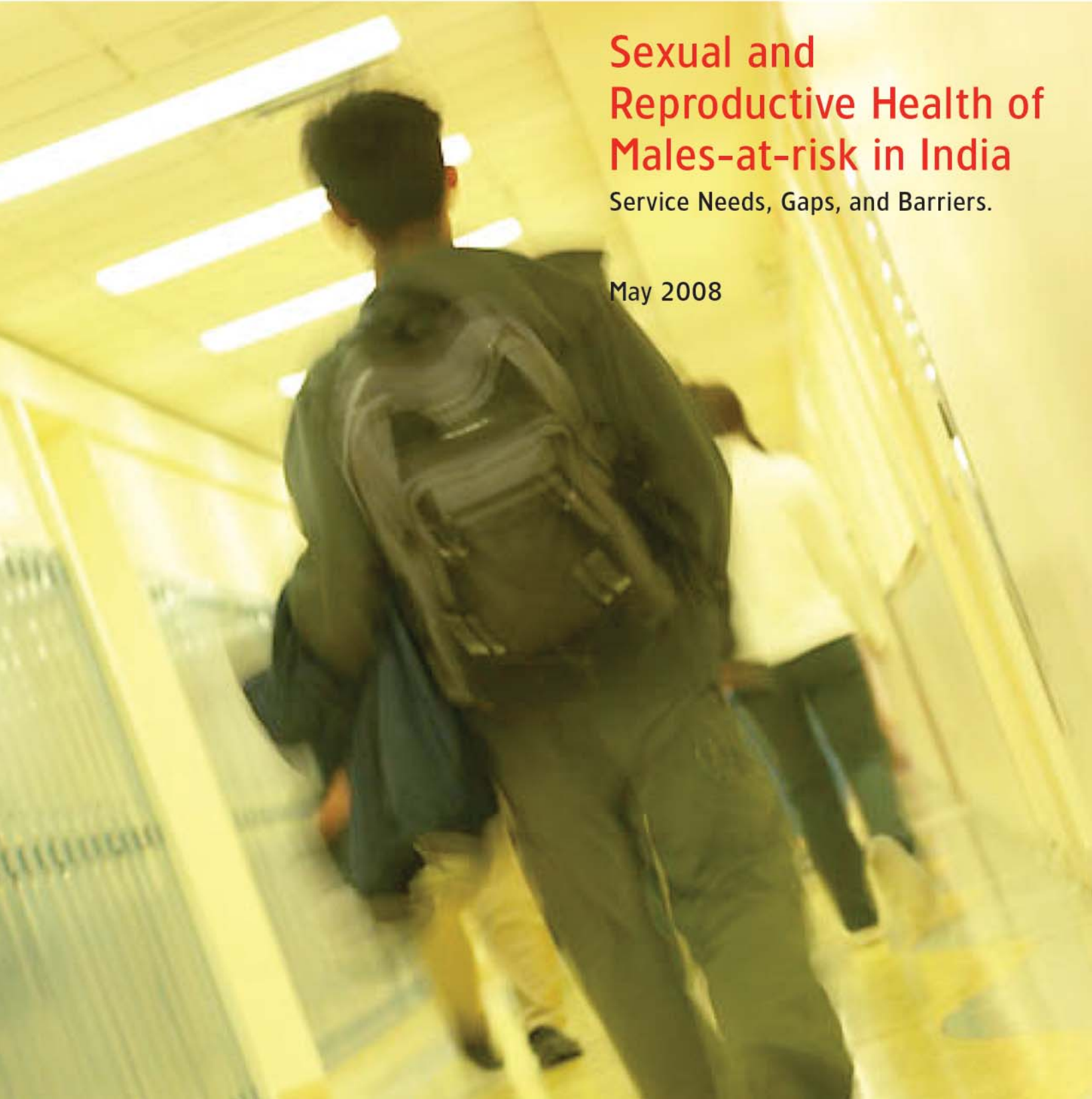


Supporting Community Action on AIDS in India

Sexual and Reproductive Health of Males-at-risk in India

Service Needs, Gaps, and Barriers.

May 2008



The India HIV/AIDS Alliance
(Alliance India) was established
in 1999 to expand and intensify

the International HIV/AIDS Alliance's
global strategy of supporting community
action to reduce the spread of HIV
and mitigate the impact of AIDS. Since
its inception, the Alliance has been
committed to fostering and supporting
the development of community-driven
approaches to HIV/AIDS prevention,
care and support and impact mitigation
in India, with an emphasis on local
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Alliance India currently provides
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secretariat based in New Delhi and four
linking organisations (or, Lead Partners)
and State Partner Organisations working
in Delhi, Tamil Nadu, Andhra Pradesh,
Manipur and Maharashtra.

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For more details, please write to:

India HIV/AIDS Alliance
Third Floor, Kushal House
39 Nehru Place
New Delhi 110019. India
Tel: +91 11 41633081
Fax: +91 11 41633085
Email: info@allianceindia.org
Web site: www.aidsalliance.org; www.aidsallianceindia.net

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Acronyms and Abbreviations

AIDS – Acquired immunodeficiency syndrome

ANM – Auxiliary Nurse and Midwife

AWW – Anganwadi Worker

ARV – Antiretrovirals

ART – Antiretroviral therapy or treatment

CBO – Community-based organization

FGD – Focus Group Discussion

FP – Family planning

HBV – Hepatitis-B Virus

HIV – Human Immunodeficiency Virus

IDU – Injecting Drug User

INP – Indian Network for People living with HIV

KII – Key informant In-depth Interview

MSM – Men who have sex with men

NACO – National AIDS Control Organization

NACP – National AIDS Control Programme

NGO – Nongovernmental organization

PLHIV – People living with HIV

SACS - State AIDS Control Society

SRH – Sexual and Reproductive Health

SRS – Sex Reassignment Surgery

WHO – World Health Organization

VCTC – Voluntary Counselling and Testing Centre

VDRL – Venereal Disease Research Laboratory Test

Executive Summary

1. Study purpose

Research studies on the sexual and reproductive health (SRH) needs of males from marginalized groups are few in comparison to those of women and adolescents. Whilst HIV-related sexual risk behaviours have been studied and documented among various sub-groups of males-at-risk (MSM, Hijras, migrant workers in slums, etc.) there is near lack of comprehensive information on the unmet SRH needs; availability of appropriate SRH services; and access to and utilization of existing SRH services for males-at-risk. In this context, the India HIV/AIDS Alliance in collaboration with community-based and non-governmental organisations conducted a research study in five states - Delhi, Manipur, Maharashtra, Tamil Nadu and Andhra Pradesh.

This study explored the needs and barriers to SRH services among males-at-risk: migrant workers in slums; male injecting drug users (IDUs); men who have sex with men (MSM); Hijras/Aravanis (Transwomen); and men living with HIV. The Alliance anticipates that this study will contribute to building an evidence base for designing appropriate policies and programmes to meet the SRH needs of various groups of males-at-risk, and inform the development of improved linkages between broader SRH services and HIV-related services for males-at-risk in India.

2. Methodology

Qualitative methodology was used. Thirty-two focus group discussions (n=226 participants) and 22 key informant interviews (with community leaders and service providers) were conducted, audiotaped and transcribed. Interview and FGD data were analyzed using a narrative thematic approach with techniques adapted from grounded theory.

This study was implemented with active collaboration of community-based and non-governmental organizations in cities located in 5 Indian states: Hyderabad (Andhra Pradesh); Chennai and Madurai (Tamil Nadu); Mumbai (Maharashtra); Imphal (Manipur); and Delhi.

3. Key findings

Migrant workers in slums

A number of barriers arose in terms of outreach to migrant workers in slums with SRH information and services: absence of government male field workers, lack of explicit sexual health and family planning information from government female field workers, and absence of government outreach at work sites. Men face a number of challenges in consistently using condoms with their female, male, and Hijra sexual partners. Condoms are sometimes not accessible due to cessation of funding for free condoms from NGOs and free condom availability that is limited to

those who attend government hospitals for STI treatment or HIV testing. Access to government health services – STI, antiretroviral treatment (ART) and family planning services – for slum men is mainly facilitated by NGOs; these men feared discrimination in the absence of NGOs. Nevertheless, a number of barriers emerged to utilization of government hospitals: large crowds; inadequate number of health care staff; lack of respect from providers; lack of privacy and confidentiality; and difficulty in navigating larger government hospitals. Spousal screening and treatment for STIs also remains a challenge. Migrant workers in slums also reported a variety of reasons for not undergoing a vasectomy: a sterilization operation is seen as synonymous with tubectomy (not vasectomy); belief that vasectomy is associated with loss of sexual potency and weakens the body; and fear of being belittled by other men.

Male Injecting drug users (IDUs)

Male IDUs reported sexual experiences with women, Hijras and men. Complex relationships between sexual drive/performance and drug use were identified: lack of control over sexual impulse while under the influence of drugs, delayed ejaculation, inability to achieve orgasm, and premature ejaculation. Some IDUs reported misconceptions about STIs/HIV and underestimate their risk of HIV infection from unprotected sex. HIV-positive IDUs discussed having adopted sexual and drug-related risk reduction behaviours after their HIV diagnosis once they were connected to drug-related services such as drug-dependence treatment or opioid substitution therapy. Homeless IDUs primarily relied on services provided by NGOs and expected NGO staff to accompany them to government health services. They sought STI treatment primarily from the NGO and government clinics, though some IDUs resorted to self-medication or going to quacks. Trained ex-drug users were the preferred providers of information to current IDUs.

Kothi-identified men who have sex with men (MSM)

Kothis face stigma and discrimination, as well as misunderstanding and misconceptions about same-sex sexuality among the general public and health care providers. Name-calling and teasing by the general public make Kothis feel bad about their sexuality and has a negative impact on their mental and sexual health. Kothis complained about the lack of healthy sexual and romantic relationships with their Panthis (masculine sexual partners). Kothis wanted to have the right to marry their Panthi partner and to have legal recognition of that marriage. Heterosexual marriage emerged as a powerful social norm and an obligation to parents that compelled Kothis to get married to women. Married Kothis complained of sexual dysfunctions with their wife and adopted several strategies to make their heterosexual marriage work. In cruising sites, Kothis especially those who engage in sex work face physical and sexual violence, and extortion of money from police/ruffians. In the context of non-consensual sex, which is abetted by human rights violations against Kothis, risks for HIV/STI are heightened and condom use is often not a possibility. Additionally, Kothis often do not know about nor do they have access to sexual post(HIV)-exposure prophylaxis or rape counselling and services.

Hijras/Aravanis (Transwomen)

Some Hijras reported cohabiting with or even getting 'married' to their Panthi, even in the absence of legal recognition. Hijras, irrespective of whether they engage in sex work, experienced difficulties in using condoms consistently with their regular, casual, and paying partners, as well as faced sexual and physical violence from ruffians and police. In government-run STI clinics, particularly in the absence of NGO mediation, Hijras reported stigma and discrimination from health care staff. As a result, Hijras preferred NGO-run clinics where they can undergo periodic anal STI screening. For emasculation, Hijras mainly seek out unqualified medical practitioners

in spite of bad surgical procedures and unhygienic clinic environments. Consequently, they face increased chances of post-operative complications such as urethral stenosis or stricture (blockage). Though Tamil Nadu state government has recently announced provision of free sex reassignment surgery in government hospitals, it has yet to be widely implemented and health care providers need proper training to be competent in providing SRS to Hijras/transgender women. Feminising procedures used by Hijras also include self-medication with female hormones, facial hair removal by electrolysis and silicone breast implants. These services are currently unavailable in government hospitals.

