

Sexual and Social Networks of Men who have Sex with Men (MSM) and Hijras in India: A Qualitative Study

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Venkatesan Chakrapani¹, Peter A Newman², Hemangi Mhaprolkar¹, Ashok Row Kavi¹

1 = The Humsafar Trust, Mumbai, India

2 = Faculty of Social Work, Centre for Applied Social Research, University of Toronto, Canada

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Contact details:

The Humsafar Trust,
II floor, Old BMC building,
Nehru Road, Vakola, Santacruz (East),
Mumbai - 400 055. India.
Phone : +91-22-26673800
Fax : +91-22-26650547
E-mail : humsafar@vsnl.com
Website : www.humsafar.org

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Acronyms and Abbreviations

- BCC** – Behavior Change Communication
- CBOs** - Community-based Organizations
- DFID** – Department for International Development
- FGD** – Focus Group Discussion
- HIV** – Human Immunodeficiency Virus
- HST** – The Humsafar Trust
- IDI** – In-depth Interview
- IEC** – Information, Education and Communication
- INFOSEM** - India Network for Sexual Minorities
- KII** – Key Informant Interview
- MSM** - Men who have Sex with Men
- NACO** - National AIDS Control Organization [India]
- NACP** – National AIDS Control Programme [India]
- NGOs** – Non-governmental Organizations
- SACS** - State AIDS Control Society
- STIs** - Sexually Transmitted Infections

EXECUTIVE SUMMARY

Sexual and social networks are the dynamic systems through which HIV is spread as well as the structures which facilitate the communication of HIV prevention messages, provide the normative reference for individuals' social practices, and enable or constrain safer sex practices. Networks, therefore, are central to our understandings of the HIV epidemic, and critical to our success in prevention of HIV/sexually transmitted infections (STIs).

National AIDS Control Organization (NACO), in its draft strategic plan of the third phase of National AIDS Control Program (NACP-III) states that: "Tracing patterns of sexual networks and strategizing to intervene at key points in the network could be a useful way forward". Thus the findings from this study will provide the evidence-base on which more effective network-based interventions for men who have sex with men (MSM) and Hijras are designed and scaled-up.

Purpose: To understand and describe sexual and social networks of MSM and Hijras in urban and rural/semi-rural areas of Maharashtra, Gujarat, West Bengal, Orissa, and Delhi.

Methodology: Qualitative research methodology was used in this study: 119 in-depth interviews with individuals from various subgroups of MSM and Hijras; 16 focus group discussions (FGD); and 16 key informant interviews were conducted. Interview and FGD data were explored using narrative thematic analysis using the analytic techniques from grounded theory.

Organization of 'Findings & Discussion' Section:

The key findings are organized into the following sections:

1. 'Sexual networks of MSM and Hijras': Demonstrates the presence of extensive sexual mixing and concurrent sexual relationships of MSM and Hijras.
2. 'Reasons for having unprotected sex with male partners': Documents the various partner-specific sexual contexts, and personal and structural factors which lead to unprotected sex.
3. 'Social networks and social support among Kothi-identified MSM': Summarizes the types of social support received by Kothi-identified MSM from their social contacts.
4. 'Social organization and social support among Hijras': Discusses the social structure of Hijra communities and the various types of support available to them.
5. 'Hijra community norms and beliefs: Relation to HIV risk': Summarizes the community norms and beliefs among Hijra communities, and proposes how influential community leaders can help to establish supportive community norms in relation to safer sex.

Key Recommendations:

Implications for Programs

- Individual-focused 'Behavior Change Communication' (BCC) approaches alone are inadequate. Powerful social and contextual factors—such as partner dynamics, stigmatization and criminalization of consensual sex between men, and sexual violence against MSM and Hijras—lead to unprotected sex.
- Reach out to men through mass media, emphasizing the importance of having safer sex with partners of any gender.
- Conduct operations research to identify program components of interventions that are not cruising site-based.
- Work with police to prevent sexual/physical abuse, and to provide protection for MSM and Hijras against ruffians.
- Prevention programs working with different male subpopulations (such as truck drivers, male migrants, male youth, prisoners, and IDUs) need to address same-sex/bisexual behavior.

Implications for Policies

- Decriminalize consensual adult same-sex relationships.
- Codify and enforce laws preventing physical and sexual abuse of sexual minorities.

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GLOSSARY

Discrimination ("enacted" stigma): Unjustifiable negative behavior toward a group or its members that singles them out because they are believed to be inherently 'bad'.

Double: Kothis and Hijras label those males who insert and receive during penetrative sexual encounters (anal or oral sex) with other men as 'Double'. These days, some proportion of such persons also self-identify as 'Double'. The equivalent terms used in different states are: 'Double-Decker' or 'DD' (Tamil Nadu); 'Dupli-Kothi' (West Bengal); and 'Do-Paratha' (Maharashtra).

Hijras: Hijras are 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". Hijras can be considered as the western equivalent of transgender/transsexual (male-to-female) persons.

Kothi: Kothis are a heterogeneous group. 'Kothis' can be described as males who show varying degrees of 'femininity' (which may be situational) and who are involved mainly, if not only, in receptive anal/oral sex with men. Some proportion of Kothis have bisexual behavior and many may also get married to a woman. Also, many Hijra-identified persons may also identify themselves as 'Kothis'. In this report, the term 'Kothi-identified MSM' is used to denote feminine males who self-identify themselves as 'Kothis' but not as Hijras.

Men who have Sex with Men (MSM): This term is used to denote all men who have sex with other men, regardless of their sexual identity or sexual orientation. This is because a man may have sex with other men but still considers himself to be a heterosexual or may not have any particular sexual identity at all. This, basically an epidemiological term, coined by public health experts, focuses exclusively on sexual behaviour for the purpose of HIV/STD prevention.

Note:

- In this report, we did not 'problematise' the term 'men who have sex with men (MSM)', though we would prefer to, considering the wider use of this term by policymakers and AIDS program managers. Some authors have pointed out the 'problems' in the uncritical usage of this term (Young & Meyer, 2005; Dowsett et al., 2006).
- In this report, for brevity, sometimes the term 'a MSM' is used. That needs to be read as 'a man who has sex with other men'.

Panthi: The term 'Panthi' is used by Kothis and Hijras to refer to their masculine insertive male partner or anyone who is masculine and seems to be a potential sexual (insertive) partner. The equivalent terms used in different states to denote masculine insertive partners are: Gadiyo (Gujarat); Parikh (West Bengal); and Giriya (Delhi).

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

Sexual networks: Sexual interrelationships within a defined group of people (i.e., intra-group) and with other groups or the larger society (i.e., inter-group).

Social networks: Social structure or interrelationships within a defined group of people and with other groups or the larger society. Social networks indicate the ways in which people are connected through various social familiarities, ranging from casual acquaintance to close interpersonal bonds that may or may not be part of social support systems.

Stigma: When a person or group of persons is looked down upon and 'marked' as bad in some way. Self-stigma is the internal feeling of being bad or worthless as a result of being viewed or treated negatively by others.

Transgender 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. Transgender 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; and male or female cross-dressers (sometimes referred to as "transvestites", "drag queens", or "drag kings"). A male-to-female transgender person is referred to as '*transgender woman*' and a female-to-male transgender 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*'.

I. INTRODUCTION

India has now become the country with the largest number of people living with HIV in the world – 5.7 million (UNAIDS, 2006). Sexual transmission accounts for more than 80% of HIV infections in India. After a decade of not addressing male-to-male sexual risk behaviors, the National AIDS Control Organization (NACO) of India took an important step in 1997, acknowledging that “...although highly covert, homosexual behavior has its sure presence in all the [Indian] cities...” but “...little is known about MSM behavior [in India]...” (NACO, 1997). The high HIV prevalence (23%) among MSM in Mumbai made NACO to comment that “...rapid increases may be taking place in this particularly vulnerable community...” (NACO, 2000).

Increasing evidence suggest that that a substantial proportion of MSM may engage in high-risk behaviors with both men and women (Chakrapani et al., 2002; Verma & Collumbien, 2004; Dowsett et al., 2006). Thus, the risk of transmission of HIV infection is not only to other men but also to their female partners and their unborn children.

Significance of studying sexual and social networks of MSM in India

Sexual and social networks are the dynamic systems through which HIV is spread as well as the structures which facilitate the communication of HIV prevention messages, provide the normative reference for individuals’ social practices, and enable or constrain safer sex practices. Networks, therefore, are central to our understandings of the HIV epidemic, and critical to our success in prevention of HIV/sexually transmitted infections (STIs). Understanding who has sex with whom will help to clarify current and future patterns of HIV transmission (Anderson et al., 1992; Morris et al., 1995), refine notions of risk, and generate information essential to design strategies to prevent the transmission of HIV/STIs (Neagus et al., 1994; Trotter et al., 1995).

Little empirical research on sexual and social networks of MSM and Hijras in India

An Indian literature review (Chakrapani et al., 2002) showed that most studies on MSM have used quantitative methods focusing on HIV related sexual risk behaviour at an individual level and assessing mainly the person’s knowledge, attitude, beliefs, and practices (KABP). These studies were also of varying quality and did not focus systematically on the effect of sexual partnerships or sexual networks on the risk posed to that individual and his partners. Another recently released multi-country literature review report on sexual networks of MSM reached a similar conclusion about the varying quality and limited information on sexual networks in India (Dowsett et al., 2006). Though a few qualitative studies from India (Asthana et al., 2001; Kulkarni V et al., 2004) have documented the various ‘typologies’ of MSM - Kothis, Panthis, Do-Paratha, Double-deckers, etc., little has been mentioned about the significance of sexual and social networks.

As part of a larger discussion paper, in a preliminary review on identities among MSM, Chakrapani et al. (2002) described sexual connections among the various subgroups of MSM and connections with female partners. In a five-state population-based study (Verma & Collumbien, 2004) and in a survey among MSM in Andhra Pradesh (Dandona et al., 2005), it has been shown that both single and married men in urban and rural areas have sex with men and women. However, there is still lack of systematically documented qualitative information on sexual and social networks of MSM. Hence, this study was conducted to address these gaps and to assist in designing appropriate network-based prevention interventions for MSM and Hijras.

Goal

The goal of this study was to build an evidence base to inform the design and implementation of effective HIV prevention interventions (including IEC/BCC programs) for MSM and Hijras (male-to-female transgender persons) in India.

Purpose

The purpose of this study was to understand and describe sexual and social networks of MSM and Hijras in urban and rural/semi-rural areas of selected states in India: Maharashtra, Gujarat, West Bengal, Orissa, and Delhi.

Definitions

Sexual networks: Sexual interrelationships within a defined group of people (i.e., intra-group) and with other groups or the larger society (i.e., inter-group).

Social networks: Social structure or interrelationships within a defined group of people and with other groups or the larger society. Social networks indicate the ways in which people are connected through various social familiarities, ranging from casual acquaintance to close interpersonal bonds that may or may not be part of social support systems.

Key research questions

- What are the features and characteristics of the sexual and social networks of MSM and Hijras?
- How do networks of social and sexual relations enhance or reduce individual HIV related sexual risk behaviour among MSM and Hijras?

Contribution to and Alignment with the National AIDS Control Program (NACP) strategies

National AIDS Control Organisation (NACO) mentions targeted interventions among MSM as one of the priority areas. The draft NACP-III strategic plan mentions: “Two of the core groups, men who have sex with men and injecting drug users, have not received adequate attention in targeted interventions” and “[t]here will be greater emphasis in NACP-III on intervention on IDUs [injecting drug users], MSM and transgender groups in addition to continued focus on sex workers’. Also, it states: “Tracing patterns of sexual networks and strategizing to intervene at key points in the network could be a useful way forward” (NACO, 2005, p-19). Thus the findings from this study will provide the evidence-base on which more effective network-based interventions for MSM and Hijra populations are designed and scaled-up.

II. CONCEPTUAL FRAMEWORKS USED IN STUDY DESIGN & DATA ANALYSIS

Social Networks

Social networks are defined as the web of identified social relationships that surround an individual and the characteristics of those linkages (Bowling, 1997). Fisher (1997) states that the social network theory approach to STD/HIV prevention (Fisher, 1988; Fisher & Misovich, 1990; Kelly et al., 1991) suggests that individuals function within social networks that establish norms for behaviour, including safer sex behaviour, and that these social networks enforce adherence to these norms. Social networks may establish and enforce norms that are relevant to safer sexual behaviour by supplying information that is supportive of a particular safer or risky norm, or by directly socially reinforcing or stigmatizing safer or risky norms and behaviours that are related to these norms (Fisher, 1997).

In this study, we explored the various social network contacts of the study participants, in an attempt to find relation to safer sex related issues. From the previous studies of the Humsafar Trust (The Humsafar Trust, 2000; Setia et al., 2000) and extensive experience with targeted interventions for MSM and Hijras in Mumbai, we knew that while some of the social contacts of gay-identified MSM could also be sexual contacts, most of the social contacts of Kothi-identified MSM and Hijras are purported to be persons from their own communities with whom they do not engage in sexual relationships. Thus, in this study, we specifically explored the social—peer and community—norms of Kothis and Hijras in relation to safer sex related issues.

According to social network theory, community leaders—social network members who are respected widely and who have the power to establish and enforce social norms—have a critically important role to play in changing STD/HIV preventive behaviours (Fisher, 1997; Kelly, 2004). This conceptualization means HIV prevention intervention programs need to address existing social norms regarding safer sex and risky sexual behaviours in an effort to change such behaviours. Along the lines of social network theory, we explored the peer and community norms among Kothis and Hijras; participants' perceptions of peer and community norms related to safer sex; whether and how the various social network members talked about or provide information about HIV/STI and safer sex; and whether there was support for them to use condoms. We also looked at any other HIV related issues where peer and community support are important – for example, testing oneself for HIV.

