Dynamics of Men who have Sex with Men (MSM) and Hijras in Maharashtra:
A Qualitative Study of Sexual Networks & Vulnerability

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**Acronyms and Abbreviations**

BCC – Behavior Change Communication  
BSS - Behavioral Surveillance Survey  
CBOs - Community-based Organizations  
FSW – Female Sex Worker  
HST – The Humsafar Trust  
IDU – Injecting Drug User  
INFOSEM - India Network for Sexual Minorities  
MSM - Men who have Sex with Men  
MDACS – Maharashtra District AIDS Control Society  
MSACS – Maharashtra State AIDS Control Society  
NACO - National AIDS Control Organization [India]  
NACP – National AIDS Control Program [India]  
NGOs – Non-governmental Organizations  
STIs - Sexually Transmitted Infections  
VDRL - Venereal Diseases Research Laboratory
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EXECUTIVE SUMMARY

Background:  
In Maharashtra, quantitative studies including HIV seroprevalence studies among men who have sex with men (MSM) and Hijras have demonstrated high risk sexual behavior and high STI/HIV prevalence among these populations. However, limited qualitative data is available on the sexual and social networks of MSM and Hijras. Sexual and social networks are the dynamic systems through which HIV is spread as well as the structures that facilitate the communication of HIV prevention messages, provide the normative reference for individuals’ social practices, and enable or constrain safer sex practices. Networks, therefore, are central to our understandings of the HIV epidemic, and critical to our success in prevention of HIV/STIs. Also, it is crucial to understand the contexts in which unprotected sex happen (especially in relation to sexual partnerships or networks) and the various contextual factors that increase the vulnerability of MSM and Hijras to HIV infection.

Goal:  
This study was conducted with the goal of creating an evidence-base for the design and implementation of more effective HIV prevention interventions for MSM and Hijras in Maharashtra.

Purpose:  
The purpose of this study was to understand the following:  
- Sexual and social networks of MSM and Hijras in Maharashtra  
- Contexts of HIV-related sexual risk behaviors among MSM and Hijras  
- Bisexual behavior among MSM and Hijras in Maharashtra  
- Vulnerability of MSM and Hijras in Maharashtra

Methodology:  
Qualitative research methodology was used in this study: 39 in-depth interviews with various subgroups of MSM and Hijras; 6 focus group discussions (n=37 participants); and 5 key informant interviews (with health care providers and community leaders) were conducted. Data collection was done in Mumbai (by the Humsafar Trust) and Sangli (by Mooknayak) districts in Maharashtra. Interview and focus group data were explored using narrative thematic analysis using the analytic techniques from grounded theory.

Organization of ‘Key Findings’ Section:  
The key findings are organized into the following sections:  
A. Identities among MSM and Transgender women: Describes the identities and labels used by MSM and transgender women in Mumbai and Sangli - including the change in the meanings attached to these identities/labels.  
B. Sexual Networks: Demonstrates the extensive sexual mixing and concurrent sexual relationships of MSM and Hijras.  
C. Sexual Practices & Condom use: Describes the various sexual practices of MSM/Hijras, and also summarizes the various contexts in which unprotected sex happens.  
D. Bisexual Behavior: Summarizes the bisexual behavior among the various subgroups of MSM, and the risk to their male/female partners and unborn children.  
E. Social Networks and Support: Summarizes the various types of social support received by Kothi-identified MSM and Hijras from their social contacts.  
F. Structural Vulnerability: Demonstrates the various forms of stigma, discrimination, and violence faced by MSM and Hijras from different people; and shows how they increase the vulnerability to HIV infection.
Summary of Recommendations:

Sexual Networks
- Develop sensitive and culturally-appropriate mass media messages on health risks related to unprotected sex with partners of any gender, to reach out to MSM who are not accessible through targeted interventions.
- Develop network-based interventions in an ethical manner to reach out to MSM who are part of sexual networks through mobile phones, personal friendships, and internet.
- Address male-to-male sex and bisexual behavior in programs focusing on specific male populations such as male youth, migrants, truck drivers, and male injecting drug users.

Social Networks
- Support formation of community-based organizations (CBOs) in different parts of Maharashtra to provide social support to and mobilize MSM and Hijras towards their health issues and rights.
- Consider the feasibility of identifying and training influential community leaders of Kothi and Hijra communities to create community norms supporting condom use - in line with the concept of ‘Community Popular Opinion Leader’ model.

Addressing Bisexual Behavior
- Outreach education among MSM also needs to emphasize condom use with their female partners.
- MSM who are facing marriage pressure from their families need to be provided with non-directive, non-judgmental counseling to help them in making informed decisions about marriage.
- For those MSM who are married, support needs to be provided in the following areas: whether to disclose his sexuality or not; what to do if there is a crisis situation like someone has revealed his sexuality to his wife; how to use condoms with his wife especially if he has STI or HIV; how to disclose to his wife that he has STI or HIV; and how to motivate his wife to come for STI/HIV screening and treatment.

Addressing contextual factors that lead to unprotected sex
The study findings suggest that though important and much needed, Behavior Change Communication (BCC) strategy alone is inadequate.
- At the interpersonal level, efforts to be taken to improve sexual communication between couples (man-man, man-woman, and man-Hijra) and improve condom negotiation skills to negotiate with different types of partners (husband and wife; male couple; Hijra sex worker and male client).
- At the structural level, potential actions include removal of legal barriers (see below) and devise strategies to change the societal attitude towards sexuality issues.

Decreasing/Eliminating Structural Vulnerability
- There is a need to decriminalize consensual adult same-sex relationships.
- To prevent hate crimes, it is essential to codify and enforce laws preventing physical and sexual abuse of sexual minorities.
- To provide optimal health care to sexual minorities, health care providers need to be trained on sexual diversity and health care issues of MSM and Hijras.
- For increasing the effectiveness of prevention and care programs for MSM and Hijras, there is a need to gain the support of law enforcement agencies by sensitizing them.
GLOSSARY


Bisexual (adj., n.): One who has significant (to oneself) sexual or romantic attractions to members of both the same gender/sex and opposite gender/sex, or who identifies as a member of the bisexual community. People who are attracted to members of both genders/sexes may still choose to have a single steady partner.

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

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

Gay: One who has significant (to oneself) sexual or romantic attractions primarily to members of the same gender or sex, or who identifies as a member of the gay community. One may identify as gay without identifying as a member of the gay community. Though ‘gay’ is a common term for male and female homosexual persons, in India, it is mainly used to denote homosexual man. Self-identified gay men do not necessarily have sex only with men, but occasionally may engage in sex with women.

Hijras: Hijras are biological/anatomical males who reject their 'masculine' identity in due course of time to identify either as women, or “not-men”, or “in-between man and woman”, or “neither man nor woman”. Hijras can be considered as the western equivalent of transgender/transsexual (male-to-female) persons.

Kothi: Kothis are a heterogeneous group. 'Kothis' can be described as males who show varying degrees of 'femininity' (which may be situational) and who are involved mainly, if not only, in receptive anal/oral sex with men. Some proportion of Kothis have bisexual behavior and many may also get married to a woman. 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.

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 not to be a 'homosexual'. This, basically an epidemiological term, coined by public health experts, focuses exclusively on sexual behavior for the purpose of HIV/STD prevention.

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

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

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

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

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

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

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

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

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

An increasing evidence suggest that that a substantial number of MSM may engage in high-risk behaviors with both men and women in India (Chakrapani et al., 2002; Verma & Collumbien, 2004; Dowsett et al., 2006). Since a significant proportion of MSM have bisexual behavior (including those who get married heterosexually), the risk of transmission of HIV infection is not only to their male partners but also to their female partners and their unborn children.

In the subsequent paragraphs in this section, we summarize the high risk sexual behavior and STI/HIV prevalence among MSM and Hijras in Maharashtra; and briefly describe the goal, purpose, and key research questions of the study.

Sexual Behavior, and Prevalence of STI/HIV among MSM in Maharashtra

In India, the state of Maharashtra had the highest prevalence of HIV as of 2005. According to NACO’s 2004 annual report, among the 49 high HIV prevalence districts in India, 14 are in Maharashtra. AVERT society, Maharashtra, has been analyzing the changing trends in the sexual risk behavior of MSM for the last three years through its Behavioral Surveillance Survey (BSS). The key findings from the second wave of BSS (BSS-II) showed that more than 95% of the MSM participants reported having had anal sex with male partners in the month preceding the survey; reported inconsistent condom use with different partners (though higher compared to BSS-I); and exhibited high prevalence of STI-related symptoms (16%) (BSS - Wave II, 2004). In Mumbai, recent data from NACO’s HIV sentinel serosurveillance sites for MSM showed HIV seroprevalence rates among MSM - 18% in 2003 and 9% in 2004 (http://www.nacoonline.org/ facts_statewise.htm).

The Humsafar Trust’s 2002 clinical data of MSM showed that 80% of MSM who had reported anal sex had never used condoms for anal sex. These data also revealed 51% of clinic attendees reported decrease in sexual pleasure as one of the common reasons for not using condoms and 15 % did not know the importance of condom usage. From the Sion hospital, a government hospital that collaborates with the HST, Mathur et al. reported the following data in 2002: among the 1400 men tested 810 (57.9%) were homosexual men, 378 (27%) were bisexual and 212 (15%) were heterosexuals. HIV-positivity among homosexual men was 19.65%, bisexuals 10.58% and heterosexuals 10.8%. VDRL (Venereal Diseases Research Laboratory - a blood test for Syphilis) was reactive in 13% of homosexual men, 7.4% of bisexual men and 4.9% of heterosexual men (Note: Here, the authors seem to use the labels ‘homosexual’ and bisexual’ for the behavior). In a recent article from the Sion hospital and the Humsafar Trust, Setia et al. (2006) looked at HIV seropositivity among 150 persons (122 MSM and 28 Transgender women/Hijras) who visited two Mumbai STI clinics. Of these, 17% of MSM and 68% of the Hijras were found to be HIV-positive.
Thus, all the studies conducted among MSM in Mumbai city in the state of Maharashtra, including those conducted by the Humsafar Trust have documented the following:
- high risk sexual behavior (inconsistent condom use)
- large number of male sexual partners, and
- bisexual behavior among significant proportion of MSM, and
- high prevalence of STI and HIV

Though a small-scale qualitative study among MSM had been conducted in Pune in Maharashtra (Kulkarni et al., 2004), there are limited qualitative studies that have systematically documented the dynamics of MSM in main cities in Maharashtra. Thus the proposed study focused on filling this important gap to assist AVERT society, Maharashtra, in designing and implementing more effective interventions among MSM and Hijras in Maharashtra.

Goal
The goal of this study was to create an evidence-base for the design and implementation of more effective HIV prevention interventions for men who have sex with men (MSM) and Hijras in Maharashtra.

Purpose
The purpose of this study was to understand the following:
- Sexual and social networks of MSM and Hijras
- Contexts of HIV-related sexual risk behaviors among MSM and Hijras
- Bisexual behavior among MSM and Hijras
- Vulnerability of MSM and Hijras

Key Research Questions
Sexual and social networks
- What are the features and characteristics of the sexual networks of men who have sex with men (MSM) in Maharashtra?
- How do sexual networks enhance or reduce individual HIV related sexual risk behavior among MSM in Maharashtra?
- What are the features and characteristics of the social networks of men who have sex with men (MSM) and Hijras in Maharashtra? What kind of social support is provided by whom?

Bisexual behavior among MSM
What are the implications of bisexual behavior among various subpopulations of MSM in relation to HIV transmission to the ‘general population’?

Contextual factors behind HIV-related sexual risk behaviors among MSM and Hijras
What are the various factors (individual, interpersonal, community and societal level factors) that lead to HIV-related high risk sexual behaviors among MSM?

Vulnerability of MSM and Hijras in acquiring HIV infection
What are the various factors, especially structural factors like social norms and laws, that make MSM and Hijras more vulnerable to HIV infection?
II. LITERATURE REVIEW

In this section, the relevant Indian and western literature, and conceptual frameworks related to the research topics are summarized.

Sexual networks
Sexual networks are the dynamic systems through which HIV/STI is spread. They are also the structures that facilitate the communication of HIV prevention messages, provide the normative reference for individuals’ social practices, and enable or constrain safer sex practices. Networks, therefore, are central to our understandings of the HIV epidemic, and critical to our success in prevention of HIV/STI. Understanding who has sex with whom will help to clarify current and future patterns of HIV transmission (Anderson et al., 1992; Morris et al., 1995), refine notions of risk, and generate information essential to design strategies to prevent the transmission of HIV/STIs (Neagius et al., 1994; Trotter et al., 1995). The National AIDS Control Organisation (NACO) mentions targeted interventions among MSM as one of the priority areas. The draft strategic plan of National AIDS Control Program - Phase III (NACP-III) mentions: “Tracing patterns of sexual networks and strategizing to intervene at key points in the network could be a useful way forward” (NACO, 2005).

Little empirical research on sexual networks of MSM in India
An Indian literature review (Chakrapani et al., 2002) indicated that most studies on MSM have used quantitative methods focusing on HIV related sexual risk behavior at an individual level. Though a few qualitative studies from India (Asthana et al., 2001; Chakrapani et al., 2002; Kulkarni V et al., 2004) have documented the various ‘typologies’ of MSM - Kothis, Panthis, Do-Paratha, Double-deckers, etc., little has been mentioned about the significance of sexual and social networks. As part of a discussion paper, in a preliminary review on identities among MSM, Chakrapani et al. (2002) described sexual connections among the various subgroups of MSM and connections with female partners. In a five-state study (Verma & Collumbien, 2004) and in a survey among MSM in Andhra Pradesh (Dandona et al., 2005), it has been shown that both single and married men in urban and rural areas have sex with men and women (i.e., act as bridge populations). However, there is still lack of systematically documented qualitative information on sexual networks of MSM.

Social Networks and Social Support
In India, there is no published literature available on the social networks and social support available for various subgroups of MSM and Hijras. Such an understanding is important from the perspective of HIV/AIDS prevention and care, since by understanding the social networks and support available to MSM and Hijras we can design appropriate interventions to offer adequate psychological and informational support, and also work with key influencers to modify the risk behavior of individuals.

Social networks are defined as the web of identified social relationships that surround an individual and the characteristics of those linkages (Bowling, 1997). Social support theory has addressed how various types of support affect an individual's psychological well-being. In a literature review on social support research, Wan et al. (1996) has distinguished between four types of support: emotional, informational, companionship, and tangible. The following descriptions about the type of support are provided in the article by Neergaard et al., 2005.