Men living with HIV

Men living with HIV may be sexually active after HIV diagnosis and many reportedly adopt safer sex behaviours and reduce their number of sexual partners. Single HIV-positive men reported a dilemma around whether or not to get married. Men who are in an HIV-serodiscordant relationship reported condom use with their wife; however, they were unaware of sexual post-exposure prophylaxis in case of condom failure. Men living with HIV reported mixed responses in regard to the availability and quality of sexual risk reduction counselling in government antiretroviral (ART) centres, and voluntary counselling and testing centres (VCTCs). While some men had general ideas about the benefits of condom use for people living with HIV, many lacked accurate information and in-depth knowledge. Men were largely unaware of family planning options for them, the need for dual methods of contraception, and emergency contraception.

4. Key recommendations

Males-at-risk, including PLHIV, need to be provided with accurate information and services to preserve and enhance their sexual and reproductive health, and to exercise their sexual/reproductive rights.

Promoting Safer Sex Behaviors

- Adopt multiple strategies to promote and sustain safer sex among males-at-risk in a variety of settings: one-to-one risk-reduction information/counselling (peer outreach and peer/professional counselling); couples counselling (tailored for those who are HIV sero-discordant and sero-concordant); and mass media campaigns.
- Provide tailored sexual risk-reduction counselling that takes into account the contexts that influence condom use— i.e., counselling that avoids focusing narrowly on individual-level factors to the exclusion of social and structural constraints (e.g., stigma, sexual violence, harassment, disrespect from healthcare providers, lack of access to free condoms).

Sexual and Reproductive Health: Policies

- Articulate SRH service needs of males-at-risk in national policies, and how those service needs can best be met through the health care system.
- Allocate adequate resources to meet the SRH needs of males-at-risk.
- Protect MSM and Hijras from the physical/sexual violence perpetrated by ruffians and police - by repealing laws that criminalize consensual same-sex adult relationships and enacting anti-discrimination laws.
- Provide legal recognition of gender identity of Hijras; and male-male and male-Hijra steady partnerships.
- Ensure adoption rights for single individuals – including MSM and Hijras.
- Provide sex reassignment surgery and feminizing procedures for Hijras/Transwomen in government hospitals with appropriately trained medical personnel.
- Enact anti-discrimination policies in the health care system.

- Improve linkages and referrals between HIV treatment and care services, drug treatment and care services, HIV/STI prevention programs, and sexual/reproductive health services.
- Ensure uninterrupted and committed funding for CBOs, PLHIV networks and NGOs working on HIV/STI prevention and care programs as well as programs that address sexual and reproductive health of various populations of males-at-risk.
- Implement tested and innovative strategies for partner screening/treatment and assist people in voluntary disclosure of their STI/HIV status to their partners.
- Address unmet information and service needs of MSM and Hijras: Information and counselling on sexuality; sex reassignment surgery (SRS) and feminizing procedures for Hijras; post-sexual assault care and counselling, including sexual post-exposure prophylaxis (for male/Hijra victims of sexual assault); and counselling and treatment of sexual dysfunctions among MSM who are married to women.

Sexual and Reproductive Health: Service delivery

- Equally involve men and women in family planning counselling to enable them in making informed choices about family planning method(s) suitable for them.
- Launch effective public education campaigns on the family planning options (including vasectomy) available for men.
- Train health care providers on SRH needs and rights of various marginalized groups. Emphasize the need to offer counselling and provide services in a non-judgmental and unbiased manner.
- Improve health care infrastructure to have private rooms for counselling/examination of patients coming to obtain SRH services, and ensure adequate number of trained health care staff.
- Address unmet information and service needs of men living with HIV: benefits for people living with HIV in using condoms; sexual post-exposure prophylaxis; 'sperm-washing' technique to allow HIV sero-discordant couple to have their own child; emergency contraception; right to get married and have children; and safe contraceptive options for people living with HIV.
- Launch antidiscrimination education campaigns in the mass media targeting the general public to combat stigma and discrimination associated with people living with HIV, same-sex attracted people, Hijras/Aravanis, and drug users.

1. Introduction

HIV epidemic in India has led to increased attention on the sexual risk behaviours of marginalized populations such as men who have sex with men (MSM), Hijras/ Transwomen, male injecting drug users (IDUs), and migrant workers in slums. Interactions between sexually transmitted infections (STIs) and HIV risk, has also renewed the focus on STI prevention/treatment among these populations. Consequently, HIV-related sexual risk behaviours and STI/HIV prevalence have been relatively well studied among these populations in different parts of India. However, when compared to those of women and adolescents, little attention has been given to understanding the sexual and reproductive health (SRH) needs of marginalized male populations in India. As a result, there is near lack of comprehensive information about these marginalized male populations on their unmet SRH needs; availability of appropriate and adequate SRH services; and access to and utilization of existing SRH services. Below, a brief review of the available literature summarizes the gaps in our knowledge on understanding SRH needs of marginalized male populations.

A limited number of quantitative studies among migrant workers in slums (primarily among Delhi and Mumbai) have documented high STI prevalence and high proportion of sexual risk behaviours among migrant workers in slums (Garg et al, 2007; Schensul et al, 2007 and

2004; Bhatia et al, 2005). A handful of qualitative studies among migrant workers in slums have primarily focused on their cultural perceptions about STIs and their categorization of sexual health problems (Verma et al, 1998); and romantic partnerships development in young people in slums (Alexander et al, 2006). Recently, some studies have documented sexual-risk behaviours among IDUs pointing out the need to focus on sexual behaviour change among these populations as well (Panda et al, 2000 and 2001; Kumar et al, 2008; Chakrapani et al, 2007a).

Among MSM and Hijras, there have been quantitative studies, government serosurveillance data, and clinical data – all of them having documented high HIV/STI prevalence in major cities such as Chennai and Mumbai (NACO, 2006; Setia et al, 2006; Hernandez et al, 2007; Srinivasan et al, 2004; Chakrapani et al, 2002). Of the few qualitative studies among MSM and Hijras, all have documented stigma and discrimination faced by MSM and Hijras in the government health care settings, and the absence of specific sexual health services for Hijras - e.g., lack of services related to gender transition (Chakrapani et al, 2004 and 2007b). Among people living with HIV, only a couple of studies have been conducted in India that focused on the sexual risk behaviours (SriKrishnan et al, 2007; Chakrapani et al, 2008) and sexual and reproductive health of people living with HIV (Chakrapani et al, 2007a).

Thus, there is scarcity of information on the sexual and reproductive health needs, and barriers to access/utilization of SRH services among the various marginalized male populations. Lack of adequate information is unfortunate because it is important to have a strong evidence-base for developing appropriate policies and programs to meet the SRH needs of these marginalized male populations.

This qualitative study's purpose was to explore and understand the sexual and reproductive health needs as well as to understand the barriers in access to and utilization of SRH services of males-at-risk in India: migrant workers in slums, men who have sex with men (MSM), Hijras/Transwomen, male injecting drug users (IDUs), and men living with HIV.

2. Research Methodology

This qualitative study was implemented with active collaboration of community-based and non-governmental organizations in cities located in 5 states in India: Hyderabad (Andhra Pradesh); Chennai and Madurai (Tamil Nadu); Mumbai (Maharashtra); Imphal (Manipur); and Delhi. The selection of research sites was based on the predominant key population the sites provide services to and also on the capacity of those sites to implement the research project. Prolonged engagement (Lincoln and Guba, 1985) over the course of several years on the part of the study team - with these agencies and the populations they serve - greatly facilitated study implementation and interpretation of the findings.

Study populations

The study groups included migrant workers in slums, men living with HIV, men who have sex with men (MSM), male injecting drug users (IDUs), and Hijras/Aravanis (Transwomen). The common eligibility criteria were to include participants who were above 18 years of age and who could give informed consent for participating in this study.

Sampling and Recruitment

Purposive sampling was used to recruit the study participants for focus groups. All recruitment was conducted only by word of mouth in order to avoid potential risks to participants. Sociodemographic questions were asked of all focus group participants. These included questions about age,

level of education, occupation, marital status, and number of children.

Focus Group Discussions (FGDs)

Thirty-two FGDs (with 226 participants) were conducted using a semistructured in-depth interview guide. Questions were modified or added over the course of the study in an iterative process to explore and reflect on emerging findings, a technique called 'progressive focusing' (Schutt, 2004). The main focus of the discussion was to identify the sexual and reproductive health needs of these marginalized groups and the various barriers they face in accessing/utilizing SRH services. Separate FGDs were held for various categories among the marginalized populations. Those categories were based on their age group, marital status, engagement in sex work, and HIV status. About 8 persons participated in each focus group and the duration of the discussion ranged from 60 to 90 minutes.

Focus group venues were chosen according to the convenience of participants, and the safety of participants and research staff. Most FGDs were conducted in a private room in the offices of implementing agencies that work with these populations. No focus groups were conducted in the 'field' (cruising sites, sex sites, or drug-use sites) owing to risks to participants and staff. Written informed consent was obtained from all participants, including consent for audiotaping of the interview. This study received ethics approval

from the internal review committee of India HIV/AIDS Alliance and an independent community advisory board.

Focus groups facilitators and interviewers received adequate training on interviewing and research ethics. All interviews and communications with participants were conducted in respective native languages. As recommended by the community advisory board, an honorarium of 250 Indian rupees (about 6 USD) was given to the study participants who attended focus groups.

Key informant interviews (KII)

In-depth interviews were conducted with 22 Key informants using a semi-structured interview guide. These key informants include the heads of organizations working with marginalized groups, community leaders/activists, and health care providers. Interviews focused on understanding key informants' perspectives and insights on the various SRH needs of marginalized male populations; barriers faced in accessing/utilizing SRH services; and what strategies can be adopted to meet their unmet SRH needs and facilitate utilization of SRH services.

Data analysis

All the interviews were tape-recorded and transcribed verbatim in native languages and translated into English for data analysis. Multiple readings of the translated text were performed by two independent investigators with assistance from three other research staff who coded the raw data. Line-by-line review of the translated text was conducted and first-level codes (descriptors of important components of the focus groups and interviews), including in vivo codes, were noted in the margins (Charmaz, 2006; Glaser, 1978). Next, text corresponding to each of the first-level codes was reviewed by at least two investigators. Using focused coding and a constant comparative method (Charmaz, 2006; Glaser and Strauss, 1967), first-level codes were refined and organized into categories. Finally, theoretical coding was undertaken to identify higher level codes,

relationships among categories, and to ensure saturation of categories (Charmaz, 2006).

Validity

Member checking was conducted with key informants to assess validity of the findings (Lincoln and Guba, 1985). Peer debriefing was undertaken with community leaders and persons working with these marginalized groups to increase trustworthiness of the findings. The results correspond to the emergent categories; all quotations are drawn from the focus groups and key informant interviews.

Limitations of the study

Most study participants were recruited through NGOs/CBOs that are providing HIV prevention and care services to the various study populations. Thus the study participants might have relatively better knowledge about SRH and better access to SRH services compared to those who are not reached out by these agencies. However, those people who were relatively new to receiving services from these agencies. Although participant recruitment procedures led to a somewhat self-selected sample, the participants who attended FGDs represented some of the major categories served by the voluntary agencies. An additional depth of understanding of this topic could be gained by seeking opinions and experiences of people from these vulnerable groups who are not reached out by voluntary agencies.

