SEXUAL HEALTH OF MALES IN SOUTH ASIA WHO HAVE SEX WITH OTHER MALES

RESULTS OF SITUATIONAL ASSESSMENTS IN FOUR CITIES IN INDIA AND BANGLADESH

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EXECUTIVE SUMMARY

Situational assessments of the sexual health of males who have sex with males were conducted in four cities in India and Bangladesh in early 2000. They involved a total of 800 respondents to a set questionnaire, 200 focused interviews, 8 focus group discussions plus site observations.

Major findings included:

- a great diversity and fluidity in social, sexual and gender identities and behaviours of these males that is very different from a western "gay" experience;
- a very high level of HIV/STI vulnerability and risk-taking amongst feminised males (kothis) who have sex with males, especially those who sold sex – resulting from low economic and social status, low self-esteem, high frequency of receptive anal sex with very low levels of condom use, a large number of different partners and poor access to sexual health diagnosis and treatment services;
- high HIV/STI vulnerability of female partners of males who have sex with males;
- inadequate access to appropriate condoms and lubricant; and
- public and community health officials who were aware of the need to respond to the sexual health needs of these men and their female partners but who did not have clear ideas about how to do that effectively.

The primary recommendations arising from the assessments are related to:

- strengthening the community-based response to provide sexual health education and services for males who have sex with males;
- encouraging support from government public health and other officials for that community based response; and
- creating a better enabling environment to assist males who have sex with males to reduce HIV/STI related vulnerability and risk taking**.**

The assessments do not attempt to provide epidemiological proof of a specific and quantifiable contribution of sex between males to the prevalence and incidence of HIV infection or other STIs in South Asian countries. They do, however, argue that sex between males is likely to have a greater significance in this region than generally acknowledged because of its scale, the way in which it is socially constructed and the amount of sex that these males have with their female partners.

Although limited in scope these studies are a useful and timely contribution to understanding and addressing these problems. They should contribute to a strengthened sexual health program and response to HIV infection in South Asian countries.

Situational assessments undertaken by Naz Foundation International, funded by FHI/Asia.
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1. BACKGROUND

This paper presents the results of, and discusses issues raised by, situational assessments about sexual health undertaken in early 2000 amongst males who have sex with males in **Hyderabad, Bangalore**, and **Pondicherry** in India and in **Sylhet** in Bangladesh.

The original assessments were funded by Family Health International (FHI) Asia Regional Office. The research was managed and conducted by Naz Foundation International (NFI) with assistance from local groups and trained peer investigators. This paper presenting the results of the research was funded by the Department for International Development India (DFIDI).

2. SCOPE AND OBJECTIVES OF THE SITUATIONAL ASSESSMENTS

The situational assessments were carried out as part of ongoing NFI and FHI programs to explore and establish appropriate responses to the sexual health needs of males who have sex with males and their sexual partners in selected cities in South Asia.

The assessments comprised two major parts. One was to collect information about aspects of identity, behaviour and vulnerability of the men. The second was to encourage and support the design, funding and setting up of local community-based projects to respond to identified needs. In addition there was an attempt to sensitise existing mainstream sexual health services to the issues.

Information collection focused on:

- demographic and ethnographic analysis;
- male to male sex behaviours, identities and genders;
- access to condoms, lubricant, STI/HIV information, and STI services;
- levels of reported symptoms of possible STIs; and
- health seeking behaviours.

Assistance in further policy and project development included;

- developing a strategic response framework for the sexual health needs of males who have sex with males;
- defining technical needs and support mechanisms for peer-led services;
- presenting the results of the assessments and possible project parameters to the responsible government agencies, NGOs and other stakeholders;
- designing project proposals for each specific site based on assessment findings and securing donor support for such interventions.

3. SENSITIVITY OF THE ISSUE OF SEX BETWEEN MALES

Sex between males is surrounded by social, legal and cultural sensitivities in most countries. This is true in South Asia where acceptance of intimacy and affection between males is juxtaposed with rejection of acknowledged homosexual behaviour.

This sensitivity has resulted in “invisibility” and “silence” about sex between males when it comes to analysing and responding to sexual health needs in the general population. In particular, these assessments argue, it has resulted in an inadequate understanding of, and response to, the dynamics of HIV infection in South Asian countries.

4. RELEVANCE OF SEXUAL HEALTH OF MALES WHO HAVE SEX WITH MALES

> *In the socio-cultural frameworks of South Asia, the issue of male to male sexual behaviours and their impact upon the reproductive and sexual health for males and females, children, youth and adults, have profound implications for any effective control and management of STDs and HIV infections in the region. (Final Report. p.15)*

Some public health officials in South Asia are aware of the need to take account of, and respond to, the role of sex between males in the transmission of HIV and other sexually transmitted infections (STIs). However, they are unlikely to have accurate knowledge about the issues, or detailed information about the social environment of the males involved. They may also have attitudinal blocks. The shame and secrecy that surrounds males having sex with other males has made it difficult to respond to their specific needs through appropriate design and delivery of policies, programs and services.

The assessments do not attempt to provide epidemiological proof of a specific and quantifiable contribution of sex between males to the prevalence and incidence of HIV infection or other STIs in South Asian countries. They do, however, argue that sex between males is likely to have a greater significance in this region than generally acknowledged because of its scale, the way in which it is socially constructed and the amount of sex that these males have with their female partners.