Sexual Networks

In this study, we have used an operational definition for the sexual network as “Sexual interrelationships within a defined group of people (i.e., intra-group) and with other groups or the larger society (i.e., inter-group). A number of quantitative studies of sexual networks in developed and developing countries have used mathematical models or epidemiological models, though some have specifically used ‘social network theory’ analysis. In quantitative methodology, in addition to the number of sexual partners, a range of variables are used to identify the sexual mixing patterns (‘who has sex with whom?’) and concurrent sexual relationships among participants.

We applied social network theory, in this case for a qualitative paradigm, by focusing on the following aspects of sexual networks during study design and data analysis.

1. *Sexual mixing patterns:*

Who are the persons with whom the study participants – MSM and Hijras – have sex with? (We cannot assume that just because they may be identified by the term ‘MSM’ that they have sex only with men.) Do they have sex with persons based on one particular criterion (for example, based on age or socioeconomic status), based on multiple characteristics, or no particular characteristics?

2. *Concurrency in sexual partnerships:*

Are they having sex with multiple sex partners concurrently (over a period of time)?

3. *Sexual Contexts:*

What are the contexts under which unprotected sex happened – especially looking at the interpersonal and structural level factors as well as individual factors.

During the analytic stage, we used modified ‘grounded theory’ techniques of narrative thematic analysis of the data and constant comparison, and focused on: sexual mixing patterns, concurrency, and sexual contexts. In the sexual mixing patterns, we specifically looked for sexual mixing across age groups; with persons belonging to different genders; with persons from different socioeconomic and educational status; with persons having different (or unknown) HIV/STI status; and with different types of partners (regular, casual, paying and paid). We also focused on the ways (routes) through which sexual mixing occurred. Thus, we explored whether the sexual mixing was assortative (mixing with persons of similar characteristics) or disassortative (mixing with persons having different characteristics). Similarly, we looked for concurrent sexual partnerships and also the various patterns of concurrent sexual relationships. We also looked for the contexts under which unprotected sex happened and focused on the reasons cited by the participants for not using condoms in certain situations with certain types of sexual partners.

Social support

In the absence of a specific theory for understanding the social support available to MSM and Hijras, we adapted the more general ‘social support theory’, which addresses how various types of support affect an individual’s psychological well-being. In a literature review on social support research, Wan et al. (1996) distinguished among four types of support: emotional, informational, companionship and tangible. The following descriptions about the different types of support are based on work by Neergaard et al. (2005).

Emotional support is associated with sharing life experiences. This type of support conveys that an individual is valued for his or her own worth and experiences and is accepted. Behaviors expressing esteem, affect, trust, concern and listening constitute emotional support. Emotional support helps enhance an individual’s self-esteem.

Companionship support serves to help distract persons from their problems or to facilitate ‘positive affective moods’ (Wan et al., 1996). Activities such as spending time with others in leisure and recreational activities are subsumed under this category (Schwarzer and Leppin, 1988) and are supposed to reduce stress and provide affiliation and contact with others (Wan et al., 1996).

Tangible (or material) support refers to the provision of financial aid, material resources and needed services. Any behaviour providing money, labour or any kind of direct resolution of a problem can serve this function.

Informational support concerns the provision of knowledge that might help an individual to increase their efficiency in responding or generating solutions to a problem (Cross et al., 2001). It may also bolster an individual's belief in own capacity to handle challenges. Behaviors that provide feedback, advice, suggestions and direction (Wan et al., 1996) come under this.

During data analysis, in addition to the above four types of support, we also explored: whether the person has someone to whom he has disclosed his sexuality or sexual behavior; what were the reactions to that disclosure and what kind of support was given (or not given); whether he/she has someone to talk to about intimate details such as sexual partnerships, romance, break-ups in relationships, and what kind of support in turn he/she receives; and whether one has someone to talk about safer sex related issues, sexual abuse related issues, and about why they did not use condoms in certain sexual encounters. Though some of these could be accommodated in one of the four types of support mentioned above, we specifically focused on the types of support available in matters related to sexuality and safer sex issues, in accordance with the focus of this study.

Thus, in this study, we focused on who constitutes the social and sexual networks of various subgroups of MSM and Hijras; what kinds of support are provided by the various social contacts; in what contexts and what forms support is provided; and which persons and relationships are perceived to be potential sources of support.

III. RESEARCH METHODOLOGY

Qualitative research methodology was used in this study: 119 in-depth interviews with various subgroups of MSM and Hijras; 16 focus group discussions; and 16 key informant interviews were conducted.

1. Participatory approach

The Humsafar Trust (HST), Mumbai, is a community-based organization (CBO) working with MSM and Hijras over the past 8 years. This study was implemented by HST in collaboration with 6 community organizations that are part of the 'India Network for Sexual Minorities' (INFOSEM), which is a national network of more than 20 community organizations working with sexual minorities in various parts of India.

Most of the field research staff had been working for a considerable period of time in community organizations serving MSM and Hijras, and thus had extensive insider knowledge about the communities, which was very useful in conducting in-depth interviews. Selection of the field research team was based on their communication skills, and ability to respect full confidentiality regarding personal information. In a centralized research training workshop, all the field research staff were given intensive three-day training on research techniques, research ethics, using voice recorders, and data management. Pre- and post-training technical support and guidance were provided for the field research team members. The field research team in each research site typically included a field research coordinator cum interviewer, and another interviewer. These team members were responsible for organizing, recruiting, and conducting most of the in-depth interviews and focus groups though some of them were conducted or facilitated by some of the research investigators.

2. Selection of study sites

Indian Network of Sexual Minorities (INFOSEM) network member organizations in respective states/areas were involved in the data collection procedures.

Selection of States

The Humsafar Trust's experience has shown that there are regional differences in regard to the organization and nature of sexual and social networks of MSM and Hijras. For example, Mumbai being a metropolitan city, MSM have access to and participate in a variety of networks – Kothi- and gay-identified MSM, *maalishwalas* (massage guys), "bar boys", and those MSM who engage in sex work. But in Rajkot, a small town in Gujarat, there is unlikely to be such a wide variety of MSM populations; many MSM in Rajkot may not have any specific sexual identity even as they engage in sex with other subgroups of MSM who may or may not be gay- or Kothi-identified MSM. To take into account these regional variations in both the extent of participation in diverse sexual networks and differences in sexual identity, five states were selected: Maharashtra, Gujarat, West Bengal, Orissa, and Delhi. The selection of the states and organizations were also dependent on their assessed capacity to implement the study within the limited time frame.

Selection of urban and semi-rural areas

In the five selected states, we considered that it was important to choose both urban and rural areas to document differences, if any, between urban and rural areas. The strategic plan of the third phase of National AIDS Control Program (NACP-III) states that - "Mapping has also shown the presence of high-risk populations in suburban and rural locations, which may not have the density to warrant a stand-alone intervention... Therefore, alternative

strategies for interventions to reach out to diffused high-risk populations *both in rural and urban settings* will be developed”.

In urban areas, compared to the rural/semi-rural areas, there are large number of migrated males who are away from their families, possibly larger numbers of self-identified homosexual men, and more space for anonymity among MSM. These factors may result in systematic differences between the sexual and social networks of MSM in urban and rural/semi-rural areas. Hence, to study and document such differences both urban and rural areas need to be chosen. Instead of rural areas, however, we selected semi-rural areas or small towns near villages because of lack of community organizations working in rural areas and the time constraint. Below is the list of selected urban and semi-rural or small town areas selected on the basis of the availability of community groups working with MSM in these areas.

Table 1. Study sites

State	Urban areas	Small towns/cities or Semi-rural areas
Maharashtra	Mumbai metro	Sangli
Gujarat	Vadodara (Baroda)	Rajkot
Orissa	-	Bhadrak
Delhi	New Delhi	-
West Bengal	-	Chandannagar

3. Study populations

The study populations were:

- Various subgroups of men who have sex with men (MSM) in urban and semi-urban areas of five states in India (Maharashtra, Gujarat, West Bengal, Orissa and Delhi) participated in in-depth interviews and focus group discussions.
- Key informants – who are community leaders from MSM populations and/or persons with knowledge and expertise about MSM and Hijras such as health care providers (doctors and counselors) working with these populations.

4. Eligibility criteria

Common eligibility criteria across subgroups of MSM and Hijras were: over 18 years of age; currently sexually active with males (any kind of sexual activity); and ability to understand and give consent to the study.

5. Methods and Sampling

Sixteen focus group discussions and 119 in-depth interviews with various subgroups of MSM as well as 16 key informant interviews were conducted (Table 2).

Table 2: Sampling Details						
STUDY SITE	IDI (n=119)	Details	KII (n=16)	Details	FGD	Details
Mumbai, Maharashtra (The Humsafar Trust)	N=15	Double married: 1 Double unmarried: 1 Panthi married: 1 Panthi unmarried: 4 Kothi unmarried: 5 Hijra Ackwa: 3	N= 2	CBO leader - 1 HIV Counselor - 1	N= 2	2 FGDs with MSM
Mumbai, Maharashtra (Sakhi Char Chowghi)	N=15	Kothi unmarried: 1 Hijra Ackwa: 10 Hijra Nirvan: 2 Khada Hijras: 2	N= 2	Community leaders - 2	N= 2	2 FGDs with Hijras
Delhi (Naz India Foundation Trust)	N=15	Panthi unmarried: 1 Kothi married: 1 Kothi unmarried: 5 Bisexual-identified MSM: 2 Gay: 2 'Double' married: 1 'Double' unmarried: 1 Panthi married: 1 Hijra Ackwa: 1	N= 2	CBO leader - 1 Medical Officer - 1	N= 2	2 FGDs with MSM
Sangli, Maharashtra (Mooknayak)	N= 14	Panthi unmarried: 4 Kothi married: 2 Kothi unmarried: 4 Bisexuals: 2 Gay: 1	N= 2	Community Leader - 2	N= 2	2 FGDs with MSM
Baroda, Gujarat (Lakshya Trust)	N= 15	Double unmarried: 1 Kothi married: 2 Kothi unmarried: 2 Hijra Nirvan: 1 Hijra Ackwa: 1 Bisexual unmarried: 2 Bisexual married: 2 Gay: 2 Khada Kothi: 1 Gay married: 1	N= 2	2: Community leader - 2	N= 2	1 FGD with Panthis and bisexuals 1 FGD with Kothis
Rajkot, Gujarat (Lakshya Trust)	N=15	Male sex workers: 2 Kothi married: 1 Kothi unmarried: 2 Hijra nirvana: 1 Hijra Ackwa: 1 Gay married: 1 Bisexual married: 1 Kothi HIV+ve: 1 Bisexual HIV+ve: 1 Khada Kothi: 2 Double married: 1	N= 2	Doctor - 1 NGO staff - 1	N= 2	2 FGDs with MSM
Chandannagar, West Bengal (Amitie)	N=15	Dupli Kothi: 1 Kothi unmarried: 4 MSM in sex work: 1 Kothi married: 1 Gay married: 1 Gay HIV+ve: 2 Hijra Ackwa: 2 Bisexual Unmarried: 2 Bisexual HIV+ve: 1	N= 2	Doctor - 1 Community leader - 1	N= 2	1 FGD with MSM 1 FGD with Hijras
Bhadrak, Orissa (Fellowship)	N=15	Kothi married: 4 Panthi unmarried: 3 Kothi unmarried: 3 Hijra Ackwa: 2 'Double' married: 1 Panthi married: 1 Bisexual married: 1	N= 2	Social Activist - 1 HIV Counselor - 1	N= 2	1 FGD with MSM 1 FGD with Hijras

a. In-depth Interviews (IDIs)

In each of the five states, in-depth interviews were conducted with various subgroups of MSM and Hijras. In order to have a diverse sample of MSM and Hijras, participants were recruited from the venues and events held at CBOs (drop-in centers, community events, support group meetings, etc.) and also from the cruising sites such as public parks, public transport facilities, beaches, etc. The different subgroups of MSM and Hijras who were recruited for this study are listed in Table 2.

At each recruitment site, field research staff approached potential participants and explained the nature of the study. After ensuring that the potential participants met the eligibility criteria and were willing to be interviewed, in most cases interviews were scheduled at the offices of the community organizations. In some cases, a private venue that ensured safety and confidentiality were chosen for conducting interviews. Most of the interviewers are MSM themselves. They were specifically told not to recruit any MSM who belonged to their sexual or social networks to avoid any possible bias in the responses since the study focuses on sexual and social networks.

Snowball sampling, opportunistic sampling, and stratified purposive sampling techniques were used to recruit these participants. The research staff informed MSM and Hijras who were using the services of the CBOs about the study and asked about their willingness to participate and eligible participants were recruited (opportunistic sampling). In these cases, often the interviews were conducted immediately. Some study participants referred other potential participants to this study (Snowball sampling). To identify the issues of selected categories of persons within the MSM subgroups (for example, married persons, people living with HIV, younger MSM, those who engage in sex work), the research staff were asked to specifically recruit persons who belong to those categories (Stratified purposive sampling) (Miles & Huberman, 1994).