Given the financial and time constraints, focus was on exploring the SRH needs of selected subcategories among the vulnerable groups that is theoretically thought to have specific and unmet SRH needs. For example, because of practical and ethical reasons FGDs were not conducted among adolescents in any vulnerable group. Also, all the subgroups among MSM were not explored and study was limited only to exploring Kothi-identified MSM and not gay-/bisexual-identified MSM. Despite these limitations, the study findings have clearly shown the unmet information and service needs for at least selected subgroups of males-at-risk.

Table 1: Details of Qualitative study methods and Sample size

Migrant workers in slums		
NGO/CBO/Network	No. of Focus Group Discussions (FGDs)	No. of Key informant interviews (KII)
VSSA, Hyderabad (Andhra Pradesh)	3 FGDs FGD-1: Married men FGD-2: HIV-positive men FGD-3: Single men	3 KIIs (NGO head and field staff)
Sahara, Delhi	3 FGDs FGD-1: Married men FGD-2: HIV-positive men FGD-3: Unmarried men	3 KIIs (Community leader and Health care providers)
Male Injecting Drug User (IDU)		
NGO/CBO/Network	No. of FGDs	No. of KII
Sahara, Delhi	3 FGDs FGD-1: Married IDUs FGD-2: HIV-positive IDUs FGD-3: Unmarried IDUs	3 KIIs (Community leader and Health care providers)
SASO, Imphal (Manipur)	3 FGDs FGD-1: Unmarried IDUs FGD-2: Married IDUs FGD-3: HIV-positive IDUs	3 KIIs (Community leader and Health care providers)
Freedom Foundation, Chennai (Tamil Nadu)	3 FGDs FGD-1: Unmarried IDUs FGD-2: Married IDUs FGD-3: HIV-positive IDUs	KII-1: Community leader
Heterosexual men Living with HIV		
NGO/CBO/Network	No. of FGDs	No. of KII
MDPS+, Madurai (Tamil Nadu)	4 FGDs FGD-1: HIV-positive unmarried men FGD-2: HIV-positive unmarried men FGD-3: HIV-positive married men FGD-4: HIV-positive married men	KII-1: Community leader
Kothi-identified men who have sex with men (MSM)		
NGO/CBO/Network	No. of FGDs	No. of KII
SWAM, Chennai (Tamil Nadu)	3 FGDs FGD-1: MSM in sex work and unmarried FGD-2: Married MSM FGD-3: HIV-positive MSM	KII-1: Community leader
The Humsafar Trust, Mumbai (Maharashtra)	4 FGDs FGD-1: MSM in sex work FGD-2: Married MSM FGD-3: Married MSM FGD-4: HIV-positive MSM	3 KIIs (Community leader and Health care providers)
Hijras/Transwomen		
NGO/CBO/Network	No. of FGDs	No. of KII
THAA, Chennai (Tamil Nadu)	3 FGDs FGD-1: Ackwa Hijras FGD-2: Nirvan Hijras FGD-3: HIV-positive Hijras	KII-1 (Community leader)
The Humsafar Trust, Mumbai (Maharashtra)	3 FGDs FGD-1: Ackwa Hijras FGD-2: Nirvan Hijras FGD-3: HIV-positive Hijras	3 KIIs (Community leader and Health care providers)

Table 2: Profile of the focus group participants

(n=226 participants in 32 FGDs)

	MSM (n=46)	Hijras (n=39)	IDUs (n=69)	Men living with HIV (n=31)	Slum Men (n=41)
Age, Mean years	29	28	36	35	27
Range	20 - 42	21 - 46	19 - 47	21 - 49	18 - 65
Education, %					
- Less than high school	41	49	38	52	71
- High school	30	36	23	22	29
- Higher secondary	22	10	23	20	
- College	7	5	16	6	
Occupational status / Primary source of income (%)					
- Unemployed	7	8	31	6	20
- Self-employed	4	3	12		10
- Private company	10		16	16	10
- Daily-wage labourer	11		12	45	51
- NGO staff	48	5	12	19	5
- Sex work	20	33	17		
- Driver		10		14	4
- Temple priest		41			
- 'Mangti' (Asking alms from shops)					
Marital status, %					
- Ever married	59		57	90	59
- Never married	41		43	10	41
Injecting drug use, %					
- Current user			28		
- Former user			72		

MSM: Men who have Sex with Men

IDUs: Injecting Drug Users

3. Key Findings

A. Migrant Workers in Slums

Sexual partners and Sexual Practices

Migrant workers in slums told that they have had sex with predominantly girls/women – who are from their own slums, their co-workers in construction sites and other workplaces, and women in sex work who are within the slums and those in the nearby areas. Some men also acknowledged having had or having known of their friends who have had sex with Hijras. While many participants denied having had sex with men, a few men mentioned that some of their friends have had sex with other men.

Participants mentioned about having had vaginal sex with women/girls and anal/oral sex with Hijras/men.

Reaching out to migrant workers in slums to provide SRH-related information

Migrant workers in slums usually go to work during day times. Since ANMs and AWWs mainly visit the slums during day time – they talk to only those women who are in their home. Also, ANMs/AWWs reportedly talk predominantly about immunization and family planning for women and provide little information about sexual health and STIs/HIV. Lack of government male field workers means ANMs/AWWs as well as migrant workers in slums may not be comfortable in discussing about sexual health related issues of men or family planning options for men. Also, ANMs/AWWs were reported

to not visit construction sites or other worksites of migrant workers in slums.

Having recognized these gaps, NGOs working in slums have introduced male field workers and they visit construction sites and other worksites of migrant workers in slums. NGOs have also trained a group of young migrant workers in slums as ‘peer educators’ to encourage peer-to-peer communication to promote diffusion of sexual and reproductive health information. However, some peer educators were of the opinion that other migrant workers in slums preferred to listen to ‘professional’ social workers and do not listen to them since they are from the same slum. But, these peer educators did provide information/ counselling about STI/HIV-related information to their close male friends. A key informant opined that peer educators may provide wrong or misleading information to other persons and hence the training of peer educators should be of high quality.

Access to SRH-related services in government hospitals

Most slum men preferred going to the government hospital that is relatively closer to their slum. Prior to NGO intervention slum people have had bad experiences with government hospitals – especially they had to face the negative attitude of health care providers. NGOs, through their interventions have built good rapport with

government hospitals and thus STI dept., Family Planning department and VCTC services in the government hospitals are friendly towards migrant workers in slums. However, for some people, even travelling to the nearest government hospital means loss of daily wages which they did not want to lose. In addition, since the outpatient services close by 11 am in the government hospital, some could not get SRH services. It also seems that NGOs have created a sense of dependency among people since they expect NGO staff to accompany them to government hospitals as they felt that they would not otherwise be given proper treatment. Some NGO managers have responded to this concern by training migrant workers as volunteer support persons in order to ensure the sustainability of this strategy and have also introduced those volunteers to the government health care providers.

Prior to NGO intervention and even now, some migrant workers in slums preferred to get services from Registered Indigenous Medical Practitioners (RIMPs) who are perceived to be welcoming, non-judgemental, affordable, and being available nearby their slum. All of which were felt to be absent in the government hospitals.

Irrespective of the type of services offered in government hospitals – STI, ART, Family planning - in general, the participants complained about: too much crowd (high patient load); apparently inadequate number of health care providers and other staff; lack of respect from health care providers and other staff; lack of privacy and confidentiality; difficulty in navigating the larger government hospitals; and problems and complexities in regard to the administrative procedures in larger hospitals.

Access to condoms

Migrant workers in slums usually get free condoms from the NGO outreach staff as well as from the 'outlets' created by the NGOs. However, participants also mentioned about the availability of condoms in medical shops and general stores but they usually prefer free condoms. Though,

condoms are available in the government hospitals in the STI clinics, VCTCs, FP clinics, and ART clinics, only those who visit these facilities seem to have access to them. Lack of time, loss of daily wages, and travel expenses to go to the government hospitals prevent many people from going to government hospitals to get free condoms.

Reasons for not using condoms consistently

Though the participants seem to have good knowledge about the need to use condoms and relatively easy access to condoms, they also faced challenges in consistently using condoms. Various contexts determined whether they used condoms in a sexual encounter. Personal barriers included: wrong belief that condoms will not prevent one from getting STI/HIV; belief that condoms decrease sexual pleasure; and alcohol consumption which decreases chances of using condoms. Interpersonal barriers included: fear that wife would suspect him that he has STI/HIV if condom is used; and lack of sexual communication with wife. Structural contexts included: stoppage of distribution of free condoms by NGOs due to lack of funds; and lack of condom 'outlets' near construction sites where sex happens.

Access to and use of HIV Testing services

While the men in Delhi slums apparently have a range of HIV testing centres (govt., NGOs, and private hospitals) to choose from, those in Hyderabad slum mainly got tested at the nearby government hospitals, sometimes, screened beforehand by rapid tests administered by NGOs. However, some participants in Hyderabad slums were not even aware about where one can get tested for HIV and also did not know the English term 'VCT', though that term was used by some of the slum men who were trained as peer educators.

Myths and Misconceptions – HIV/STI

Over the years, awareness about STI/HIV among the slum people is claimed to have been increased. Many FGD participants mentioned

correct modes of HIV transmission and how to protect oneself from HIV. However, HIV-positive men told that other people in the slums still have misconceptions about HIV and AIDS - such as HIV can spread through: mosquito bites; and by staying, eating and sharing clothes with HIV-positive people. Participants and key informants gave a list of several misconceptions about STIs among the slum people that include: misattributing symptoms of STIs to AIDS; misattributing STI-related symptoms to 'heat' in the body (by eating 'heat-generating' foods or wearing certain kind of clothes).

STIs/HIV – Disclosure and Partner treatment

Men with STI-related symptoms who are not well connected to NGOs first visit unqualified medical practitioners or RIMPs since they are accessible and also seen as affordable, friendly and non-discriminatory. Participants mentioned that some of their friends have tried home remedies such as lemon juice or got medications from pharmacies – before going to qualified doctors. Outreach staff of NGOs working in slums refer or accompany patients with STI-related symptoms to the nearby government hospitals. Partner (Spouse) screening and treatment of STIs especially seems challenging since sometimes wives are in their native places and these men might have passed on STI/HIV infection to them when they visit their native places. So, while men get treated at government hospitals in cities, their wives would be screened and treated at their hometown. If wife lives with them in the slum, then some men disclose their STI/HIV status to their wives – risking marital discord. Some seek the help of NGOs to tell the wife about STI/HIV and for screening and treatment. Also, irrespective of disclosure some bring their wives to government hospitals for treatment.

Access to and use of family planning services for men

In general, most participants reported that family planning (including 'operation') is a duty of women. Consequently, they did not know

much information about family planning options available for either men or women. While some participants did articulate that condoms could be used for both pregnancy prevention and STI/HIV prevention, condom use with wife was seen problematic unless the wife had been counselled by the doctors to use condoms to postpone first pregnancy or to have adequate spacing in between first and second child. In such scenarios, women bring condoms from the FP clinics to home and usually men do not go or accompany them to FP clinics since they go to work during daytime.