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

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

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

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

In this study, the focus was on who constitutes the social networks of various subgroups of MSM and Hijras; what kinds of support are being provided by them; and under what contexts these support are provided.

**Vulnerability of MSM in acquiring HIV infection**

In general, the term ‘vulnerable’ refers to “able to be easily physically, emotionally, or mentally hurt, influenced or attacked” (Cambridge Dictionary, 2004). In the context of HIV epidemic, vulnerability of MSM can be seen as individual or structural vulnerability.

**Individual vulnerability**: Refers to the lack of protection for an individual against a public risk, partly for reasons inherent to the individual (for example, lack of adequate knowledge), and partly because he or she belongs to a group that is an overall victim of structural vulnerabilities.

**Structural vulnerability**: Refers to the lack of protection for a group (that shares a stigmatized characteristic, such as being a member of an ethnic, religious, or sexual minority) against a public risk, when that lack of protection arises from social exclusion. Numerous research studies from developed countries on HIV vulnerability among MSM have identified various individual factors, such as levels of self-esteem, internalized homophobia, intimacy problems, among others (Toro-Alfonso, 2002). Without going into the structural factors that cause these vulnerabilities (such as social norms, legal barriers), we cannot focus only on the individual factors that can contribute to an increase in risk behavior among MSM. Another important aspect in the personal processes of MSM is the impact of their own perception of their sexuality. Some authors say that homophobia can be an enormous obstacle in the development of safe sexual behavior (Toro-Alfonso, 2002). Levels of internalized homophobia may be related to a person’s comfort with their sexuality and establishing proper relationships (Pharr, 1997; Toro-Alfonso, 2002)).

People with low self-esteem tend to try to seek acceptance in indirect ways. It has been found that individuals who engage in safer sex have higher self-esteem, experience less anxiety or depression and fewer behavioral problems, and consume smaller quantities of alcohol than those who engage in sexual risk taking (Rotheram-Borus et al., 1992). Other studies have identified factors such as low perceived individual risk, health-related beliefs, and negotiation skills as important elements in individual HIV vulnerability in MSM. Many research studies (Stall...
et al., 2003; Mays & Cochrane, 2001) found that perceived discrimination was associated with a low quality of life and with high levels of psychiatric morbidity.

In USA, Herek (1999) have conducted many studies relating the stigma associated with the disease and the vulnerability of MSM to the HIV epidemic. In India, various studies have documented the stigma, discrimination and violence faced by MSM in various settings and the relations to unprotected sex and thus increased risk of HIV transmission/acquisition have been discussed (Chakrapani et al., 2007, in press; PUCL-K, 2001 & 2003).

Contextual factors behind sexual risk behaviors among MSM and Hijras
Though many quantitative studies in India have demonstrated the higher proportion of high-risk sexual behavior among MSM and inconsistent condom use (Dandona et al., 2005; Setia et al., 2000), there is little understanding about under what circumstances high-risk sexual behaviors occur and whether there could be factors operating at different levels – individual, interpersonal, community, and societal levels.

A recent study conducted in Chennai among HIV-positive MSM has demonstrated that several contextual factors are responsible for unprotected or safer sex among HIV-positive MSM (Chakrapani et al., 2005). That study highlights that there are several formidable obstacles to secondary HIV prevention for MSM: lack of HIV prevention and care resources for MSM; stigma against MSM and PLHA in the healthcare system; misconceptions and misinformation about HIV transmission; the complex relationship between sexual behaviors and self identification; the ubiquity of marriage among MSM and challenges with female spouses; systematic harassment and violence perpetrated against MSM and HIV/AIDS outreach workers by police and ruffians; and the criminalization of sex between men in India. And they recommend “culturally competent, multi-level interventions developed in collaboration with community stakeholders are needed to facilitate effective prevention strategies for HIV-positive MSM in South India.”

Bisexual behavior among MSM in India
Studies have documented that various subpopulations of MSM have bisexual behavior. A population-based study on sexual behavior of men in four states showed that nearly 10% of unmarried men and about 4% of married men also have had anal sex with men in the past one year (Verma & Collumbien, 2004). Another population-based random sample survey among slum men found that among the slum men who have had sex with men nearly 57% were married (Vivian Go et al., 2004). Similarly a substantial proportion of MSM who attended a community based clinic in Chennai (Chakrapani et al., 2001) and who attended government STD clinics in Chennai (Srinivasan et al. 2004) and Mumbai (Setia et al., 2000) were also found to have bisexual behavior. In Maharashtra, same-sex behavior among a cohort of STI clinic male attendees increased from 2.5% in 1995 (Mehendale et al., 1995) to 9.8% in 2000 (Brahme et al., 2003).

Thus, while we do know about the extent of bisexual behavior among MSM, there is a gap in the understanding of the contextual factors behind the unprotected sex or factors that facilitate safer sex with their female partners. The differences in sexual risk practices with female sexual partners, if any, between self-identified homosexually oriented men who get married and MSM with no self-designated identity are not known. Also, we are not sure whether heterosexual marriage has any effect on the sexual risk taking behavior of self-identified homosexually oriented men. These grey areas need to be explored to better understand whether bisexual behavior among MSM has significance in relation to increase in the HIV prevalence in the ‘general population’.

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III. RESEARCH METHODOLOGY

Qualitative research methodology was used in this study: 39 in-depth interviews with various subgroups of MSM and Hijras; 6 focus group discussions (n=37 participants); and 5 key informant interviews (with health care providers and community leaders) were conducted.

1. Participatory approach
The Humsafar Trust, Mumbai, is a community-based organization (CBO) working with MSM and Hijras over the past 8 years. This study was implemented by the Humsafar Trust in collaboration with Mooknayak, a CBO in Sangli, Maharashtra.

Those persons who had been working MSM and Hijras were interviewed and hired, based on their communication skills and ability to respect full confidentiality regarding personal information. The field research staff were given intensive three-day training on research techniques, research ethics, using voice recorders and data management. Pre- and post-training technical support and guidance were provided for the field research team members. The field research team in each research site (Mumbai and Sangli) typically included two persons: a field research coordinator-cum-interviewer, and an interviewer-cum-recruiter. These team members were responsible for organizing, recruiting, and conducting most of the in-depth interviews and focus groups though some of them were conducted or facilitated by some of the research investigators.

2. Selection of study sites
Mumbai and Sangli cities were selected to cover various subgroups of MSM and Hijras since Humsafar Trust’s experience has shown that there are differences in regard to the organization and nature of sexual networks of MSM in Mumbai and other districts. For example, Mumbai being a metropolitan city, MSM have access to and participate in a variety of networks – Kothi- and gay-identified MSM, maalishwaalas (massage boys), “bar boys”, and those MSM who engage in sex work. But in Sangli, many MSM may not have any specific sexual identity even as they engage in sex with other subgroups of MSM who may be gay- or Kothi-identified. To take into account these variations in both the extent of participation in diverse sexual networks and differences in sexual identity, Mumbai and Sangli cities were selected.

3. Study populations
The study populations included:
   b. Transgender people: Hijras and ‘Jogti Hijras’.
   c. Key informants: Health care providers, and community leaders from MSM and Hijra populations.

4. Eligibility criteria
Common eligibility criteria across subgroups of MSM and Hijras were: over 18 years of age; currently sexually active with males (any kind of sexual activity); and ability to understand and give consent to the study.
Table 1: Sampling Details

<table>
<thead>
<tr>
<th>SITES</th>
<th>IDI (n=39)</th>
<th>FGD (n=6 FGDs, with a total of 37 participants)</th>
<th>KII (n=5)</th>
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</thead>
<tbody>
<tr>
<td>Number</td>
<td>Details</td>
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<td>Hijra unmarried: 6</td>
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</table>

5. Methods and Sampling
Six focus group discussions (with 37 participants) and 39 in-depth interviews with various subgroups of MSM as well as 5 key informant interviews were conducted (Table 1).

a. In-depth Interviews (IDIs)
A total of 39 individuals who were MSM, Hijras, and ‘Jogti Hijras’ (See Table 1 for details) participated in the in-depth interviews, which lasted for about 60 to 90 minutes. Snowball sampling and stratified purposive sampling techniques were used to recruit these participants. The research staff informed MSM and Hijras who were using the services of the CBOs) about the study and asked about their willingness to participate. Some participants referred other potential participants to this study (Snowball sampling). To identify the issues of selected categories of persons within the MSM subgroups (for example, married persons, people living with HIV, younger MSM, those who engage in sex work), the research staff were asked to specifically recruit persons who belong to those categories (Stratified purposive sampling) (Miles & Huberman, 1994).

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

b. Key Informant Interviews (KII)
In-depth interviews were conducted with 5 Key Informants using a semi-structured interview guide. These key informants included the heads of community organizations, community activists, and health care providers. They were selected because of their extensive experiences in working at the grass-root or policy level and for their insights regarding the sexual and social networks; and vulnerability of these marginalized populations. Topics discussed were: various subgroups of MSM and key features of those subgroups; any differences in the sexual behavior of MSM belonging to various subgroups; types of linkages between the various subgroups of MSM and Hijras; various ways by which the networks of MSM are connected to the ‘general population’; non-sexual contacts and social relationships of MSM; and social support systems for MSM and Hijras.

c. Focus Group Discussions (FGD)
Six focus groups (with 37 participants) were conducted using a semi-structured open-ended interview guide. Separate FGDs were held for various subgroups of MSM and Hijras. Individual informed consents, including consent to be audiotaped, were obtained before beginning the FGD. The main focus of the discussion was on identifying community norms that facilitate or enhance the risk of HIV behavior as well as the sexual and social relationships of the community members. About 5 to 8 persons participated in each focus group and the duration of the discussion ranged from 60 to 120 minutes.

6. Data analysis
All the in-depth and focus group discussions were conducted in native languages. A few key informant interviews were conducted in English. In-depth interviews, key informant interviews and focus group discussions were audiotaped and then transcribed verbatim in native languages and then translated into English. During transcription, all personal identifiers were removed and a subject/interview code was assigned to protect confidentiality. Transcription and translation of most of the native transcripts were done by professional transcriptionists / translators. Standard guidelines were given to these persons to ensure accurate transcription and translation. The research coordinators checked the accuracy of the transcripts by randomly choosing about 40% of the transcripts and comparing them with the respective audiotapes by listening to them. Also, the transcripts were compared with almost all the translated texts with the corresponding native language transcripts to find whether the translation had been done accurately with no substantial differences in the meaning.

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

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

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

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

8. Internal validity (Trustworthiness) of the study
In ensuring internal validity, the following strategies were employed. 

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

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

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

The findings are organized into 6 main areas. The first section looks at sexual identities and behavior; the section focuses on the sexual networks of MSM and Hijras; the third section looks at the sexual practices and contextual factors behind not using condoms; fourth section is on bisexual behavior; fifth section is on social networks and social support; and the last section focuses on the structural vulnerability of MSM and Hijras.

A. IDENTITIES AMONG MSM AND TRANSGENDER WOMEN

In an oversimplified view, the conventional understanding about the indigenous identities of MSM and transgender people is as follows:

**Kothi**: Feminine homosexual male who is a receptive partner in a sexual encounter with a male.

**Hijra**: Males who identify as women or as neither-man-nor-woman and who are in woman’s attire.

**Panthi**: Masculine male who only inserts other males.

**Double or Double-decker**: A male who can be an insertive and/or receptive partner in a sexual encounter with a male.

In the ‘field’, self-descriptions and views about identities (such as Hijras, Kothis and Panthis) are much more complex. This section summarizes the self-descriptions of identities and labels used by various subgroups of MSM and Transgender people in Mumbai and Sangli. Correlation between a particular identity and presumed behavior was also explored during focus group discussions in addition to such exploration in individual in-depth interviews.

1. Hijras

Traditionally Kothi-identified MSM are considered distinct from Hijras since Kothis are considered as equivalent to feminine homosexual males and the Hijras to male-to-female transgender or transsexual women. Similar to some earlier studies (Chakrapani et al., 2002), it was found that there are persons who identify as Kothis and not as Hijras but it seems that most Hijras also identify as Kothi. Though some Hijras in an FGD shared the view that “today’s Kothi is tomorrow’s Hijra” (meaning that a Kothi-identified person later becomes a Hijra), they agreed that not all Kothi-identified males eventually become Hijras. Though a Hijra said, “Some Hijra can identify as Kothi”, later during the discussion some Hijras expressed that they would like to be called as Kothis by outsiders and not as Hijras. When a Hijra told, “Some [Hijras] identify as a woman”, it was challenged by a Nirvan Hijra (a Hijra who has undergone emasculation) - “How can they identify as a woman? [They can identify] only as Hijra”. According to her, “A Hijra is a Hijra” – distinct from biological females. Another Hijra said, “I identify as a Hijra...as a Kothi...If a male behaves like a woman and wears sari, then others call that person as Hijra.” Thus, this person identified both as Hijra and Kothi but clearly says only when she wears sari, other persons (general public) call her as Hijra.

Hijras were asked about what it is to be a Hijra, each Hijra came out with different versions. A Hijra told, “First everyone was Mard [man]. Then they indulge in ‘homosex’. Then those who want to wear sari and become woman are known as Hijras.” Thus, though this person gave importance to sexual attraction towards men and then brought the gender identity issue, her description is broad enough to show that Hijras were born as males (biological sex) and they want to become a woman (gender identity) and thus wear sari and behave like a woman (gender expression). Another Hijra described Hijras as follows - “From the beginning those [males] who do not have masculinity and those who do not have desire to have sex with
women...those who have femininity ...those who do not have ‘water of man’ [masculinity or semen]...means Napunshak...” Another Hijra objected to the term ‘Napunshak’ and told, “No. Some Hijras can have sex with other Aadmi [men] like ‘Double’ [means can get erection and insert] and thus not Napunshak.” Thus, there is an open acknowledgment that Hijras being a biological male (without any hormonal imbalance) can get erection and can also play an insertive role. One Hijra added, “Some Hijras can also have sex with each other. Both are Nirvan...Chaptibhaj [rubbing against the pubic areas].” Hence, just like two women having sex there is an acknowledgement that two Nirvan Hijras (both have undergone emasculation) can have sex by rubbing against their pubic areas.

Mentioning the subgroups among Hijras, a Hijra explained, ‘Some are Ackwa [have not undergone emasculation] and some are Nirvan [undergone emasculation]. Some [Hijras] want to leave the earth in the way they were born [means some do not want to undergo emasculation].” Thus, even those Hijras who do not want to undergo emasculation seem to be still accepted as Hijras in the Hijra community. As noted earlier by Chakrapani et al. (2002), Ackwa Hijras and Nirvan Hijras can be considered as western equivalents of ‘pre-operative’ (or ‘non-operative’) transsexuals and ‘post-operative’ transsexuals, respectively.

