

**UNDERSTANDING MEN WHO HAVE SEX WITH MEN (MSM) AND HIJRAS
&
PROVIDING HIV/STI RISK-REDUCTION INFORMATION**

Handbook for Clinicians & Counselors in Sexual health/STI/HIV

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Two gay Englishmen once came to Gandhi – - this was in the 1930's --- and asked him what he thought about their relationship. After questioning them a bit, Gandhi fell silent for a short time, and then said, "The greatest gift that God gives us is another person to love." Placing the two men's hands in each other's, he then quietly asked, 'Who are we to question God's choices?'"

(From 'Tackling gay issues in schools'. A resource module edited by Leif Mitchell. GLSEN Connecticut. 1999. II edition.)

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(The following articles have to be read along with this handbook. These articles will be given as separate handouts.

- Stigma and Discrimination faced by Hijras in the Indian health care system
- Answers to your questions on homosexuality and sexual orientation)

ABBREVIATIONS

AIDS - Acquired Immunodeficiency Syndrome

CBOs - Community-Based Organizations

HIV - Human Immunodeficiency Virus

IPC - Indian Penal Code

GLBT – Gay, Lesbian, Bisexual, Transgender

HCP - Health care providers

MSM - Men who have Sex with Men

NACO - National AIDS Control Organization [India]

NGOs - NonGovernmental Organizations

SRS – Sex Reassignment Surgery

STDs - Sexually Transmitted Diseases

STIs - Sexually Transmitted Infections*

*The World Health Organization recommends that the term ‘sexually transmitted disease (STD)’ be replaced by the term ‘sexually transmitted infection (STI)’. The term sexually transmitted infections has been adopted as it better incorporates asymptomatic infections.

Purpose of this handbook

Often health care providers rarely had the opportunity to understand the sexual diversities and to be educated about the health issues of sexual minorities. Keeping that in mind, this manual has been compiled to provide basic but essential information on men who have sex with men (MSM) and Hijras in India. This handbook is expected to increase the knowledge and enhance the skills of doctors/counselors on the health issues of sexual minorities that will ultimately lead to improvement in the quality of services available to MSM and Hijras in the clinical and counseling settings.

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INTRODUCTION

Health care providers are concerned about their clients' behaviors. They want to know whether their clients are having any health risks and how to minimize those risks. For example: in helping people reduce their risk for sexually transmitted infections/HIV. In dealing with sexuality, health care providers need to understand that sexual orientation, sexual behavior, gender expression, and sexual identity are all separate entities, may be fluid over time, and might overlap in different ways for various persons.

In assessing risk of men for HIV infection it is not enough to ask same-sex behavior in only those men who show some feminine mannerisms. A male who has some feminine mannerisms can have any sexual orientation and also any kind of sexual behavior. Also, those who self-identity as 'gay' may have bisexual behavior. Therefore, it is important to discuss the range of behaviors with people of any sexual or gender identity and ask questions about same-sex/bisexual behavior regardless of gender expression. It is equally important to know about the sexual orientation and sexual identity of patients so as to provide holistic and comprehensive care to them. Also, we need to accept the gender identity chosen by some of our clients though their biological sex may not be congruent with their gender identity or gender expression.

In this handbook, detailed information on the above issues are given to enable doctors, counselors and other health care providers to provide appropriate and effective risk-reduction counseling for clients who are men who have sex with men (MSM) or Hijras.

SECTION-A: UNDERSTANDING MEN WHO HAVE SEX WITH MEN (MSM) & HIJRAS

1. DEFINITIONS OF SEXUALITY-RELATED TERMS

The definitions of the words given below are *not standardized* and are used differently by different individuals and in different parts of the world. The meanings of words also change over time. Concepts and attitudes toward gender identity and sexual identity are changing in the society as a whole, as well as within the sexual minority communities. Therefore, the meanings of these words will continue to change as well. (Most of the ‘definitions’ are adapted from the websites - www.siecus.org, www.biresource.org and www.gendertalk.com)

Male/Female: An individual’s biological status as male or female. Hence the term ‘male’ denotes individuals who are born with male genitalia and ‘female’ refers to individuals born with female genitalia.

Man: A term referring to someone who identifies as a man, who may often exhibit masculine characteristics (see *masculine* and *male*). Popularly understood within a binary gender system to refer to someone who is male-bodied. (Note: In this manual, the term ‘man’ is used to denote the masculine gender while ‘male’ denotes an individual’s biological status)

Masculine: An often ambiguous term that refers to self-expression, actions, behaviors, dress, grooming, adornment, and speech popularly associated with someone who is male-bodied within a binary gender system. People of any gender can self-identify as masculine or as having masculine characteristics.