A HIV-positive man in slum mentioned that he has two daughters and wants a male child. Since his wife is HIV-negative he did not know how to have their own male child without infecting his wife. When probed he replied that he did not know about 'sperm washing'. Also, HIV-positive men did not know about sexual post-exposure prophylaxis.

Men in slum also told that if an unmarried minor girl gets pregnant and wants to undergo abortion, usually it is not performed without the permission of her parents. Unmarried father usually denies having had sex with a girl and usually the girl suffers. This means both adolescent girls as well as men (including adolescents) do not have adequate information and tools to prevent unintended pregnancy.

Why men do not undergo vasectomy?

Many participants were of the opinion that as women are at home they can undergo tubectomy and take rest after an operation. However, if men undergo vasectomy, they could not afford to lose daily wages. The concern of losing income was not related to only the few days post-operation but also the possible weakness following vasectomy that would prevent them from engaging in any hard work thereafter. Some also mentioned with a giggle that vasectomy can make a man impotent and others would laugh at a man who had undergone vasectomy. Though most of them had not personally heard of anyone about becoming weak after undergoing vasectomy. One person

said that he had heard from a friend who had undergone vasectomy and that he had become weak. Though the latter's statement could not be confirmed it seems that even among men who had undergone vasectomy there might be a feeling that vasectomy might lead to or is responsible for 'tiredness' or 'weakness'. This is similar to the tiredness/weakness and a list of variety of symptoms (mis)attributed by women to tubectomy.

Participants discussed about the other reasons which they thought are not openly discussed about but which could also be the hidden reasons for asking women to undergo sterilization. They felt that in case if the wife dies men would want to get remarried and have children through second wives. It may deter them to go for vasectomy. For similar reason men want their wives to undergo tubectomy since they would be sure that she would not give birth to children of another man if they happened to die first. Some also expressed that even in case if the wives engage in extramarital sex then they would not get conceived. But in case if a man had undergone vasectomy and then his wife gets conceived it is a shame to the entire family. Thus, there are also other complex reasons related to sexual morality, seeing wife as a property, and avoiding bringing shame to their family, that prevent men to undergo vasectomy.

Preferred sources and ways of providing SRH information

Since NGOs now provide information to slum people in slums through their male and female outreach workers, slum men preferred to have information about SRH of men from outreach workers. However, some men felt that after they come to their homes after work hours they are too tired to listen to what the outreach workers say. Also, some felt that in the presence of other family members and children it might not be appropriate to discuss about HIV/STI and other SRH-related issues with the outreach workers. NGOs have also trained some of the active slum

youth as peer educators so that they can provide information about SRH to their peers. However, in the FGDs, some of the peer educators felt that their peers preferred to have information from 'professionals' (referring to NGO staff) rather than someone from their own slum. Thus, some peer educators were not convinced that it is possible for them to reach out to sufficient number of peers though they did reach out to their close friends.

With regard to the mode of passing on SRH-related information many preferred face-to-face interactions since they can clarify their queries there and then. These interactions could be with the NGO outreach workers, friends, or people known to them. Some also preferred to get information from Television and Radio. Many participants agreed that pamphlets and other print materials may not be of much use since many slum people are illiterate and would just throw them away. However, they suggested that outreach workers can use flipcharts with pictures in them that would generate interest among them.

Perception that SRH programs focus on women to the exclusion of men

Participants and key informants felt that men had been neglected when it comes to SRH programs, and information and services were predominantly 'women-centric'. This has led to a KI mentioning that women know better about SRH-related issues than men. Another KI who has been running interventions among slum people for several years felt that though initially their interventions focused only on women, after their understanding that 'men control women' in several issues, they decided to provide outreach education to men as well. Another NGO head, a KI, mentioned that she came across many anonymous queries related to SRH issues of men that were dropped in their NGO 'query box' which made her realize that they need to reach out to men also.

B. Male Injecting Drug Users (IDUS)

Sexual partners and Sexual practices

Most participants said that they have had sex with women and some have had sex with Hijras. Many participants from all the study sites reported having had sex with males as well. They reported having had vaginal sex with women and anal/oral sex with other men/Hijras. Across the study sites, male IDUs who have had sex with other males tend to see themselves as ‘man’ (read ‘normal’) and those with whom they have had sex with as “homosexual”. They used derogatory terms in the local languages as well the English term “MSM” when they referred to the men with whom they have had sex with. Presumably they know the term “MSM” because of their association with NGOs.

Drugs, Sexual Drive, and Risk behaviours

There seems to be a complex relationship between sexual drive and drug use. Participants reported varied experiences and perspectives. Many participants felt that ‘smack’ (brown sugar) decreases and ‘coke’ (cocaine) increases sexual drive. For some, if they have craving for drugs, until they have drugs they will not even think of having sex. After taking drugs, some participants mentioned about an uncontrollable impulse that prevents them from taking rational decisions on whether or not to have sex with someone or whether or not to use condoms. Some also engaged in aggressive sexual behaviour after taking drugs. Participants also mentioned that while they are high, there is problem in ejaculation – usually they have very delayed ejaculation. This means their female sexual partner (or spouse) might have achieved orgasm and hence they do not wish to continue to have sex with them. Thus, IDUs justified having multiple sexual partners – even on the same day – since they could not achieve orgasm (read ejaculation) with a single sexual encounter.

Delayed ejaculation when high was mentioned as another reason for not using condoms, since

condoms are supposed to delay ejaculation. They were afraid of discussing these issues (delayed ejaculation, increase in sexual drive, sexual compulsivity) with their health care providers since these issues were not seen as ‘drug-related’ issues and were apprehensive of how their health care provider would then treat them. Once IDUs reach a stage in which they have severe withdrawal symptoms if they do not use drugs, then sexual desire is supposed to become very low. After they get enrolled in drug de-addiction program, some IDUs mentioned that their sexual desire increase (though some mentioned that it could be just regaining of their ‘original’ sexual desire which is now seen as ‘increased sexual feelings [drive]’).

Though we have seen how drug use influences sexual drive, some people have primarily hooked into drug use since they started using drugs as a kind of aphrodisiac or sexual performance enhancers. A participant from Delhi talked about nude parties in certain high socioeconomic class societies in which drugs are used and that was how he got into drug use.

In almost all the study sites, IDUs talked about the overlap of the street-based drug use sites and the cruising sites of MSM and Hijras. Thus, after they have taken drugs, IDUs have access to male and Hijra sexual partners. Some IDUs also get paid by some ‘MSM’ to have sex with them. Those IDUs who get paid do not see themselves as ‘MSM’ (or sex worker) since they see that as a way to get money to buy drugs and to ‘release their sexual tension’ as well.

Sexual Behavior Change

Male IDUs reported that after marriage they had decreased the number of sexual partners. Some even mentioned that after hearing HIV prevention messages from NGOs they have become monogamous. HIV-positive male IDUs mentioned that after their HIV-positive diagnosis, they have decreased the number of partners but the proportion of HIV-positive partners has

increased. Some of them have switched to only self-masturbation. Some IDUs told that there was no significant change in the number and type of sexual partners they have had before and after their HIV-positive diagnosis but in general their condom use has increased.

Reasons for not using condoms

Participants also enumerated several reasons for not using condoms consistently with their sexual partners. These include: drug use taking precedence over any risk-avoiding behaviour; no condoms used if sex happens under the influence of drugs and/or alcohol; lack of control over sexual impulse; perception that condoms decrease sexual pleasure; and non-availability of condoms when needed.

Beliefs and Misconceptions – STI/HIV-related behaviours

Some participants, who are better educated through their association with NGOs, mentioned that their friends believe having sex with 'house-wife' or 'homely-girl' is safe as long as she does not have sex with other men. The assumption that 'house-wife' is safe prevents men from using condoms. Also, some men mentioned about having had assumptions which they realized to be simply misconceptions. For example, the belief that sex with women during menstrual period leads to 'boils', and the belief among some participants that if they are relatively older (beyond middle age) they do not have high chances of getting HIV/STI.

Access to SRH-related services

In the study sites, a wide range of options seem to be available for men to undergo HIV testing; STI screening and treatment; HIV treatment (ART) services, and family planning. However, most IDUs, especially those who are from lower socioeconomic status and who are homeless, mainly rely on services provided by NGOs because they are reached out only by NGOs and through them they know where one can get various services. However, they expect NGO staff to accompany them to avail government

services since they fear discrimination in the government settings if they go on their own. One participant commented that even for homeless IDUs, the infrastructure of government hospitals is intolerable and they do not want to become in-patients in government hospitals. In addition, lack of understanding and sensitivity among the health care providers and other hospital staff serve as a deterrent for some IDUs to go back to government hospitals.

Participants and key informants talked about the need for having strong linkages and referral mechanisms among the drug-related services and STI/HIV-related services for IDUs. For example, it was mentioned that once IDUs become 'stabilized' under opioid substitution therapy (OST), they would be more willing to undergo HIV testing because of their improved health seeking behaviour.

Many IDUs mentioned that they came to know about STIs only after they started receiving drug-related services from NGOs. Some of them, after having had STI-related symptoms, adopted safer sex behaviours (using condoms) to protect themselves from getting HIV since many stopped sharing syringes after NGO interventions. Thus, STIs served as a warning sign. However, some of the participants did have misconceptions about STIs such as 'men have lesser chance of getting STIs than women'. When probed it was found that it was the misinterpretation of the message 'asymptomatic STIs are more common among women than men'.

After started receiving information/services from NGOs, for STI screening/treatment IDUs go to government hospitals or use the NGO clinics. However, prior to the contact with NGOs they used to go to quacks who gave 'Rs.10 injections' and claimed to cure STIs. Some of them have even tried 'home remedies' such as pouring radish juice or urine over the ulcers in the genitalia. They got the information from their peers (co-drug users). Participants also mentioned that those IDUs who are not in touch

with NGOs might have less knowledge about STIs than those who have access to NGOs. Though some married participants claimed that they did tell their wives when they had STIs and asked their wives to get tested for STI and treated. A key informant who is a doctor managing a NGO clinic for IDUs and their partners told that he had never seen or treated the spouse or regular partner of IDUs with STIs.

Preferred sources of SRH-related information

Though FGD participants preferred to have ex-drug users as their major source of information providers, some key informants were against using ex-users as 'peer educators' since they might give 'wrong information' to other IDUs. Another key informant offered a solution to avoid this mistrust towards ex-users. He suggested that ex-users should receive proper and adequate training – may be even a certified and periodic training – so that others are convinced that they could provide correct and unbiased information to IDUs.

C. Men who have Sex with Men (MSM)

Sexual partners and Sex sites

Unlike Hijras, Kothi-identified MSM are generally located within their biological family and try to conceal their sexuality from others. Most MSM have had sex with casual partners while some have steady sexual relations with same-sex friends/neighbours. The sites of sexual activities for MSM are in general more varied than those used by Hijras and include beaches, gardens, trains, urinals and theatres apart from bushes and jungles. Kothi participants in Mumbai reported about their access to internet where they chat and look for male sexual partners. They talk over phone and meet male partners at places such as beaches and gardens.