The assessments suggest that ignoring the sexual health needs of males who have sex with males results in unnecessary pain and suffering and imposes costs on individuals, communities and the health care system through infections that could otherwise be prevented.

Although limited in scope these studies are a useful and timely contribution to understanding and addressing these problems. They should contribute to a strengthened sexual health program and response to HIV infection in South Asian countries. The assessments:

- provide structured and comprehensive qualitative and quantitative data about sex between men in the four cities and about their vulnerability and risk taking in regards to HIV/STIs;
- point to the need for much more research and understanding of various aspects of the identities, behaviours and vulnerability of these men;
- make specific suggestions for policies, programs and services that can be developed for males who may be more vulnerable to, or at greater risk of, HIV infection because of the sex they have with other males; and
- raise issues about the needs of the female partners of these men.

5. METHODOLOGY USED IN THE ASSESSMENTS

The methodology to collect information included:

- 200 structured interviews in each city using a set questionnaire with 66 questions;
- approximately 50 tape-recorded focused interviews in each city;
- 2 focus group discussions in each city;
- interviews and discussions with a range of secondary stakeholders; and
- site observations.

In total this represents approximately 800 interviews by questionnaire, 200 face-to-face interviews and 8 focus group discussions. This is, therefore, probably the largest study of its kind in the region to date and complements similar assessments already undertaken by NFI and its partner sexual health projects in Dhaka and Chennai.

The implementation of the project was managed by a principal investigator from NFI. A Local Focus Person (LFP) was recruited in each city to manage local logistics. An Assessment Team of local peer investigators conducted the information collection. The team was drawn from local networks of males who had sex with males and who underwent a six-day training course.

Before all workshops and interviews an “Oral Informed Consent Statement” was read out, consent obtained and the form signed by the workshop leader or interviewer. Confidentiality and anonymity was promised. All respondents were above eighteen years of age. No payment was made for participation.

The reports from each assessment acknowledge that, for reasons explained in the section below on findings, only some networks of males were accessed during the process. The results therefore apply to certain males and may not apply to others. The reports argue that the males accessed in the assessments are at greater risk of HIV and other STIs than most other males who have sex with males. However, while suggesting this the reports also argue that services are required for all males who have sex with males.

[Please see Annex 1 Data: 1A – 1E]

6. Major Findings of the Assessments

Reflecting the assessment design, scope and objectives the findings cluster around five main areas:

- Identities, genders and behaviours;
- HIV/STI vulnerability and risk taking;
- Signs and symptoms of STIs;
- Health seeking behaviours and access to services; and
- HIV prevention policies and programming.

6.1 Identities, genders and behaviours

6.1.1 Identities, genders and behaviours

> *Assessments … in a range of cities in South Asia indicate significant levels of males who have sex with males, with a majority of such males practising such behaviours without a "homosexual" identity. Further there appears to be a growing number of male sex workers due to poverty, economic pressure, and migration from rural to urban areas. (Final report p.15)*

This is one of the most complex and sensitive areas of discussion in the assessment reports. The discussion draws upon other analytical work undertaken by NFI and its partners in South Asia and by a range of other individuals and agencies some of whom hold divergent views.

Most analyses agree that western descriptions of sex between males are not generally relevant to a South Asian situation. In part because the western framework essentially provides an option of being “heterosexual” or homosexual”. South Asian cultural, social and historical realities present quite different frameworks in terms of behaviour and identity for males who have sex with males.

> *These frameworks provide a sense of amorphous and shifting identities, gender identification, and actual behaviours, whether based on male to male desire, or desire for specific acts (i.e. anal sex), or just semen discharge arising from "body heat". They indicate a fluidity and an emergent, or even evolving, framework of sexual identities. (Final report p.33)*

However, despite broad agreement at this level views differ about how to describe, and organise around, the behaviour and identities of males who have sex with males in South Asian countries.

The term “men who have sex with men” has been used widely in sexual health programs to try and focus on the sexual behaviour rather than the identity of the person. These assessments argue that this term has become limiting as people use it to categorise an identity and it seems to be being used to describe an exclusive group rather than to reflect fluidity and diversity. They also suggest that it masks a lot of sex involving younger males and sex within families. So the term “males who have sex with males” is used. However, this is not acceptable to some men who prefer to call themselves “gay” and assert their right to display, and organise their lives around an acknowledgment of, their “homosexual” desire.

The assessment reports focus on the vulnerability and risk taking of:

- “feminised” males, mainly from lower social and economic classes, who mainly practice receptive anal sex, many of whom sell sex; and
- their “masculine” male partners who mainly practice insertive anal sex, most of whom have sex with females as well.

Different names are given to these males in different locations. For the purpose of the assessment reports the term “khoti” is used for the first and “panthi” for the second. The assessments reports do not try to present a picture of an homogenous experience across South Asia that can be described using this terminology. However, they do argue that there is a similarity of experience that should be further explored.

The reports describe the khoti identity as self-determined and defined largely by gender i.e. the idea of being feminine and being attracted to men. The panthi identity is ascribed to other men by khotis and their sexual behaviour is defined as a simple desire for “discharge” rather than an acknowledgment of any attraction to, or desire for sex with, someone of the same sex.