Informed consent was obtained from all participants, including specific consent for audiotaping of the interview. (In-depth interview guide is given in appendices). The interview consisted of open-ended questions to understand the characteristics of their sexual partners that include - sex, age, sexual identity, socio-economic status, educational status and sexual history (if known), STI history, and HIV status. The participants were also asked about the circumstances under which they had unprotected sex with various types of sexual partners in the recent past or what facilitated them to have safer sex if they have consistently used condoms for anal and vaginal sex. Questions related to identifying social network contacts and the types of support (emotional, companionship, tangible, and informational) they get from different social contacts were also asked. As categories emerged, subsequent interviews with other participants were used to explore the emergent categories and conditions. Therefore, as the analysis progresses, the focus of the interviews were tailored to the experiences of the interviewees ('progressive focusing', Schutt, 2004). Data collection continued until saturation of major categories was achieved.

b. Key Informant Interviews (KII)

In-depth interviews were conducted with 16 Key Informants using a semi-structured interview guide. These key informants included the heads of community organizations, community activists, and health care providers. They were selected because of their extensive experiences in working at the grass-root or policy level and for their insights regarding the sexual and social networks; and vulnerability of these marginalized populations. Topics discussed were: various subgroups of MSM and key features of those subgroups; any differences in the sexual behaviour of MSM belonging to various subgroups; types of

linkages between the various subgroups of MSM and Hijras; various ways by which the networks of MSM are connected to the 'general population'; non-sexual contacts and social relationships of MSM; and social support systems for MSM and Hijras.

c. Focus Group Discussions (FGD)

Sixteen focus groups were conducted using a semi-structured open-ended interview guide. Separate FGDs were held for various subgroups of MSM and Hijras. Individual informed consents, including consent to be audiotaped, were obtained before beginning the FGD. Like interviews, the venue of the focus groups was either a private room in the office space of the community organization or a private room in an outside venue where confidentiality could be assured. The main focus of the discussion was on exploring community norms in relation to condom use; identifying community norms that facilitate or enhance the risk of HIV behaviour; identifying sexual and social contacts of the community members. About 6 to 8 persons participated in each focus group and the duration of the discussion ranged from 45 to 120 minutes.

6. Data analysis

All the in-depth and focus group discussions were conducted in native languages. A few key informant interviews were conducted in English. In-depth interviews, key informant interviews and focus group discussions were tape recorded and then almost all of them were transcribed verbatim in native languages and then translated into English. During transcription, all personal identifiers were removed and a subject/interview code was assigned to protect confidentiality. Transcription and translation of most of the native transcripts were done by professional transcriptionists cum translators. Standard guidelines were given to these persons to ensure accurate transcription and translation. The research coordinators checked the accuracy of the transcripts by randomly choosing about 20% of the transcripts and comparing them with the respective audiotapes by listening to them. Also, the transcripts were compared with almost all the translated texts with the corresponding native language transcripts to find whether the translation had been done accurately with no substantial differences in the meaning.

As mentioned earlier, not all transcripts were completely translated. Less than 10 in-depth interviews (out of the total 119 IDs) and 2 focus group transcripts (out of 16 FGDs) were summarized in detail in English by professional translators to expedite data reduction and analysis process. However, these summaries retained many original illustrative quotes as necessary to minimize translator bias. If clarifications were needed in such summaries, verbatim transcripts were reviewed and original quotes were reproduced and used as illustrative quotes.

Two investigators individually analyzed the cleaned translated texts, followed by team analysis at regular intervals throughout the analytic phase of the project. Interview and FGD data were explored using narrative thematic analysis using the analytic techniques from grounded theory (Strauss & Corbin, 1990) and then the conceptual frameworks described earlier (section-II) were used for more focused analysis. Initial themes were identified using line-by-line coding. Themes were then listed, compared and contrasted by using the method of constant comparison. Constant comparison is a process through which each piece of data is compared and contrasted with other data to build a conceptual understanding of the categories within the phenomenon of interest. Themes were subdivided in an inductive process according to the data that emerged, and were then applied across all interviews and focus groups. The results correspond to the emergent categories and all representative quotes were drawn from the interviews and focus groups.

We used NVivo7 textual analysis software to help us in compiling, sorting and retrieving textual data. Findings were arrived at by triangulation of the key informant interviews, focus group discussions and in-depth interviews. We discussed the findings/interpretation at a meeting with the field research team members and selected community representatives from different subgroups of MSM and Hijras. Their inputs and suggestions were also included as 'feedback data' and analyzed further.

7. Protection of participants: Informed consent, Confidentiality, and Ethics

The study protocol was reviewed and approved by the Institutional Review Board and the community advisory board of the Humsafar Trust. Informed consent was taken from all participants. Participants in in-depth interviews and focus group discussions were paid Indian rupees 250 each (about US \$ 6) to compensate for their time. Key informants were not paid.

At the beginning of each interview or focus group, the interviewees were provided with information about the purpose of the study, and the established conditions for anonymity and confidentiality. The participants were asked whether they had understood the information and if they were still willing to participate. To preserve the anonymity of the participants, they were asked to only make an 'X' mark to denote their consent on the informed consent form so there was no written record of their names. Additional measures taken were: replacing the participant's name with a code number on the tapes and in the transcripts; removal of names, places, and other identifying characteristics from the transcripts and translated text.

8. Internal validity (Trustworthiness) of the study

In ensuring internal validity, the following strategies were employed.

Triangulation of data: Data were collected through multiple sources – interviews with key informants; interviews with various subgroups of MSM and transgender people; and focus group discussions with MSM and Hijras.

Community member checking: The community advisory board set up by the Humsafar Trust provided inputs throughout the analysis process. Community members were involved in most phases of this study, from the study guides development to checking interpretations and conclusions.

Transferability: Rich, thick, and detailed descriptions are provided so that anyone interested in transferability will have a solid framework for comparison. Data collection and analysis strategies have been reported in detail in order to provide a clear and accurate picture of the methods used.

9. Role of the funding agency

The sponsor of the study had no role in study design, data collection, data analysis, data interpretation, or writing the report.

IV. KEY FINDINGS AND DISCUSSION

This section is organized as follows.

1. 'Sexual networks of MSM and Hijras': Demonstrates the presence of extensive sexual mixing and concurrent sexual relationships of MSM and Hijras.
2. 'Reasons for having unprotected sex with male partners': Documents the various partner-specific sexual contexts, and personal and structural factors which lead to unprotected sex.
3. 'Social networks and social support among Kothi-identified MSM': Summarizes the types of social support received by Kothi-identified MSM from their social contacts.
4. 'Social organization and social support among Hijras': Discusses the social structure of Hijra communities and the various types of support available to them.
5. 'Hijra community norms and beliefs: Relation to HIV risk': Summarizes the community norms and beliefs among Hijra communities, and proposes how the influential community leaders can help establishing supportive community norms in relation to safer sex.

A. SEXUAL NETWORKS OF MSM AND HIJRAS

This section demonstrates that concurrent sexual relationships are quite common among MSM and Hijras. It also demonstrates that though assortative mixing happens, more commonly, disassortative mixing among the various subgroups of MSM and Hijras occur.

Extensive sexual mixing across persons having various characteristics is the norm. Below, we have summarized the extensive sexual mixing patterns that occur:

- across different age groups
- across different socioeconomic classes
- with persons of any gender (man, woman, or Hijra/transgender woman)
- with any type of partner (regular, casual, paid, paying)
- with persons from different HIV/STI status
- with persons from different geographical areas, and
- with persons with different sexual identities

Box 1. Type of male sexual partners

Being a qualitative study, we did not use any 'operational definitions' for the following terms. However, these terms are explained below to understand the context in which they are used in this report.

Regular partner: Refers to the primary partner whom the study participant identified as lover or 'husband'. Often, study participants expressed strong emotional and affectionate relationship with this partner though some 'regular' partners are more like 'sex buddies' (i.e., partners with whom one regularly has sex with but without much emotional attachment)

Casual partner: Refers to the non-primary partners of the study participant whom he/she has not met before or has only been recently met.

Paying partner: The partner who has paid money to the study participant for having sex with him/her.

Paid partner: The partner who was paid money by the study participant for having sex with him/her.

1. Sexual mixing across age groups

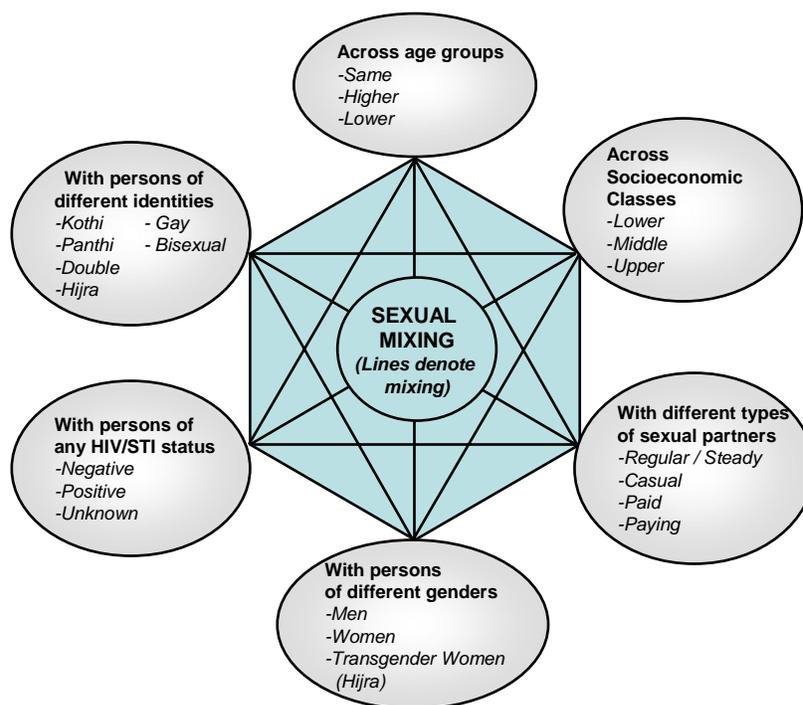
While some men preferred to have sex with men from a particular age group, many mentioned about having sex with men from different age groups. When asked about the age of the last two male partners he had sex with, a 25-year-old MSM said, "One was around 40 [years] and another one was a student - 18 years old...[With] both [I] had anal sex." A 25-year-old MSM who did not want to self-designate himself mentioned: "I prefer a person who

is good - positive in thinking. I do not see the age but see the person's nature. I have had sex with 50 year- and 70-year-old men. I try to satisfy myself as well as others. Satisfaction is the key and that is my preference."

Those MSM who engage in sex work seem to be flexible with regard to the age group of their male clients. A 22-year-old MSM who once in a while exchange sex for money said, "I mostly like males of younger age but if people who are of old age ask for sex then we ask money from them." A Hijra engaging in sex work also said in a similar manner, "If you are asking in *Pun* [sex work] then we have sex even if the person is 70-80 years or even if his one leg is in the grave. If he pays for sex then age doesn't matter."

However, there are some persons who would prefer to have sex with persons from a particular age group (i.e., assortative age mixing). A MSM explained why he prefers to have sex only with older men: "Yes, I like persons who are older because if I have sex with younger [persons] I feel difficult to penetrate [anal sex] but with experienced older guys - they have open [anus] - so we can enjoy any type of 'shot' [sex] with him and have pleasure." In contrast, a Panthi-identified MSM mentioned that he prefer men with tight anus over women with loose vagina. A MSM had a specific choice in regard to the age of his male partners. He had sex and like to have sex with "guys who are in between 18 and 20 years of age." And he reported that "Within the last three months, I [had sex] with around thirty to forty persons. They are all about 20 to 22 [years]." Thus, some chose to have sex with persons who belong to a particular age group but many did not want to restrict having sex with only persons from a particular age group.

Fig 1. Extensive Sexual Mixing Across Persons With Different Characteristics



2. Sexual mixing across socioeconomic classes

Mixing with persons from different socioeconomic classes was reported by many people especially those in sex work. A Kothi-identified MSM in sex work said, "I have a Panthi who is kept by me [means he regularly pays that boy friend]. But on *Pun* [sex work] - it can be anyone - taxi driver, lorry [truck] driver, drunkard - anyone. It is only money that matters to me. For money I can sleep with anyone. There are college guys; gym boys also - who come to me." Similar response was given by a Hijra who engage in sex work: "...good people, bad people, aged men and young boys come to us...'good men' means the men who come from rich families and officers. These men who are rich then take us to the hotels and the one who are from lower class do the job in the bushes."

A Hijra in sex work also reported such class differences and some of her clients from lower class had cheated her. She said, "...the decent persons give us 500 [Indian Rupees] when we had asked for 300 [Rupees]. But there are ruffians who after having sex also take away our money...some do not even pay after having sex with us." Another Hijra in sex work said that she had "sex with Panthis, more of anal sex and also oral sex at times. I have never [penetrated] a man." When asked about who are these Panthis, she replied: "They are men who come in cars, school going boys, [injecting] drug users, drivers - all sorts of men. [I find them] on the road, in the urinals." Another Hijra in sex work also shared information about with whom she has sex with: "I have sex at [place]. There I stand wearing a saree and a people in the car come and pick us. Some take us in the auto-rickshaws. The one who has money books a room or else some do the job [sex] in the 'auto' or in the car. Some take us to the dark corners or bushes."

Thus, it is evident that the clients of these persons who engage in sex work come from all socioeconomic classes – lower, middle, and upper; and also have different educational status.

Not only among those who engage in sex work, class mixing across socioeconomic classes is common even among those who do not engage in sex work. A MSM who identified as 'Kothi and gay' said, "I give [insert] as well as take [receive]. I get partners who suck me as well there are partners for whom I do the sucking. I get big people who come in cars, people in my area, [insurance] agents,"

Though MSM who engage in sex work were recruited purposively because they are 'sex workers', some MSM who were purposively recruited in other categories (such as 'married MSM' or 'HIV-positive MSM') also reported having engaged in sex work. But among the study participants, all of those who engaged in sex work also had male casual partners and they expressed desire to have sex with other men.

Also, though some MSM who exchanged sex for money articulated or admitted that they engage in sex work (*Dhanda* or *Pun* - as referred to by some Kothis and Hijras), there were some grey areas too: some MSM who did exchange sex for money did not see themselves as sex workers. When asked whether he had received money for having sex with men a MSM said, "Some men do give. But I never demand. They say 'Keep money it will useful to you.' Some men give money for snacks or give gifts. Till now, 2 or 3 men would have given either money or gifts." A HIV-positive MSM told, "No, I did not ask for money but they [some partners] give me." He acknowledged that some of his friends who are MSM do exchange sex for money and he also accepted the money given to him since once he was in need of money. Some MSM reported only one or two instances where they were given money by their male partners. As a MSM said, "Before seven years, one person from [a village] gave

me money for having sex...his age...about 60 years.” Not in all these sexual encounters, condoms were used.