2. Kothis
A Kothi-identified male explained what it means to be a Kothi, “Kothi means ‘like a girl’. Not attracted to girls. [They] want to have sex only with boys. No attraction towards females.” Another Kothi-identified male said in a similar manner, “[Kothi means] not attracted to females. Attracted to men...thus I identify as Kothi.” Another Kothi explained that the term Kothi usually refers to “…Kadha Kothi, means those Kothi in T-shirt and pants. They have short hair [compared to the long hair of Hijras but longer than the average male]...Has sex only with Panthis....not with women.” Thus, attraction towards men was strongly emphasized so was not getting attracted to women.

During the discussions, it never spontaneously came out from Kothi-identified males that they engage only in receptive sex but it was a Panthi-identified male who mentioned that “…Kothi means those who ‘take’ [receives] and Panthi [means those who] ‘gives’ [inserts].” However, he acknowledged that he has been both receptive and insertive when he engages in sex work with male clients. Thus, Kothi’s sexual role was not emphasized by the Kothi-identified focus group discussants and receptive sexual role of Kothi was actually brought out by a Panthi-identified person. During the discussion it was also acknowledged that Kothis also insert other males and Kothis also have sex with females and get married to women.

Differences between Kothis and Hijras
Hijras in an FGD were asked to differentiate between a Kothi and a Hijra. In replying to that question, a Hijra said, “Kothi can stay in the [general] society...Even if the person is Kothi [feminine] then he can stay in [his] home like a man. But a Hijra can not.” Another Hijra told, “Kothi can roam with a Panthi and then go back to home. Accepted [by family]. If we become Hijra [here it means starts wearing sari, a traditional woman’s attire], society does not accept. Even in our family if there are some parents who are good then they accept. If some parents care about honor then they keep them [Hijras] away from home and community. I have been out of the whole community.” Thus, a male being feminine alone may not pose big problems but if a male starts wearing sari and express the desire to become a woman then they face a lot of problems from their family.

A Hijra narrated how she became a Hijra from being a Kothi. “First I was in male dress. Then I was with my Panthi...Then I found a Guru [master] and became a Chela [disciple]. Then
started wearing sari. Started Mangti [asking for money from shopkeepers]. When I was in pant and shirt, Yes, I was calling myself as a Kothi. Then I became devotee to Matharani [a goddess] and thus was accepted by the society. Then I joined the Hijra community and become a Hijra.” Another Hijra narrated a similar process: “[First] they are Kothis…No Hijra comes out of father/mother with sari. First they are in male dress ….then their masculinity goes off and then they start wearing sari…then [they] become Hijra.”

A Hijra explained why she identified herself as a Hijra from the beginning. “I was in pant and shirt…run away from family…[came to Mumbai]. My Gurubhai [currently] gave me shelter. Then [I] became Nirvan.” Thus, this person directly entered into the Hijra community without first identifying herself as a Kothi.

3. Panthi
Panthis are traditionally seen as labels given by Kothis and Hijras to their masculine insertive partners (Chakrapani et al., 2002). When asked about what does ‘Panthi’ means, a Hijra said, “Panthi means those man with whom we have [sexual] relation - those whom we love. Those who cohabit with us and whom we call as mera mard [my man].” Another Hijra added, “…For whom we leave everything. Whom we love very much. [We] call them Panthi.” Thus, in the descriptions of Panthi, there is a near lack of articulation about the sexual role (insertive or receptive) but love, romance, and cohabitation were associated with labeling someone as Panthi.

Though ‘Panthi’ is typically a label assigned by Kothis and Hijras to their masculine partners, currently some persons have also started identifying themselves as Panthis. According to a Hijra that could be because the persons whom they cohabit with come to know about all these terms and also spread information about these terms to other people. As she said, “For mard, why they need Kothi Basha [language]? My Panthi now knows all the words…Kothi, Panthi….all…Yes…[now] he calls himself as Panthi when I introduce him [to other Hijra friends].”

A Panthi-identified MSM told that he learnt the term ‘Panthi’ from his friends who have sex with Kothis and Hijras; some of his friends did so for money. He too then started having sex for money – with Kothis. Hijras and women. According to him, a Panthi is “a man who has sex with Kothis, gays, women.” He agreed that if the male client wants and pays more money he also serve as a receptive partner, which is seen as part of the job (sex work), and thus did not induce any conflict with his masculinity. “Yes, insert or receive…..for money…some take us saying we need to insert them and then their ‘behavior’ changes and says we will do [insert]..they would have told 200 Rupees for inserting…now they will give 500 Rupees for [we] being receptive…hence for money we will do…both things are same….even then we identify ourselves as ladka [boy] – Panthi.” He reported that even Kothi-identified males sometimes ask him to be a receptive partner. Thus, the emphasis of Panthi being a real man who only insert may no longer remain a rule among at least some subsections of the Kothi or Hijra communities. He also acknowledged that he remembered having attraction towards other males when he was studying in a school and also narrated sexual encounters with his school friends – both insertive and receptive. Thus, after he came to know the terms such as Panthi and Kothi, he might have chosen the term Panthi since he would not consider himself fit to be called as ‘Kothi’. However, though he knows the expected behavior of his identity, he still engaged in both insertive and receptive sex - apparently without any internal conflict.
4. Gay
Conventionally ‘gay’ is used both as a label and as an identity. It usually refers to self-identified homosexually oriented man who identifies as a man and sexually attracted to and has sex with other men. However, in India, the term ‘gay’ may be used differently by MSM from different socioeconomic classes.

A 19-year-old middle-class gay-identified person in an FGD explained why he identifies as ‘gay’, “I am an Aadmi [man] and I am interested in other Aadmi. Hence, I am a gay.” Though he gave a text-book type description of who is a gay, he also added, “I am not getting attracted to girls as I am not considering myself as a man.” Thus, he also placed emphasis on him not getting attracted to women. It is not clear whether the reason behind not considering himself as a ‘man’ was because he was not attracted to women or because he was attracted to man (thus ‘not heterosexual’ = ‘not man’). To add to the complexity, later he said, he feels like a girl and wants to become a girl. It is not uncommon for some transgender people to initially identify as ‘gay’ only later to be discovered by themselves that they are actually ‘transsexuals’. Thus, it also suggests that one can not predict the gender identity and sexual orientation of a person with a particular identity but talk to that person in detail to find out what do they mean by having that particular identity. Only then the service providers can offer appropriate and quality services to them. According to the same person, gay is equivalent to Kothi. A Kothi-identified person shared a similar view, “Gay means Kothi, Kothi means Gay”. These views may not be acceptable for gay-identified persons from middle and upper socioeconomic class who are usually not the clients seeking the services of community-based organizations. The participants being recruited through CBOs and who are service users of CBOs thus may have different perceptions about what it is to be a gay and whether a gay-identified person would equate himself with a Kothi-identified person.

5. ‘Bisexual’, ‘Double’ and Panthi
(Note: Unlike previous paragraphs, this is not separately titled as ‘Bisexual” since there was a greater degree of overlap in the discussion about these identities or labels)

One person who identified as ‘bisexual’ reported that he is a bisexual since “bisexuals have sex with girls too (in addition to men)”. Thus, it seems that he viewed ‘bisexual’ men as homosexual men who also have sex with women. However, he said, “I have sex with Kothis...Not yet had sex with girls...yes, I like girls...so far only had ‘body sex’ with them [girls]...will have [penetrative sex with girls] if I get [a chance].” Thus, he has revealed that he is attracted to both men and women. He also added, “[I am a bisexual] because I also give and take [insert and receive].” Thus, being capable of engaging in insertive and receptive sex also makes him to be seen as ‘bisexual’. He learnt the term ‘bisexual’ from his Kothi friends - after he started using the services of a CBO. Though he has Kothi friends he did not consider himself fitting the ‘Kothi’ label. He has also heard from his other friends that bisexuals are those who “have sex with Kothis and Panthis.” They might have probably meant that ‘bisexuals’ can be both insertive and receptive partners when having sex with other men. Thus, a person who identify as ‘bisexual’ in a CBO setting could mean that a person has bisexual orientation (attracted to both males and females); can be both insertive and receptive partner; can have sex with both Kothi-identified persons; or can be ‘Panthis’ who do not have any homosexual identity (as explained below).

A gay-identified person equated Panthi with bisexual since “…for ‘enjoyment’ Panthi goes to man and he also has sex with girls.” Thus, Panthi is also labeled as ‘bisexual’ though Panthi is usually considered to be a ‘mard’ or man [in this context it means heterosexual] by Kothis and Hijras. But the same person, to denote his heterosexual friends used the term ‘Panthis’: “I have
Panthis friends…they are *mard* [men]…they consider themselves as *ladka* [boy]…they are not bisexual…not gay.” Thus, the label Panthi could refer to a masculine ‘bisexual’ man as well as a masculine heterosexual man. This differentiation coming from a gay-identified person who has Kothi friends may not be surprising since different people have different perspectives. But it is important to note that when the term ‘Panthi’ is mentioned one should be clear about what do they mean by that term.

From the focus group discussions and interviews, it seems that the term ‘Panthi’ refers to:
- Those men who are lovers and husbands of Kothis or Hijras who may or may not cohabit with them.
- Those men who have fleeting sexual relationships with Kothis and Hijras and who do not identify as bisexual or gay (or homosexual).
- Those masculine men who are supposed to be only or predominantly heterosexually oriented.

A person who identified as ‘Double’ told that it means “…having sex with men and women.” He has heard that term in a CBO about three years ago. Before that he was identifying himself as a Kothi since he came to know that term through his Kothi-identified friends. But because he was also attracted to women (and later got married to a woman) he relabeled himself as ‘double’. He also has had sex with female sex workers before getting married. Thus this person presumably has bisexual orientation and behavior. Though he initially identified as Kothi because he learnt that term from his peers, later he wanted to re-label himself as ‘double’. It is not known whether that decision was taken because he was constrained by the behavior or role expected out of a Kothi-identified person - since a Kothi is supposed to be attracted to men; to be receptive; and not to be attracted to women. Having found the term ‘double’, which might have given him more freedom in relation to sexual behavior, sexual role, and heterosexual marriage, he might have chosen to identify himself as ‘double’. Maybe, had he heard the term ‘bisexual’ earlier, and had he been better educated, he might be identifying now possibly as ‘bisexual’.

All these discussions only show that over the years there has been considerable change in the meanings attached to identities and what a person with a particular identity can or can not do. As noted in an earlier discussion paper (Chakrapani et al., 2002), because of so many factors, the meanings attached to identities keep changing. No one can compel that people need to adopt a rigid definition for a particular identity and should follow what a person with that particular identity should do. From the perspective of HIV prevention and care, we need to acknowledge the diversity of identities among MSM and the importance they give to these identities. Though sexual behavior may not be dictated by the identities, to work with the various subgroups of MSM and to mobilize them, targeted interventions among MSM and Hijras need to focus both on identities and behavior.

6. Jogtas, Jogtis, and ‘Jogti Hijras’

The discussion presented here is based on the information gathered from: an FGD with 6 ‘Jogti Hijras’ in Sangli; an FGD with 6 Hijras of which 3 were ‘Jogti Hijras”; 2 in-depth interviews with ‘Jogti Hijras’ in Mumbai; a key informant interview with a Sangli-based Jogta *Pujari* (Priest), a heterosexual man; and a key informant interview with a ‘Jogti Hijra’ community leader in Mumbai.

Jogtas are those persons who are dedicated to and serve as a servant of Goddess Renukha Devi (Yellamma) – whose temples are present in Maharashtra and Karnataka. ‘Jogta’ refers to male servant of that Goddess and ‘Jogti’ refers to female servant (who is also sometimes...
referred to as ‘Devadasi’). One can become a ‘Jogta’ (or Jogti) if it is part of their family tradition or if one finds a ‘Guru’ (or ‘Pujari’) who accepts him/her as a ‘Chela’ or ‘Shishya’ (disciple).

In this report, the term ‘Jogti Hijras’ is used to denote those male-to-female transgender persons who are devotees/servants of Goddess Renukha Devi and who are also in the Hijra communities. This term is used to differentiate them from ‘Jogtas’ who are heterosexuals and who may or may not dress in woman’s attire when they worship the Goddess. Also, that term differentiates them from ‘Jogtis’ who are biological females dedicated to the Goddess. During the focus group discussions and in-depth interviews, when ‘Jogti Hijras’ referred to themselves they often used the terms ‘Jogti’ (female pronoun) or ‘Hijra’, though, some referred to themselves as ‘Jogtas’ once in a while.

When asked about whether they see the term ‘Jogtas’ as synonymous with ‘Jogtis’, they clarified that they would prefer to be called as ‘Jogtis’ (female pronoun) but since outsiders cannot understand why they would like to call themselves as ‘Jogtis’ they sometimes refer to themselves as ‘Jogtas’ (using a male pronoun). However, to avoid confusion and to be consistent, similar to the term ‘transgender women’ and to differentiate them from ‘Jogtas’ and ‘Jogtis’, we proposed to them whether we can use the term ‘Jogti Hijras’ to refer to them. The FGD participants and a community leader found this term acceptable. The key informant also pointed out that there is no separate group among Hijras who call themselves as ‘Jogti Hijras’ but Hijras from any Gharana can become a ‘Jogti [Hijra]’. However, certain Gharanas such as Punawale Gharana (also referred to as ‘Mandirwale Gharana’) are more likely to have large number of ‘Jogti Hijras’.

Hijra who wants to become a ‘Jogti Hijra’ needs to find a ‘Guru’ (who can be a heterosexual man or a Hijra) and after receiving the Dharsan (Mangalsutra or sacred thread) or ‘Moti’ (beads or pearls), she becomes a ‘Jogti Hijra’. Having the Dharsan is seen as a ‘license’ for her to announce to other persons that she is now a ‘Jogti [Hijra]’ and it also asserts her rights to ask for alms (‘Jogwa’) in areas allocated to her by her Guru. Some of the ‘Jogti Hijras’ might have been married heterosexualy before they joined the Hijra community. One of the in-depth interview participants from Mumbai was a ‘Jogti Hijra’ who was HIV-positive and also married to a woman.