> *Kothis see themselves as the feminine in a masculine/feminine sexual partnership, and play out the perceived gender role in the culture. Most kothis in this study felt relatively comfortable with their choice …. The men who access these kothis for sex, and sometimes for sexual relationships and partnerships, are seen as "real men" by the kothis, men who play the "dominant", "active" and "penetrating" role. Such men do not see themselves as "homosexuals", since the people they have sex with are not "men", but feminised males. They do not have a sexual identity term for themselves … They see themselves as men. The term panthi is used by kothis to describe them, meaning a "real man", a man who will penetrate them, and who also will have sex with women given the opportunity. Many kothis speak of all men as potential panthis, accessible to them as sexual partners ... not based on male to male desire, but because of what was perceived as an urgent need for sexual discharge, and gendered roles.*
> *(Final Report p.33)*

The reports acknowledge the emergence of “gay” identified males who see themselves as males who are attracted to other males and who want to construct loving relationships and a lifestyle that reflect and legitimise that attraction within a local context.

> *In major urban settings, certain men were identifying as gay. Primarily these men came from an English speaking urban elite or upper middle class. Others from the English speaking middle class did speak of themselves as "a gay" or practising "homosex". Certainly in Hyderabad and Bangalore, gay groups and networks existed, and were very active in developing a gay-identified sensibility modelled very much from the West. In Pondicherry and Sylhet no gay-identified men were accessed by the Assessment, and there were no visible gay group or organising. (Final Report p.7)*

The assessments found very little interaction between the gay identified males and the khoti/panthi identified males.

> *In Hyderabad and Bangalore, relationships with the gay groups in these cities and some more educated kothis were usually termed as friendly but seen as different. However in many discussions kothis felt very uncomfortable with gay-identified men because of a lack of English skills, class and economic differences and being marginalised by these gay-identified men. The sexual networks and "cruising" areas often differed, and rarely was there any socialising and mixing between them.*
> *(Final Report p. 40)*

The reports acknowledge a range of other possible permutations of identity and behaviour including an emergent dynamic of “double-decker or AC/DC” to describe a situation where both partners might penetrate and/or be penetrated. The assessments also identify occasions or situations where sex between males might take place regardless of identity.

These particular assessments do focus mainly on khotis and panthis. This results from some preoccupations of the investigators and an assumption of their greater vulnerability and risk taking in relation to HIV/STIs. There is some evidence that there is a strong element of socialising, networking and inter-reliance amongst kothis. The reports argue that this has the potential to form a strong basis for further community building and the development of community-based responses to the problems associated with HIV/STI.

> *Without an effective welfare system, individuals are usually reliant upon their families for a range of economic support. They can also provide a psychological context of support. ….But for many kothis and gay men, their emotional support systems come from their personal networks of other kothis or gay men. Such networks can provide a supportive affirmation. Friendships are formed through these networks. …The support mechanism arises from a shared identity framework and behaviour.*
> *(Hyderabad Assessment Report p.67)*

The reports, however, do point out that many of the most vulnerable kothis may not have the organising skills to build movements or organisations that can sustain community-based responses to HIV/STIs.

> *While many gay men are working actively towards building a sense of community with other gay men, kothis are not so organised or thoughtful. Many gay men are activated towards social organising, developing supportive resources, and working towards a supportive gay community. For kothis this organising is absent…. Such an absence may be due to a range of factors that constrain forms of activism among the lower income groups. Stigmatisation, constant pressures around income, family, social status, survival which focus attention on these issues. Activism and building social communities require self-reflection, time and commitment. These are difficult attributes to be manifested in the context of many kothis. (Hyderabad Assessment Report p.67)*

The reports argue that while they do not explore in detail the vulnerability and risk taking behaviour of males who have sex with males other than kothis and panthis this does not mean that vulnerability and risk does not exist amongst them. The reports argue that all males

who have sex with males deserve adequate sexual health services regardless of identity or perceived level of vulnerability and risk.

The individual reports from each city assessment and the final synthesis report contain extensive and rich discussion about identity, behaviour and gender. This material should be accessed directly by agencies and individuals that become directly involved in service delivery or more focused behavioural research.

[Please see Annex 1 Data: 1F]

6.1.2 Scale and diversity of male to male sex

The assessments make no pretence of having made reliable or defensible quantitative analyses of the numbers of males who have sex with males in each of the locations. However, they do extrapolate from the direct observations in sites visited and from the "expert" knowledge of the respondents interviewed.

These processes result in what the reports call "guesstimates" of males who have sex with males numbering approximately:

Hyderabad: 120,000 plus in a population of 4 million plus
Bangalore: 120,000 plus in a population of 4 million plus
Pondicherrry: 35,000 plus in a population of 700,000 plus
Sylhet: 55,000 plus in a population of 700,000 plus

These figures appear consistent with general research that places levels of "homosexuality" in a majority of populations at between 3 – 7 %. Especially given the argument made in these assessment reports and other sources that the extent of male to male sex, regardless of any kind of "homosexual" identity, may be higher in South Asian countries.

The assessments also capture respondents' observations on the diversity of males who have sex with males. Essentially this ranges across ages, class, family relationships, and professions.

> *….from adolescents to much older men, from close relatives to the domestic servant, from the rickshaw driver to the businessman, from the rag-picker to the shop-keeper. (Final Report p.8)*
>
> *adolescent males are also vulnerable [to HIV/STIs], where significant [numbers] have their first sexual encounters with a male relative or neighbour before the age of sixteen. (Final Report. p.16)*

The respondents reported a high number of partners, a high level of receptive anal sex and a low level of condom use.