Romantic relationships with Panthi and Sexual rights

Kothi participants expressed that many Kothis might have 'husbands' with whom they have

steady romantic and/or sexual relationships. Kothis in Chennai differentiated between Panthis whom they consider as 'husband-like' and Panthis with whom they have casual or paid sex. Some Kothis cohabit with their Panthi husband. Kothis are aware that one day their Panthi might leave them for a woman since that is supposed to be the nature of Panthis. Also, they felt that in the current legal context, it is not possible for two males to get married to each other. Consequently, most Panthis as well as Kothis eventually get married to woman. Thus, the sexual right of same-sex attracted people – the right to choose and get married to a same-sex sexual partner – is not fulfilled.

Relationship dynamics between Kothis and their Panthi 'husband'/lover

Some Kothis have regular Panthi partners who regularly get money from Kothis and spend it on their girl friend. Kothis, though aware of this, could not stop it - as Panthi is supposed to be a "man" (in this context it means 'predominantly attracted to women'). Also, some gave money without questioning since they did not want Panthi to leave them. Some FGD participants blamed Kothis for having spoiled Panthis by habituating them to take money from Kothis. When asked whether those Panthis who periodically receive money from Kothis could be seen as 'sex workers' since they have sex with Kothis and also get money on a regular basis from them, Kothis were quick to point out that even in heterosexual married couples, husband and wife help each other by giving money and it is not seen as 'sex work'. There are also some Kothis who outrightly refuse to give money to Panthis if they continue to ask for it. However, from the discussion we could not find out whether Panthi husband of Kothis are with them only to exploit or live on Kothis' money. Kothi participants also expressed that not all Panthis are with Kothis for sex and money – some Panthis love Kothis and they look after their Kothi partners very well and even give money to them.

Sexual communication/negotiation and partnerships

Before initiating sex with a casual Panthi partner, usually there is no direct communication about sex and condom use. Kothis who engage in sex work may explicitly state the type of sexual services they offer and how much they charge for those services. Even with their regular Panthi partners there is rarely discussion about whether condoms should be used though some did use condoms even with their regular Panthi.

Sexual violence and Intimate partner violence

Kothis, especially those in sex work, also faced physical and sexual violence from police and ruffians ('Beeli'). However, they tend to see such physical and sexual violence as one of the routine activities in their life – though they did suffer from STIs and physical trauma as a result of such violence. They were not aware of sexual post-exposure prophylaxis and they also did not have any post-rape counselling and care.

Kothis, sometimes are subjected to physical abuse by their Panthi husband and the reasons could vary from sexual infidelity to fight over money issues. Though, observers might see a Panthi husband beating a Kothi as 'intimate partner violence', Kothis see that as a normal phenomenon that happens between couples since it is seen similar to a man beating his wife. FGD participants told that some Kothis would even fantasize about being beaten up by their Panthi because then it is seen as 'manly' behaviour and then they can boast of their Panthi's manliness to other Kothis and how they suffer for being 'married' to him. Thus, intimate partner violence affirms Kothis' expectations that their Panthi husband is a 'real man' but also helps them to play their part as a 'wife' who shares with other 'women' her story about being physically abused by Panthi. In the absence of an alternative marital relationship model, Kothis and Panthis just enact what would be happening in a heterosexual marital relationship.

Sexual risk behaviours and Risk perceptions

Many participants seem to have good knowledge of safer sex practices and were practicing them. A married Kothi said: "HIV can be transmitted from both male and female partners. So one should always use condom [irrespective of gender of sexual partners]." Despite this awareness, some continue to engage in unprotected sex. As a Kothi mentioned: "Even if they have pus and wound on the penis, they have sex."

Participants reported using condoms even during oral sex if they have dental or gum problems. However they also mentioned that many do not want to use condoms for oral sex. Married MSM who rarely engage in sex with male partners mentioned that when they have the opportunity to have sex with other men then they do not care much about using condoms.

A variety of reasons were given for not using condoms consistently for anal and vaginal sex with their male and female sexual partners. With male steady partners, these reasons include trust and fear of abandonment by regular partner as they insist on condom use. With casual partner, Kothis do not use if a Panthi is good-looking and do not want to lose him by bringing up the issue of using condoms. With paying partners, Kothis did not use condoms if more money is paid. Not to give rise to suspicion of wife especially if she has already undergone tubectomy; and the need to have children prevented using condoms with wife. In forced sex by police and ruffians, they could not negotiate using condoms.

STI-related knowledge

There are different perceptions about STIs among Kothis. Those who have visited CBOs are more informed about STIs than those who have not. There is more awareness about HIV than other STIs as a key informant (a doctor treating MSM) opined: "MSM are well aware of HIV but not STIs. We can tell only [about STIs] to those who come to us for counselling and testing."

There were several misconceptions about STIs prevailing within these communities but such misconceptions may also persist within the mainstream population as suggested by a key informant doctor. Some MSM believe that one cannot get STIs if they do not penetrate 'deep enough'. Some others believed that once the symptoms of STIs recede on their own, they believe that the disease has cured. It may be incorrect according to the KI counsellor for MSM since syphilitic external lesion (a type of STI) heals on its own but still infection remains in blood: "[M]any say that I had a lesion - I applied some ointment and it healed - and I am fine - but they do not realize that they have just treated a symptom and not a disease. It is necessary to do VDRL test to know for sure and it needs to be treated if seen in blood." According to a participant, some MSM (especially Panthis) believe that HIV is not transmitted through same-sex relations and they think that HIV spreads only by having sex with women. This was also reflected in comments made by a married Kothi: "I think that HIV comes from a woman while STIs are transmitted in [same-sex relations]." A key informant who is a doctor said that some MSM feel that one cannot get HIV infections through oral sex.

Understanding their sexuality as they grow up

As Kothis grow up, even before they realized their same-sex attractions, they started to show mannerisms and behaviours that would be labelled by the society as 'feminine'. Thus, they face ridicule and teasing from their neighbours, school friends and relatives. Consequently, family members want Kothis to behave in a 'proper' (masculine) manner. A kothi expressed how he felt he was the only one in the entire world to behave in a feminine manner and having sexual attractions to men – until he met other Kothi-identified males. Participants complained about the complete lack of correct and supportive information about same-sex sexuality in the mass media and print media. Many of them, however, have seen how Hijras were badly depicted in the movies though they did not remember having

seen any same-sex attracted male characters in movies. During the focus group discussions, participants were using various terms to describe their same-sex sexuality – some were referring to it as 'habit', some as 'innate/inborn' nature, and some as some kind of 'aberration' at birth. Thus, being Kothi-identified MSM does not mean they have consistent/shared understandings of their same-sex attractions.

Predominantly adult Kothis were approached by NGOs and CBOs working with MSM. These agencies too, however, seem to focus primarily on HIV prevention and not sufficiently addressing sexuality-related issues of Kothis including their civil rights or human rights violations. Thus, Kothis do not get accurate information about same-sex sexuality while growing up, do not receive any services from NGOs/CBOs until they become adults, and do not adequately receive sexuality-related information/counselling from HIV-focused NGOs/CBOs. This point out the sensitive issue of how to reach out to same-sex attracted youth with non-biased and accurate information about sexuality issues as they grow up.

Getting married to a woman

Though Kothis are primarily seen as same-sex oriented persons, some of the FGD participants in the married and unmarried focus groups agreed that some Kothis are attracted to both men and women – though possibly more towards men. Thus, for some Kothis, getting married is not seen as a 'problem'. But, for some other Kothis, getting married to a woman is seen as a social norm which they should not and could not question. Some see that getting married to a woman is one of the ways to repay their obligations to their parents. A key informant mentioned that society would see parents as irresponsible and selfish if their son do not get married beyond a particular age. Hence to avoid being labelled by the society as 'bad parents', parents of Kothis would urge their sons to get married 'on time'.

A kothi participant shared that since he was the only son in his family his mother persuaded him

to get married to a woman as there would be no one to look after him after his mother dies. Most participants did not explicitly state that there was a 'pressure' from the parents to get married to a woman though they were sympathetic to the feelings of their parents who want them to get married. However, some participants and key informants were of the opinion that if getting married is not seen as social norm then many Kothis would have chosen not to get married. Another key informant mentioned that if Kothis are financially independent then they would not have to 'succumb' to their parents' demand to get married to a woman.

Relationships with wife and Sex life after marriage

After getting married, Kothis see having sex with their wives as a 'duty' and they were mainly concerned about their ability to satisfy their wives. Having sex with their wives was also seen by some participants towards having a child to avoid being labelled as 'impotent' by others. Having children thus proves to others that they are not 'lesser than a man'. Participants told that if Kothis are like 'double' (in this context 'double' refers to those Kothis who have bisexual orientation) then there would not be any problem in 'satisfying' their wives but if they are not 'double' then there would be problems in getting/sustaining erection.

According to FGD participants, some Kothis might fantasize having sex with a man when they have sex with their wife so that they can get erection sufficient enough to 'satisfy' their wife. Though many married Kothis said that they do not face any problems in their marital life, two of the participants differed. One of them told that "We can not deny [marital] problems. Some even get divorced since they have problems in having sex with their wife. I have given counselling to many 'MSM' regarding this. Some have succeeded [in their sexual relations with wife] but others did not." Another person talked about the lack of professional marital counselling on these issues. A key informant mentioned that even if

they go to a psychiatrist or a counsellor they do not reveal their sexual orientation and hence do not get proper counselling. Some participants mentioned that though almost all married Kothis do not disclose their same-sex attraction to their wives but somehow wife of some Kothis might come to know about it. After realizing about their husband's same-sex behaviour, some women continue to remain with their husband, and some decide to leave.

Sexual dysfunctions and infertility/subfertility

One key informant, a doctor treating MSM in a CBO-run clinic for MSM, mentioned that many married MSM do come with sexual dysfunctions such as premature ejaculation and erectile impotence. And some married MSM who have low sperm count and who have not been able to father a child also wanted treatment and counselling for infertility/subfertility.

Sex with male partners after heterosexual marriage

Married MSM reported no change in their sexual desire towards men after they got married to woman. However, many mentioned that having to raise money to take care of their family and day-to-day family-related work prevented them from actively seeking male sexual partners. Thus many reported having reduced the number of male sexual partners after their marriage. Also, many reported having avoided anal sex but they continued to practice oral sex. And even those engage in anal sex reported 'always' using condoms during anal sex since they were afraid of getting and passing on STI/HIV to their wife and children to be born.

Barriers to accessing STI and HIV testing services

Because of CBO interventions in Chennai and Mumbai, Kothis found it easier to access selected government hospitals – though they expected outreach staff to accompany them. Some Kothis also utilized private clinics and NGO-run STI

clinics where they also get monetary incentives for periodic screening for STIs. Fear of being seen by others, fear of being labelled by others as having STI or HIV, long distance, long waiting time and perceived fear of discrimination from the health care providers – all served as barriers for MSM to access STI and HIV testing services as well as to go back for follow-up. Partner screening and treatment was also not possible in many instances because they had hesitations in revealing their STI/HIV status to their male regular partners. In Mumbai, wife of Kothis who have STIs were asked to be referred to a family planning clinic where wife is screened and provided treatment without revealing the sexuality of their husband.

Family Planning

Married Kothis have not thought much about family planning. Having children was important to Kothis not only because some of them wanted to have children of their own (irrespective of their willingness to get married to a woman) but the ability to procreate also served to prove to their Kothi friends and others in the society that they are 'not impotent'. For some, the ability to reproduce and have children is a kind of defence: if someone who suspects their sexuality and use derogatory words to refer to them, Kothis can then say - "Why are you calling [derogatory word]. I have two children." Though some married Kothis denied being discriminated against or laughed at by other single Kothis, some other persons agreed that single Kothis might laugh at married Kothis.

