of HIV/AIDS prevention research and prevention service have to be devised.

- There is a growing body of evidence pointing to the importance of community involvement in health interventions (Minkler M et al, 1997). Thus support should be available to strengthen groups representing self-identified gay/bisexual men as well as persons with other identities (like Kothis/Hijras), enabling them to promote HIV prevention and care programs.

- National guidelines for the management of oral and ano-rectal STDs, which are at present lacking, need to be developed and widely disseminated.

- Adequate resources (financial and non-financial) should be allocated for intervention programs for MSM by the Govt. of India and other donor agencies. Government and research agencies should ensure that funding and technical assistance for NGOs/CBOs that work in the area of MSM be available.

- Sexual orientation/identity and gender identity measures should be included within the national HIV/STD surveillance systems.

- Sincere efforts should be made to educate the public about sexuality issues. Several studies indicate that exposure to truthful information about GLBT/Sexual minority communities often leads to reduction in homophobia. Effective methods of breaking down social and cultural barriers against the discussion of male-to-male sex should be identified and implemented. More determined efforts must be made to change public perceptions and to get rid of denial and prejudices on the subject of same-sex/bisexuality.

B. RECOMMENDATIONS TO NGOs/CBOs: (WHICH ARE WORKING OR INTEND TO WORK WITH SEXUAL MINORITIES)

- **Commitment to work with sexual minorities**
  Self-assessment of NGOs prior to undertaking prevention intervention programs for MSM is a must in order to work effectively with them.

- **Education of all employees and volunteers**
  In the Self-assessment, anti-homophobia training and awareness raising courses should always be identified. These measures will be useful in removing barriers in undertaking the work and to facilitate good practices in implementation.
  Self-education of the planning team and program personnel is needed to ensure that they understand the scientific realities of the HIV epidemic, the sociology of the same-sex/bisexual behaviors and the efficacy of different forms of health educational activity.

- **Hiring of sexual minorities as staff**
  A formal process of planning which includes a well-resourced planning team consisting of both professional and sexual minority community expertise should be followed.

- **Needs assessment need to be conducted locally**
  A proper initial assessment should be conducted to identify the local needs and allocate resources most effectively.

- **Monitoring and evaluation (Outcomes research)**
  Prior to implementation of the programs, clear evaluative criteria and mechanisms need to be established. Programs should be regularly reviewed and evaluated. The interim reviews should be used to modify the future course of the program. The final evaluation of the program should be used to guide the development of the next long-term program.

- **Co-operation and collaboration with government organizations**
  NGOs should work in collaboration with the State AIDS Control Societies, City AIDS Control Societies, government hospitals, and local health departments.

- **Co-operation and collaboration with other NGOs/CBOs**
  There is a need for co-operation and collaboration with various NGOs/CBOs that work for MSM. Networking to share lessons learnt, technical expertise and educational materials should be developed. Differences in ideology and competition in getting funds should not interfere in the relationships between different NGOs/CBOs that work for sexual minorities.

- **Training programs**
  Training workshops/seminars for organizations working with MSM should be

promoted and organized, at the local, state, and national levels, in order to strengthen these organizations in terms of project planning, management methodologies and organizational development.

- **To include sexual minority rights in the agendas**
  The issues of sexuality minorities and human rights should be promoted and included in the agendas of NGOs/CBOs that are progressive in social, political and cultural terms, in order to build strategic alliances.

- **Participation in conferences and seminars**
  Organizations working with MSM should be encouraged to attend and participate in conferences, seminars as well as events on HIV/AIDS and/or human rights so as to improve exchange of experiences with other organizations and create opportunities for debate and problem solving.

- **Guiding mass media to portray sexuality issues in a proper manner**
  Media awareness of homo/bisexuality, human rights, and HIV/AIDS should be improved to reduce stigmatization, discrimination, and repression of sexual minorities. NGOs/CBOs should, whenever possible, help and direct media to focus on sexual minorities in a nonjudgmental manner and to not think of the issues of sexual minorities as just sensational news.

- **Helping in government's efforts in educating others**
  NGOs/CBOs should assist in government's efforts to educate and sensitize the public and health care providers about HIV/AIDS, sexuality and human rights issues.

- **Advocacy for sexual minority rights**
  NGOs/CBOs should advocate for the human rights of sexual minorities including lobbying to repeal all the criminal laws and discriminatory legislations used against sexual minorities.

- **Disseminating information on HIV epidemic**
  The information about the gaps in the knowledge on the HIV/AIDS epidemic (in relation to MSM in India) should be disseminated so as to improve the methodology of HIV/AIDS surveillance procedures and to gain the focus of government on MSM issues.

- **Reaching the unreached**
  Effective strategies to reach those MSM who don't have a self-conscious sexual identity and those who don't cruise should be identified and implemented.

- **Directory of NGOs/CBOs**
  A directory, which describes the various projects undertaken by different NGOs/CBOs among MSM in India, must be prepared, published and disseminated to organizations that work or intend to work on sexual minority issues.

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