3. Sexual mixing with persons of any gender

While some participants reported having had sex only with men, there were many who reported having had sex with women and some of them were also married to woman. A married MSM reported that he currently has sex with both men and women – besides his wife. He said, “I have sex with men and women. I am married since one year.”

Some reported casual female partners. A MSM said, “Yes, with *Bhabhis* [in this context refers to ‘Married women’].” And he denied having given any money to them. “No. Some [women] are doing for [sexual] satisfaction,” he clarified.

Some mentioned that their male partners have female partners and some of those male partners are heterosexually married. In responding to a question whether his male partners have any other partners, a MSM said, “Yes, most of them have wife - [or] girlfriends.” A MSM from West Bengal discussed about the female partners of his male regular partners: “He [regular partner] has ‘Niharini’ – his girl [friend]. Among my 4 regular male partners two are ‘bisexual’ [have bisexual behavior].” A Kothi-identified person said that his male partners “mostly have sex with women and Hijras. They are also married to their girlfriends.” And also they had asked him to insert them “many a times.”

A gay-identified person from Rajkot said that he also had sex with girls: “Most of my sexual partners are males but I have girl friends [also]. But I feel having more pleasure with boys...I did [had sex] with a girl but I didn’t enjoy it.” Though he reported that he did not enjoy having sex with that girl, he also admitted to having sex with many other girls.

A MSM in Gujarat discussed in detail about his sexual encounters with female sex workers: “If they [female sex workers] are of 20–22 years they take [ask money] 100 or 150 [Indian] Rupees and if 40-45 years then take 50 [Indian] Rupees.” And he goes to female sex workers “one or two times every month.” This person is thus likely to have bisexual orientation and have sex with both males and females. Another MSM reported having two girl friends and he “just did it [had sex with girl friend] yesterday”, though he reported having sex mostly with males.

Some Hijras reported that they are married to women. In a FGD, one Hijra thought that [heterosexually] married Hijras are very few and Hijras usually do not get married to woman. A key informant explained that some Hijras when they were Ackwas (not yet undergone emasculation) and in ‘pant-shirt’, are forced by their family members to get married to a woman and they might also have their own children. However, a study participant who is an Ackwa Hijra liked to have sex with her wife also - though she identified herself as a Hijra (thus distinguishing between her gender identity and sexual orientation – in this case, bisexual orientation.) In FGDs among Hijras, some Hijras agreed that they knew of Hijras who are married to women and some of them enjoy having sex with their wife.

Thus, many MSM from different subgroups have different types of female sexual partners (casual, regular, or paid) and also are married to woman. Some Ackwa Hijras in male attire (‘pant-shirt’) too get married to women because of family pressure.

4. Sexual mixing with persons having different HIV or STI status

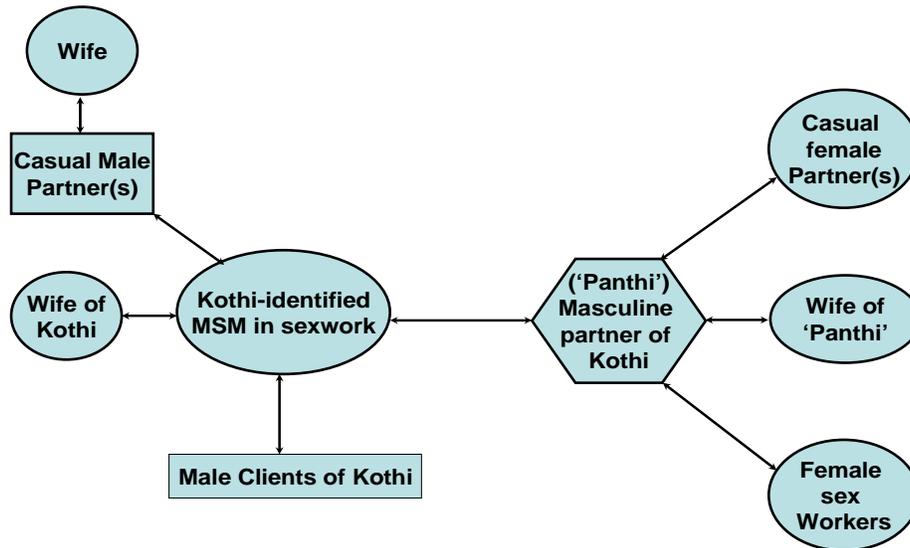
A 20-year-old Kothi-identified MSM who engage in sex work once in a while reported that: "Once, a man forcibly [inserted me] in the back and then I had STI. He had sex without condoms and also his semen fell into my anus. So I was worried about HIV. But I later came to know that it was 'Syphilis' [an STI] and not HIV." Though this person was treated for Syphilis, that client being an unknown person, he could not be traced back for providing partner treatment.

A gay-identified person contracted STI from his male steady partner. He said, "my friend [male lover] - he had scabies and the tip of his [sexual] organ looked like as though it was ruptured and scratches were there; a white fluid was also coming out. I took him to a doctor and he recovered. And it got transmitted to my anus and frequently I got bleedings, ruptures. So I used [self-medications]." When asked why he did not go to doctor for treatment, he replied: "Do the doctors listen to you? If we go they will say that you have done dirty, nasty things. I never went." Thus, the previous negative experience with a doctor prevented him to go for treating his condition and he relied upon self-medications.

A MSM said that he once met a man who had symptoms suggestive of anal STI but he still had sex with him without condoms because he was sexually aroused: "Yes. I have had sex with people who have STI but I did not know that. When I am aroused I can't control myself and I have sex with them. Once while having sex with my partner it started bleeding from his back - like girls bleed after having sex. I asked him what happened then he told me that he had a 'mole' [warts] there." Another MSM knew beforehand that a person had STI but still had sex with him. But he denied having got STI from him: "One of my friends had [penile] STI...I had sex with him...No, I did not get it [STI]." This shows that some persons do have sex with persons who have symptoms suggestive of STI.

A HIV-positive Hijra in sex work acknowledged that sometimes she has unprotected sex with her male clients. According to her, "...because of them [men] only I have this disease. It must be somebody who had this disease and came to me - and now I have this HIV. That is why I sometimes allow people to have unsafe sex with me if they insist." When asked why condoms are not used, a HIV-positive MSM replied: "Because now I already have HIV." Thus, shifting the responsibility of condom use to the partners and ignorance about the importance of safer sex even among people living with HIV to protect their own health means unprotected sex happens between people who are HIV-positive and those whose HIV status is not known.

Fig 2. Sexual partners network of a Kothi-identified MSM



5. Sexual mixing with persons of different sexual identities

Persons having a particular sexual identity also had sex with persons with other sexual identities or those who do not give a label to themselves. A Kothi-identified person in Rajkot, Gujarat, said that he had sex with “With double and *Gadiyo* [equivalent to the term ‘Panthi’, which means masculine partner]. But I rarely do anal sex.” Thus, in spite of not engaging frequently in anal sex, he identified himself as Kothi and also labeled his partners as ‘double’ and ‘Gadiyo’.

A gay-identified MSM in Delhi said that he “get partners who are passive – [or] completely active – and those who are ‘Doubles’. I ‘do’ [have sex] as they prefer [means he can be receptive or insertive].” A Kothi-identified person in Mumbai declared: “I have no preference. Any one will suit me.” Thus, he did not specify that his partner need to be a Panthi or need to be only an insertive partner.

As we have seen earlier (and going to see in forthcoming sections), many MSM from different subgroups (and Hijras) also have sex with casual male partners whose identities they do not know and who are more likely not to self-designate themselves.

6. Sexual mixing with specifically targeted male populations

HIV prevention intervention programs specifically target certain male populations in a compartmentalized manner: male youth, male injecting drug users, male migrant laborers, and truck drivers. However, many MSM and Hijras have mentioned about having sex with male youth, and male migrant laborers (some of who themselves are migrants). Some Hijras also stated that have had sex with truck drivers and injecting drug users. A Hijra engaging in sex work said that she had “sex with Panthis, more of anal sex and also oral sex at times. I have never [penetrated] a man.” When asked about who are these Panthis, she replied: “They are men who come in cars, school going boys, [injecting] drug users, lorry [truck]

drivers - all sorts of men..[I find them] on the road, in the urinals.” Another MSM narrated this incident how he happened to have unprotected sex with a truck driver: “Once I met a person at [place] and he asked me to come to [place] and I went with him. He told me that we would come back in within 3-4 hours ...We had sex... I did not have money to come back [to my place]. I asked him for money but he refused. Then by having a sex with a lorry [truck] driver, I reached [home].”

This shows the importance of the need to address same-sex and bisexual behavior in the programs for specific male populations like male youth, male injecting drug users, male migrant laborers, and truck drivers. Looking at these specific male populations as rigid and non-overlapping compartments means we miss the opportunities to address the health risks associated with unprotected male-to-male sex.

Sexual mixing occurs through a variety of ways

The extensive sexual mixing across persons having different characteristics are facilitated by the following.

- Migration and/or having sex with frequent travelers
- Migration from rural to urban areas and thus connecting urban-rural sexual networks
- Fairs and festivals in which there are lots of opportunities to meet potential male sexual partners
- Through informal sexual friendship networks and phone contacts
- Internet

Migration and/or having sex with frequent travelers

Many MSM reported that they had traveled to various places as part of their job or had temporarily lived in those places. During their travel or in a brief stay, they develop sexual relations with men in those places. In a FGD, a Hijra said, “I had 400 to 500 male partners with whom I had sex but not with a single woman. I was in Baripada, Chandabali and Bhubaneswar and wherever I had been, everywhere I had sex with only men but not with women.” This person also admitted to not using condoms consistently with her male partners. A MSM said, “I had been to Bihar and stayed there for two years. I had sex with men there. Again, I went to [another place]. Four to five men were there who had anal sex with me. Then I stayed in [another place]. There also I had sex with three to four men. In this way, the number of sex-partners might be about 500 to 600.”

Some reported that they have had sex with men from other states who currently work in their native places. A MSM said, “Then I thought what would happen if I do [have sex with men] for money. But I was afraid [to ask money]. At that time, one of my friends who has a massage parlour asked me if I want to work in his parlour. He gave me a client in a hotel - he was a migrant - Bihari - from [place]. I had three encounters with him on the same day and all without condoms. Because he was not willing to use, and I did not tell him [to use condoms]. And my parlour friend - he also did not say anything about condom and he was very much present there.” Thus, this person working in a massage parlour had unprotected sex with persons from different cities.

A MSM explained the various sexual contacts he had during his travels: “...had many of out-of-state contacts and also of out-of-India...[Also had contacts] outside Rajkot - Bhavnagar, Morbi, Vadodara, Jamnagar...Once at Chandigarh when we went out to play football – found

a gay from Mizoram [a north-eastern state]. We had sex in a hostel room...In a garden at Delhi I met a person and we enjoyed [had sex] in a hotel.”

Some Hijras who stand in the highway have sex with many people who pass along those highways. As a Hijra in sex work said, “...where I stand - is a highway. I get people in cars - guys roaming. But I have only 3 or 4 customers [per day]. I don't run behind money.” Thus there is also mixing across persons with different socioeconomic classes.

Some Hijras had traveled a lot during their life in an attempt to find a suitable place to earn enough money to live. As a Hijra narrated: “...Then I came to Delhi - there I had sex with my aunt's neighbor. Then I came to Mumbai. Here I had sex with one boy because I didn't have money and I was helpless. I found a customer on the beach and we had sex he gave me 200 [Indian Rupees] only. I had no place to live in Mumbai that is why I went to Gujarat and started *Dhandha* [sex work] there.”

Thus, through their travels, many MSM and Hijras virtually bridge the sexual networks in different cities or states (called 'Spatial bridging'), which have implications for transmission or acquisition of HIV/STIs across cities and states (see Fig 2).

Connecting urban and rural sexual networks

Some people from rural areas found a lot of potential male sexual partners when moved to big cities. As this person in Delhi said: “I used to talk in a manly manner [in this context means talking about girls]. At that time I used to like some guys in the village and also had slept [had sex] with them. But they never disclosed this [to others]. But when I moved to city [Delhi] - there in the urinals and bus stops – I saw that many men come there to find partners for sex. Later, even I started going there and having sex.” Thus, anonymity and the huge population in major cities along with lots of male migrants offered this person more opportunities to find potential male sexual partners. This person also goes back to his village every few months and has sex with men from their village – thus connecting the urban and rural sexual networks.

Sometimes, men in the villages come to cities and pick up other men or Hijras in the cities. As a Hijra said, “Sometimes at Gondal, Padhari - villages nearby Rajkot – Gadiyo [Masculine partners] come with their car and bike, we go with them.” Thus, though in less populated villages it might be difficult to find potential male sexual partners, some men from villages specifically come to nearby cities to pickup and have sex with potential male or Hijra partners.