Since ‘Jogti Hijras’ are supposed to be servants of the Goddess, talking about sex or condoms within some subgroups of Punawale (or ‘Mandirwale) Gharanas is a taboo. Thus, though ‘Jogti Hijras’ do have sex they can not talk about it. A ‘Jogti Hijra’ explained: “We can not talk about condoms at all. If our Guru knows she will shout at us. We get condoms from the guys from [community organizations]. That too, secretively. We will signal him [outreach worker] to go away when our Guru is with us. Later, we go and collect [condoms] from him.” Thus, silence about sexuality issues and unable to talk about condoms openly within their community means ‘Jogti Hijras’ are in a very vulnerable position. In spite of the lack of supportive community norm, some ‘Jogti Hijras’ understand that they need to use condoms and periodically receive condoms from the community organizations who reach out to them - even though the community leaders (some Gurus) might not like to talk about condoms.

There is a need to look into greater detail about the situation of ‘Jogti Hijras’, especially about the community norms in relation to condom use and how to gain the support of influential community leaders to reach out to those ‘Jogti Hijras’ who need HIV/STI prevention and care services.
B. SEXUAL NETWORKS OF MSM AND HIJRAS

In this section, we demonstrate that:
- There is an extensive sexual mixing (disassortative mixing) among the various subgroups of MSM and Hijras, and
- Concurrent sexual relationships are commonly seen among the various subgroups of MSM and Hijras.

1. Extensive sexual mixing in various subgroups of MSM and Hijras

Assortative mixing refers to mixing within a homogenous group. For example, if gay-identified persons have sex with only gay-identified persons, it is an example of assortative mixing. In this study, we found predominantly non-assortative sexual mixing across the various groups of MSM and Hijras as described below.

MSM and Hijras have sexual relationships with people who are from or belong to:
- different age groups
- different socioeconomic status
- any gender (man, woman, or Hijras/transgender woman)
- any type of partner (regular, casual, paid, paying)
- different HIV/STI status
- different geographical areas
- different sexual identities (refer to the previous section on ‘Identities’)

Box 1. Types of male sexual partners

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

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

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

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

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

a. Sexual mixing with male partners of different age groups

Some participants used to have sex with males belonging to their own age group. For example, a 19-year-old Kothi-identified MSM said that he preferred those between 19 to 25 years. A 23-year-old Hijra in sex work though initially said it depends since money was the aim, later said, “…actually I have [sex] with young men only.” Thus, even among those who engage in sex work some might prefer men of particular age group only. However, many participants from various subgroups expressed no special preference in relation to the age group of the male partners they have sex with. As mentioned by a 19-year-old Kothi-identified MSM, “There are some who are young and some who are old; I have anal sex with them.” A 22-year-old Hijra in sex work said, “…from young boys to aged men, I have had [sex] with every kind of Panthis.” Thus, there is disassortative sexual mixing across the age groups.
b. Sexual mixing with male partners from diverse socioeconomic classes
Most of the study participants especially those who are Kothis or Hijras are from lower economic class. Though some of them mentioned that they have sex with persons from similar economic class, some other persons, especially those who engage in sex work, have had sex with males belonging to relatively higher economic status. When asked about the job profile of typical male partners, a Hijra said, “...they are working as laborers, and other odd jobs.” However, some MSM and Hijras who engage in sex work had male clients from all socioeconomic backgrounds.

Participants who are gay-identified reported that they have sex with predominantly persons from similar economic background and often these sexual encounters are non-transactional. As a gay-identified person explains: “No. I have never paid anyone because most of them are from well-to-do families. So we used to pay for the movies, snacks or gifts...[But] no money. Sometimes even if you ask for money they refuse to have sex but they maintain relations with me.” However, a key informant mentioned that in Mumbai, some gay-identified persons do pay some of their male partners who may be gay- or Kothi-identified MSM.

c. Sexual mixing with different types of partners
MSM and Hijras reported a variety of partnerships. Almost, all the study participants have multiple partners except for one Kothi-identified person who reported being monogamous for the past one year since he wanted to be loyal to his partner.

A married MSM having a married male lover
Some persons had both a male lover and wife. A 30-year-old MSM said, “He [male lover] was not against my marriage but he was upset that now that I am married I might not go to him. But I convinced him. I continued having sex with him even now.” The same person also reported that his male partner has been married to a woman: “Yes. He was married before meeting me and he has two kids.” While it is not known whether this male couple was forced to get married to women, they continued their romantic and sexual relationship even after heterosexual marriage.

Having sex with males, female casual partners, and female sex workers
A person who identified as ‘Panthi’ reported having had sex with female sex workers. He has a female lover but has not yet had sex with her. He said, “Yes. I do have sex with females [also]. I have a girl friend but I don’t have sex with her. I have been to female sex workers.”

MSM and Hijras have paying and paid partners
Some Kothis and Hijras who engage in sex work mentioned that they themselves pay some good-looking Panthi for having sex with us. A Panthi reported that his Hijra partner periodically pays him. He said, “She likes me, feeds me, gives me money, she does oral sex with me which I like …without condoms”. Though, Panthi who cohabits with a Hijra or Kothi is often declared as lover or husband (to outsiders), some Hijras during discussions referred to their Panthi as “the person whom I am ‘keeping’ [with me]” - in this context equating him with a regularly paid partner.

Though some Kothis and Hijras who reported exchanging sex for money explicitly acknowledged that they are in sex work, some did not see themselves as sex workers since they receive money once in a while or they do not demand the money. A HIV-positive married man said that he was working in a hotel and he never explicitly mentioned that he engaged in sex work. Later, when asked by the interviewer whether he had accepted money from some
men for having sex with them, he replied, “Yes, if they are willing [to give] I take it. They usually offer me around 25 [Rupees].”

Some MSM who self-identified as ‘Panthis’ also engaged in sex work. A Panthi-identified MSM told, “We have sex with others — men and women — and get money from them…some [clients] are Kothis. We [other men who engage in sex work] meet together and discuss and get contacts from them.”

d. Sexual mixing with partners of different HIV/STI status
A 35-year old divorcee MSM who is HIV-positive said that he had 12 to 15 male sexual partners in the last year. When asked about condom use with those male partners he said, “…must be 2 or 3 – with whom I used condoms. [With] rest did not use.” The contextual factors regarding unprotected sex among HIV-positive MSM are discussed in the subsequent section. This person has also occasionally received money for having sex with male partners and reported not able to use condoms with some male clients.

Only if the STI symptoms are obvious, some refuse to have sex with persons who have STI-related symptoms. A married MSM reported: “Once with a man I was having sex and as his male organ got erected, pus and sticky fluid started coming out so I understood that there was some problem and refused to have sex with him.” While symptoms like these are visible, many STIs even in men can be asymptomatic (e.g. asymptomatic shedding of genital herpes virus) or not obvious (e.g. small warts) and thus going by the symptoms alone may not help in choosing a safe partner.

e. Mixing with persons who have different sexual identities (or no identity)
The previous section on identities illustrated that MSM of different sexual identities do have sex with MSM of any other or no identity.

[Note: This section also provides evidence for concurrency in sexual relationships. That is, many participants or their male partners have multiple sexual partnerships with different types of partners (regular, anonymous, paid, and paying partners), and persons of any gender (men, women and Hijras).]

2. Extensive sexual mixing is achieved through various ‘networks’
The extensive sexual mixing with partners of diverse characteristics is facilitated through various ways. These include: traditional cruising sites (“public sex environments”); “referral networks” (direct or mobile phone); fairs and festivals; and internet. These are summarized below.

Cruising sites
Many participants reported getting male sexual partners by ‘cruising’ in specific public places (cruising sites or ‘Public sex environments’). MSM who cruise these sites may seek male partners mainly for sexual pleasure, though some MSM exchange sex for money. However, even those who engage in sex work reported that they would like to have sex with male partners of their choice (casual or non-paying partners) and sometimes even pay them.

Migration
Some MSM migrate from one city to another in search of jobs and consequently develop sexual networks in the place where they have migrated to. As a Kothi-identified MSM explained: “Yes. I had sex with two or three boys there [Sangli] but soon I left and went to Goa with the money I had earned… When I was sitting in a garden, a Kothi came and asked what
work I can do...And he did give me a job in a hotel. There my duty used to get over by eight [pm] and then I used to roam around with the boys and also I used to have fun with them.” Often, they come back to their native places once in a while thus spatially linking the sexual networks in their native place and the place where they have migrated to for their job.

“Referral networks” (Direct and Mobile phone)
A MSM refers another MSM to a potential male sexual partner by directly introducing that person to other MSM. Participants also mentioned that now many of them meet potential male partners through mobile phone contacts as the numbers are being passed on from one person to another. A key informant explains: “…again, these networks are only sexual – just passing on the numbers of good-looking men and who are available. After their sexual needs are over, they do not even talk to each other again.” Thus, he cautioned that these are primarily informal sexual networks and not ‘communities’.

Fairs and festivals
Key informants and participants reported that during certain festivals and local fairs where a large number of people gather, they would able to find a lot of potential male sexual partners. In these fairs and festivals, not only there is sex between men but also between men and women, and men and Hijras.

Internet
Some educated MSM especially gay-identified persons use Internet to seek sexual partners. A gay-identified MSM said, “There are a lot of websites now through which we can meet other persons...we can chat and get their mobile number...later we contact them [over phone].” A key informant commented that these days Kothi-identified persons, who are supposed to be primarily from the lower socioeconomic status, also access internet to meet potential male sexual partners.

3. Concurrent sexual relationships
If the relationships are concurrent then the risk of getting or transmitting HIV/STI is relatively high when compared to non-concurrent sexual relationships (such as monogamy or serial monogamy). Concurrent relationships are already evident from the findings presented in the subsection on sexual mixing. While various permutations and combinations are possible in concurrent relationships, the following examples illustrate some of the common concurrent relationships seen among the study participants.

Equal frequency with male and female partners
Some MSM, especially those who do not want to self-designate themselves or those who self-identify as ‘Panthi’, reported almost equal number of male and female partners. A 34-year old MSM who is a widower in replying to the question when was the last time he had sex said, “My last sex was on 24th [day of the current month] with a Kothi, and on 22nd it was a woman and on 20th also it was with a woman. In a month I have sex at least 18 days with Kothis and the remaining days with women.”

More male sexual partners than female partners
Some MSM limited having sex with females either to their girl friend or wife. In a FGD, a gay-identified person said, “I have a girl friend and I have sex with her too. But my condom gets torn while having sex with males and with her too. So I am always scared that I will get some infection from somewhere.” Thus, incorrect condom usage with both male and female partners means everyone in this sexual network is at risk.
In steady relationship with a male partner but both have casual or paying male partners
A Hijra engaging in sex work said that though she has a husband he also has sex with other Hijras and men. She said, “He [male lover] also sleeps with others and once I caught him red handed sleeping with another man.”

Kothi-identified MSM and gay-identified MSM also acknowledged that their steady partners might be having sex with other men. A gay-identified person who had more than one regular partner said, “Yes they [male lovers] have [sex with other males] but they don’t tell me. They show that they are loyal to me”. However, some persons told their partners have sex only with them.

Some MSM are married and have married male partners
A married MSM said that he had a married male partner. He said, “Yes, he was married before meeting me and he has two kids.” A married MSM who identified as ‘Double’ reported that he was having sex with only one married MSM. But most of the married MSM and Hijras in the study sample continued to have sex with their male lovers, casual male partners, and paying male partners.

(Note: Figure 1 shows the sexual networks of a Kothi-identified MSM and his male regular partner up to certain levels of sexual contacts)

Fig 1: Sexual partner network of a Kothi-identified MSM

Some are married and engage in sex work
A Panthi-identified married MSM who has two children reported that he has sex with men and women for money. A married Ackwa Hijra also continued to have sex with paying partners as well as her regular male partner.

(Note: Only one Kothi-identified participant in the study sample reported he has only one partner in the last one year and he “…[feel] loyal to him.”)
Kothi-identified MSM and Hijras have sexual linkages with specific male populations
AIDS programs have targeted interventions for specific male populations like male migrants, male youth, injecting drug users, truck drivers, and male clients of female sex workers (see Figure 2). From the previous illustrative quotes, it has been shown that Kothis and Hijras have sexual linkages with male youth, male migrants, and male clients of FSW. Though in this study, the study participants did not report having had sex with male injecting drug users, the key informants from Mumbai stated that since the drug use sites and cruising sites often overlap (for example, beach-X in Mumbai), such sexual mixing happens. A Hijra key informant also talked about sexual linkages between Hijras and truck drivers. She said, “Hijras go and stand on the [highway] roads…sometimes they are asked to [insert] the drivers and they get more money for it…drivers know they [some Hijras] have [male genitalia].” Thus, with truck drivers, Hijras can engage in receptive or insertive anal sex.

Fig 2. Sexual linkages between certain targeted male populations and Kothis/Hijras

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C. SEXUAL PRACTICES WITH MEN AND CONDOM USE

This section describes the various sexual practices reported by the study participants and also the use of any barrier methods, especially condom use in penetrative sexual practices.

Understanding the various sexual practices of MSM and Hijras are important since penetrative sexual practices, if condoms are not used, carry high risk for transmitting and acquiring HIV infection.

1. Anal sex

Not all MSM have anal sex with men

While some might assume that sex between men equals to anal sex, it is not the case always. Several quantitative studies have documented that some proportion of MSM may not practice anal sex at all (Ref). In this study, irrespective of the subgroups, some MSM mentioned that they never engaged in anal sex. As a 40-year-old unmarried MSM reports, “I never had anal sex and never felt like doing so because I don’t like it. I have only done [mutual] masturbation.” While being a receptive partner is often central to Kothi identity, some Kothi-identified MSM did not report having ever engaged in anal sex. In a FGD, Kothis agreed that not all Kothis engage in anal sex. A FGD participant said, “I know of Kothis who do not want to ‘take’ in the back [means do not want to be receptive]... do not want to ‘give’ [means do not want to insert other men]. In a FGD among Hijras, the participants told that they knew of some Hijras, some of them are Nirvan (emasculated) Hijras, who never had engaged in anal sex – receptive or insertive.

Many do have anal sex with other men

The study participants reported having engaged in insertive anal sex only; receptive anal sex only; and both insertive and receptive anal sex. Replying to the question about his sexual role, a 34-year old MSM said, “I always insert.” A gay-identified MSM mentioned, “I am a top and I always have top sex. I need not change my sexual practices.” Some are flexible in their sexual role, they insert and receive, as a MSM said, “If there is any partner who wants to have sex in any way I agree to it.”

Sometimes, the reported behavior is not consistent with the presumed behavior associated with their identity. For example, a Kothi-identified MSM also reported having been an insertive partner in anal sex (see the section on identities).