The percentage of the 800 respondents reporting more than 7 different partners in the past month was 90% in Hyderabad, 93% in Sylhet, 60% in Bangalore and 58% in Pondicherry. In Hyderabad and Sylhet more than 20% reported having more than 51 different partners in the past month.

The percentage of all respondents reporting receptive anal sex in the last month ranged from 65% in Bangalore to 78% in Sylhet. The use of condoms in receptive anal sex was reported as ranging from 29% of the time in Hyderabad to 45% of the time in Bangalore.

The total number of anal sex acts reported by all respondents in the previous month totalled 19,657. This is close to an average of 25 per respondent. Anal sex was reported as around two thirds of all sex acts.

[Please see Annex 1 Data: 2A, 2B, 2C]

6.1.3 Locations where sex takes place or contact is made

The assessment respondents identified almost any locale where a measure of anonymity and access to males was possible as sites where contact might be made or sex take place.

> *Sites where men can meet other men include parks, bus-stands, railway stations, auto-taxi stands, cinema halls, public toilets, cemeteries, specific streets, bazaars, market places, shopping centres .... While sexual activities did take place in many of these sites, much also took place in construction sites, guest houses, lodges and hostels, as well as [private] homes, where after meeting the partners the men would go for .. sex. (Final Report. p.8)*

> *Police activity appeared to be low key. Several kothis spoke of having sex with a range of police officers. On a range of site visits …..[the] kothi escort knew several policemen on very friendly terms, even though he was obviously a kothi. He told me that he had sex with all these police officers at one time or another. (Final Report. p.40)*

> *In all these cities, public environment sex was very rapid, leading to discharge in a few minutes. Such a [method] involving anal penetration ….. led to several kothis speaking of anal bleeding and pain. Combined with a lack of sexual knowledge, low condom usage, low access to treatment, no access to an appropriate water-based lubricant, this type of sexual practice created high risks for STI/HIV transmission. (Final Report. p.40)*

There was an attempt to identify the number of separate sites in each city where males looking for sex with other males meet. These are reported as:

Hyderabad: 92+
Bangalore: 65+
Pondicherrry: 16+
Sylhet: 28+

6.1.4 Male sex work

A large number of the khotis, on average 40% across the four cities, reported selling sex as a consequence of poverty. A smaller proportion described themselves as a “male sex worker”. Frequency of sexual transactions ranged from once per week to ten clients in one day. Khotis reported that receptive anal sex was the most common request, although they were occasionally asked to penetrate the client.

> *Sylhet has a high level of unemployment, and even many who do have work, have a low income. This has led to many kothis to sell sex. Poverty was .. in some cases extreme. For many kothis, living conditions were very poor, with hygiene, food, clean water, and adequate shelter very problematic. The urgency of survival was clearly visible and painful. (Final Report p.40)*

Though not studied in the assessments there were anecdotal reports of middle class “gay” sex workers. They were described as seeking greater consumer purchasing power and retaining a masculine identity.

Of the 200 respondents in each city 62 reported being paid for sex in Hyderabad, 60 in Bangalore, 72 in Pondicherry and 56 in Sylhet. The number of paid sex acts by all of these males in the previous month totalled 10,493.

The average number of paid sex acts in the previous month per respondent who was paid for sex was approximately 40 in Hyderabad, 20 in Bangalore, 17 in Pondicherry and 106 in Sylhet. Around 52%-54% of these acts in each city involved receptive anal sex.

Condom usage in the most recent 5 paid sex acts was reported as "never" by 40% in Hyderabad, 34% in Bangalore, 92% in Pondicherry and 52% in Sylhet. It was reported as "all times" by 12% in Hyderabad, 27% in Bangalore, 1% in Pondicherry and 9% in Sylhet.

[Please see Annex 1 Data: 3A, 3B, 3C, 3D,3E,3F, 4A, 4B, 4C, 4D]

6.1.5 Marriage and female partners of males who have sex with males

Most of the respondents in the assessments reported they were married or would have to marry at sometime in the future. At the time of the assessment in Hyderabad 25% were already married, in Bangalore 30%, in Pondicherry 26% and in Sylhet 22%.

> *marriage is a social, cultural and religious necessity, a central issue within people's lives and a mainstay of family and community life...Marital status signifies adulthood, social responsibility…The majority of kothis and their sex partners…accepted the social necessity of compulsory marriage…There appeared to be a fatalism operating here, and a sense of not being able to challenge family and society's strictures.*
> *(Final Report p.9)*

> *The central objective of marriage is the production of children, specifically male children … Sex with ones wife is often seen as a duty, rather than as pleasure. The statement "I do duty to my wife" is quite common, meaning I have sex with my wife. Also asking one's wife to perform certain sexual acts, such as oral sex or anal sex becomes shameful. She is the vessel of one's children. ..this often lead to a concept of sexual pleasure of men as only available outside of marriage. Others would be asked to perform sex acts that could not be asked of a wife. (Final Report. p.41)*

Assessment respondents reported quite high levels of sexual activity with their wives. In Bangalore and Hyderabad a majority of males reported 11 – 20+ sexual interactions with their wives in the previous month. In Pondicherry the level was 29%. Some males reported that they had expected when they married that their sexual interactions with males might stop or decline. However, most reported that for various reasons they still wanted to, and did, have sex with other males.