Fig 3. “Spatial Bridging”: MSM connect sexual networks across cities/states by travel

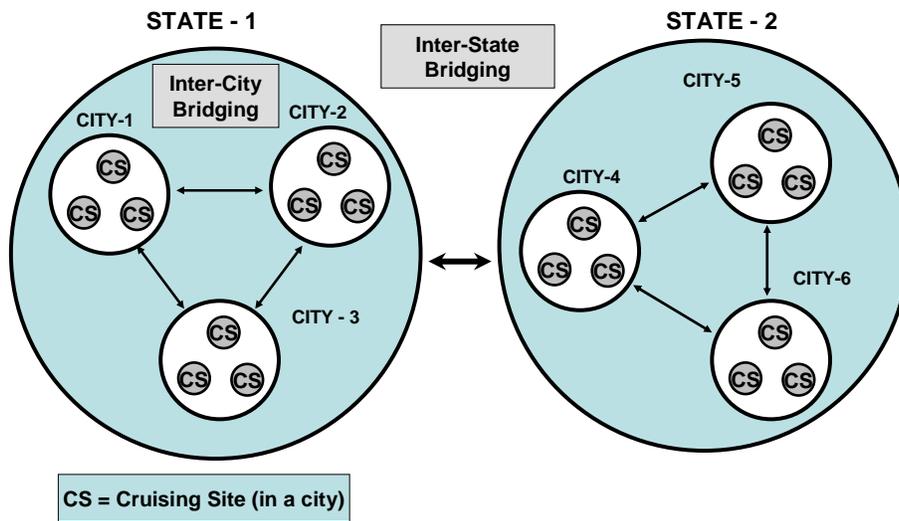
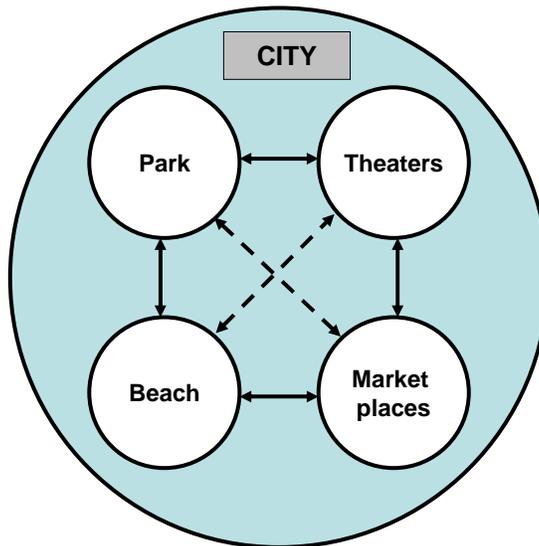


Fig 4. MSM access multiple ‘cruising sites’ in a city



Fairs and festivals

During fairs and festivals, lots of men and women gather and thus the chances of finding potential male sexual partners are high. MSM in Gujarat mentioned about some local fairs in which one can meet potential male sex partners. As a MSM said: “Fair happens in Rajkot, Junagadh, Ranuja... Fair of *Parikrama* [‘Circulation’]...at night everyone is playing in *Mandal* [a play in which Kothis and Hijras dance]...there we get men.” FGD participants also listed many other fairs and festivals such as Tarnetar festival, Ambaji Fair, Shivratri, Bahicharaji, and Parab. They told that one could easily make out that a lot of sex is going on in these festival gatherings since “once fair gets completed there are only condoms on the ground...underwears too...” Though, seeing a lot of condoms after the fair gets over seems a good sign that many are aware about and use condoms, FGD participants stated that not all men engage in safer sex.

One-to-one ‘referrals’ and contacts through mobile phones

A MSM from Delhi explained how he gets so many sexual partners without having to work hard: “It is like a chain - that one who has had sex with me forwards my [mobile phone] number to his friends and this is how my contacts grow.” A similar view was expressed from a MSM in Vadodara, Gujarat, who attributed most of his contacts to mobile: “Most of the time I get contacts through friends and secondly, I get contacts through internet. And if do not get contacts from these two sources, I go to cruising places....[Mobile has] made it easy to get contacts: 70% of my contacts are through mobile.” Several other participants also mentioned about the usefulness of mobile phones in getting connected to potential male sexual partners.

Internet and inter-city movements

MSM in cities as well as in small towns reported having used internet to find potential male sexual partners. Internet facilitates meeting of partners from different cities and of different socioeconomic classes or sexual identities. A MSM said, “Yes, many times. One of my friends in Delhi met me on internet and he told me that he frequently visits Rajkot as he is doing job in [X] field. He is a Punjabi and whenever he comes to Rajkot he calls me and I go there and we enjoy. He also tells me to bring my friends and I take my friends also there.” This, internet has enabled this person to develop sexual relationships with men from other cities or states. And even those who do not have personal access to internet are helped by their friends who have access to internet. Another MSM who does not personally use internet said, “[from] internet I got many contacts. One of my friends put my number on internet.” Key informants clarified that when people say ‘internet’ they might mean not just internet websites but also private e-groups or closed e-mail networks of MSM.

(Note: Through the various examples given in the above section, we have also seen that many MSM and Hijras have concurrent sexual relationships with male and female partners)

B. REASONS FOR NOT USING CONDOMS WITH MALE PARTNERS

This section summarizes the various contexts of unprotected sex with different types of partners (regular, casual and paying) and also the interpersonal factors and structural factors.

Partner-Specific Contexts (Inter-Personal Factors) In Not Using Condoms

1. Contexts of unprotected sex with male regular partner

MSM and Hijras who previously had or currently have male regular partners reported that they did not use condoms during anal (or oral) sex. Some did not specify any reasons for not using condoms but some other persons conveyed that intimacy, love, and trust led them to have unprotected sex with their male regular partners.

a. No specific reason

A MSM reported using oil alone while having receptive anal sex with his male regular partner for over years – without using any condoms. He said, “I used oil [only] when we have [anal] sex. Never used condoms in the 4 years [of relationship].” Not feeling the need to use condom was the reason given by that person. He could not think of any reason since he never seriously thought about that.

b. Both (Self and partner) dislike using condoms

Another MSM reported that they (he and his partner) did not like to use condoms at all: “No. I don’t use [condoms with regular partner] because we don’t like it at all.”

c. Intimacy and love

A MSM told that ‘closeness’ with his ex-regular male partner prevented him from using condoms with him: “Mostly he used to [insert] me, I used to be less in that and he used to fight with me...No. we did not use condoms. We were very close.” Similar reasoning was given by another MSM: “I have not used condoms [with regular partner]. He is my personal man [means close friend]. We have body sex, oral sex, and anal sex.”

d. Trust

A MSM trusted his male regular partner who is also a medical doctor: - “No [condoms] - because he is an M.B.B.S doctor and I trust him that he never goes out [have sex] with anybody else.” Another person who does not currently have a male regular partner said that, “They [male couple] say to each other that they are faithful but in reality they have multiple partners.” Thus, this person has the perception that multipartner sex is common even if a person has a male regular partner. Another MSM reported that before he found a male steady partner he used to have safer sex with a lot of casual male partners but he is not using condoms with his steady partner.

Some MSM did use condoms even with their male regular partners. As this MSM says: “My friend is much educated and he will not do any such mistake [of not using condoms]. I am proud of him that he is using condoms 100%.” Thus, among this male couple, condom use was not associated with lack of trust. This could possibly be related to the higher educational status of the regular partner and open communication among this couple. A Hijra said that she insists her male lover to always use condoms with her because “I had learned that HIV can come from anywhere and I can be positive. Anybody can be positive.” Thus, both the lack of awareness about her own HIV status as well as the fear of getting infection from her male lover encouraged her to always ask her male lover to use condoms.

5. 'Negotiated safety'

A 29-year old unmarried MSM explained why he does not use condoms with his steady partner: "We have tested our HIV status and both of us are negative. Only because of that we do not use condoms when we have sex with each other." Thus, though they have unprotected sex, if both are HIV-negative, then it could actually be considered as 'safer sex' in the context of HIV acquisition. But non-adherence to 'negotiated safety' agreement and nondisclosure of breaking the agreement can pose risk to both.

2. Contexts of unprotected sex with male clients

Some MSM and Hijras who engage in sex work reported several incidents of unprotected sex with their male clients.

a. Not enough condoms but too many clients

For some MSM who engage in sex work, the high number of male clients in a day means that they do not have condoms for all encounters. "Sometimes we have safer sex, sometimes the condom tears, and at times the customers are so many that we are not left with any condoms to use. Then we have sex without condoms."

b. More money offered - No condoms

Sometimes, if there is a need for money and the clients offer more money for unprotected sex then they do.

A MSM reported that he knew of an unmarried MSM in his 40s who pays his friends to have sex with him but he never uses condoms. This participant said, "I gave him advice lots of time but he does not understand. He said that he is old now and it is okay [even if he gets any infection]." Thus, that person was not worried about getting HIV or STIs since according to him he is already aged and thus it does not make any difference to him. According to this participant, his friends had unprotected sex with that old person because of money.

A Hijra in sex work reported having had unprotected insertive oral and anal sex since more money was offered: "...Now, when we go for *Pun* (sex work) we are only concerned with money - you pay us and we will provide you service. There are men who come for oral sex and do blow job for us. We do it by lifting our sarees [attire] up for money - we do insert them [anally] also [without condoms]...all for money."

However, some MSM and Hijras in sex work deny having sex without condoms even if more money is offered. A Hijra said that it was because of the need to maintain one's health so that one can earn a lot on a long-term basis.

c. Shifting the responsibility to the partners

A HIV-positive Hijra who engage in sex work reported that sometimes she could not use condoms because her clients insist on not using condoms. She said, "Because of them [men] only I have this disease. It must be somebody who had this disease and came to me - and now I have this HIV. That is why I sometimes allow people to have unsafe sex with me if they insist." Thus, this poses risk of transmission of HIV from her to others and also transmission of new infections from others to this Hijra.

3. Contexts of unprotected sex with 'known' male partners

a. No condom in group sex with known persons

A MSM mentioned that when there is group sex with his friends, condoms are not used: - "There is a friend's place where every Saturday and Sunday, we gather and we all remove our clothes and have sex ... No, no condoms."

b. Could not control sexual urge and could not think about condoms

A MSM who did not want to label himself said, "There is a lad I know whom I like so much like girls and I have had sex with him many times. I get aroused very fast when I see him and most of the times I have [inserted] him. I used to love [inserting] him and I used to feel like he is a girl." He said that he never used condoms with that person.

c. Casual visits by friends end up in sex - hence no condoms

A gay-identified MSM said that he invited his friends once in a while to his home and sometimes sex happens without condoms: "It is like that they come to visit me and we end up having sex. We don't use condoms then." Thus, though he might be aware that sex could happen during such visits he did not bother much about keeping or using condoms.

4. Contexts of unprotected sex with causal male partners

a. Not carrying condoms

Many MSM reported that they knew about condoms but since they do not always carry condoms, they sometimes have unprotected sex. As a MSM said: "I don't carry condoms with me but if the other person has condoms then I won't deny using it. But I know that others also don't carry condoms with them so then most of the time we have sex without condoms."

Another MSM in Delhi reported that he had unprotected sex since he or his partners did not carry condoms. He listed the incidents in which he had unprotected anal sex: He said, "One was in the urinal of a restaurant and second was with a hunk in a hotel room. I had everything with him [means including anal sex] but without condoms because both of us didn't have condoms. Then, it was in a disco I met one guy and he introduced me to two other guys that he knew. We didn't have a place so we had [anal] sex in their car."

One MSM reported that he goes 'prepared' (with condoms) to cruising sites but sometimes he meets potential male sexual partners in unplanned encounters where he do not carry condoms. As he said, "Oral sex is what happens most of the times since I have anal sex with only those persons who are appealing to me. If I find any of my friends at the parks or gardens then I have sex with them with condoms but if I meet them in any social meetings where I don't have condoms then without condoms is also fine."

A divorced MSM who takes care of his children mentioned that he could not carry condoms and thus could not use condoms. He said, "No. I don't use condoms [with casual partners]. I can't keep condoms in my bag or purse because suppose if [my] kids or others see them then it is not good. These days, everybody knows about condoms."

Thus, MSM from various subgroups gave a variety of reasons for not carrying condoms with them.

b. Multiple encounters and Focus on pleasure preclude condom use

Talking about the use of condoms among MSM, a Kothi-identified MSM says, " Generally, Kothis and Panthis have sex in public places and some times it becomes difficult to search condom and to wear it on penis. There are some people who have sex for six to eight times

[in a day] and it becomes tedious to use condom each time. For some [MSM] sex is more important than safety.” Thus, multiple encounters and focus on pleasure may prevent some MSM to use condoms in all encounters.

c. Partner is ‘good-looking’

For some, good-looking partner is more likely not to have any infections and hence it is safer to have unprotected sex with him. A MSM said that he would not mind having sex without condoms if the partner is “good”. When asked what did he mean by “good” partner, he replied: “[‘Good’] means decent, one who looks handsome and one who behaves well to me too. One who’s penis is clean; has no boils or lesions on his penis, then I don’t mind having unsafe sex also.” Thus, some take external appearance and lack of obvious STI-related symptoms in a potential partner as a proxy for lack of infections and decide to have unprotected sex. Also, if a good-looking potential sexual partner is seen, not wanting to lose that opportunity prevented many people to even raise the discussion on condoms.

d. Difficult to control sexual urge (and also no access to condoms)

A MSM acknowledged that while he goes out to cruising sites where there is no access to condoms, the sexual urge makes it difficult to think about buying and using condoms. “...whenever I had oral sex I have always had it without condoms but [if it is] anal sex - I have with condoms - with my friends. But if I go out in the community [here it means cruising sites] I don’t use condoms. When we have sexual urge it’s very difficult to control – if I don’t have condoms - I do it without condoms.”

Another MSM also expressed similar opinion: “Yes mostly [I use condoms]. It is like if I have I use it but if I don’t have it then I don’t use it. Sometimes you are so much aroused that you don’t think of condoms at all. [Also] One cannot carry condoms all the time.”

