Male-to-male sex and HIV/AIDS in India

A briefing summary

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Who is MSM – behaviour or identity?

The category "men who have sex with men" (or males who have sex with males - MSM) was developed in response to a recognition that not all male-to-male sexual behaviours falls within a framework of sexual orientation or identity. Within this behavioural category there are multiple frameworks of male-to-male sex, including those who are self-identify as homosexuals/gay men, males who self-identify within a gendered framework, such as *kothis* and *hijras*, as well as normative males from the general male population who sexually access such gendered males, along with others, usually as the penetrating partner. Male-to-male behaviours also exist in a range of all-male institutions and occupational groups including prisons, juvenile homes, and the armed forces, along with truck drivers, and in other service industries. In this context, the sexual practice is primarily based on a lack of access to females, "body heat", and immediate discharge.

Size estimations

The difficulty for developing size estimations of MSM is the confusions regarding self-identified MSM – gay men, homosexuals, *kothis* and *hijras* - and that of non-identified MSM whose male-to-male sexual behaviours are not based on a sexual/gender identity. The confusion impacts on what is being counted, and whether it is identity-based or behaviour based, where the two are not synonymous.

Despite a range of shortcomings, current knowledge is indicative of substantive male-to-male sexual experience:

- 25% of medical students at Patna Medical College in a 1992 survey revealed that they had same-sex relationships (Wyatt, 1993)
- Of the 1500 men who replied to a questionnaire in an English men's magazine in India, Debonair, 29.5% stated that had sex with another man before the age of 20 years (Roy Chan, et al. 1998)
- A survey of 527 truck drivers in northeast India revealing that 15% had sex with men (Ahmed, 1993)
- In a study of sexual behaviour among 1600 college students in Chennai, (Hausner D, 2000) it was found that approximately 20% of male students reported having had sex at least once in their lifetime and among these, 35% had their first experience with another male.
- A cross sectional survey of 2910 rural Indian men aged 18-40 years from five rural districts in five different states in north India revealed that nearly 10% of single and 3% of married men had had unprotected anal sex with a man in the past year. Homosexually active men are not a separate sexual category, and report extensive mixing with female partners. They have more female partners than other men and they practiced anal intercourse in 11% of their heterosexual contacts. (Ravi Verma, 2004)

In fact there is sufficient evidence to indicate that a substantive percentage of the sexual active male population is behaviourally bisexual, taking into account the following factors:
- Social policing of females making them more difficulty to sexually access;
- Ready availability of males involved in male-to-male sex in certain environments;

- Socially compulsory marriage, but often delayed till mid-twenties and older;
- Poverty leading to the provision of sex as transactional commodity

Male-to-male sex and risk behaviours – who is at risk?

Not all male-to-male sex involves risk activities, and not all males who have sex with males practice risky behaviours.

Risky sexual practices would include:
- Unprotected anal sex for both the penetrated and the penetrator
- Multiple partners
- Having sexually transmitted infections

Amongst self-identified MSM, particularly those who have feminised identities, the preferred sexual practice is anal sex as the penetrated partner, multiple partners, with many involved in commercial sex. Further their penetrating partners also have sex with female sex workers. At the same time one or both sexual partners may well be married. Further low condom use appears to be common, along with low access to STI treatment.

MSM, vulnerability and stigma

Stigma, discrimination, illegality, harassment, and violence, impede access to HIV/AIDS/STI prevention, treatment, care and support services where they exist, as well as impeding development of appropriate services.

Fear of blackmail, denial, social exclusion, violence and abuse leads many MSM not to access services, self-identified or otherwise. For the manly penetrating partner who only acknowledges his 'heterosexuality", accessing services would be within this normative dynamic. These factors could also have an impact on HIV sentinel data being collected.

HIV/AIDS and male-to-male sex

Current information on levels of HIV infection in India indicate that there are some 5.1 million such infections, where there is less than 1% infection across India as a whole. But this information hides some very highly localised rates of infection, for example in Maharashtra, Andhra Pradesh, Karnataka and Tamil Nadu. Information on rates of HIV infection is very limited at the moment, with Mumbai reporting about 20%, and Chennai about 4%. Information from rural areas appears to be non-existent, but it has been reported that Baroda in Gujarat has about a 5% infection rate amongst MSM (personal communication from SHRC). These are significantly high levels of infection.

The question here would be: which MSM?

STD prevalence amongst MSM

Similarly only limited data are available about STD prevalence amongst MSM in India. A preliminary analysis of STDs amongst 85 MSM attending an STD clinic in Mumbai indicated 16% STI prevalence rate. The point prevalence of HIV in this population was 15% and VDRL reactivity was 16% (Maninder Setia et al, 2000).

In a 2001 study from Chennai, analysis of 51 MSM who attended a community-based clinic over a period of three months showed the following. Thirteen (26%) MSM were clinically diagnosed to have one or more STDs. (Venkatesan C and Sekar B, 2001).