Married kothis told that they were not even involved when the decision was taken to undergo tubectomy. After the second child was born, doctors routinely ask women to undergo tubectomy. If it is a vaginal delivery, tubectomy is advised usually within a few days or weeks after delivery, and if it is a caesarean section, then doctors usually would have got the 'permission' beforehand so that tubectomy can also be conducted when they perform caesarean section. It seems that doctors asking women to undergo

tubectomy after delivery has become an unspoken medical norm – that excludes men to participate in this important decision-making process. They mainly ask the 'permission' of husband and other family members to allow the woman to undergo tubectomy. Also, health care providers do not provide information about male sterilization to men. Consequently, once two children are born, a woman 'automatically' undergoes tubectomy.

Similar to heterosexual males, Kothis mentioned many reasons for not undergoing vasectomy: loss of income – not only during the 'operation day' but also because they could not engage in hard labor afterwards; weakness and (unknown) side-effects following vasectomy; fear of undergoing surgery; to sustain their generation; and not having adequate information about vasectomy.

D. Hijras / Transwomen

Hijras are transgender or transsexual women (male-to-female transgender people). Those hijras who have undergone emasculation or sex reassignment surgery (SRS) call themselves as 'Nirvan' while those who have not undergone emasculation/SRS call themselves as 'Ackwa'. Both the Nirvan and Ackwa hijras may be in women's attire (in 'Satla'). There are, however, some Ackwa hijras who crossdress only when they engage in sex work. Some of these Ackwa hijras are married, and stay with their family.

Livelihood – Sex work and 'Mangti'

Majority of the hijras earn their living through sex work and/or begging. Some of the Nirvan hijras informed that they do not involve in sex work if they have money and resources to sustain themselves. The sites for finding male paying partners are generally located away from the public places. They include forest, bushes and places along highways. One participant, however, observed that sex between hijras and their clients can take place in many other places. The partners of hijras also take them to hotels, lodges and some private rooms for sex.

Sexual Practices

Hijras engage in oral and anal sex with their male partners. Some also engage in ‘thigh sex’ (taking partner’s male genitalia in between thighs). Hijras feel that they are ‘penetrated’ in the same manner as women when they have ‘thigh sex’. A participant told that it was safer to have sex between the thighs than anal/oral sex. Though the hijras prefer to be the receptive partners in the sexual relation with their Panthis because they imagine themselves as women, some Ackwa Hijras have to act as insertive partners during sex as and when demanded by their male clients who pay for the sex work. One Ackwa Hijra informs: “We get such [male] clients who ask us to insert in their [anus].and we do it for money’. Another person told: “[A]t times they pay us more [money] to insert them than what they pay to insert us’. Hijras also use the term ‘Double’ to refer to those male clients who engage in both insertive and receptive sex with them.

Romantic and Sexual relationships with Panthis

Hijras desire to be like women and aspire for a masculine male sexual partner known as ‘Panthi’ in the Hijra subculture. One participant expressed: “We do not know about having sex with females... even though we have a penis and we are not emasculated we do not feel like having sex with a female”. Another participant remarked: “Hijras think that Panthi should love them and stay with them forever, but the Panthis leave them when their [sexual] needs are over’. Some of the Hijras, however, have steady partners with whom they live like husband and wife. A hijra participant felt that most of the steady partners who are living with hijras are poor, with no money and shelter, and that was the main reason for them to be with hijras. However, she felt that there are only a few Panthis who genuinely love their Hijra partner.

Participants also talked about casual and regular partners. There are some clients who consistently visit hijras and establish intimate relations with them. They are viewed as regular partners

(Husband or lover). And those who are seeking sex in lieu of money are ‘Dhandha Panthi’ (casual or paying partners).

Physical, Verbal and Sexual Abuse

Hijras as well as Kothis reported physical and verbal abuse from family and society. Some hijras have left home to save the honour of the family. One participant said: “[W]e desire to be a woman since our childhood and we behave like them. So as we grow up our parents objected to such (feminine) behaviour because others taunt them that their child is a ‘Hijra’. We can tolerate our own insult but we cannot see our family being insulted and hence we leave our home and join the hijra community”. Another Hijra informed that her father could tolerate that she is a HIV-positive person but could not tolerate that she got infected by having sex with men.

Police and ruffians perpetrate physical and sexual abuse, and also extort money from Hijras. Police pose as clients for Hijras and then beat them badly as well as extort money.

Risk Behaviours, Risk Perceptions and Condom use

Hijras are aware that unprotected sex poses risk of STI/HIV and they expressed their desire to use condoms. Some Nirvan hijras were very particular about condom use. A few of them only engaged in ‘thigh sex’ since it is seen as safe. One NH participant narrated: “Now we want to live. So we tell Panthis that if you want to have Kowdi’ [thigh sex] it is okay otherwise you can go.” Another participant informed that she has anal sex only with those Panthis who are close and well known to her: with all other men she use condoms or would have ‘thigh sex’.

STIs: Knowledge and Misconceptions

Participants had relatively good knowledge about STIs. Symptoms narrated by participants include: burning sensation during urination, itching on penis, lice in pubic hair, fluid coming out of male sexual organ, warts, boils, and rash. One Hijra key

informant (a community activist) mentioned that there are ample information about HIV through media but they are addressed to heterosexual couples. One hijra participant informed that some hijras think that they are healthy, they eat good food, and hence they will not get HIV infection in their lifetime irrespective of their sexual behaviour.

Some Hijras acknowledged that one can not identify whether their customers have STIs or not. One HIV-positive Hijra said, "How will we know that he is having STI because it is in their private parts; it is not written on his face that he has STI." And some do not seem to know that some STIs can be asymptomatic and still can be transmitted to others. One participant mentioned that some Hijras may misattribute their STI-related symptom to allergy or lack of hygiene and thus may have unprotected sex even in presence of a lesion.

Barriers to accessing STI and HIV testing services in government hospitals

Many Hijras preferred CBO/NGO-run STI clinics and HIV testing facilities over government hospitals – except for a handful of government hospitals that were sensitized by the CBOs.

In spite of the sensitization of health care providers Hijras continue to face stigma and discrimination from the government hospitals because of a variety of reasons. Some of the ways by which Hijras are discriminated against are summarized below. Actual or perceived fear of discrimination acted as a strong barrier to accessing STI and HIV testing services in government hospitals.

Negative attitude and discriminatory behaviour of the co-patients in the hospitals

A Hijra participant narrated: "[T]hey sent me one day to undergo [ultrasound] scan. There were many pregnant women in the queue. Those women asked me why I was standing in the queue. They complained to the attendant there who asked me to go away saying that Hijras do not need scan. They treat us like animals and not as humans."

A key informant mentioned that, "The way they [Hijras] walk or behave evoke a lot of mockery from the general public. Under such circumstances they prefer not to avail these [free] services [from the government centres]."

Negative attitude of health care providers

An Ackwa Hijra observed that, "We get better treatment at private hospitals because the doctor is not concerned about us but bothered about money. In the Government hospitals [since it is free] doctors are not good to us and we feel discriminated."

Fear of being ridiculed prevent Ackwa Hijras from going to hospitals

A Hijra narrated that, "Ackwa hijras are afraid of going to the Government hospitals because they do not want their [male] genitalia to be seen by others. So even if they have STI, they hide it from [government doctors]. They are willing to go to CBO-run clinic [since there is no fear of discrimination]."

Long waiting hours at Government hospitals discourage Hijras to access services

A key informant mentioned that for Hijra time is money as they need to go for asking money from shops during the daytime and engage in sex work during evening and night hours. Hence, many Hijras do not prefer to go to government hospitals because of the huge crowd and long waiting time. Thus, those who can afford go to private clinics and others go to CBO-run clinics. Similar information was given by another Hijra key informant: "For a Hijra, sex work is like wage work. So they do not have time to think about small boils and rashes. They do sex work all night and sleep during day time. Money is priority for them and not health. So, unless the service is brought to them, they will not avail the services."

Reproductive health issues are seen as 'irrelevant'

For most of the Hijras in woman's attire, reproductive health and family planning issues are

perceived as irrelevant. One participant observes: 'There is no purpose talking about all these. We will talk about the issues that are necessary.' Another Ackwa Hijra participant mentioned: 'I have never spoken to anyone about 'female problems' [referring to reproductive health], I only talk about the problems that I have'. However, an Ackwa Hijra mentioned that there is a need for the married hijras and MSM to know about the reproductive health and family planning issues as it is good for them as well as their family.

Gender Transition

Many Hijras expressed that enhancement of their femininity takes precedence over other issues. As a Nirvan Hijra said, "We hope to become a 'complete woman' one day." Another Ackwa Hijra expressed, 'I think that emasculation is good because what you are going to do with a penis? It is of no use.... At times when you are questioned, at least you can prove that you are a hijra. Without emasculation you are neither a man, nor a woman. In some fight, any ruffians will tear your clothes, then your penis will be seen. They will mock at you that you are a man and not a Hijra...' One hijra KII opined that hijras spend more money on breast enhancement or sex change operation than on their health. The cost for a sex change operation is between fifty and eighty thousand rupees. A participant expressed her concerns about undergoing sex change operation: "I may undergo [sex change] operation and take hormonal therapy to be like a female. But at some point it is possible that I may repent this decision. Because after sex change I may not be accepted in the society. When a hijra [biological male] is in male attire, he can at least get some job, but when a male [here refers to Hijra] is in female attire, nobody would be willing to give even a housemaid job. No options are opened to her [other than going to sex work]." Thus, her dilemma about undergoing SRS seems to be more on the lack of financial security and being in female attire rather than undergoing SRS since her concern is about the difficulty in getting a job as a Hijra in female attire.

Emasculation (not 'SRS') by Quacks

Hijra participants in Chennai and Mumbai reported that many Hijras go to unqualified medical practitioners in a place in Andhra Pradesh where emasculation is conducted for about 6000 Indian Rupees. Hijras in Chennai also reported going to two other places in Tamil Nadu where the surgeons are assumed to be qualified allopathic medical practitioners. Usually no pre-operative counselling about emasculation is given to Hijras. As a Hijra explains, "There is no counselling before undergoing emasculation. Hijra wants 'Nirvan' [emasculation] and doctor wants money. Both of them are in such a hurry that they do not look at any protocols." However, before they decide to go for emasculation, Hijras might seek the advice of other Hijra friends and their Guru.

Before emasculation, HIV testing is done by both the qualified and unqualified practitioners but no counselling precedes HIV testing. If one is found HIV-positive, operation is not denied but without any proper counselling they would be told the test result and asked to pay an additional 3000 Indian Rupees – for taking 'extra precautions'. Those who have been to that clinic mentioned that the operation room was not hygienic.

Post-operative complications such as blockage of urine (due to urethral stricture/stenosis) were reported to happen to many Hijras and then they have to go for 'second operation' to correct that problem. Hijras reported that even urologists in the major government hospitals do not treat them properly – even if they require surgery. They can not go to private urologists since they can not afford it or those urologists are not aware about Hijras and their issues.

Feminising procedures

For breast enhancement, many Hijras were taking female hormonal pills on their own – with the information they get from other Hijras or asking the pharmacists. They do not go to qualified medical practitioners or endocrinologists for hormonal

therapy. Some Hijras who can afford go to some private practitioners for silicone breast implants.