Thus lack of access to condoms coupled with perceived uncontrollable sexual urge led to unprotected sexual encounters.

e. Difficult to get or maintain erection – if condom is used

A MSM explained that for him it is difficult to get or maintain erection which prevents him from using condoms. This person has a steady partner but still sometimes have sex with ‘unknown persons’ – often without condoms. “Just think that you are about to [insert] someone and your dick becomes stiff - at that time would you really get the packet and then open it and put on the condom? By that time, the sex is gone. Then after applying the condom you will have to rub your penis again to harden it... [Hence] it is better to get infected by any disease rather than using condom.”

f. Belief that since already HIV-positive - nothing more to lose

When asked about the reason for not using condoms, a HIV-positive MSM replied: “Because I already have HIV.” Thus, ignorance about the need to protect one’s health by having safer sex means this person is posing health risks not only to others but also to himself.

g. Shyness in asking for condoms from Chemists

A MSM reported that he was too shy to ask for condoms from the chemist shop: “sometimes if I meet someone and they give [condoms] then its fine. But I don’t go to the medical [shop] and buy condoms... because I feel shy to do so.”

h. Non-availability of condoms

For some MSM, the lack of shops near the cruising sites prevented them from having access to condoms. A MSM complained, "On highway, we do not have condoms...Condom use [in such places] is about 50 to 60%"

Personal Factors In Not Using Condoms

1. Personal dislike of using condoms (since decreases pleasure)

Sometimes personal dislike for condom also leads to unsafe sex. A MSM explained why he does not like condoms: "If I wear a condom and have sex then I don't feel like I have had sex. If sex is without it [condoms] then I feel good. Till the sex is not over that feeling [pleasure] should remain." According to another MSM when someone else wears condoms and inserts him he does not feel that penis enters in entirety which diminishes his pleasure. As he explained: "Yes, there are some who prefer condoms and don't do anything with out condoms. I tell them that I don't have it but if you have use it but I don't like condoms personally because I feel that the man's penis is not going completely inside...The plain condoms are okay but there are some condoms that are dotted which give a feeling that there is something obstructing." Thus while some people do not like condoms in general (after trying them), some do not like specific type of condoms (like dotted condoms).

2. Lack of knowledge about condom (especially in rural settings)

Though all the study participants did know about condoms, some reported that some years ago they were not aware about the need to use condoms during [penetrative] sex – especially sex with males. As a MSM whose native is a small town said: "No. I did not use condoms at that time [before some years]. Because I did not have any information [about condoms]. I was also not aware that even in 'homosex' there are possibilities of [getting] 'STD' and 'AIDS'." In FGDs, many participants opined that MSM in rural areas and small towns do not have access to information about STDs, HIV, and condoms. Thus, lack of availability information in rural settings is a contextual factor too.

3. Unemployment forced some to take up sex work temporarily and have unprotected sex

Lack of job sometimes forces MSM to exchange sex for money when there is a need for money. But they need not see themselves as 'sex workers'. A MSM reported that when he was unemployed he engaged in sex work temporarily. He said, "Yes, due to unemployment they [other MSM] are doing so [sex work] and having sex without condom...Once I had a trial [asked money] & that person gave me fifty rupees...no condom [was used in that]." Unemployment can also be seen as a contextual factor – not just personal.

Structural Factors In Not Using Condoms

1. Forced sex by policemen – No condoms

Many Kothi-identified MSM reported having heard of or personally been sexually abused by policemen. In some areas, it has become such a routine matter that they consider sexual abuse by policemen as part of their life. As a Kothi-identified MSM said, "I remember one incident where a Kothi was caught by police from [place]... took him into police van and forced him to have anal sex. They did not use condom. Every Kothi [in that area] came to know about this incident. How can a Kothi tell police to use condom?" Key informants and FGD participants stated that the presence of Indian Penal Code Section-377, which criminalizes same-sex behavior, is misused by police not only to extort money from MSM but also to sexually assault feminine MSM.

2. Forced sex by ruffians and clients – No condoms

Many MSM, especially Kothi-identified, reported several incidents of forced sex. Talking about his experience of forced sex, in a FGD, a Kothi-identified MSM said, “Once a person took me from [train] junction on his bike under [a bridge] and two other people came. By showing me a knife forcefully they had sex with me...without condoms.”

Another Kothi-identified MSM reported an incident in which he was forced to have sex with a group of men and condoms were not used.

“On a winter night I was looking out for one address [house]. That time I was wearing a nice outfit and had a long hair. I was lost so I enquired about the whereabouts of that place to some guys standing over there – there were about four to five [guys]. They said ‘Come, we will show you’...I refused...but took me to a garden and threatened me showing a knife. I was scared and told them I had no money but they said that they did not want money but they wanted to have sex with me... they forcibly took me to a room and there they had sex with me one after the other...later there was a swelling in the back side as big as a ‘ping-pong ball’. It was difficult to sit.”

This person did not complain this incident to police but took treatment from a private doctor telling some other reason for the swelling in the anal area.

MSM and Hijras who engage in sex work also narrated incidents in which they were forced to have unprotected sex with their male client. Often, forced sex happened with a group of men. A Kothi-identified MSM in sex work explained how he was cheated by his client and gang-raped by a group of men that led him to contract STI. He said:

“Once my client called me to his place and said that he was alone. But I did not know that he had also called up his office colleagues. They started drinking alcohol and after drinks they forced me to have unsafe sex in the back [anal sex] with them. I suffered from [anal] STD problems after this incident. I was scared that I would have got HIV. I came to [CBO] and regularly got myself tested and now I am sure that I am not having HIV.”

Loss of faith in the law enforcement agency and the presence of the criminal law which does not differentiate between consensual and non-consensual same-sex behavior means many MSM continue to face sexual assaults and also do not get proper medical and psychological care for the same. Only in some major cities certain CBOs provide STI screening and treatment to MSM but not all have professional counselors to deal with the trauma faced by male victims of sexual assault.

C. SOCIAL NETWORKS AND SOCIAL SUPPORT AMONG KOTHI-IDENTIFIED MSM

1. Support from Kothi community friends

MSM who self-identify as Kothi seem to have a lot of Kothi-identified friends than straight (or 'general') friends. In contrast to the gay-identified persons who have sex with one another, among the Kothi community, a Kothi having sex with another Kothi is frowned upon – since they are feminine and more like sisters; and they are expected to have sex only with Panthis or masculine male partners. Attraction towards masculine men and being feminine (and thus facing discrimination) bring Kothis together as a common group.

a. Informal 'Kothi support groups' at cruising sites

Kothis go to cruising sites not only to find out masculine partners but also to socialize with other Kothis in the cruising sites.

Cruising sites as socializing sites for Kothis (Kothis in a FGD)

- “During holidays or in our free time, we go and sit in the 'cruising points'. We meet other Kothis and [non-sexual] relationship happens.”
- “If we didn't go there for 2-3 days then they [other Kothis] ask everyone where is she? Why she did not come?” (Note: Using female pronouns when referring to other Kothis is a way of binding among Kothi-identified MSM)

In the cruising sites, Kothis discuss a range of topics – about their sexual partners to problems faced in their family to problems they face from police. Among other Kothis, they also behave in a feminine manner since that is not going to be looked down by them. Below is the list of some of the topics discussed by Kothis in the cruising site informal gatherings. Though for some this might look trivial, for Kothis, discussions about these topics are very important since they cannot discuss about these with any other people and also other people will condemn or disapprove their feminine mannerisms.

A sample list of topics discussed by Kothis in a cruising site

- “How many Gadiyos* did you eat [had]?”
- “Talk about problems at home”
- “Talk about the size [of male organ] of Parikh*”
- “Why did you give a wrong [phone] number of that Panthi*?”
- “Teasing and blaming each other”
- “Are you using condoms or not?”
- “Condoms are available there.”

(*In different states in India, different terms were used by Kothis and Hijras to refer to their masculine male partners - Gadiyos, Parikhs and Panthis)

Thus, in these informal group discussions at cruising sites, Kothis get and give not only emotional support but they also informational support (about HIV and safer sex).

In one city, the informal support offered by these informal Kothi groups seem to be so strong or attractive that even a gay-identified person wanted to mingle with them since for some reasons he was reluctant to mingle with gay-identified persons. As he explains: “I share a good relation with them [Kothis]. They are good. I also sometimes behave like the way Kothis behave [in a feminine manner] because they like that. My appearance is not effeminate but I behave like that for their pleasure. By looking at them I feel like behaving like them for some time.”

b. Kothis who are ‘confidants’

Apart from the group support, some Kothis also have one or more Kothis as their confidants – with whom they share intimate details. These ‘confidant’ Kothis support their Kothi friends by discussing with them and helping them to sort out their problems. They provide counseling and guidance on a range of issues that include:

- Dilemma in relation to whether to leave their family or not (since family members ask Kothis not to behave in a feminine manner or Kothis face physical abuse by brothers)
- Solving problems between two Kothis because of a fight over a Panthi
- Advising on strategies to avoid problems from police and ruffians

Thus, these ‘confidant’ Kothis also serve as mentors for junior Kothis on certain issues.

Sometimes, if they suffer from any STI, Kothis might reveal them to certain trustworthy Kothi friends who act as confidants. As explained by a Kothi: “One day vegetable vendor asked me ‘What happened? Why are you not coming to the market? Is everything all right?’ He is also a Kothi. I told him everything. He took me to the doctor for check-up. I had to take treatment for two months for the problem I had in my back [anal area]. He told the doctor that I have sex with men. He introduced me to many other boys like me [Kothis]. I felt I was not alone; there are many boys like me.” Thus, that person not only helped this Kothi in getting treatment for his anal STI but also introduced him to a supportive peer group and removed his loneliness.

c. “Adopting” a Kothi as ‘daughter’

Sometimes, mimicking the tradition followed in Hijra community (see next section), senior Kothis may also ‘adopt’ a junior Kothi as their ‘daughter’. ‘Mothers’ are supposed to take care of their ‘daughter’. Though this kind of mother-daughter bonding among Kothis seems comparatively less strong than the more ritualized emotional bonding between a Hijra and her ‘Hijra Mother’, it serves the purpose of formalizing the emotional bonding between two Kothi-identified persons and builds a sense of community.

2. Support from family members

Most MSM do not reveal their sexuality to their family members. Even some Kothi-identified persons suppress their feminine mannerisms at their home not only to conceal their sexuality but also in an attempt to not to bring any ‘shame’ to their family members. However, there are some Kothis who cannot suppress their feminine mannerisms and consequently they face disapproval of their feminine mannerisms and behavior from other family members – especially father and brother. In a FGD, participants also mentioned that usually there is no open discussion about the sexuality or sexual behavior of their feminine son but most parents condemn feminine mannerisms in their son.

As explained by a Kothi-identified person: “They [Parents] didn’t know anything much about me. They only knew that I am more like a girl [feminine] but they support me because I am their child. They were little upset because I used to put on make-up and [sharpen] eye-brows...I am close to Mom, my brothers and sister’s children. People don’t like me because I am a Kothi [here it means ‘feminine’]. My mother is always supportive - after all a mother is the only one who understands her child.”

Some MSM felt guilty that they have not yet disclosed their sexuality to their parents. “I share everything with her [mother] - she is very close to me. She knows about my friends and that I go to the parties but she doesn’t know anything about my [gay] identity. I feel bad and I know that I am cheating my parents but I can’t do anything.”

Inability to disclose their sexuality and guilty feelings related to non-disclosure about their same-sex behavior place these persons at a great psychological stress.

3. Support from 'Panthis' or Masculine male lovers

Though Panthis (masculine partners) are seen as important, many Kothis were of the view that only Kothis can understand other Kothis. However, there were some other Kothis who felt that not all but at least some Gadiyos have very good relationships with their Kothi partner.

Kothis understand other Kothis, Not Panthis

A Kothi in a FGD: "One thing is clear – relationships between a Kothi and another Kothi is of feelings [emotional bonding] and between a Kothi and Panthi [masculine partner] it is only sexual."

Only a few Gadiyos understand Kothis (Kothis in a FGD)

- "Gadiyos only come for sex. Only a very few of them are helpful."

- "Gadiyos did not even say 'Hi! Hello!' [at cruising sites] But Kothis always say 'Hi! Hello!'"

Panthis are also seen as not reciprocating the love of their Kothi partner and for their Panthi partner some Kothis have even consumed poison attempting to take their life away.

Gadiyos - not reciprocating the love of Kothis

"If Gadiyos suffer from anything then Kothis reach there to enquire but Gadiyos don't."

Kothis - dying [literally] for Panthis

"When Panthis walk away [break the relation] Kothis drink poison."

Though those Panthis who come to the cruising sites may not want to be emotionally attached to Kothis, there are some Panthis who form steady relationships with Kothis and they help each other.

Kothis are also aware about the relative instability of the relationships with Panthis who might leave them and get married to woman. Some Kothis continued their sexual relationship with their Gadiyos even after marriage and some discontinued their sexual relation though they might be affectionate to each other.

Thus, the lack of recognition of same-sex marriage; and heterosexual marriage being seen as a social norm and family duty to be fulfilled – mean that steady long-term partnership between a Kothi and their masculine male partner is often not possible and consequently many engage in multi-partner sex and also get married heterosexually.