A MSM argued that there is no need to judge someone who does not stick to the presumed sexual role dictated by their identity:

In a heterosexual relation too a man would like to have different types of sex[ual practices] with his wife. Similarly, a wife also feels that my husband should experiment in sexual practices. Like that, a bisexual or ‘double’ would like to have the pleasure of being fucked [means receptive] and also fucking somebody else [means insertive]. It depends on where his satisfaction lies: nothing wrong in this - everybody has the freedom to do what they want.

Also, though Hijras usually do not engage in insertive anal sex, some Ackwa (non-emasculated) Hijras reported having been insertive partners in anal sex especially with their paying male partners. Being an insertive partner did not conflict with their gender identity as a woman since it was seen as part of the job (sex work) and the need to provide satisfaction to the client for the money he provides. An Ackwa Hijra said, “If I am getting paid for it [insertive sex] I will do it. I do suck and also give for sucking and if he [client] wants me to insert him [anally] I insert.”
2. Oral sex
Participants from various subgroups of MSM and Hijras reported having engaged in oral sex. In general, condom use in oral sex is low as it is not seen as a risky activity. Though oral sex carries a relatively low risk of HIV infection, some participants were willing to take that risk while some did not want to. A MSM said, “I think oral sex is safe. In sucking if we use condoms then there is no problem, but without condoms there are chances that the teeth might hurt and even if there is any blood then that will go in our mouth so it is good to use condoms while having oral sex also.”

3. ‘Body sex’ and other sexual practices
Many MSM and Hijras reported “body sex” [primarily non-penetrative sex such as body rubbing] as one of the sexual practices liked by them. For some MSM it would be just one of the many pleasurable activities with any other men and a stand-alone sexual activity; not just seen as part of the foreplay. A MSM reported when talking about the last three sexual contacts he had mentioned that: “I had ‘body sex’ and kissing [with a male].”

4. Risk reduction strategies adopted by MSM and Hijras
Many MSM and Hijras reported various risk reduction strategies to prevent acquisition or transmission of HIV/STI. These include:

a. Condom use
Many MSM reported using condoms, though not consistently, with their male partners. They used the condoms distributed to them by the outreach workers of CBOs or buy condoms from pharmacies. Some reported using condoms “all the time”: “In the last three events [sexual episodes] two gave money and one was with my Panthi [male lover]. I had anal sex in all three of these and with condoms.” Some used condoms with specific type of partners: “If the person is unknown to me then I use condoms for sure.” And some have consistently used condoms.

b. Reduction in the number of male sexual partners
Only one participant reported being currently monogamous (see before). However, some shared their aspirations to live with only one male partner and to reduce the number of male sexual partners. A Kothi mentioned, “I want to be a nice man and have sex with one man only. Not live [have sex] with ten thousand people. I have to take care of my future.” However, lack of societal and legal recognition and acceptance prevent many from initiating or continuing their same-sex relationship with a single male partner.

c. Non-penetrative sexual practices
Some participants mentioned that they would resort to non-penetrative sexual practices especially if there are no condoms. Replying to what he would do if the partner is not willing to use condoms, a Kothi said, “I don’t have sex with such people. Since I came to know about condoms I have been using them always… It is different when I didn’t know about condoms but that now I know about it I don’t want to take any risk. And if somebody still insists then I do it with hands.” A gay-identified FGD participant told, “I try not to do anal sex when I am not having condoms, I do body sex and finish it.” A 45-year-old married ‘homosexual’-identified MSM reported that he has stopped having anal sex because of fear of HIV. He said, “I do body sex only. No oral sex or anal sex. I stopped [anal sex] 10 years ago.”

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5. Reasons for condom use

a. Protecting oneself from HIV and STIs
Some used condoms because they were “scared of HIV” and had seen their friends dying of AIDS. As a 31-year-old Hijra mentioned, “We had seen our friends dying of AIDS so we were very scared and always used condoms with all partners.” A Kothi-identified MSM gave similar reason: “Yes, I am scared of HIV because two of my friends died of HIV and I knew that those guys never used condoms. So I was scared and by then I knew that condom is a must if I want to be alive. I am scared of death and torture of unhealthy living and worried about my family.” A 34-year-old married gay man gave an explanation for why he is using condoms: “I realized physical touch with males could also transmit HIV virus due to bleeding or cuts. I realized it in the year 1995 through [news]papers…hence I started using condoms.” Thus though this person has not personally seen people dying of AIDS, his knowledge about HIV helped him in taking a decision to use condoms.

b. To protect their partners since they were not sure about their HIV status
Some other persons wanted to protect their partners since they were worried that their inconsistent condom use means that they might be possibly infected. A Hijra said, “I tell them [partners] ‘Using condoms is good for me as well as for you too. It is possible that I might have HIV and also that you might have some disease that we will give to each other. So it is best to use condoms whenever possible.’”

A 20-year-old Panthi-identified MSM said, “I use condoms only with my [Hijra steady] partner and not with anybody else. I don’t like using condoms at all. My partner also doesn’t like to use it [but] I use condoms with her only because she is very close to me. I think she should live as long as I live. She gives me money and feeds me so I think that I should safe with her.” Thus, intimacy and love with his Hijra partner motivated this person to use condoms though he also might feel his financial support from her might not be available if she becomes sick.

6. Contextual factors regarding unprotected sex with male partners
Though many MSM seem to use condoms, some did not consistently use condoms due to a variety of circumstances. The various factors are summarized as follows.

i. Individual factors
This section summarizes the factors which made people not to using condoms because of their individual characteristics (like or dislike) or other related factors.

a. Decrease in pleasure
Though Kothis and Hijras did not explicitly mention about not wanting to use condoms because of reduction in sexual pleasure, a Panthi-identified MSM mentioned, “I don’t like using condoms…..because they don’t give pleasure.” And in a FGD, some participants reported that decrease in sexual pleasure with condom use could be one of the barriers in using condoms: “They [MSM] feel that if they have sex without condoms then skin-to-skin touch gives more pleasure to them.”

b. Could not afford to buy condoms
In a FGD of MSM, one person said, “I live in a group and there are some gays in it. We tend to have sex among us. But when we don’t have money to buy condoms sometimes so we have unsafe sex.” Though one another FGD participant was opposing this statement arguing that free condoms are distributed by NGOs, it might be difficult for NGOs to ensure that all MSM in a city have access to condoms every time they engage in sex.
d. Fear of losing a good-looking partner
Sometimes MSM might decide not to use condoms depending upon the external appearance of a person. A gay-identified person in a FGD said, “We don’t use condoms when the person is really good.” Another gay agreed with his view. “It is difficult to save ourselves from HIV as it is widespread. But when I find a handsome guy who is ready to have sex with me and I don’t have condoms then I will never think of getting a condom. It is not possible or tell him that I will not have sex with him [without condoms].” Thus, there seems to be a hopelessness that they are at higher risk of HIV and also this shows the lack of skills in talking about condoms with a potential partner for fear of losing him. Similarly, a married MSM who knew that a good-looking man might have HIV, admitted that he could not resist having sex with him even if that person does not agree to use condoms.

e. Belief that condom needs to be used only with unknown partners
An elderly MSM in late 50s mentioned that, “HIV happens only when you sleep with people whom you do not know.” Though he was aware that “one should not sleep with people who have this [HIV]…and always use condoms before sleeping with [such] people.”, he still insisted that “if anyone who is not known to you calls you to sleep then don’t go.” Thus, this person might have a false belief that having sex with known persons is safe.

(Note: All the study participants knew about condoms since they were primarily recruited through CBOs. However, it is possible that a significant proportion may not be aware about using condoms as was the cause with many who are now using condoms. When asked about why they did not use condoms earlier, many mentioned - “I didn’t know about condoms [at that time].”)

ii. Inter-personal factors

a. Partners do not like to use condoms
Some MSM reported that though they would insist on condom use their partners might not want to use condoms. A Kothi complained, “I used to [ask partners to use condoms] but they refused because they didn’t want any barrier while having sex. They [said they] did not get any pleasure by having sex with a condom.” A similar complaint was made by a gay-identified person: “Sometimes my partners do not like to have sex with condoms. They feel it is better to have sex without it so that they can feel the body.”

b. Presumed fidelity of the male partner and Intimacy
Some trusted their male partner so they did not want to use condoms with them. As a gay-identified person said, “No my partner only sleeps with a lady and she is very strict [meaning she does not allow him to have sex with others].” A Kothi-identified MSM in a FGD said, “I always use condoms with unknown people. I don’t use condoms with my Panthi… because we are together for the past twelve years and we are loyal. My Panthi never has sex outside and I have [sex] very rarely [with other men] but I always use condoms [with other men].” A Hijra reported that when she was steady with a man, she did not use condoms. “No. I never used condoms with him [Husband]…. because as long as I was with him I never slept with anybody else.”

c. Could not negotiate condoms with anonymous partners
Some MSM mentioned that they could not negotiate condom use with their male partners. A FGD participant (MSM) told, “Once I met a partner of my choice and we went in a room to have sex. I asked him to use condoms but he refused saying that ‘I am safe. Do you have any
problem?’ I specified that ‘I will not lie but in case if I have HIV will you have sex with me?’ He said, ‘Yes’, he will have sex with me even then.”

d. More money offered by paying partners
Though some MSM and Hijras who engage in sex work reported that they would insist on condoms even if they were offered more money, some others mentioned that they would agree to it because of the need for money. A Hijra told, “I have no problem in using condoms. I don’t have sex if I don’t use condoms. I clap on their face and ask them to get lost. These clients then go to other sex workers there. I try and tell them that use condoms and don’t entertain such clients but what will they do they have to earn money for a living. They don’t mind dying of HIV in few years then dying of starvation in few days.” Another Hijra justified why she would still go ahead and have sex without condoms: “I do explain [to use condoms] but not much because if I sit to explain much then the other clients run away to others.”

e. Alcohol use
Incidents were narrated in which either the participants or their partners were under the influence of alcohol and hence condom could not be used. Police and ruffians who had forced sex with Kothis or Hijras were reported to be under the influence of alcohol during those incidents. Some, however, have successfully handled partners who had consumed alcohol and who refused to use condoms. A 25-year-old ‘Jogti Hijra’ explained how she had successfully avoided unprotected sex with an alcoholic, “Yes, there are partners who...force me to have sex [without condoms] when they are under influence of alcohol. I refuse then they create a scene and beat me but I also beat them in return.”

iii. Structural factors
a. Presence of criminal law makes police force to abuse its power
Participants narrated many incidents of forced sex by police (without using condoms). A FGD participant who is a Kothi said, “It is all wrong. Why should we be treated as trash because we have sex [with men]. The police come and take money from us and they also ask to have unsafe sex with them. When we are not willing to do so they also treat us very badly. We are arrested even if we did not do any mistake and in the police station we are molested.” More incidents on forced sex by police are narrated in another section.

b. Lack of protection from police means ruffians could get away with forced sex
Some persons knowing about the shame attached to homosexuality; blackmail MSM extorting their money, and sometimes even forcing them to have unprotected sex with them. Kothis and Hijras could not complaint this to the police since they do not know what will be the consequences of it and also they do not have faith in police. A Kothi-identified person in a FGD said, “Cheaters’ also have sex with us without condoms and they also threaten us that they will spoil our name by telling the world that I am a homosexual and I do unnatural sex. If we complain in the police they don’t give us any justice because they think we deserve all this because we have sex in the open [places] and unnaturally.”

Only one participant who was forced to have sex by a ruffian reported that condom was used in that encounter. In response to the interviewer’s question, “How did you know [he used condom] when he had forced and shut your mouth?”, he replied, “I heard him tearing the condom cover and after he had finished I saw him removing it [condom].” Otherwise, in almost all the forced sexual encounters typically condoms are not used.

Dynamics of MSM & Hijras in Maharashtra, Report, AVERT/Humsafar, May 2007
c. Silence in talking about sex and condoms in certain communities
In certain subsections of ‘Jogti Hijras’ irrespective of where the Pujari (Guru of ‘Jogti Hijras’) is a heterosexual person or a ‘Jogti Hijra’, it might be difficult to discuss about anything related to sex when they have ‘get-togethers’. A heterosexual ‘Pujari’ said that he could not discuss HIV/AIDS with his ‘Shishyas’ (Disciples) though he knew that five of his Shishyas were known to have STIs. But he was aware of voluntary organizations working with them providing information and condoms. A ‘Jogti Hijra’ also told that they have difficulty even in keeping the condoms with them. She said, “It is difficult to keep condoms because if condoms are seen with us Guru will shout at us for having sex because it is not permissible in our community.”

Hijras also reported that in some Gharanas they are not supposed to engage in sex work as they have to only go for Badhai (asking for alms, esp. from shopkeepers) Hence they expressed that without the knowledge of their Guru they get condoms from some voluntary organizations. A key informant, however, partially differed from this view. She felt that Hijras in almost all Gharanas, especially when they are young, engage in sex work. But she also pointed out that not in all Gharanas there is openness in talking about sex work and HIV. Consequently, Hijras in those subsections feel they do not have community support to use condoms.

d. Anonymous and quick sexual encounters hinder condom use
Often sex in the public places are quick since MSM are afraid that someone else (especially police) might watch it. Though some sexual encounters are non-penetrative sometimes even if the sexual encounters are penetrative, condoms were not used. As a gay-identified person in a FGD said, “We meet such people [MSM] in the dark [in cruising sites] and we are generally in hurry. So there are no condoms available and we don’t use.” Thus, though outreach workers from voluntary organizations distribute condoms in cruising sites, certain situations prevent MSM from using them.
D. BISEXUAL BEHAVIOR

Participants from various subgroups of MSM and Hijras reported sex with women. This section summarizes the information about the bisexual behavior among the participants and their perspectives about bisexual behavior in their communities.

1. Heterosexual marriage – Forced or Voluntary?
From various subgroups of MSM and Hijras, some married persons were also recruited in this study. Some opined that the heterosexual marriage was forced by their family and they could not refuse it. For some, marriage was not forced upon them but conducted with their ‘full willingness’ since they also liked having sex with women.

A Kothi-identified MSM was of the opinion that Kothis should not get married since they spoil a woman’s life” but he also acknowledged that there are Kothis who like to have sex with both men and women. A 20-year-old bisexual-identified person said that he would get married to a woman in the near future on his own willingness.

A MSM who now identify as “double” (previously used to identify as ‘Kothi’) mentioned that his marriage was not forced by his family but he felt that was the right thing to do. He said, “My parents did not force me. I felt that I was doing wrong [by not getting married]. It was done with my full consent. I agreed to it.” He also said that he was attracted to both men and women, and he has had sex with female sex workers before his marriage.