For removal of facial hair, some Hijras continue to use the traditional 'chimta' (hair plucker), these days they also undergo electrolysis or laser treatment, if they can afford.

E. Men Living with HIV

Men living with HIV who participated in this study were recruited through PLHA networks and hence presumably have better knowledge and practice safer sex behaviours compared to those who are not part of any PLHA network. However, the findings showed several gaps in their SRH-related knowledge and practices.

STI knowledge

Participants who are accessing services from the PLHA networks for sometime seem to have had better knowledge than those who have recently joined networks. Before joining the networks, many barely knew about STIs. As a participant said, "I know that [STD] means pus discharge and smell like a spoiled egg. That's all I know. Now they counsel that [STD] can be completely cured." Similar comment was made by another participant, "My friends told me that if a person has STD – one can not sit beside that person. It will 'smell' a lot." Even those who have had STIs were not given adequate information by the doctors. A participant who had been to a private practitioner said that, "Doctor told me that I got this disease because of women [having sex with women]. He told he will give penicillin injection now and then I need to go back to [government hospital] for follow-up."

Experiences in getting STI treatment and counselling from government hospitals

Many participants have had bad experiences in getting STI treatment from government hospitals. Some narrated discriminatory incidents before and after they were diagnosed to have HIV. Even doctors have used offensive language when talking to those with STIs. A participant said,

"The Doctor asked me to which [derogatory term referring to a sex worker] have you gone?... He asked me to behave properly once that sore gets healed." Another participant shared similar incident: "Doctors will talk in 'vulgar' language. They will say 'If you go to prostitute you will get pain like this'. Then they will insert a stick and clean it [probably refers to inserting swab to take urethral discharge sample]."

Participants have had equally bad experiences in getting information/counselling about STIs from the government hospitals. As one participant said, "In [government STI clinic] they give penicillin shot and then sent me off. I was not given any counselling about STD." Lack of time might have prevented a government doctor from giving adequate information. As explained by a participant, "I asked doctor for more details about the problem [STD] I had. He was very busy. He told if you go to prostitutes you will get this. That's all he said. I did not know full information about STD." Even the VCTC counsellor did not provide much information about STI to a participant. As he explained, "[VCTC] counsellor told to have sex with condoms. Not given counselling about 'STD'...told not to spread HIV to wife – so use condoms...You have to keep her negative." A participant who was diagnosed to be HIV-positive one week ago said he was not counselled about condom use by the VCTC counsellor.

In government hospitals, huge patient load with relatively small number of health care providers mean no time to provide adequate counselling or information. As a participant eloquently summarized: "They will say 'Get ART and go to your home without even turning back'. No one will call and provide you with information [on condoms and STIs]. Each day about 200 to 300 people come to get ART. It is like a festival crowd. No one gives counselling even for 5 to 10 minutes in ART centre." Thus, counselling by the PLHA networks assume significance. A participant said, "Counselling given by people in 'DLN' [district level PLHA network] is the best. We also feel it is best to follow the counselling given by them.

Doctors only provide treatment – that’s all.” Many other participants also felt that PLHA counsellors have the motivation to provide proper counselling to other PLHA. A participant talked about the apathy of health care providers in the government hospital: “Only affected people [HIV-positive] give counselling to affected people. Those in government do not teach [counsel] any one. They come and sit and go with out any concern.”

Why tubectomy is the norm and not vasectomy?

Married Men living with HIV were asked why men do not undergo vasectomy and why it is almost always women who undergo sterilization operation (tubectomy). Several reasons were mentioned. Men thought that it is a ‘tradition’ or social norm that women undergo sterilization operation. Some participants felt that men are neglected when family planning counselling is given to their wife and thus men do not have adequate knowledge about vasectomy. Apparent absence of government promotion campaigns on vasectomy also meant that no information is available from popular media. When interviewer asked whether they have received any type of family planning information for men in VCTC, ART centre, and STD clinic, participants said that besides information about condoms, in none of these places they received information about family planning options for men.

Positive Prevention

Sexual risk reduction counselling

Participants gave mixed responses in regard to sexual risk reduction counselling and condom access in VCTCs and ART centres.

A participant confirmed that he did receive sexual risk reduction counselling from VCTC counsellor: “[VCTC] Counsellor told to have sex with condoms. ...Told not to spread HIV to wife – so use condoms... You have to keep her negative.” Another participant mentioned about having received counselling from ART centre counsellor. However, some mentioned that counsellor did

not give information about sexual risk reduction or condoms. A participant also mentioned that, “Counsellor told me since both of you [husband and wife] are positive, there is no need to talk about condoms.” Thus, it is possible that the counsellor was not aware about re-infections and the need to use condoms even if in HIV-seroconcordant couples. Though participants knew that condoms need to be used even if both the couples are HIV-positive, they lacked in-depth knowledge. As explained by a participant, “Even if husband and wife – both have HIV – they should use condoms since viruses from their body will get exchanged from one to another...CD4 count will change.” Another participant mentioned that, “One [of the couples] might be on ART. Other one might not. Then it can create some problem.” Some participants also thought that “there is a chance that using condoms increase enjoyment.” A participant mentioned about the need for condom demonstration and he wanted condom demonstration to be shown by a male counsellor for a man and by a woman counsellor for a woman.

Access to condoms

Some participants buy and keep a stock of condoms. As one participant said, “I always have stock of condoms. I never missed using condoms. I have sex once in a month. But always use condoms.” But others have difficulty in getting free condoms from the government hospitals. As participants mentioned, “In ART centre, condoms are kept beside the doctor. Hence we can not take them.” Another participant said, “Only in [PLHA] network I was told about condom use. In GH [government hospital] they have kept many pockets of condoms in trays. No one – including the doctor – told me to use condoms.” Participants denied having received information about STIs, condoms, and family planning from care and support centres.

Box 1: Perceptions of men from all subgroups (men in slums, male IDUs and men living with HIV) on why men do not want to undergo vasectomy?

1. 'Tradition' for women to undergo family control operation

"It is tradition in our society that women have to undergo sterilization. Men do not have the habit of undergoing [sterilization]. There is a perception that men may become weak and could not do any hard work; women undergo [sterilisation]."

2. Men do not know correct information about vasectomy

a. No public education campaigns on vasectomy

'Just like AIDS awareness campaigns why cannot [government] talk about family control [operation] for men in a simple manner and make the public understand? Then men will come forward and undergo without hesitation.'

b. Men not involved in Family Planning and PPTCT counselling

"[FP] information was also given by counsellor in PPTCT...[counsellor] was talking with my wife... not me." (By a man living with HIV)

"Even when I accompanied my wife to family planning [clinic] in [primary] health centre, no one informed me that even 'gents' can undergo [sterilization]."

3. Misconceptions: Loss of 'potency' and weakness follows vasectomy

"I know about it [vasectomy]. But I did not want to do it...because I can not then do hard work after the operation. Can't run fast. They will put stitches. There are many issues. [Interviewer clarified that there is no need for stitches ('no-scalpel' vasectomy) and one can work as usual even after vasectomy. Interviewer then asked whether now he would support vasectomy]...No. I will not [support vasectomy]. [Masculinity] Potency is important for men."

Information about STIs and Family Planning for men living with HIV

Men living with HIV get information about STIs from a range of sources: PLHA network counsellor, VCTC counsellor, PPTCT counsellor, training programs of PLHA network, and support group meetings. PLHA network was cited as the most common and preferred source of getting information regarding STIs and family planning. But even among those men who come to network, some were embarrassed to discuss about sex-related issues with the peer counsellor or PLHA network staff. As participants said, "I am embarrassed to ask about information on STIs from the [PLHA] network though you [network] are teaching me everything."

Compared to information about STIs, information about family planning options for men were not provided to men living with HIV. A participant complained that, "I have joined [PLHA] network two months ago. Have not heard about FP operation for men from network." Thus, even PLHA networks, which seem to provide all kinds of information, apparently did not seem to provide FP information to men living with HIV. Almost none of the participants had heard of sexual post-exposure prophylaxis and about the 'sperm-washing' technology – or other methods - to help sero-discordant couples to have their own child without infecting the female partner.

Right to get married and have a child

Single HIV-positive men might have a dilemma whether or not to get married and to whom they should get married to – only to a positive woman or woman of any HIV status? Single men find it difficult to discuss about this issue with the government counsellors/doctors because he was mainly counselled to always use condoms when he has sex with women. As a single man summarizes: “I want to remain with out getting married. But my mother wants me to get married. If I reveal my HIV positive status in my village they will keep us out [of the village]....I haven’t

discussed this [dilemma in getting married] with any one. In [govt.] hospitals, they [health care providers] talked about only condom use during sex.” Another participant, however, mentioned that he did get counselling from government ART counsellor regarding marriage: “In ART centre, I was counselled to get married to a woman with HIV...Yes, if I get married to a HIV-positive women I will surely want to have a baby.” Some other single men have decided to get married but did not decide about whether or not to have a baby. As mentioned by a participant: “I am not thinking of having a baby. I might think about it after getting married.”

4. Discussion and Recommendations

This qualitative study has identified several gaps in information and service needs in relation to the sexual and reproductive health of males-at-risk. It is important that these unmet needs are met and barriers to accessing and utilizing existing mainstream SRH services are removed.

Though the participants had good knowledge about STI/HIV and reported practicing safer sex practice, many misconceptions and challenges in consistent use of condoms with various types of partners were found in all the subgroups of males-at-risk. This reiterates the need to further intensify safer sex information and counselling for these marginalized groups. Marginalized communities preferred their peers to provide HIV/STI and SRH-related information. Thus, it is important that these peer educators are given adequate training to ensure that they offer correct and unbiased information to their peers. In the case of married males, offering couples counselling (including HIV serodiscordant and seroconcordant couples) might be a better strategy, which will also help in promoting sexual communication. Also, through mass media campaigns, sexual and reproductive health promotion messages can be given. When offering sexual risk reduction counselling to males-at-risk, it is important not only to discuss about individual-level barriers to safer sex but also acknowledge and address the interpersonal and structural barriers (e.g., discrimination from

health service providers, sexual assault, and other problems from police/law) and assist them in choosing strategies to tackle or avoid situations in which they might not be able to use condoms (for example, such strategies could be - not taking alcohol before having sex, and always carrying condoms with you).

The plan developed by the National AIDS Control Organization (NACO) for the third phase of the National AIDS Control Program (NACP-III) focuses on HIV prevention among various marginalized groups including various subgroups of males-at-risk. However, providing or linking up these marginalized groups with SRH information and services are not articulated in detail in NACP-III. Similarly, in the Reproductive and Child Health Policy (RCH-II) of the Indian government, much of the focus has been on women and children to the near exclusion of males-at-risk. Thus there is a serious policy gap – lack of explicit policies that articulate the SRH needs and services for males-at-risk and how they can be met at least through the existing SRH services.

Considering the severity and extent of human rights violations against MSM and Hijras by police/ruffians, the Indian government needs to uphold the human rights of MSM/Hijras – which needs to be crucial component in reducing HIV/STI vulnerability and to improve their sexual and reproductive health. Decriminalization of

adult consensual same–sex sexual relationships is needed as a first step toward enacting and enforcing anti-hate crime legislation that would hold individuals accountable for violence and abuse targeting MSM and Hijras (Chakrapani et al, 2007b). Decriminalization is also an essential step towards legal recognition of adult same-sex civil partnerships or marriage between two men or between a man and a Hijra. Another policy intervention that might be helpful could be to enact and enforce anti-discrimination policies in the health care system.