ANNEX I

Strategies to address vulnerability and risk to HIV/STI amongst MSM

NFI suggests the following comprehensive service package towards reducing risk and vulnerability to HIV/AIDS/STIs amongst MSM. These include:

1. Knowledge generation
The need for more knowledge is abundantly clear, involving anthropological, sociological, behavioural and epidemiological studies, along with good practice methodologies. It is also suggested that such research is conducted with MSM HIV/AIDS agencies as partners.

2. Increasing Coverage
A rapid increase in coverage, and scaling up of interventions is urgently required. The model suggested here is the provision of technical support and assistance to MSM networks to develop and manage their own HIV/AIDS community-based interventions. Appropriate NGOs can provide development, capacity-building, and technical assistance, as well as mentoring.

3. STI Clinical Services
While HIV/AIDS interventions amongst MSM can refer potential patients to appropriate clinics, take-up of such services may be higher is such clinics were housed within community-based projects. Further intensive training will be required for clinicians regarding male-to-male sex, anal STIs and their treatment, developing a sympathetic and empowering environment, along with reduced costs of treatment.

4. VCTC
Appropriate Voluntary Testing and Counselling Centres are an essential component for any effective intervention strategy. This is even more so for at-risk MSM. However, it will be essential to ensure that all staff at such a Centre are thoroughly sensitised to the issues of MSM, have a clear understanding of the dynamics of MSM constructions, can provide strict confidentiality, appropriate counselling (both pre- and post-test), as well as ensure that such MSM can access appropriate support and care services. Well-supported links will need to be established with MSM service providers.

5. Condoms and lubricant
Many at-risk MSM have significant levels of penetrative sex on a regular basis, so it will be essential that sufficient good quality condoms are easily and cheaply available at different outlets, including places where sex takes place. Further since condoms suffer additional stress when used for anal sex, it will also be essential to ensure that adequate supplies of affordable water-based lubricants suitable packaged are also readily accessible.

6. Counselling
Any MSM intervention must include appropriate counselling on psychosexual and personal concerns. Many MSM such as *kothis* and *hijras* have low-esteem and a deep sense of disempowerment and self-hatred which leads to higher levels of risk and self destructive behaviours. With all this there are deep issues of concern around families, wives and children that also must be addressed, particularly in regard to family knowledge of sexual, STI and HIV status.

7. Advocacy and legal issues
Stigma, discrimination and social exclusion are central in the lives of many at-risk MSM, particularly those with feminised identities, such as *kothis* and *hijras*. Legal and judicial impediments to effective community-based interventions amongst MSM will need to be address.

Advocacy will need to be conducted with legal and judicial services, as well as parliamentarians towards addressing these concerns, in particular Section 377 of the Indian Penal Code.

Further, advocacy work will need to be conducted with the media and the public to destigmatise MSM behaviours, while MSM will need to be trained on their legal rights.

8. Training of the judiciary and law enforcement agencies

As an urgent necessity, the judiciary and local law enforcement agencies will need to be sensitised to the issues of MSM, their own STI/HIV risks, and the needs of specific MSM sexual health interventions. This will mean a closer relationship between Home and Health Ministries as well as the judiciary and police forces.

9. Working with other NGOS who provide services for the general male population

The MSM behavioural category does not only include self-identified MSM, but also non-identified MSM, many who identify as "heterosexual" and from the general male population. While it will be possible to access many of these males/men through their *self-identified* partners, it will also be necessary to ensure that any HIV/AIDS awareness programme and specific interventions with particular occupational groups, such as rickshaw drivers, auto-drivers, truck-drivers, factory workers, street children and so on, must include anal sex as a risk factor in HIV and not only discuss female sex workers and vaginal sex. This will mean collaborative work with other HIV/AIDS and sexual health NGOs working with the general male population. This will further require that these NGOs will need to be sensitised and educated about the dynamics of male-to-male sexual behaviours in Indian society.

10. IEC materials

Education and sexual health promotion materials can be an effective component of any intervention towards preventing the spread of STI/HIV/AIDS. However to be such it requires that such resources are meaningful to their users. This will mean ensuring that appropriate language and imagery are used that makes sense to those accessing these resources.

11. Funding and commitment

It is clear from what has been discussed above that at-risk MSM form a substantive population that is extremely vulnerable to HIV in terms of themselves, but also in regard to the general population through their bridging role. Therefore, it makes sense to ensure that support for MSM led interventions is also substantial, significant, and that a strong commitment from government and donors is made. Funding needs to be adequate and at appropriate levels to achieve this, and should be provided to the appropriate agencies, while assistance is also provided to develop such agencies. UNAIDS and others strongly believe that community-based agencies are the appropriate and best interventions agencies. In the case of this paper, this means MSM based and owned agencies would be appropriate.

12. Women's sexual health

Behaviourally bisexual activities appear to be common, where not only many MSM also have sex with women, but also anal sex between men and women are not uncommon. These issues will need to be addressed appropriately.

Certainly these primary recommendations for action are not the only areas that need to be developed. There are others that perhaps can be seen to be as equally important. Discussions should be initiated with local experts in the field of MSM HIV/AIDS and sexual health so that a comprehensive strategy can evolve that is significant, sustainable, and well supported. It will require a strong political and social will to achieve this.

ANNEX II

Documents

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