A MSM who referred to himself only as “homosexual” throughout the interview mentioned that he has always been attracted to men and women ‘from the beginning’. He told, “I was having sex with males as well as with the females. I was working in a hotel and I eloped with the owner’s daughter. I have had too much sex with females also. The girls didn’t leave me - they always huck on to me.” Talking about marriage he opined that, “Yes. It is good to get married. Otherwise life is a waste. If you have children then your generation runs ahead [sustained]…If they [MSM] are forced they will get married and lead a good life.” Thus, though this person identify as ‘homosexual’, from his descriptions, he seems to have bisexual orientation and that could explain why he was supporting marriage among MSM even to the extent of forcing MSM to get married. Desire to propagate his family line also seems to be a reason for him to get married.

2. Post-marriage: Sex with men
All the married MSM and Hijras in this study sample reported continuing to have sex with men after marriage. In a FGD, the participants told that after marriage some MSM continue to have sex with males with no reduction in the number of male sexual partners while some might reduce the number. A married MSM who identified as “Double” reported that after marriage he has reduced the number of male sexual partners and mostly have sex only with his male lover who is also married to a woman. Talking about his married Kothi friend, a Kothi said, “After marriage, he was having sex with males as usual. Outside – it was with men. When he comes home, it was with his wife. Both were going on.” One person reported that his former male steady partner got married to a woman and from then he stopped having sex with him. He said, “I did [had sex] with him only [at that time]…He got married and so it stopped.” Thus, though some predominantly heterosexually oriented men may stop having sex with other men after marriage, in this case, it is not sure whether his partner continued to have sex with other men after his marriage.
A married Jogta reported stopped having sex with males after his marriage. He said, “I had sex [with males] for the first time when I was 28 years old. Before that, I was always busy with my father, doing Pooja and worshipping the God. So I didn’t pay any attention to the boys around. Later I wore sari only once or twice, and that was when I had sex with two or three boys. After that I got married and then never had sex with males at all.” Thus, this person who became a Jogta because of his family tradition might not be having same-sex orientation and thus he stopped having sex after marriage. However, we can not rule out whether it was because of his religious beliefs that he stopped having sex with men.

3. Disclosure to wife about one’s sexuality and consequences
Most of the participants who were married have not yet disclosed their sexuality to their wife. One person blatantly dismissed the query saying that how could one discuss about this with their wife since she will leave immediately. However, though one person disclosed to his wife that he also has sex with men, he told, “…wife was fine with that.” It was not known what the reactions of the wife to disclosure were and what happened to their relationship after that disclosure.

A Kothi-identified MSM reported that his Kothi friend got married to a woman and on the second day the wife “found out” that he was “Namard” (means ‘not man’) and she left him. He agreed to that marriage because of his parents and he could not refuse since his family members did not know about his sexuality. A Hijra who is married to a woman mentioned that she also likes having sex with women and she has told her wife (who lives in a village) that since she is a dancer she has to behave in a feminine manner. And wife would not ask any questions about it.

One person reported that his wife came to know about his sexual behavior since one of his relatives revealed his same-sex behavior to her. Even after that she continued to stay with him for three more years and then they got separated.

4. Sex with female sex workers and paying female partners
A double-identified married MSM reported that he accompanied his straight friends when they went to have sex with female sex workers. When asked whether it was because he wanted to prove his masculinity to his straight friends he denied saying that, “…even before marriage I was attracted to girls.”

A married Panthi-identified MSM who engage in sex work reported that though he has sex with men and women for money he had been to female sex workers by paying money to them. Thus he has concurrent sexual relationships with other men (including Kothi-identified MSM), his wife, paying female partners, and also female sex workers.

5. Condom use with wife
In a FGD with MSM, the participants talked about the difficulty in using condoms with wife. One married MSM reasoned that, “I have sex with only my male lover and that too with condoms…I do not trust him…he is also married…and have sex with no other persons…Got tested for HIV before marriage. So why I need to use condoms with my wife?” Thus, he justified that though he did not use condoms with wife he has taken all possible precautions to prevent transmission of any infections (including HIV) to his wife. He also mentioned that he is a “family man” now and thus after setting up a family it is a sin to introduce disease into the family.

A Panthi-identified MSM who receives money for having sex with men and women explained how he has successfully started using condoms with his wife: “In the beginning I did not use
condoms with her...had problems (STIs)...She watches TV and know about AIDS. I told her that I have sex with women outside. We tested ourselves [for HIV]. For the past two years I have been using condoms with her.” Thus, without disclosing that he has sex with males or engages in sex work he could able to use condoms with his wife.

For a MSM, the problem was solved after his family doctor advised the couple to use condoms to avoid further pregnancy. He said, “My doctor told both of us to use condoms. I started using condoms with my wife from then...still continue. My wife does not question me.” When asked about whether he uses condom with his wife, a MSM retorted, “…do you mean to say that my wife has sex with someone else outside? If I use with her then she will suspect that I am having sex outside. If I am taking the precautions [when having sex] outside then why should I do so at home? Even then if it is in my destiny to happen it will happen.” Thus the possible fear of marital discord if condoms are used prevented this person from even talking about it with his wife.

A married HIV-positive Ackwa (non-emasculated) Hijra in men’s attire continued to have unprotected sex with wife. When asked whether wife has been tested for HIV, she replied, “No. She [wife] is little educated and if I ask her to do the HIV test then she will suspect and leave me.” Thus, possible fear of rejection from wife prevented this Hijra from revealing HIV status and also prevented practicing safer sex. (Note: This Hijra-identified person reported attraction towards men and women)

6. Discrimination faced by married MSM from their community friends
Kothi-identified MSM if gets married to a woman, sometimes have to face discrimination from their own Kothi community friends who may not like Kothis getting married to a woman. A Kothi said, “We will tease him and ask him ‘So who is having sex with your wife. You can’t do it. Isn’t it?’”. Some Kothis might not tease married Kothis since they also face pressure from their family members to get married. So some see marriage as a social norm to be fulfilled and not see the decision to get married being within the control of a person. A key informant was of the opinion that discrimination of married MSM is found mainly in CBO settings where there is a stigma attached to being married to a woman as it is seen as spoiling the life of an innocent girl and that MSM would be blamed of having ‘best of both worlds.’
E. SOCIAL NETWORKS AND SOCIAL SUPPORT

Though social networks of different subgroups of MSM include a wide range of relationships, often they seem to rely upon people from their own community (such as Kothis or Hijras) for much of their social support. This section focuses on the persons who form the social support circle for Kothis and Hijras.

1. Persons from their (Kothi or Hijra) own community
[Note: There is some overlap between Kothi and Hijra communities since the Kothi identity is shared by both Kothi-identified feminine males (who are referred to as Kothis in this report) and by Hijras, who may also continue to identify as Kothi.]

Close friends (Kothis or Hijras)
Many Kothi-identified MSM mentioned that they have very close Kothi friends with whom they share intimate details regarding them and with whom they seek psychological support. Thus, these close Kothi friends act as confidants for Kothi-identified MSM. A Kothi explained: “Yes I have many close [Kothi] friends and they will support me because I feel they are mine and like us so they can understand us better. We discuss about everything openly with them so I know they will support us.” Another Kothi-identified MSM mentioned what he usually discusses with his close Kothi friends, “I share it [any problems] with my friends…[discuss things] in relation to Panthis or sexual abuse then I talk it out [with them]…” These friends might also provide information about HIV/STI; distribute condoms; and they are usually from the same age group.

Hijras too reported having close Hijra friends as their confidante. Many reported ‘Gurubhai’ [fellow disciple of their Guru] as their close friend with whom they share intimate details. Some did not want to share anything with Hijras except for their very close Hijra friend or Guru for fear of spread of that information to other people. As a Hijra said, “You know how things spread in our community…if I tell anything to her then she will go around and tell everyone…eventually everyone knows about you.” In spite of such apparent mistrust with their community people, all agreed that it is their Hijra community that offers much of the support when they need most.

‘General’ Kothi or Hijra friends (or acquaintances)
With some other Kothi friends who they meet in the cruising sites or in other areas they might not have close relationships but still they spend sometime in talking with them. Some times these friends who primarily provide companionship, also provide information about HIV/STIs though often they would be more interested in talking about their male partners and issues of importance to their personal life.

Talking about his general friends, a Kothi-identified MSM told, “We used to discuss about sex. These boys [Kothis] had life partners and they were steady with them. So I liked talking about it with them as I didn’t have any steady partner. I wanted to have one. But I was not getting anyone. We used to discuss about HIV/AIDS also.” The socializing talks about sex and sexual partners though might seem trivial to outsiders, may be very important to Kothis since they could not discuss about these with anyone else. As a Kothi explained: “Yes, they [Kothis] support me. They are good. We discuss about our Panthis…we discuss everything freely with them. I enjoy talking to them as I can talk what I want [to talk about]. They accept me as I am. I can’t do that at home.” In a FGD Kothis also expressed that being called by female names by other Kothi friends and being able to behave in a feminine manner among their Kothi friends give them happiness and provide emotional support to them.

These general friends also provide information about HIV in addition to socializing with others in relation to their sexual life and male lovers. As a Kothi said, “they also tell me about using
condoms and they ask me to check the partners before going with them; they are supportive and I behave as myself with them." Even Hijras who are not close friends come for help when needed as narrated by this Hijra, "…there were 5 boys who wanted to have unsafe sex with me when I was not ready for it. So they were trying to rape me. But just in time some Hijras from my area came there and they saved me from those demons.”

“Mentor” Kothis and Hijra “Gurus”
Some other Kothis who are senior guide the younger Kothis on how to take care of themselves and also offer solutions to problems faced from police or ruffians. Some of these Kothis ‘adopt’ the junior Kothis and form pseudo kinship relations such as ‘mother’ and ‘daughter’.

In Hijra community, mentorship was mainly provided by the ‘Guru’ who is often a senior Hijra. Many Hijras talked high of their Guru and mentioned that Guru provides guidance, provides money if there is a need, and also offers emotional support. Guru is also seen as someone whom they can trust and who will not spread information about them to other people. As a Hijra said, “My guru has great concerns about me and will accept me [if I am HIV-positive]. Some make it known [to other Hijras] some keep it secret.”

When asked about whom they would approach when they need money some mentioned that they will earn through sex work but also ask other Hijra friends. A Hijra though replied she will be self-reliant since she would “…do Dhanda [sex work] and earn…”, she also added, “I will ask my Guru [for money].” For some Hijras, Guru has the obligation to help them as they periodically provide money to Guru. Some Hijras also mentioned that their Guru helps them if they are arrested by police: “When we stand in the ‘bus-stand’ for Dhanda [sex work], police look at us with suspicions and arrest us thinking that we are pickpockets. Then our guru comes and releases us.” Thus, being senior persons, some Gurus could negotiate with police or pay money to release their disciples.

2. Family members
Often the family members may not know about the sexual orientation of Kothi-identified MSM or gender identity of their Hijra child. However, they might be condemned for being effeminate. Irrespective of the disclosure of sexual orientation, mother seems to be a primary source of emotional support for Kothi-identified MSM.

Though some Hijras may continue to live with their family even after disclosing their gender identity, many often many leave their home to live with the Hijra community. Some Hijras reported that they take care of their biological family and it seems that there is tolerance in the family because they are now earning members of the family. A Hijra reported that when she goes to her parent’s home in a village, she goes in ‘pant-shirt’ and gives some excuses for her long hair. According to her, no one in her family knows about her since she is also married to a woman. She told, “No. They [family members] don’t know anything. When I go there [parents’ home in a village] I wear shirt-pant and not sari. I remove all my ornaments but I have my hairs long… I tell them that I am growing [hair] as [I have] a vow in temple.” But another Hijra though effeminate and was wearing women’s attire can able to convince her family members that she is a dancer and that was why she need to keep her hair long and dress-up like a woman when she go out for some dance programs. She said, “My sister sometimes used to help me and lend me her clothes or make-up for my dance.”

Kothi-identified MSM often do not behave in a feminine manner at their home since they would face trouble if they do so. But some Kothis can not hide their femininity in their parent’s home.
Though some families do not tolerate such a behavior from their son, some family members seem to provide support to Kothis. A Kothi-identified MSM explained, “Yes, my mother did support me. She didn’t know about me as a Kothi but she used to defend me saying that I am like this because there are girls in the neighborhood and I am influenced by that. And though I dance that doesn’t make me a girl. So she used to defend me as much as possible.” Thus, though this Kothi had support from mother there was still no discussion about his sexuality or there was a denial or a contract of silence in talking about it.

A 25-year-old ‘Jogti Hijra’ explained why she is not going to her parent’s home: “I have sisters who are married and their husbands don’t like that I am a Jogti [Hijra] so I don't go there at all so that my sister’s happiness should sustain.” Thus, in not wanting to bring trouble to her sisters, this Jogti did not want to associate herself with her parents. But a heterosexual Puja (Guru of Jogtas) had a different opinion. According to him, “they [Jogti Hijras] want to be free from the family ties [control]”, and that is why they do not want to stay with their parents. Also, he said, those Jogtas who are in women attire can go and visit their parents but are not supposed to stay with them. Hence whether it is by choice or not, Jogtas in women attire (‘Jogti Hijras’) then will have limited support from their parents.

3. Male lover
Referred to as ‘Husband’ by some Kothis and Hijras, male lovers seem to be an important source for emotional support though some felt their love is often not reciprocated. Some Kothis and Hijras even supported their ‘Panthis’ financially (Note: ‘Panthi’ in this context refers to male lovers or steady partners). Though Kothis and Hijras have realized the non-acceptance and non-recognition of same-sex partnerships socially and legally, some cohabit with their male lovers and some Hijras even got ‘married’ to men. Though many Hijras complained that they need to spend a lot of money on their Panthi, some Hijras who cohabit with their male lovers mentioned that they will ask Panthi if they need money. A Hijra explained why she will ask money from her Panthi and not from other Hijras: “They [Hijra friends] will give two rupees and [then will] accuse me of taking ten rupees.” Thus, some cohabiting male partners do help Hijras when there is a need for money.

4. General (Straight) male friends
Some MSM did not even have any straight friends for fear of rejection and discrimination. Even if they have straight friends, fear of rejection does not allow some persons to reveal their sexuality to them. While some Kothi-identified MSM did mention that their ‘general’ (straight) friends might help them in case they have any problems only a very few actually mentioned incidents in which their straight friends have helped them. Some MSM even get money or material support from their straight friends but probably not much of psychological support. But a MSM who do not have any “homosexual friends” mentioned that his straight friends know about his sexuality as well as his HIV-positive status but still support him. He said, “My [straight] friends know about me [same-sex behavior] and also my [HIV] status but they have been supportive. They fed me when I lost job and also gave me some money and even today if I want they get ‘tiffin’ [food] for me from their home.” But not many MSM seem to be that lucky to have nonjudgmental straight friends.