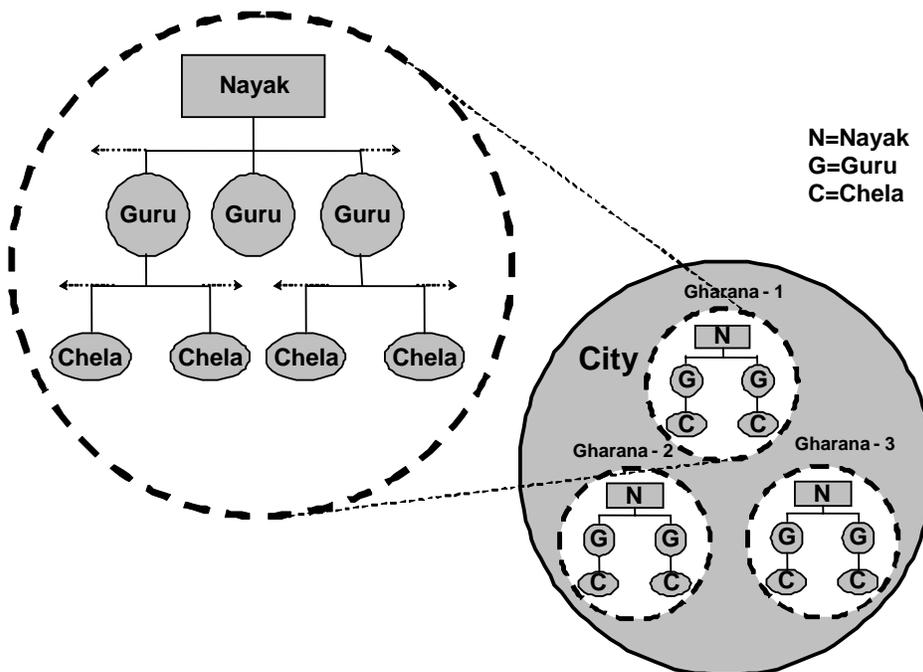
D. SOCIAL ORGANIZATION AND SOCIAL SUPPORT AMONG HIJRAS

1. Social hierarchy and 'Kinships'

In India, Hijra communities are organized into seven major '*Gharanas*' (literally means 'houses'). Each of these *Gharanas* has a key person called *Nayak*, a senior Hijra. Under each *Nayak*, there are many *Gurus* (Master or Teacher), and under each *Guru* there are many '*Chelas*' (Disciples). A person can be *Chela* of a particular *Guru* as well as *Guru* for some other persons (that is, have their own *Chelas*). The *Chelas* under one *Guru* refer to one another as '*Gurubhai*'. For a *Chela* under a particular *Guru*, the '*Gurubhai*' of the *Guru* becomes the '*KalaGuru*' (Aunt) and the '*Guru of Guru*' becomes the '*Nani-/Nana-Guru* or *Dada-Guru*'.

Thus, there is a complex hierarchy and 'kinship' relations among the Hijra communities about which some Hijras expressed their pride.

Fig 5. Social Organization of Hijras



2. Gharanas, Nayaks and Jamaat

A Hijra belongs to either one of the seven *Gharanas* (see box 2), with some regional variations in their names. Though previously these *Gharanas* were distinguished from one another by certain specific characteristics, these days, those distinctions have largely become outdated. Not all *Gharanas* are present in a state or a city.

The ultimate authority of each *Gharana* is the *Nayak*, who can not be questioned or challenged by other Hijras. *Nayaks* have the ultimate say in any disputes arising within the Hijra communities. For each state, there is usually only one *Nayak* for a particular *Gharana*. There are thus seven *Nayaks* in the state of Maharashtra, which has all the seven *Gharanas*. In each major city, one can find Hijras from different *Gharanas*, and the senior *Gurus* of

these Gharanas in these cities convene and preside over the *Jamaat* (a community gathering), which plays an important role in the local Hijra community. The *Jamaat* members participate in the various functions of Hijra communities such as a *Guru* accepting a new person as her *Chela*. *Jamaat* also resolves any disputes that arise within the local Hijra communities.

Box 2. Seven *Gharanas* of Hijras

- Block-waale
- Lashkar-waale
- Bhendibazaar-waale
- Chakla-waale
- Laalan-waale
- Pune-waale
- Dongri-waale

3. *Gurus*

Gurus of a particular *Gharana* come under their *Gharana's* *Nayak*. Some of the *Gurus* serve as representatives of the *Nayak* in different areas or cities. *Gurus* under a particular *Gharana* are usually of equal status (have equal rank) though age and wealth may also determine the status of a particular *Guru*. The *Guru* is respectfully considered as a mother, father or even husband (but without sexual involvement). *Guru* is supposed to take care of all the needs of her *Chelas*. *Gurus* set the territories for their *Chelas* to go and ask for alms ('*Badhai*, see below').

A Hijra was talking highly of her *Guru*: "There is a saying among us that 'Meeting any Hijra is like meeting your mother'. So I like to stay here with Hijras and I don't bother about the society at all. I don't even think about by Panthi [male lover] when I am sitting with my *Guru*. Our life is dedicated here - we have to live here and die here." Thus, this Hijra articulates her attachment to the Hijra community and her love for *Guru*.

In a FGD, many Hijras talked about the kinds of support they get from their *Guru*. As a Hijra said, "When we become ill...if our *Guru* or *NunGuru* is informed, they help us with money." Another Hijra added, "They take us to the hospital, and help us through the [medical] check-ups." However, a Hijra who had faced problems from her *Guru* told that now she is no longer in any *Gharana* and now she is in 'pant-shirt' though she considers herself only as a Hijra - but '*Khada* Hijra'. A key informant (a Hijra *Guru*) was however of the opinion that it would not be possible for a Hijra not to have a *Guru* and if one *Guru* ill-treats her *Chela*, she can always complain against that *Guru* and change to a different *Guru* or *Gharana*. One Hijra has "changed three *Gharanas*" because of some issues with those in her former groups. According to another Hijra, some but not all *Gurus* ill-treat their *Chelas*. She said, "My *Guru* is very good. But there are issues with others over money. My *Guru* does not demand money or force me to give. She accepts what I give. But others might not do the same. I have seen *Gurus* beating their *Chelas* for not giving enough money. Then the *Chelas* change their *Gharana*. I am in this *Gharana* for the last 7 years." Thus, the presence of a redressal system with the Hijra community (if *Guru* ill-treats *Chelas*) seems to be working for many Hijras.

4. Chelas

A person who joins the Hijra community has to first find a *Guru*. She has to pay a nominal fees (for example, Indian Rupees 5.25) to join the Hijra community and accepting a person as her *Guru*, and this is usually done as a formal function (*Reeth* – see below). *Chelas* respect their *Gurus* and show obedience in the form of formal greetings and bowing down and touching their feet to get their blessings.

The *Chelas* of a *Guru* are like sisters though the Hindi term '*Gurubhai*' literally translates into '*Guru-Brother*'. Many study participants mentioned their *Gurubhai(s)* as their confidante. A *Chela* can change the *Guru* (and even *Gharana*) by paying small fees to the *Nayak* either directly or through *Nayak's* representatives.

A Hijra talked about how she was taking care of one of her *Gurubhai* who is HIV-positive: "One moment - she is smiling and in another moment she starts crying. She was living life but empty... I take her to movies and roam around with her and give love to her - because such people need that [support]." Thus, this person is providing companionship and much needed emotional support to a HIV-positive Hijra. Though, some Hijras do discriminate HIV-positive Hijras, some take care of them.

5. Living arrangements

Though, even now, many Hijras live together in a single household, some have also started living on their own or cohabit with their male lover ('*Panthi*'). In some areas, Hijras sharing a household also engage in sex work, though in some *Gharanas*, Hijras are not supposed to engage in sex work. Usually, Hijras in a household belong to the same *Gharana*.

6. Livelihood

Most of the Hijras join the Hijra communities after running away from their families at an early age, and thus usually have not completed any formal education. Thus, lack of education and lack of other job opportunities mean many Hijras resort to one of the following ways to earn money for their livelihood.

Chelas earn money through *Badhai*, *Mangti* and/or *Dhandha* (sex work), and give the money to their *Guru*.

Badhai: Refers to asking for money and materials by going to occasions and functions such as marriage, birth functions (especially birth of male babies), and opening of new shops. They use 'Dholak' (drums) and other musical instruments when they sing and dance on these occasions.

Mangti: Refers to asking money and materials from going shop-to-shop; from passengers at the traffic signals; and by blessing the couples on the beach.

Dhandha (Sex work): Key informants reported that some proportion of Hijras from any *Gharana* may engage in sex work, though previously Hijras from certain *Gharanas* (such as '*Pune-waale Gharana*') are not supposed to engage in sex work. In Mumbai and Kolkata, there are separate brothels of Hijras, alongside or separate from the brothels that have female sex workers.

Other work: Some Hijras work as domestic servants or cooks. These days, some are working as field staff in some community organizations and NGOs working with Hijras.

7. Social Customs, functions and Social Control

Hijras participate in a wide variety of social functions organized for and by Hijras. The following lists some of the social functions and regulatory mechanisms within the Hijra communities.

a. 'Reeth' (Formal Induction Ceremony)

If a new person wants to formally join the Hijra community, a function called *Reeth* is arranged in which in presence of senior Hijras from different *Gharanas*, the *Guru* formally accepts that person as her *Chela*.

b. 'Dood-dar' ('Milk-pouring' function)

Some Hijras undergo emasculation operation – either through qualified surgeons or through unqualified practitioners. After 40 days of emasculation, a function is held by inviting all the Hijra community friends, which serves as a public announcement that she has become *Nirvan* (undergone emasculation).

c. Formalizing mother-daughter relationship

A Hijra can be adopted as a 'daughter' by another senior Hijra though that Hijra might also be a *Chela* of another Hijra. Not all Hijras have Hijra 'mothers'. *Mother* is supposed to take care of her daughter throughout her life. Though one can change their *Guru* (and *Gharana*), one cannot change their 'mother'. (Note: This is different from the system in some parts of South India, where only the *Guru* is the 'Mother'.)

d. Area allocation for 'Badhai' by senior Hijras

The places where Hijras can go for *Badhai* are allocated by senior Hijras in a locality, who function as the representatives of the *Nayak* of that *Gharana*. Usually there is no such restriction for the areas where Hijras go for *Mangti*.

e. Regulations and Punishments

All Hijras are expected to respect their elders and behave modestly and honestly. In case, there are any incidents where disputes arise; for example, a Hijra verbally or physically abusing a senior Hijra or *Guru*, then that case will be heard by a panel of community leaders (see *Jamaat*) And if the magnitude of the problem is severe, it will go to *Nayaks*. If the offence is small, the offender will be asked to give a formal apology to the person she had assaulted and if she does not agree to apologize or pay fine, then she will be temporarily outcasted by the entire Hijra community until she pays fine and/or asks for a formal apology.

8. Marriage with 'Panthis' and Support

Some Hijras cohabit with their masculine lovers, whom they call Panthis (or Gadiyos in Gujarat and Parikh in West Bengal). Though in some Hijra communities, cohabiting with a Panthi and/or getting 'married' to a Panthi is not allowed; in some communities they are accepted. It seems that if the *Guru* accepts the marriage everyone else does. As this Hijra says: "I found a nice man and told my *Guru*. She called for a get-together of Hijras and she made my Panthi wear me a *mangalsutra* ('sacred thread' symbolizing marriage union). Now I am living with my Panthi for the last two years."

Some Hijras may have male lovers but they may not cohabit with them. While Hijras support Panthis financially whenever there is a need, some Panthis also provide financial support to their Hijra partner. A Hijra tells why she asks her Panthi and not her supportive parents: "My parents cannot help me financially. Hence I take help from my Panthi. He helps me full

heartedly.” But, in a FGD, many Hijras were of the view that many Hijras spend a lot of money on their Panthi and they do not get anything in return.

Some Panthis also support their Hijra partner even if they are known to be HIV-positive or suffering from STIs. As a Hijra explained:

Till six months I was scared that my Panthi [male lover] will also get infected because of me. But later I asked him to undergo [HIV and STI] test. He said that if you are positive then let me also do the test and see what it is. His reaction on hearing my status was very good. If there was any other man he would have left me - but he supported me and never left me. And till my ‘herpes’ [a STI] got well he was with me. I didn’t have sex with him till six months with fear. But he still used to come regularly to me and he used also get his blood tested every three months.”

Thus, this Panthi seems to have an affectionate, not just sexual, relationship with this Hijra. Open communication about HIV and STI status among this couple is also not widely seen among other ‘man-Hijra’ couples.

Thus, we have seen that Hijra communities have their own social customs, and rules and regulations to be followed. The importance of understanding the Hijra community structure and norms in relation to HIV prevention and care are discussed in the next section.

E. HIJRA COMMUNITY NORMS AND BELIEFS: RELATION TO HIV RISK

1. Hijra community norms about using condoms

As we have seen earlier, *Guru* (of a group of *Chelas*) seems to play a key role in their lives providing guidance, emotional, and material support. Some *Gurus* are supportive of condom use among their *Chelas*. For example, a Hijra said, “I started using condoms because our *Guru* had informed us not to have sex without condoms. Even now we do regular check-ups. I like to be in the Hijra community, because whatever wishes I had in my heart have been fulfilled after coming here.” Thus, support from her *Guru* and a strong sense of belongingness to Hijra community motivated her in consistently using condoms. However, another Hijra felt that most Hijras in sex work do not use condoms. As she said, “I know of many Hijras in *Dhandha* [sex work] not using condoms. I think they might be [HIV] positive. That is why they do not use [condoms].” Thus, resistance to using condoms among some Hijras who engage in sex work was felt by some other Hijras that many Hijras are likely to be HIV-positive.

These days, Hijras are employed as outreach workers and peer educators by CBOs working with Hijras and MSM, to provide information about HIV and to distribute condoms. This peer outreach seems to be an effective strategy. Not only those Hijras who are employed by CBOs provide HIV information to other Hijras but some Hijras also volunteer to spread information about HIV and the need to use condoms to other Hijras. As a Hijra explained, “[CBO staff] gave me all the information [about HIV and condoms] then I transferred all that information to other Hijras.” Thus, in spite of being not compensated for their time and efforts, some Hijras volunteer to educate other Hijras about HIV since they do not want their community people to contract HIV.

An increasing perception that anyone can be HIV-positive might also be a reason for the increased community support for using condoms. When asked why she uses condoms even with her male lover, a Hijra replied: “Because I had learned that HIV can come from anywhere and I can be positive. Anybody can be positive.” In a FGD, Hijras discussed about the risk from their male partners: “We have risk from every kind of man – married or unmarried.” Thus, it is possible that this increased risk perception among Hijras motivate them to use condoms with their male partners.

In a FGD of *Panthis* (masculine men who have sex with Hijras and Kothis), some *Panthis* complained that it was the Hijras who refuse to use condoms and not them. Though this is in contrast to the versions of some Hijras that it was their male lovers or clients who refuse to use condoms, it is possible that some proportion of Hijras as well as some proportion of *Panthis* may not want to use condoms for a variety of reasons (as seen in the earlier section) and thus it is important to change their negative attitude towards condom and increase its use among them.