If you add estimates of the numbers of wives and female sex partners of these males who have sex with males to the "guesstimates" of amount of male to male sex listed in section 6.1.2 above then you have identified a very large number of the sexually active adults in any of the four cities.

This is part of the scenario that the assessments argue in terms of male to male sex having a greater significance in HIV/STI transmission than is currently acknowledged.

[Please see Annex 1 Data: 5A, 5B, 5C, 5D]

6.1.6 Family and religion

Respondents reported family ties and obligations as very important. The family is seen as a mutual support system.

> *Both Hindus and Muslims expressed similar sentiments about family and social expectations, of performing as men, fulfilling duties, maintaining family honour, of*

> *marrying and producing children, particularly sons. Choice of marriage partner was still seen as a parental duty, and separation from the family as not an option.*
> *(Final Report p.9)*

The assessments did not directly ask questions about the influence of religion but it was raised as an issue by respondents. They could not name specific parts of Hindu or Islamic texts that prohibited sex between males but they had a general feeling that their religion condemned this behaviour. This added to feelings of shame and exclusion.

> *All those interviewed professed affiliation to a specific religious tradition [and] accepted their specific religious traditions. None could conceive anything else…….Yet these respondents found ways to balance their sexual practices, identities and desires within the context of being a Hindu or a Muslim, or a Christian. Whilst many of those who identified as kothi would speak of shame, guilt, dishonour, they also believed that what they were, who they were, and what they did, was between themselves and God. Religious belief was still important to them and a central part of their self definition. (Final Report. p.46)*

The family and religious organisations are critical social institutions that can affect these males' self-esteem and through that their vulnerability and risk-taking behaviours in regard to HIV /STIs.

6.1.7 Psycho-sexual issues

In the assessment reports these issues are seen mainly as the myths, beliefs and practices that result from lack of knowledge and that produce considerable psychological disturbance about sexual matters. These include issues such as masturbation, penis size and shape and virility.

The other major issue raised through the assessments relates to the very high levels of shame and stigma that some males face surrounding their desire, identity and behaviour. This is known from studies in other countries to contribute significantly to low self-esteem and higher levels of risk-taking behaviour. (source) While this link is not directly demonstrated in these reports it appears highly likely and would benefit from further detailed behavioural research.

6.1.8 Injecting drug use among males who have sex with male

This was not a direct focus of the assessments. However, 9% of respondents in the three cities in India reported injecting drugs at least once in the previous 12 months.

6.2 HIV / STI vulnerability and risk taking

The greatest vulnerability and level of risk taking identified in the assessments was for lower-income khotis who sold sex. The factors leading to this conclusion included:

- low self-esteem;
- low income;
- low education;
- high frequency of receptive anal sex;
- high frequency of partners;
- access to partners from a broad social range;
- very limited condom use;
- limited access to information; and

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- limited access to sexual health diagnosis and treatment.

Their panthi partners were at some level of risk as well, given their desire for penetrative anal sex and a disinclination to use condoms.

The female partners of both the khotis and panthis were assumed by the investigators to be highly vulnerable because in most cases they did not know of their partners male sex experiences. The social need to produce children and to hide the sex with males meant that condoms were not widely used within marriage.

"Gay" identified men were assumed in the assessments to be less vulnerable because of higher self-esteem, greater access to information, greater access to social support, lower levels of receptive anal sex, selection of partners from a more limited social range and ability to purchase condoms. This was not fully confirmed in the assessments and requires further investigation.

[Please see Annex 1 Data: 9A, 9B, 9C, 9D, 9E, 10A, 10B, 10C, 10D, 10E, 10F]

6.3 Signs and symptoms of STIs

Respondents in Hyderabad and Sylhet reported higher levels of anal bleeding, anal and penile discharge, genital sores and a variety of other symptoms. The Principal Investigator notes that the lower levels reported in Bangalore and Pondicherry might be the result of poor data collection.

Male sex workers reported higher levels of symptoms than other respondents.

The assessment did not capture the total numbers of respondents that reported any symptoms at all. However, it would appear that an estimate of a minimum number of respondents in each site reporting at least one symptom of anal or penile discomfort, discharge or pain would be 37% in Hyderabad, 10% in Bangalore, 31% in Pondicherry and 60% in Sylhet.

[OPTION: insert: 6A, 6B]

6.4 Health seeking behaviours and access to services

6.4.1 Health seeking behaviours

> *Accessing adequate STD care is very difficult for the poor and uneducated within these networks. Embarrassment and lack of money, coupled with providers' ignorance of … sexual practices [of males who have sex with males] and the lack of a syndromic algorithm for anal STIs adds up to poor treatment and continuing infection.*
> *(Final Report p.50)*

Over 60% of respondents in Hyderabad, Bangalore and Sylhet reported neither accessing treatment from a doctor nor accessing drugs at a pharmacy. In Pondicherry the figure was 37%. Only around 27% - 31% of respondents reporting attending a government hospital clinic. Respondents accessing a private clinic was reported in Hyderabad at 20%, in Bangalore at 7%, in Pondicherry at 35% and in Sylhet at 9%.