Legal recognition of the gender identity of Hijras is another area where consensus needs to be built as the Hijra communities seem to be divided on whether they should be recognized as women or as ‘third gender’. In the Indian passport application, in the ‘sex’ column, there are three categories – male, female and ‘others’ (<http://passport.gov.in/cpv/ppapp1.pdf>). Some Hijras have applied as ‘female’ and have got their passport as ‘female’ while some others have reportedly got their gender as ‘Eunuch’ (marked as ‘E’) – with protest against using the term ‘Eunuch’ or the letter ‘E’ from some other Hijra activists. Thus, there is a need to bring clarity to the legal recognition of the gender identity of Hijras in India by organizing national level consultations with Hijra/Transwomen communities and other key stakeholders.

With regard to service delivery, several things need to be accomplished. These involve changing some of the routine practices, introducing new services, and creating an enabling environment for males-at-risk to access and utilize the existing services. Currently, only women are involved in family planning counselling both at the family planning clinics and prevention-of-parent-to-child-transmission of HIV centres. Hence, there is a need to equally involve men and women in family planning counselling to enable them in making informed choices about family planning method(s) suitable for them. Also, since men seem to have limited knowledge about the family planning options (including vasectomy) available for them,

there is a need to launch effective public education campaigns on the same.

Since discrimination is a major obstacle for accessing SRH services, antidiscrimination education campaigns in the mass media targeting the general public also may be an important intervention to combat stigma/discrimination associated with people living with HIV, drug users, and MSM/Hijras (Chakrapani et al, 2007b; UNAIDS, 2001). Specifically, there is also a need to focus on stigma and discrimination in the health care settings. In addition to the technical training on the family planning methods, health care providers also need to be trained on SRH needs and rights of various marginalized groups (PLHIV, MSM, Hijras, IDUs, etc.) to assist them in offering counselling and provide services in a non-judgmental and unbiased manner.

Poor health care infrastructure prevents people from utilizing the available SRH services and hence there is a need to have private rooms for counselling/examination of patients coming to obtain SRH services, and ensure adequate number of trained health care staff are available to avoid long waiting time of the patients. In addition to STI screening and treatment of those visiting SRH services, males-at-risk also need assistance in how to voluntarily disclose their STI/HIV status to their partners (wife or regular female partners) for which providers need to implement tested and innovative strategies in partner screening/treatment.

There are several unmet information and service needs of MSM and Hijras. These need to be fulfilled: information and counselling on sexuality especially when they are growing up as adolescents; sex reassignment surgery (SRS) and feminizing procedures for Hijras/Transwomen; post-sexual assault care and counselling, including sexual post-exposure prophylaxis (for male/Hijra victims of sexual assault); and counselling and treatment of sexual dysfunctions among heterosexually married MSM.

Similarly, for men living with HIV, the unmet information/service needs include: education on the benefits for people living with HIV in using condoms; education about and availability of sexual post-exposure prophylaxis in case of accidental condom failure among HIV serodiscordant couples; need for free or affordable/subsidized 'sperm-washing' technique to allow HIV sero-discordant couples (Husband: HIV-positive; Wife: HIV-negative) to have their own child; education about and availability of emergency contraception for HIV-positive couples to avoid unintended/unwanted pregnancy; education for PLHIV about their right to get married and have children; and education about and availability of safe contraceptive options for people living with HIV.

Current services for marginalized populations and PLHIV operate in isolation. For example, there are no effective functional linkages between HIV treatment and care services for people living with HIV, drug-dependence treatment and care services for IDUs, HIV

prevention services for marginalized groups, and sexual/reproductive health services. Hence there is a need to create strong linkages among these various services so that holistic care is provided to males-at-risk.

Non-governmental and community-based organizations including PLHIV networks reach out to and provide information/services to various marginalized communities and people living with HIV. In the absence of these agencies, reaching out to the various marginalized communities would not have been possible. Hence, government and international donors should make every effort to stabilize funding and offer technical support to these organizations. In addition to the support for specific behavioural components of HIV prevention interventions, it is important that funding should also be available to ensure that sexual and reproductive health and rights of the various marginalized communities are addressed in the programs that aim to mitigate HIV epidemic.

Box 2: Key recommendations

Males-at-risk, including PLHIV, need to be provided with accurate information and services to preserve and enhance their sexual and reproductive health, and to exercise their sexual/reproductive rights.

Promoting Safer Sex Behaviors

- Adopt multiple strategies to promote and sustain safer sex among males-at-risk in a variety of settings: one-to-one risk-reduction information/counselling (peer outreach and peer/professional counselling); couples counselling (tailored for those who are HIV sero-discordant and sero-concordant); and mass media campaigns.
- Provide tailored sexual risk-reduction counselling that takes into account the contexts that influence condom use—that is, counselling that avoids focusing narrowly on individual-level factors to the exclusion of social and structural constraints (e.g., stigma, sexual violence, harassment, disrespect from healthcare providers, lack of access to free condoms).

Sexual and Reproductive Health: Policies

- Articulate SRH service needs of males-at-risk in national policies, and how those service needs can best be met through the health care system.
- Allocate adequate resources to meet the SRH needs of males-at-risk.
- Protect MSM and Hijras from the physical/sexual violence perpetrated by ruffians and police - by repealing laws that criminalize consensual same-sex adult relationships and enacting anti-discrimination laws.
- Provide legal recognition of gender identity of Hijras; and male-male and male-Hijra steady partnerships.
- Provide sex reassignment surgery and feminizing procedures for Hijras/Transwomen in government hospitals with appropriately trained medical personnel.
- Enact anti-discrimination policies in the health care system.
- Improve linkages and referrals between HIV treatment and care services, drug treatment and care services, HIV/STI prevention programs, and sexual/reproductive health services.
- Ensure uninterrupted and committed funding for CBOs, PLHIV networks and NGOs working on HIV/STI prevention and care programs as well as programs that address sexual and reproductive health of various populations of males-at-risk.

Sexual and Reproductive Health: Service delivery

- Equally involve men and women in family planning counselling to enable them in making informed choices about family planning method(s) suitable for them.
- Launch effective public education campaigns on the family planning options (including vasectomy) available for men.
- Train health care providers on SRH needs and rights of various marginalized groups. Emphasize the need to offer counselling and provide services in a non-judgmental and unbiased manner.
- Improve health care infrastructure to have private rooms for counselling/examination of patients coming to obtain SRH services, and ensure adequate number of trained health care staff.
- Implement tested and innovative strategies for partner screening/treatment and assist people in voluntary disclosure of their STI/HIV status to their partners.
- Address unmet information and service needs of MSM and Hijras: Information and counselling on sexuality; sex reassignment surgery (SRS) and feminizing procedures for Hijras; post-sexual assault care and counselling, including sexual post-exposure prophylaxis (for male/Hijra victims of sexual assault); and counselling and treatment of sexual dysfunctions among heterosexually married MSM.
- Address unmet information and service needs of men living with HIV: benefits for people living with HIV in using condoms; sexual post-exposure prophylaxis; 'sperm-washing' technique to allow HIV sero-discordant couple to have their own child; emergency contraception; right to get married and have children; and safe contraceptive options for people living with HIV.
- Launch antidiscrimination education campaigns in the mass media targeting the general public to combat stigma and discrimination associated with people living with HIV, same-sex attracted people, Hijras, and drug users.

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6. Glossary

Contraception

Prevention of conception using techniques, devices or drugs.

Discrimination

Unjustifiable negative behaviour 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).

Dual method

Using a barrier method for protection against sexually transmitted infection and another method for contraception.

Dual protection

Prevention of both STI/HIV infection and unwanted pregnancy. This can be achieved by the correct and consistent use of condoms alone or by the simultaneous use of two methods, one of which must be a condom.

Family Planning

Implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their

births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.

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.

Information, Education and Communication

A programme to ensure that clients or potential clients of sexual and reproductive health services are given the means to make responsible decisions and childbearing, and about their sexual and reproductive health.

Information involves generating and disseminating general and technical information, facts and issues, in order to create awareness and knowledge.

Education, whether formal or non-formal, is a process of facilitated learning to make rational and informed decisions.

Communication is a planned process aimed at motivating people to adopt new attitudes or behavior.

Impotence

Impossibility of a man to have or sustain erection.

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 behaviour and many may also get married to a woman. A significant proportion of Hijra-identified persons 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.

Marginalized people

Those groups in society who, for reasons of poverty, geographical inaccessibility, culture, language, religion, age, gender, migrant status or other disadvantages, have not benefited from health, education and employment opportunities, and whose sexual and reproductive health needs remain largely unsatisfied.

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)' 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 and Meyer, 2005; Dowsett et al., 2006).

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).

Reproductive Health

Reproductive health is defined by WHO as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.

Reproductive rights

"Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number and spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health." (Para. 95, Beijing Platform for Action, 1995)

Sexual and reproductive health services

Defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health. (Para 7.2 ICPD Programme of Action)

Sexual health

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual rights

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

Sexually Transmitted Infections (STI)

Infections that people get by having intimate sexual contact, including having sex (vaginal, oral, or anal intercourse) with someone who already has the infection. There are many different kinds of STIs including herpes, HIV, and syphilis. All STIs are preventable.

Sero-discordant

A term used to describe a couple in which one partner is HIV positive and the other is HIV negative.

Seroconcordant

A term used to describe a couple in which both partners are of the same HIV status (i.e. both are HIV positive or both are HIV negative).

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'.

Voluntary surgical contraception

Female and male sterilization (also known as tubectomy, tubal occlusion or tubal ligation and vasectomy) are among the most effective contraceptive methods available for men and women who desire no more children and are associated with low mortality and complication rates. The sterilization procedure blocks either the sperm ducts (the vasa deferentia) or the oviducts (fallopian or uterine tubes) to prevent the sperm and ovum from uniting.

Internet Sources (URLs):

http://www.who.int/reproductive-health/publications/conflict_and_displacement/pdf/appendix9.en.pdf
<http://www.wpro.who.int/NR/rdonlyres/C8DE0A54-6014-42B3-82CF-7CF0938A3E51/0/glossary.pdf>
<http://www.who.int/reproductive-health/gender/glossary.html>
http://www.who.int/reproductive-health/publications/fpp_97_33/fpp_97_33_12.en.html
http://www.who.int/reproductive-health/publications/rtis_gep/glossary.htm
http://www.who.int/reproductive-health/publications/rtis_gep/glossary.htm
http://www.kidshealth.org/teen/infections/stds/std_hepatitis.html
<http://www.kidshealth.org/teen/infections/stds/hepatitis.html>
http://www.rho.org/html/definition_.htm
<http://www.rho.org/html/glossary.html>
http://www.who.int/reproductive-health/gender/sexual_health.html
http://www.cdc.gov/nchstp/od/gap/pmtct/Trainer%20Manual/Adobe/Glossary_RG_TM.pdf
<http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/index.htm>
<http://en.wikipedia.org/wiki/Serodiscordant>
<http://www.ippf.org>
<http://www.indianglbthealth.info/Home/Sexual%20Behavior.html>



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