2. ‘Periodical HIV testing’ as an emerging community norm among Hijras

When asked why she went for a HIV test, a Hijra replied: “Everyone [other Hijras] was testing so even I felt like doing it.” She told that she periodically underwent HIV testing every three months. It could be because this Hijra participated in the projects among sex workers that promote periodic STI screening. But, since periodic HIV testing is not directly promoted by such project campaigns, it is possible that at least in some sections of Hijra communities in Mumbai, undergoing HIV testing is now seen as a prudent way to take care of oneself.

Another Hijra said that she underwent HIV testing since she wanted to get relieved of the tension whether she was infected or not. As she said, “Everyone [Hijras] was doing the test. I am in *Dhandha* {sex work} and also know about HIV. So I thought that I should get tested. I was in doubt [about HIV status] and hence I underwent that test. Now I am free of tension that I don’t have the disease.” In contrast, for another Hijra, knowing her HIV status would make her tensed and hence she did not want to know it: “I do not even want to know whether I have the disease [HIV] or not. I am scared that if I come to know that I have HIV then I will die of that tension.” For some, HIV testing was just a routine. As a Hijra in sex work said, “Yes. I have done it [HIV testing] two-three times...For my safety – because I engage in sex work.” The need to repeat HIV testing might mean unprotected sexual episodes do happen. As another Hijra said: “Yes, I test myself [for HIV] once in a year because I am afraid that sometimes under the influence of alcohol if I had done anything wrong [means not using condoms] then I might have got this disease.”

A key informant opined that the increasing visibility of a lot of HIV-positive Hijras and increasing deaths among Hijras due to HIV-related illness might have encouraged more number of people to go for HIV testing. Another Hijra who have undergone HIV testing also noted that discrimination of HIV-positive Hijras by other Hijras prevent some to undergo HIV testing. Thus, there is also a need to provide appropriate and accurate information among Hijras not to discriminate HIV-positive persons.

3. Certain risk reduction measures are becoming peer norms among Hijras

Some Hijras have successfully developed many strategies and techniques to decrease the risk of HIV acquisition. And some of these are passed on to others and hopefully they also become community norms or practices.

a. Encouraging others to adopt the stance – “No condoms, No sex”

Many Hijras in sex work seem to have adopted this stance. For examples, a Hijra explained why she refuses to engage in unprotected sex even if she was offered more money: “...I cannot spoil my health for little more money.” And another Hijra gave a similar reply: “I would not have sex without condoms even if more money is offered ...If I live well I will earn more.” Thus, using condoms is seen as a long-term investment in her health and thus ensure getting money consistently over a long period of time. She was aware that not using condoms and getting more money for it is not only places her at risk of HIV/STI but also diminishes her long-term earning capacity. A key informant was of the opinion that similar to the female sex workers in Kolkata, West Bengal, (where there is a strong female sex workers union) if every Hijra refuses to have unprotected sex with her male partner then all the male clients of Hijras will have no other option but to use condoms and thus all could remain safe.

b. Successful negotiation skills are passed onto other Hijras

Certain Hijras have gained skills in negotiating condom use with their clients as well as their steady partner. A Hijra explained how she negotiates with her client who is unwilling to use condoms. She would say, “I would tell him ‘It is okay to have sex with me without condoms because you know me and know that I do not have any disease. But suppose you meet someone unknown and if you like that person, how can you say that she is not infected? So it is better that you use condoms. It is safe.’” Some senior Hijras pass on these strategies to other Hijras so that they also follow those successful strategies. It is possible that such ‘diffusion of knowledge’ help many Hijras to adopt these skills as part of community practices.

c. Advising other Hijras to avoid situations where forced sex can happen

Since forced sex happens in isolated places, Hijras in a FGD told that experienced senior Hijras advise their juniors not to go to isolated places where they could not find people who can come for help if someone is going to force them to have unprotected or non-consensual sex. A Hijra told that once when a man forced her to have sex with him she screamed so loudly that he ran out of that place. Though these look like very simple strategies and plain common sense, many Hijras, who were not aware about this practical knowledge gained by the experience of senior Hijras, take the risk of going alone with a male client to isolated places and face the risk of gang rape or forced unprotected sex. Thus, this kind of mentoring of junior Hijras by experienced Hijras seems an acceptable way of teaching Hijras about some practical risk reduction measures.

4. Sexual silence in certain *Gharanas*

Though many Hijras have sex with men and do engage in sex work, *Gurus* in some *Gharanas* do not talk about sex or HIV. According to a key informant who is a Hijra *Guru* herself, “Many *Gurus* are from older generations. They will be talking only about the olden days – [They will say] – ‘We lived like this – We lived liked that’ [meaning being ascetic and not sexually active]. But now, the time has changed. It is important to get their support... [but] don’t tell [teach] them everything about sex and HIV in a single sitting. That needs to be done slowly...over a period of time.” Thus, according to this key informant, senior Hijras need to be sensitized about HIV and the reality that Hijras do engage in sex and sex work and thus there is a need to break that silence.

Another key informant also mentioned that Hijras from certain *Gharanas* such as Pune-waale *Gharana* who worship Goddess Renukha Devi (‘Jogti Hijras’) are not supposed to have sex as they are dedicated to the Goddess. *Gurus* from that *Gharana* (Pune-waale or Mandir-waale) may not approve of distributing condoms to them. In a FGD, a Hijra was quick to point out that some *Gurus* engage in sex but one cannot question them since they are seniors. Talking about this apparent ‘double-standard’ another Hijra defended the *Gurus* saying that even in the general population juniors cannot question the elders about what they do.

Thus, the respect accorded to *Gurus*; not in a position to challenge *Guru*’s beliefs or activities (since one could be punished for it – ‘Dund’); and the religious beliefs – all pose challenges to talk about safer sex and HIV/STI among certain sections of Hijra communities.

5. ‘Emasculatation’: Community perceptions, Availability of operation in public hospitals, and Relation to HIV risk

Some Hijras expressed that there is a belief among Hijras that if emasculatation is done by a senior Hijra (called ‘Daiamma’) rather than by a doctor, then all the ‘masculine blood’ will go away from that Hijra’s body and thus she would become more feminine. A key informant (who is a Hijra *Guru*) informed that after becoming HIV-positive some Hijras undergo emasculatation under the false belief that the blood lost during emasculatation will reduce the amount of HIV in their body. While similar information was also shared by another key informant, this information was not discussed in the in-depth interviews and FGDs. However, this information points out the need to remove certain misconceptions associated with emasculatation.

In a FGD, Hijras were divided on the opinion about within the Hijra community whether a Nirvan (emasculated) Hijra is considered to have a higher status than an Ackwa (non-emasculated) Hijra. Some Hijras were of the view that since those who have undergone ‘Nirvan’ are considered superior many chose to undergo emasculatation. Some other Hijras

argued that both Ackwa and Nirvan Hijras are considered equal in the Hijra community and no one is ever forced to undergo emasculation – only those who want to undergo emasculation are provided assistance by the Hijra communities. The lack of availability of sex change operation in the public hospitals was also mentioned by some Hijras why they go to unqualified medical practitioners. A key informant in Gujarat mentioned that a CBO in Baroda has sensitized the local public hospital to offer sex change operation to those Hijras who are eligible for that operation – but still that operation is not entirely free of cost. Recently, Tamil Nadu state government has issued an order that states that public hospitals in Tamil Nadu will begin to offer free sex change operations for those Hijras who are eligible.

In absence of the availability of free sex change operation in public hospitals, many Hijras resort to unqualified medical practitioners for undergoing emasculation. Since they require anywhere from Indian Rupees 10000 to 15000 for emasculation operation, Hijras engage in sex work to earn that money – sometimes agreeing to have sex without condoms. Thus, lack of access to free sex change operation in public hospitals is indirectly associated with increased HIV risk to Hijras.

Thus, we have seen that though there is an increase in the risk perception and increase in the uptake of HIV testing among Hijras, there are other challenges that are linked to HIV risk directly or indirectly: silence about sex and condoms in some *Gharanas* of Hijra communities; misconceptions about emasculation; and lack of availability of sex change operation in the public hospitals.

V. CONCLUSIONS & RECOMMENDATIONS

A combination of extensive sexual mixing, concurrent sexual relationships, and inconsistent condom poses increased risk of HIV transmission and acquisition

This study has documented extensive sexual mixing within and across various subgroups of MSM. Though assortative mixing (mixing within homogeneous populations) does occur, disassortative mixing seems to be more common. Thus, there is mixing across age groups, socioeconomic classes, and with persons of different sexual identities and STI/HIV status. Extensive mixing occurs through: cruising sites in the cities; frequent travellers connecting urban and rural sexual networks or connecting different cities in different states; sex work; phone contacts; referrals through personal friendship networks; and the Internet. Additionally, MSM from various subgroups engage in bisexual behaviour either out of choice (bisexual orientation) or because of family pressure to get married to a woman. Many sexual relationships are concurrent. Extensive sexual mixing along with concurrent sexual partnerships and inconsistent condom use poses a high risk of transmission and acquisition of HIV and STI within and across various subgroups of MSM and also to their female partners and unborn children.

Need to reach out to MSM who are not accessed through site-based targeted interventions

Almost all current targeted interventions for MSM are city-based and reach out to MSM who self-identify as Kothi or gay. Thus, targeted interventions miss a large number of MSM who do not access cruising sites and who meet other MSM in various other ways. One possibility for reaching out to these MSM is through mass media campaigns that address the risk of HIV/STI through unprotected sex with men, women or Hijras. However, it is also necessary to develop other strategies that are ethical and appropriate to the various subgroups of MSM who may not be accessed through site-based targeted interventions. For example, the feasibility of Internet-based interventions should be considered. Operations research studies to design appropriate program components for reaching out to diverse groups of MSM are needed.

Address contextual factors: Move beyond behaviour change communication (BCC) approaches

Often, HIV prevention views the individual as solely responsible for his/her behaviour, irrespective of the particular theoretical model on which the behaviour change communication (BCC) strategy is designed (such as the AIDS Risk Reduction Model or the Health Belief Model). As a result, the focus of intervention is on changing an individual's personal attitude towards condoms (for example, his personal dislike of condoms) or imparting skills in using condoms, through condom use demonstrations. However, BCC approaches seem to largely overlook contextual factors, including interpersonal (for example, power differentials) and structural factors (such as law and social control). For example; How can we help a person to use condoms who is concerned that asking his steady partner to use condoms will affect their relationship; What can we do to address situations where MSM know about using condoms and always carry condoms, but are forced by policemen or ruffians to have unprotected sex with them? Thus, there is a need to assess these contextual factors (interpersonal and structural) and to devise appropriate interventions. For instance, improving sexual communication skills and condom negotiation skills among MSM can be

one of the many possible ways to break the silence around talking about condoms within steady or casual relationships. Addressing structural factors, such as legal barriers (Indian Penal Code Section-377), which lead to police abuse of power against MSM and Hijras, will take time, but is vital to reduce the spread of HIV. In addition to the need to decriminalize adult consensual same-sex behaviour, there is also a need to retain the criminalization of non-consensual same-sex behaviour, since many ruffians and policemen have forced sex with feminine MSM and Hijras.

Influential community leaders can help to create community norms that support safer sex behaviours and decrease discrimination faced by HIV-positive people

Kothi-identified MSM and Hijras often have seniors as their confidants or mentors. While the peer education model is being successfully implemented in most parts of the country among different key populations, there is relatively little understanding about whether and how we can make use of influential community leaders whose advice is followed by their community members. In Hijra communities, senior *Gurus* and *Nayaks* are possible community leaders who can help in creating supportive community norms in relation to safer sex, treatment of STI and HIV, and decreasing discrimination faced by HIV-positive Hijras from their own community members. The 'community popular opinion leader' (CPOL) model used in some developed countries (Kelly, 2004) can be adapted to suit the Indian context.

Promoting social acceptance of MSM and Hijras requires educating the public about sexual diversity and changing social norms

Most MSM and Hijras have only their own community members as close social contacts who offer emotional and material support to them. MSM, including Kothi-identified persons, often do not discuss their sexuality openly with their family members and consequently do not get emotional support from them. Hijras are often shunned and disowned by their own family members, forcing them to leave their home and to join Hijra communities. Although MSM do not disclose their sexuality to relatives, neighbours, and straight friends, they may face discrimination nonetheless, especially if they are feminine. Promoting social acceptance of MSM and Hijras requires educating the general public about sexual diversity among humans and emphasizing the need to accept that diversity without discriminating against those who have diverse sexualities. A long-term strategy is required to achieve the goal of having a society that does not discriminate against persons on the basis of their sexual orientation or gender identity since stigma and discrimination directly or indirectly increases the risk of HIV acquisition and also hinders HIV prevention efforts.

Box 3. Summary of Recommendations

Implications for Programs

- Individual-focused ‘Behavior Change Communication’ (BCC) approaches alone are inadequate. Powerful social and contextual factors—such as partner dynamics, stigmatization and criminalization of consensual sex between men, and sexual violence against MSM and Hijras—lead to unprotected sex.
- Assist individuals in disclosing STI and/or HIV status to their male and female steady partners.
- Reach out to men through mass media – emphasizing the importance of having safer sex with partners of any gender.
- Develop locally relevant program models to adapt the ‘community popular opinion leader’ concept, in which influential community leaders endorse safer sex messages.
- Conduct operations research to identify program components of targeted interventions that are not cruising site-based.
- Work with police to prevent sexual and physical abuse, and to provide protection to MSM and Hijras against ruffians.
- Prevention programs working with specific male populations (such as truck drivers, male migrants, male youth, prisoners, and IDUs) need to address same-sex/bisexual behavior.

Implications for Policies

- Decriminalize consensual adult same-sex relationships.
- Codify and enforce laws preventing physical and sexual abuse of sexual minorities.
- Enact anti-discrimination laws to make it illegal to discriminate by sexual orientation and gender identity.

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