6.4.2 Access to information and support

> *Sex education was absent amongst the participants in the Assessment. Knowledge of the male and female bodies, of reproduction, of the sex organs was almost non-existent. What did exist was gained from friends, pornographic videos, and magazines … many men had no idea how babies are conceived, developed in the womb, or even*

> *born … the lack of knowledge of their own and female bodies led to a range of risky practices, such as rapid discharge, or anal bleeding, achieved through dry and rapid penetrative acts. (Final Report. p.44)*

The assessments found that only in one of the four cities was there any structured or systematic HIV prevention program for any males having sex with males. This was in Hyderabad, operated by a "gay" organisation and was reported as tending to reach out mainly to gay identified males.

Despite this the assessments found that the level of knowledge about HIV was relatively high, with a range from 85% in Bangalore to 57% in Pondicherry having heard of "AIDS" and an average of around 63% able to identify unprotected vaginal or anal sex as risky. However, the level of risk-taking that was also reported indicated that the knowledge was not being converted into sustained behaviour change.

6.4.3 Access to condoms and lubricant

> *'The significant levels of shame felt by kothis as well as other [males who have sex with males] … reduced their ability to purchase condoms at local shops or attend STI treatment centres". (Finale Report. p.40)*

Stronger condoms that are suitable for anal sex were not found in the four cities taking part in the assessments. Water based lubricant was only available in large quantities at a relatively high price.

Respondents reported an average of 30% for condom usage in penetrative sex with only a very small number reporting 100% condom use. Reasons given included cost, stigma and shame and the fact that they or their partner was not sick. Saliva was often used for condom lubrication and use of oil-based lubricants was also reported.

6.4.4 HIV antibody testing

Numbers of respondents who had had an HIV antibody test were very low. In Hyderabad 25 out of 200 respondents had had a test and 1 was HIV positive. In Bangalore 38 out of 200 respondents had had a test and 6 were HIV positive. In Pondicherry 4 out of 200 had had a test and 1 was HIV positive. No respondents in Sylhet had had a test.

While there is no suggestion that these figures are representative of all males who have sex with males or taken from any kind of random sample they are cause for concern. The figures in Bangalore and Pondicherry in particular, if reflected in larger samples, are extremely high.

The assessment reports do not directly comment on the quality or confidentiality of available HIV testing facilities. Nor do they comment on reasons why people may not have had an HIV antibody test. However, the comments about the generally poor quality of sexual health service delivery for males who have sex with males, the generally poor health seeking behaviours described by respondents and the issues around stigma and shame suggest the services may not be appropriately designed or delivered.

6.5 HIV prevention policy and programming

In meetings with various stakeholders during the assessment process the Principal Investigator found that most government and non-government agencies had some level of knowledge that sex between males was an issue that had to be integrated into sexual health policy and programming. However, at this stage there was a lack of detailed knowledge and understanding about how to go about this effectively.

> *Too often these discussion demonstrated a "Western" preoccupation on a heterosexual/homosexual [dichotomy] ... The concept of a polymorphous sexual behaviour within which gendered identities operate was not clearly perceived or understood. …. since the construction of intervention strategies and prevalence data focus on heterosexual or homosexual transmission, this is understandable. But this framing of male to male sexual behaviours creates many barriers to the development of appropriate and effective sexual health services for [males who have sex with males]. (Final Report. p.12)*

More worryingly he found that the level of preparedness of sexual health diagnosis and treatment facilities to address adequately the sexual health needs of males who have sex with males was very low. Limited knowledge, negative attitudes towards khotis and towards anal sex, together with the absence of protocols for diagnosis and treatment of anal STIs, were the major concerns identified.

7. CONCLUSION

The information presented in the reports make a substantial and valuable contribution to the growing body of knowledge about the sexual health of males who have sex with males in South Asian countries. They provide very useful qualitative and initial quantitative data that highlight these males' vulnerability to, and risk taking behaviours for, HIV/STIs.

The analysis of this information makes a powerful case for governments, donors and a range of other stakeholders to take more seriously the role that male to male sex plays in HIV/STI transmission in South Asian countries.

It also calls for a range of stakeholders to strengthen their capacity to understand and respond to the sexual health needs of these males and to pay greater attention to the vulnerability and the sexual health needs of their female partners.

The findings highlight a challenge that faces public health authorities and community workers. This concerns the gap between the knowledge that these males have of their HIV/STI vulnerability and risk taking and their inability to reduce that vulnerability or adopt new, less risky behaviours.

In responding to this challenge strong arguments are presented in the reports for greater support for community-based responses to sexual health needs of these males, developed in collaboration with government and donors.

The reports highlight the vulnerability and risk-taking behaviours of a particular group of males who have sex with males and raise questions about the inadequate allocation of financial and technical resources to respond to the sexual health needs of those males. While doing this they also advocate for response to the sexual health needs of all males who have sex with males.

Finally, the assessment reports make a large number of constructive and specific recommendations that are very useful in assisting people who make policy, design programs and deliver services to respond more effectively to the sexual health needs of males who have sex with males.

These are summarised below. Readers should refer to the full reports for the detailed recommendations.

8. SUMMARY OF RECOMMENDATIONS MADE IN THE SITUATIONAL ASSESSMENT REPORTS

8.1 The overarching recommendation is that:

As an urgent priority all sexual health policy, programming and service delivery should address issues related to the sexual health of males who have sex with other males.