A Hijra who had some college education mentioned that she was supported by straight friends when she left her parents home. At that time she was not in women’s attire. She said, “My [general] friends were very supportive and they kept me in their room when I left my home.” However, most of the Hijras said they did not have any straight male friends from whom they get any support.
F. STRUCTURAL VULNERABILITY: STIGMA, DISCRIMINATION, AND VIOLENCE

Structural vulnerability, here refers to the lack of protection for MSM and Hijras against a public risk, when that lack of protection stems from social exclusion. In this study, various subgroups of MSM and Hijras shared their experiences of stigma, discrimination and violence. One common pattern was feminine MSM (Kothis) and Hijras faced relatively greater degree of stigma and discrimination than compared to those MSM who are masculine and who can thus ‘pass’ as heterosexual men.

Many masculine MSM in this study reported that they do not face any discrimination from the society since they are masculine and are thus seen as ‘normal’ (meaning heterosexual). A 40-year-old married masculine MSM explained why he never faced any discrimination: “Because I don’t behave in an effeminate manner like other men [feminine MSM] do. I am seen as a married man who is living his life within the parameters set by the society – so I have not been a target of any discrimination.” While a key informant was critical of such men since they were seen to have ‘best of both worlds’, under the current societal situation of lack of acceptance of same-sex relationships, one of the coping mechanisms adopted by such men could be just to ‘pass’ as a heterosexual in the society. However, even among those MSM who are masculine (and married) may have to cope up with the psychological stress related to non-disclosure of their sexuality and also have to deal with their self-stigma on their own without anyone else to talk to about it.

This section mainly focuses on the stigma, discrimination, and violence faced by Kothi-identified MSM and Hijras unless otherwise specified.

1. Oppression by the police force

MSM and Hijras who use public spaces to find male sexual partners (causal or paying partners) face discrimination and violence from the police force. A Kothi-identified MSM narrated how the policemen, by threatening to arrest them, used to have forced sex with them: “There are some policemen who tell us that we need to have sex with them otherwise they will put us behind the bars. They force us to have sex.” Thus, feminine MSM (or Hijras) are seen as sexual objects and police know that public will not come to support them even if they abuse their power.

Some policemen blackmail and extort money from MSM by threatening to expose their same-sex behavior to their family members. Some MSM and Hijras who engage in sex work are forced to pay money regularly (‘Hafta’ or regular bribe) to the policemen in their beats to allow them to stand in that place where they will look for potential paying male partners. Some MSM and Hijras have been arrested under false allegations and in the police station police have forced them to have sex (without condoms). “We are arrested even if we have not done any mistake and in the police station we are molested”, reported a Hijra. For some Hijras, even standing in a public place has posed problems. A Hijra said, “I missed the last train and on the bus-stop a police met me and he started accusing me of things [that she is standing there to get male clients].”

A Kothi-identified MSM reported that once he was cheated by someone and when he went to complain in the police station it was not registered because he was perceived to be a feminine and thus a ‘homosexual’ person. He said, “Once I met a nice guy and went with him to the corner but that guy took my mobile and purse. He also beat me. I went to the police [station] to complain but they shouted at me that why did I go with that man.” Thus, police do not even register complaints from feminine-looking lower class persons who are presumably an MSM thus not performing their duty.
2. Violence faced from Ruffians and ‘Cheaters’
(Note: The English term ‘Cheater’ was used by several study participants to refer to men who pretend as potential sexual partners and later rob Kothi- or gay-identified MSM and Hijras)

Often, feminine MSM and Hijras face problems from ruffians who blackmail and extort money from them; physically abuse them; and force them to have sex with them. But, sometimes even masculine-looking MSM face problems from ruffians. A gay-identified person in a FGD said:

I never face any problems from the police because I am not effeminate like others [Kothis] and I also I don’t do things [have sex] in public. But I face problems with the ruffians as they come to us posing like a potential partner and then they take away our mobiles, purse and chains that we have. They threaten us and also have forced sex with us. We have a fear that our families will know about our [same-sex] behavior and so we try not to mess with such ruffians.

Thus, stigma attached with same-sex behavior is utilized by the ruffians to extort money from self-identified homosexually oriented men who use public spaces to find potential male partners.

A 40-year-old MSM shared an incident of him being cheated by a person, “Once on the bus-stand I met a man and went with him to have sex. After having sex he threatened me that he will tell every body about all that we did if I do not give him things that I have. He took my clothes [and money] and ran away.” This shows again, how the stigma attached to same-sex behavior prevents some people to resist any such blackmailing or to report such incidents to police. Even if some people have the courage to report to police and mention the circumstances police may not take any action as a MSM said, “they [police] think we deserve all this because we have sex in the open and unnaturally.” [Participant’s emphasis]

A HIV-positive Kothi-identified MSM told that he was physically abused by a group of men when he refused to have unprotected sex with them. “[Once] 5 men from my locality came to me and asked me to have sex with them - that too without condoms. So when I refused they beat me so much that I had a severe head injury. I told them that I am HIV-positive but they didn’t listen….they also snatched my money.” So, this person was not even immune to violence from men in his own locality and no one came for his help.

3. Oppression within the family

Family members seem to control any feminine mannerisms in their son/sibling though they may not be explicitly talking about their sexuality or sexual behavior. But it is also possible that being feminine is equated with engaging in sex with men and thus seen as a behavior to be condemned. Sometimes, the stigma attached to having a son who is effeminate is so much that some family members either disown them or resort to violence to ‘change’ them. As explained by a Kothi-identified MSM, “We not only suffer at the hands of the police and cheaters but also at the hands of our own friends, family and colleagues. They are also ashamed of us or think that we are wrong and they don’t want to be associated with us. So we are left all alone to face the world.” Thus, the fear of ‘stigma by association’ or ‘passive stigma’ might compel some families to dissociate themselves from their own son or sibling.

Under a false belief that heterosexual marriage will solve the ‘problem’ (feminine behavior or same-sex behavior), some parents force feminine MSM or Hijras to undergo marriage. A Hijra explained how she was forced by her parents to undergo marriage, “When I came to Mumbai I was 16 [years]. After that my father came here and took me back to the village and looked for a girl. But I refused and fled to Mumbai again…after some years I became a Nirvan [undergone}
emasculation].” In contrast, another MSM was asked to leave the home for his feminine mannerisms —“...they [parents] told me that if I continue to behave like this [in a feminine manner] then I need to leave the home.” She later left her home, came to Mumbai, and joined the Hijra community.

A Kothi-identified MSM reported that he had even experienced physical violence from his brothers, “…my brother and father used to hate my [feminine] behavior. They used to beat me at times. They knew that the people in the locality call me a Hijra so they didn’t like it at all and didn’t want me to be associated with such a thing.” The family members of this person have beat him as a punishment for transgressing the social norms and also possibly to prevent him from bringing shame to their family.

A Kothi identified MSM described why he had to leave his family even though he was not abused by his parents. “I broke off 4 years ago [with my boy friend]. My parents told me if you want your friend [male lover] leave us and my Panthi said if you want your parents then leave me. So I left both of them and came here”. Thus this person was caught in a dilemma of choosing between parents and lover and he has to finally let go both of them. Non-acceptance of same-sex love and lack of legal and societal recognition of same-sex partnerships means many MSM could not able to live together with their male lover even if both of them want to.

On some occasions, the entire family is stigmatized because that family has a feminine male. One MSM said, "When they [villagers] noticed these changes [feminine mannerisms] in me they used to tease me and family that a Hijra is born in your family and so it was so bad that for six months they didn’t invite any of my family members for any function in their house... I fought with the neighbors that I am like this and not my family then why my family is being troubled. So I left my house. My dad was the ‘Sarpanch’ [head of the village] and they all used to call him names because of me.” Thus, the entire family is ostracized in some areas and to prevent bringing shame to their family members some feminine MSM choose to leave their family though the family members would have been otherwise supportive.

4. Discrimination in the health care settings
Absence of specific training for the health care providers on MSM and Hijras and their health issues means they lack knowledge and have misconceptions about these marginalized populations. A widespread discrimination of MSM and Hijras in the health care settings has been well documented in India (Chakrapani et al., 2007 & 2004; Periasamy et al., 2004; PUCL-K, 2001 & 2003).

Many MSM and Hijras complained about the lack of knowledge about the issues of sexual minorities among the health care providers. The family members of a Kothi-identified MSM took him to a doctor for ‘curing’ him from his feminine behavior. He explained the lack of sensitivity and knowledge about the issues of MSM in that male doctor as follows: “...he [doctor] checked me. Then he touched my genitals and asked me whether I feel like getting fucked or I feel like fucking someone.” Thus, it seems that there is a lack of understanding about the concept of sexual orientation among both the family members and that doctor, and also the thinking that feminine mannerisms (and indirectly it means ‘homosexuality’) can be ‘fixed’ medically.

Another MSM who developed a penile ulcer after a sexual encounter with male said that when he asked his doctor why he got boils in the penis, he was told, ‘Because [you] have drinks [alcohol] and tobacco.” This explanation by that doctor could be because of the discomfort in asking about the sexual history or could even be due to lack of knowledge about STIs with consequent misdiagnosis and mistreatment. But, the key issue is, this person was not provided...
correct information about his condition and also the opportunity to provide sexual risk reduction counseling was missed by that doctor.

An incident was narrated by a MSM in which doctor assumed him to be a heterosexual. He said, “I went to him [doctor]. He asked me if I was visiting any call girls. He did not know at that time I also have sex with men. He asked me if I used to drive and hurt my self somewhere. I asked him what he meant and the doctor laughed.” Again, there seems to be discomfort in this doctor in taking an open sexual history let alone asking whether the patient had sex with females, males or both.

A Kothi-identified MSM narrated an incident of forced sex and ill-treatment in a public hospital:

In the place where I worked my boss forcefully had sex with me. Then I went to doctor and openly told him what happened. I even complained that to the police...It [forced sex] happened by 6 in the morning. I came to the [public] hospital by 9 o’clock [in emergency ward]. I was bleeding...The duty doctor told ‘big [senior]’ doctor is going to come’...I was sitting and sitting and it became 5 [pm]...[When the senior doctor arrived] she scolded other doctors to behave properly with patients and she told all the blood from my body must have gone if she was not there on time to stitch. I was given blood [transfusion].

Thus, he was made to wait unnecessarily until a senior doctor come and attended him. While the junior doctor might have been hesitant since that was a medico-legal case at least he could have provided first-aid help and other necessary medical procedures. This could not only be because of the lack of knowledge among the doctors to respond to such a relatively unfamiliar situation (male sexual assault) but also reveals the lack of skills in how to deal with or counsel a victim of male sexual assault. When asked about what happened to the police case he filed against his boss, he replied: “...the police case [on the boss] was closed since there was no response [from the police]...They [Police] told you might have done something to your boss to make him come to you...Why should I do something to attract that old chap [boss]. He might have given money [bribe] to the police. He is rich.”

Thus, this Kothi from lower economic class could not even able to file a case against the person from upper economic class who had forced sex with him. Lack of distinction between consensual and nonconsensual sex between same-sex adults is another drawback in why justice is not available to victims of male sexual assault.

Talking about their experiences in the health care settings, Hijras said that if they go with referral slips from CBOs then they are treated with respect and feel welcomed in the government hospitals in Mumbai. Even then some Hijras expressed some pitfalls in the current health care system. There seems to be some confusion in which queue (‘line’) Hijras will stand to be registered as an outpatient. To avoid such embarrassment, in the hospital, Hijras often clap their hands in a peculiar manner (‘Thali’) and move forward to the outpatient ticket counter - jumping the queue. At the counter, they either give their ‘Panthi nam’ [means their male name] or their ‘Hijra nam’ [their ‘feminine’ name]. As a Hijra narrated, “We clap our hands and say we are not man and we are not woman...where can we stand [in the queue]...and we go forward...I gave my Hijra name,” Another Hijra said, “I gave my ‘Panthi nam’ [male name]”. A Hijra FGD participant was upset that even if they are in sari [women’s attire] they are registered in their male name [meaning they are registered as males] and they are called by their male name by the health care providers. She said, “They register us in our Panthi name. They also used to call me as [a male name]. I was angry.”
Thus, in the current health care system there are no guidelines regarding in which gender Hijras need to be registered; and what would be the registration and admission procedures if Hijras are in male dress or in women’s attire - or if they are Ackwa or Nirvan; and how to address Hijras without hurting their feelings. The lack of such guidelines and training means Hijras continue to face embarrassment and ridicule from the hospital onlookers in which queue (“line”) they have to stand; in which gender (which name – male or female name) to be registered as out-/in-patients; and in which ward they will be admitted as in-patients; and also face discrimination from health care providers who do not use appropriate (female) pronouns when they speak to Hijras.

5. Male lovers: Intimate partner violence

Even male lovers of Kothis and Hijras sometimes physically abuse them or force them to have sex with them. A Kothi said, “He [male lover] beats me…then he repents having relation with somebody like me and that I am not leaving him and his name is being spoiled because he is associated with me.” It is possible that this Kothi’s male lover is in a conflict since he is attracted towards a male as well as he feels bad about their same-sex relation. Internalized homophobia in the male lover might have resulted in blaming the Kothi partner and expressing his dilemma in the form of physical violence. Intimate partner violence (physical and emotional) in same-sex couples is an understudied area in India and there is a need to better understand it to devise strategies to reduce or eliminate it and to assist same-sex couples.

6. Discrimination in the workplace

A Kothi-identified MSM working in an office shared his experiences of discrimination by his co-workers. He said, “They [co-workers] tease and call me names, and women also used to mock at me. Some [males] used to make signals [for sex] when I go to office.” Another Kothi-identified MSM had sex with one of his colleagues and later that colleague spoiled his name by indirectly revealing that since he is feminine he has sex with males. That Kothi-identified person said, “I did have [sex] with one of them [co-workers] but then he was bad mouthing me and he used to address me as a girl in the presence of other colleagues so I decided that I will never have sex with anyone in the work place.” Thus, though that colleague had sex with this Kothi-identified MSM that person being masculine made him immune to any discrimination from co-workers but the feminine Kothi-identified person then had to face discrimination from his co-workers since his former sex partner ‘outed’ him (i.e., revealed his sexuality to others).