8.2 To ensure this is done effectively the assessment reports recommend that all relevant agencies:

Assist in developing an enabling social environment as an essential step towards minimising the exclusion and stigmatisation of males who have sex with males;

Support further behavioural research to strengthen understanding of the diversity of male to male sex in South Asia and particularly to identify patterns of HIV / STI vulnerability and risk taking;

Provide adequate levels of funding and technical assistance to develop community-based sexual health promotion programs run by and for males who have sex with males;

Facilitate the provision and social marketing of condoms that are appropriate for anal sex and water-based lubricant at affordable prices;

Facilitate the development of appropriate and accessible STI and HIV treatment services for males who have sex with males;

8.3 Specific recommendations made in the assessment reports are grouped in the following categories:

8.3.1 Behavioural and anthropological research

The assessment reports recommend that research is done in the areas of:

- The construction of masculinity/ies and male sexual behaviours with a focus on male to male sexual behaviours;
- STI prevalence amongst males who have sex with males with a focus on anal STIs; and
- Issues related to female partners of males who have sex with males, including wives, and focusing on STI/HIV.

8.3.2 Developing community-based AIDS service organisations by and for males who have sex with males

In recommending support for the development of community-based programming the assessment reports focus on:

- empowering local networks of kothis to implement and manage these programs;
- providing these programs with appropriate funding and technical assistance to build capacity in: a) infrastructure development; b) project management; c) financial management and accountability; d) service design and delivery; e) monitoring and evaluation;
- ensuring availability of sufficient affordable, high quality condoms and water-based lubricant including social marketing and free distribution;

- creating psycho-social support services including: a) telephone lines ("hotlines") providing free and anonymous advice and information; b) social support groups; and c) sexual health discussion groups;
- developing effective and supportive relationships with the local police;
- encourage mainstream NGOs sexual health services to include anal sex and male to male sex in their safer sex promotion programs;
- consultation taking place between community-based male sexual health service agencies and the national and state level government sexual health management agencies; and
- ensuring sustainability and continuity of community-based male sexual health services.

8.3.3 Education and prevention

In recommending that more attention is given to addressing the HIV and STI education and prevention needs of males who have sex with males the assessment reports suggest:

- that governments should implement appropriate and accurate sex education programs in the formal and informal education sectors;
- the design and implementation of public education campaigns that de-stigmatise the public discussion of sexual behaviours;
- the development and wide distribution of a range of educational resources describing the sexual practices of males who have sex with males, including anal sex, and specifically targeting differing social, economic and behavioural groups;
- educating all health and social care workers with regard to prevention, counselling and related issues on HIV/AIDS;
- developing educational resources that cater for those who are not literate.

8.3.4 Condoms and lubricant

Recommendations focus on:

- ensuring availability of affordable and accessible condoms suitable for anal sex;
- ensuring availability of affordable, easy to carry and use water-based lubricant; and
- ensuring that all sexual health education programs include the correct use of condoms.

8.3.5 STI services

Recommendations focus on:

- encouraging community-based agency to operate their own STD treatment service to ensure confidentiality, safety, acceptance and accessibility;
- provision of subsidised HIV/STI treatment for those who cannot afford it;
- provision of training for all STI service staff about issues related to the sexual health of males who have sex with other males; and
- ensuring confidentiality and anonymity for males accessing public and private sexual health services.

8.3.6 Sexual health of female partners of males who have sex with males

Recommendations focus on:

- developing appropriate strategies to address the sexual health needs of wives and other female partners of males who have sex with males; and
- ensuring that women's sexual health programs address issues of anal sex between males and females.

8.3.7 Psycho-sexual counselling

The assessments have one main recommendation that:

- all sexual health centres have available trained counsellors who can offer non-judgmental, appropriate and accurate advice, information and support about sex, sexuality and particularly issues related to male to male sex.

6.3.8 The role of governments and donors

The assessments see a critical role for government and recommend that government agencies:

- should ensure that the appropriate recommendations listed above are implemented;
- should review and amend laws, regulations and policies that stop males who have sex with males accessing sexual health services, or discriminate against them through intimidation, fear, harassment, violence, denial or the risk of imprisonment.
- should provide training for all health care workers, police and the judiciary on issues regarding males who have sex with males and their sexual health.
- should develop and/or support advocacy programs for males who have sex with males to ensure their individual human rights are being respected, and that those who are harassed or violently abused can seek legal redress.
- play a lead role in encouraging and enabling the development of a peer-led community-based AIDS service organisation by investing in, and empowering them, to deliver appropriate STI/HIV prevention and sexual health services for males who have sex with males including provision of:
- long term financial support
- technical assistance
- capacity-building
- legal and regulatory support

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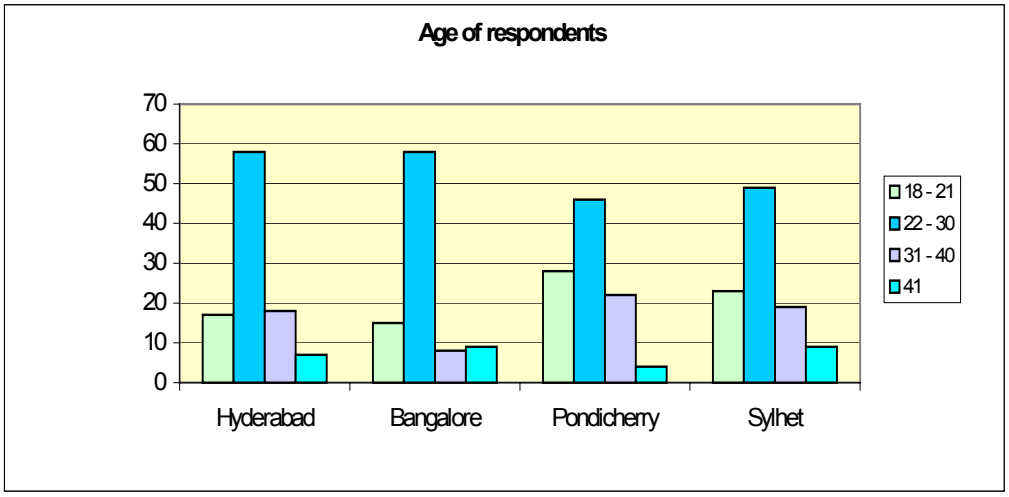
Annex 1