7. Self-stigma and Fear of discrimination

Various degrees of self-stigma were reported by MSM and Hijras in this study. A MSM who once wanted to discontinue his same-sex behavior was prescribed vitamin tablets by a doctor. He told, “I asked my doctor that I do not want to be like this [having sex with other men] and I want to [stop it]. He told I have some vitamin deficiency and gave me some tablets.” This shows that not only some MSM internalize the society’s negative attitude and thus have internalized homophobia (self-stigma) but doctors are also equally ignorant about the current medical views about homosexuality and conveniently give some pseudoscientific explanations and prescribe medications.

Previous negative experiences from social interactions prevent some MSM from making any new friendships. Sometimes, the mere fear of non-acceptance and rejection are so strong that some give up any social interaction and isolates oneself. As a MSM said, “I don’t make friends with anyone. [I am afraid] that they will mock at me.” Thus, fear of discrimination if he is known to be an MSM prevented him from even forming friendships with straight persons.

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Non-disclosure about one’s sexuality also prevents some people to get emotional support in crisis situations. Talking about his separation from his male lover, a Kothi-identified MSM told, “…I knew that I will have to face societal rage [if I disclose]…[Thus] I am not open in the society or to my family. I had kept quiet when my three-year long [boy] friend left me because I was scared what will the society think if I am vocal about this issue.” Stigma associated with homosexuality and lack of acceptance of same-sex relationships prevented this person from openly discussing about his romantic relationship and also the break-up - thus leaving him without any emotional support from anyone. One of the key informants commented that if there is self-stigma even among those MSM who have peer support and who can utilize support services offered by CBOs then one can expect even a greater degree of self-stigma among those who are not using such services and who do not have peer support.

Not just passive victims
Not all MSM or Hijras suffer as passive victims when they are oppressed. A Kothi-identified MSM shared one such incident: “Yes. Once some men took me with them to have sex and they snatched my money and tried to beat me but I created such a noise that they ran away.” In some other situations, they received help from other Kothis or Hijras and escaped from sexual abuse or physical violence from ruffians.

Some Hijras too fight back when they are teased or ridiculed by the general public. As a Hijra narrated, “People in my locality used to tease me and call me Hijra. I used to get angry and abuse them [verbally] and that too in feminine way.” Some Hijras even physically assault those who ill-treat them. A Hijra said, “Sometimes I get very angry and beat them with sticks and throw stones. Also, punch and break their face. And I beat them saying ‘Do not tease me’.” In presence of rampant discrimination from the society when some Hijras resort to verbal or physical abuse against those who discriminate them it might make the society to further discriminate Hijras as they are then seen as uncivilized or evil. Stopping this vicious cycle would be a challenge but one of the ways to decrease stigma and discrimination would be to educate and sensitize the society about the needs and rights of Hijras and MSM.
V. DISCUSSION & RECOMMENDATIONS

Developing sexual network-based interventions

This study carried out in Mumbai and Sangli has demonstrated that in both metro setting and small city setting, there are a variety of wide-spread and intertwined sexual networks among MSM and Hijras. Because of the stigma associated with sex between males and criminal laws against certain sexual practices (other than vaginal sex), many MSM tend to meet potential male sexual partners clandestinely through various ways – visiting public places frequented by potential male sexual partners (‘cruising sites’), phone contacts, friendship networks, and these days, through internet. In addition, inter-city migration and job-associated frequent travelling also connect MSM across cities and states.

This study has also shown that extensive sexual mixing occurs across the age groups or generations; with partners who are from different gender or who have different gender identity (women or transgender women) or sexual identity; and partners who are of different types (regular, casual, paying and paid) or who have different HIV/STI status. This extensive disassortative sexual mixing in presence of significant proportion of MSM and Hijras engaging in penetrative sex without consistently using condoms means there is a high risk of transmission or acquisition of STI or HIV in these sexual networks.

Targeted interventions typically reach out to those MSM who frequent cruising sites to meet potential male sexual partners to have ‘deliberate incidental sex’ (Dowsett et al. 2006). Even in the cruising sites, often it is easier to reach out to those MSM who have some kind of sexual identity than to reach out to those MSM who do not have any. Thus, a large proportion of those MSM who do not have any sexual identity (or those who refuse to self-label) and those who do not frequent cruising sites are often not reached out through targeted interventions. While one way of reaching out to these persons is through mass media messages that address the health risks associated with unprotected sex with persons of any gender, other possible opportunities include developing ethical strategies to intervene in various other networks – those connected by personal friends, phone, and internet.

The presence of various subgroups of MSM (such as Kothi, Panthi, Double, and gay) means specific strategies need to be developed to effectively reach out to those subgroups. Also, there is a need to design and deliver services that are acceptable and relevant to each of those subgroups. Operations research studies need to be conducted to assist in designing such subgroup-specific services or interventions.

Addressing bisexual behavior

Irrespective of the sexual identity or gender identity of MSM and Hijras, many do have bisexual behavior and some appear to have bisexual orientation. Since forced heterosexual marriage is mentioned as one of the reasons for getting married to a woman by even homosexually-oriented males with sexual identities like Kothi or gay, until the societal norm on heterosexual marriage changes, possible ways to help those MSM who do not want to get married to a woman be identified. For example, conducting a workshop on resisting marriage pressure from their family or counselling MSM to develop a personal-tailored plan to avoid marriage are some of the possible ways. At the same time, it should also be not forgotten that some MSM ‘choose’ to get married – this could be because they have bisexual orientation or because of various other contextual factors.
Not talking about bisexual behavior or not addressing the need to as well as challenges in using condoms with wife, leave many MSM to determine on their own what they need to do. For those MSM with bisexual behavior including those who are already married, support should be available to help them in issues such as - whether to disclose to wife/girl friend about his sexuality or not; what to do if there is a crisis situation like someone has revealed his sexuality to his wife/girl friend; how to use condoms with their wife/girl friend especially if he has STI or HIV; how to disclose to his wife/girl friend that he has STI or HIV; and how to motivate their wife/girl friend to come for STI/HIV screening and treatment. All these are challenging, yet very important issues, from the perspective of HIV/STI prevention and care to the female partners (including wife) and unborn children of MSM and Hijras. Operations research needs to be conducted to develop possible program activities to address these issues. Also, since discriminating married MSM (especially in the CBO setting) is going to further increase the psychological stress faced by them, there is a need to create a supportive and understanding environment for those MSM who are often not in a position to make decisions about their marriage.

Beyond ‘Behavior Change Communication’ (BCC) approach: Addressing contextual factors in interventions

The study findings also demonstrated that while there are individual factors (such as personal dislike of condoms) that are related to not using condoms, often the factors behind inconsistent condom use are dependent on various contexts - interpersonal or structural. For example, though a Kothi-identified MSM may know about condoms and even has condoms with him, he could not able use it if he was forced by a ruffian or police to have sex with him. Similarly, a married MSM, for fear of marital discord, may not be able to use condoms with his wife though he also has unprotected sex with many other males. In the conventional ‘BCC’ approach, whether or not it is theory-based (such as health-belief model or AIDS risk-reduction model); the individual is seen as responsible for his/her behavior. Consequently, the focus is mainly on improving his/her knowledge or imparting new skills (condom use) are pursued. Thus, the study findings suggest that though important and much needed, BCC approach alone is not sufficient.

For addressing the various contextual factors regarding unprotected sex, there is a crucial need to focus on sexual partnerships (interpersonal factors) and also the structural factors. For example, at the interpersonal level, efforts to be taken to improve sexual communication between couples (man-man, man-woman, and man-Hijra) and improve condom negotiation skills to negotiate with different types of partners (husband and wife; male couple; Hijra sex worker and male client). At the structural level, potential actions include removal of legal barriers (as discussed below) and devise strategies to change the societal attitude towards sexuality issues. The latter would be a long-term strategy and might take a longer duration to achieve; nevertheless it should be initiated.

Social support: Possible interventions through influential community leaders

Kothi-identified MSM and Hijras seem to rely more on their peers for getting emotional support since with peers, they can able to be who they are and can talk about their same-sex attraction and male sexual partners without being judged. For Kothis, socialising with other Kothis at the cruising sites or in safe places like CBO drop-in centers, are not thus trivial but an important part of their social support system. In this study, Kothis often used the term ‘Kothi Samaj’ (Hindi) which in English literally translates into ‘Kothi community’. Some key informants in this

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study and some researchers have questioned the existence of ‘community’ of MSM in India (Chakrapani et al., 2002; Dowsett et al., 2006). In case of sexual networks among MSM, especially who do not have conscious sexual identity, it may be true. But from Kothis’ perspective, at least for those Kothis who can be reached out by CBOs, not one but multiple concurrent ‘Kothi communities’ exist, though maybe they are still in a nascent stage. These emerging communities are predominantly non-sexual social contacts of Kothis. Some Kothis in these virtual nascent communities are respected by their juniors and fellow Kothis, and they act as mentors for juniors.

Similarly, in the well-established Hijra communities, there are ‘Gurus’ who are senior Hijras and they are respected by other Hijras. While the concept of ‘peer education’ is well understood and have been operationalized in the HIV prevention programs, by training peer educators and asking them to talk to others and provide condoms, a similar (and possibly overlapping) concept of ‘community popular opinion leader’ (CPOL, for short) is not yet widely understood or operationalized. While the ‘CPOL’ strategy has ‘western origins’ (REF), there is a need to explore the possibility of getting the help of influential community leaders in Kothi and Hijra communities to endorse safer sex behaviors thus helping in creating and sustaining a community norm of condom use and health care-seeking behavior.

**Structural vulnerability**

Kothi-identified MSM and Hijras face stigma, discrimination, and violence from various persons in a variety of settings. Often, persons who are ‘obviously feminine’ are subjected to discrimination. In India, where women are often considered as inferior by men (misogyny), those males who are feminine are also thus considered inferior, if not deviant - making it seem justifiable to discriminate them and even take extreme measures to ‘fix’ the ‘deviants’. While some Kothi-identified persons may behave in a masculine manner in their home to avoid discrimination, those who are (future) Hijras, find it very difficult to hide their feminine mannerisms or their feelings related to becoming and dressing-up like a woman. Consequently, they are condemned and punished by their own family members.

Apart from forced eviction from their parents’ home, either to save their family honor or to be free to what they want to be or do, many Hijras run away from their family and come to major cities such as Mumbai. Once they join the Hijra community in those cities, in absence of education and in presence of widespread discrimination, they go for Badhai or Mangti (asking for alms) and/or engage in sex work. Thus, lack of understanding about persons with different gender identity, expectations about gender norms and need to confine to the expected social and gender role, and the need to avoid potential stigma of the whole family – all these factors compel Hijras to leave their family and ultimately engage in sex work. Consequently, these make Hijras socially, economically, psychologically, and legally vulnerable to many conditions such as poverty, STI/HIV infections, discrimination from the larger society, lack of job opportunities, arrest by police, and psychological stress.

Presence of the criminal law against certain sexual practices (Indian Penal Code – Section 377) and misuse of power by the police force make sexual minorities vulnerable and exploited economically and sexually with no possibility of redressal. The archaic nature of section-377 and power abuse by the police curtailing the human rights of sexual minorities strengthen the argument to decriminalise adult consensual same-sex relationships though there is a need to retain the criminal nature of non-consensual adult same-sex relationships. Considering the rampant discrimination and violence faced by MSM and Hijras from ruffians, some members of
the general public, police force, and workplace colleagues, there is also a need to codify and enforce anti-discrimination laws which punishes those who engage in ‘hate crimes’.

Among the health care providers, there is ignorance about sexual minorities and often there is a lack of skills in relation to sensitive sexual history taking or attending to a male sexual assault. All these lead to insensitive, inappropriate, and substandard quality of care to sexual minorities. Lack of specific guidelines on registration and admission procedures for patients who are Hijras point out the heterosexism in the health care institutions and inattention to the needs and rights of sexual minorities. Thus, there is a need to train health care providers on sexual diversities among humans; improve their knowledge and skills in relation to sensitive sexual history taking, sexual risk reduction counselling and other issues like dealing with and counselling sexual minorities who are victims of male sexual assault.

Thus, to eliminate stigma and discrimination against sexual minorities a variety of ways need to be adopted and simultaneously implemented. Those include: changing the societal norms about sexuality and gender-appropriate behavior; eliminating misogyny; changing heterosexism in various institutions; removing criminal laws against adult consensual same-sex relationships; and working with family members of sexual minorities. Though these are challenging tasks, still need to be done – on an urgent basis.
Box 2: Summary of Recommendations

**Sexual Networks**
- Develop sensitive and culturally-appropriate mass media messages on health risks related to unprotected sex with partners of any gender, to reach out to MSM who are not accessible through targeted interventions.
- Develop network-based interventions in an ethical manner to reach out to MSM who are part of sexual networks through mobile phones, personal friendships, and internet.
- Address male-to-male sex and bisexual behavior in programs focusing on specific male populations such as male youth, migrants, truck drivers, and male injecting drug users.

**Social Networks**
- Support formation of community-based organizations (CBOs) in different parts of Maharashtra to provide social support to and mobilize MSM and Hijras towards their health issues and rights.
- Consider the feasibility of identifying and training influential community leaders of Kothi and Hijra communities to create community norms supporting condom use - in line with the concept of ‘Community Popular Opinion Leader’ model.

**Addressing Bisexual Behavior**
- Outreach education among MSM also needs to emphasize condom use with their female partners.
- MSM who are facing marriage pressure from their families need to be provided with non-directive, non-judgemental counseling to help them in making informed decisions about marriage.
- For those MSM who are married, support needs to be provided in the following areas: whether to disclose his sexuality or not; what to do if there is a crisis situation like someone has revealed his sexuality to his wife; how to use condoms with his wife especially if he has STI or HIV; how to disclose to his wife that he has STI or HIV; and how to motivate his wife to come for STI/HIV screening and treatment.

**Addressing contextual factors that lead to unprotected sex**
The study findings suggest that though important and much needed, Behavior Change Communication (BCC) strategy alone is inadequate.
- At the interpersonal level, efforts to be taken to improve sexual communication between couples (man-man, man-woman, and man-Hijra) and improve condom negotiation skills to negotiate with different types of partners (husband and wife; male couple; Hijra sex worker and male client).
- At the structural level, potential actions include removal of legal barriers (see below) and devise strategies to change the societal attitude towards sexuality issues.

**Decreasing/Eliminating Structural Vulnerability**
- There is a need to decriminalize consensual adult same-sex relationships.
- To prevent hate crimes, it is essential to codify and enforce laws preventing physical and sexual abuse of sexual minorities.
- To provide optimal health care to sexual minorities, health care providers need to be trained on sexual diversity and health care issues of MSM and Hijras.
- For increasing the effectiveness of prevention and care programs for MSM and Hijras, there is a need to gain the support of law enforcement agencies by sensitizing them.
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