The data

1. Profile of respondents

1A *Age*



Situational assessments undertaken by Naz Foundation International, funded by FHI/Asia.
Paper prepared for publication by JSI UK, funded by DFID India.

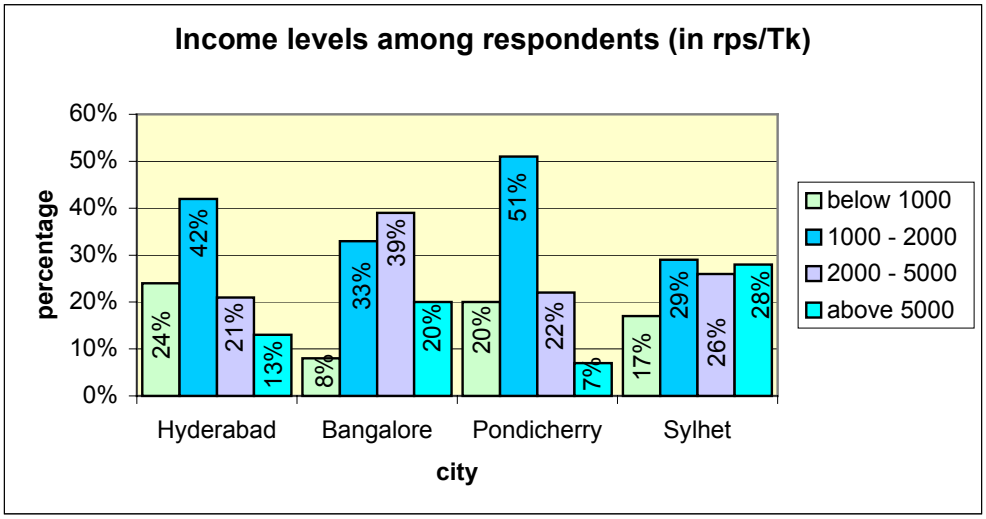
1B ***Marital Status***

	Hyderabad	*Bangalore*	*Pondicherry*	*Sylhet*
Un-married	75%	70%	74%	78%
Married	25%	30%	26%	22%

1C ***Employment***

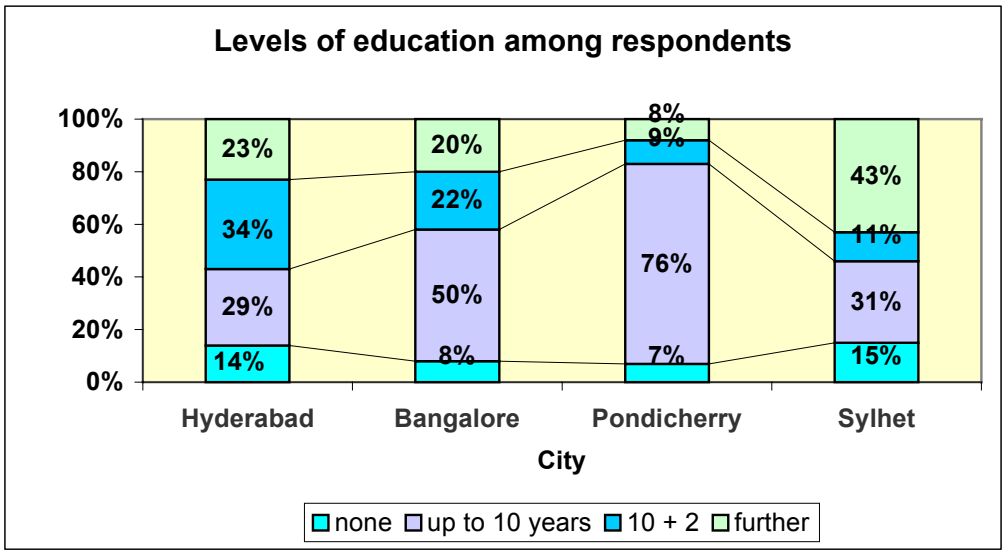
	Hyderabad	*Bangalore*	*Pondicherry*	*Sylhet*
Employed	57%	72%	74%	84%
Un-employed	43%	28%	26%	16%

1D ***Income (in Rps/Tk)***



Situational assessments undertaken by Naz Foundation International, funded by FHI/Asia.
Paper prepared for publication by JSI UK, funded by DFID India.

1E ***Education***



1F ***Self labelling***

	Hyderabad	*Bangalore*	*Pondicherry*	*Sylhet*
Kothi	52%	36%	64%	68%
Panthi	15%	11%	12%	24%
Double-decker	15%	42%	19%	5%
Heterosexual	1%	2%	4%	1%
Homosexual/ Gay	15%	8%	1%	-
Other	2%	1%	-	2%

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