Feminine: An often ambiguous term that refers to self-expression, actions, behaviors, dress, grooming, adornment and speech popularly associated with someone who is female-bodied within a binary gender system. People of any gender can self-identify as feminine or as having feminine characteristics.

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. This is because a man may have sex with other men but still considers himself to be a heterosexual or may not have any specific sexual identity at all. This term, coined by public health experts, focuses exclusively on behavior for the purpose of HIV/STD prevention.

Males who have sex with Males (MSM): This is used as an umbrella term under which all biological males who have sex with other males are included, regardless of their sexual/gender identity. Thus it includes transgender/transsexual (male to female) persons since they are actually biological males.

Note: Some transgender/transsexual persons (male to female) do not want to be included under this term. To denote such persons, a term “*Transgender persons who have Sex with Men*” (TSM) has been coined but is not widely used.

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.

Lesbian/Lesbian woman: A girl or woman 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 lesbian community. In India, this term is sometimes used to indicate bisexual women also.

Heterosexual or Straight (n., adj.): 1. Sexual or romantic behavior between a member of one sex and a member of another gender or sex. 2. One whose significant (to oneself) sexual or romantic attractions are primarily to members of the opposite gender or sex.

Homosexual (n., adj.): Individual with a primary sexual and affectional orientation or emotional attraction toward persons of the same sex. Male homosexuals are often referred to as 'gay', where as female homosexuals are referred to as 'lesbians'. A term often viewed as negative, overly clinical, or disempowering by gays, lesbians, bisexuals and transgender persons. (Note: The word 'homosexual' is most often used as a label and it is less often used as an identity. This term is sometimes considered derogatory and not preferred by persons with same-sex behavior)

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.

Gay community: The group of people who are open enough about their erotic attractions/sexual behavior towards persons of same gender/sex that they identify as members of the gay community.

These days, the terms '*Gay communities*' or '*Gay populations*' are used to stress that, these communities or populations are very diverse.

Bi(sexual) community n.: The group of people who are conscious of their erotic attractions/sexual behavior towards persons of either gender/sex or who identify as members of the bisexual community. One may identify as bisexual without identifying with the bisexual community.

MSM population(s): This term is used to denote the population of men who have sex with men who may or may not have 'gay, bisexual or any other sexual identity'. The term '*MSM populations*' is used to stress that, these populations are diverse.

GLBT - acronym for Gay, Lesbian, Bisexual and Transgender; sometimes as LGBT

GLBT community: This represents the community of **G**ays, **L**esbians, **B**isexuals and **T**ransgender/transsexual persons. These groups often jointly fight against discrimination and stigmatization based on one's sexual orientation and/or gender identity and thus identify as a common community. Also used as a term to denote the entire community of sexual minorities irrespective of identities. These days, the terms '*GLBT communities*' or '*GLBT populations*' are used to stress that, these communities or populations are diverse.

Sex: 1. A term used historically and within the medical field to identify genetic/biological/hormonal/physical characteristics, including genitalia, which are used to classify an individual as female, male, or intersex person. 2. A person's biological or anatomical identity as male, female or intersex person. 3. Activity engaged in by oneself, with another, or others to express physical attractions, satisfy desires, and/or to express love. (also see *sexuality, sexual behavior*)

Sexuality: Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. Its dimensions include the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles and personality; thoughts, feelings, and relationships. The expression of sexuality is influenced by ethical, spiritual, cultural, and moral concerns.

Same-sex sexuality: Currently, this term is being used as an alternative to the term 'homosexuality' (though some would like to use only this term instead of the term 'homosexuality'). Similarly, the term 'homosexual behavior' is being replaced by the terms - same-sex behavior, same-sex sexual behavior, and same-gender sexual behavior.

Sexual Orientation. One's erotic, romantic, and affectional attraction. It could be to people of the same sex, to the opposite sex, or to both sexes.

Heterosexuality. Erotic, romantic, and affectional attraction to people of the opposite sex.

Bisexuality. Erotic, romantic, and affectional attraction to people of both sexes.

Homosexuality. Erotic, romantic, and affectional attraction to people of the same sex.

[Neither the term heterosexuality nor the term homosexuality existed before 1890. The terms 'homosexual' and 'homosexuality' may have the connotation that same gender attractions are a mental disorder (medical term: homophilia), and are therefore distasteful to some people. Also see - *Same-sex sexuality*]

Prejudice: A negative judgement of a group and its individual members.

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.

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

Homophobia (n.): [Gr. homo (man) + phobia (fear).] 1. An irrational hatred and fear of LGBT people that is produced by institutionalized biases in a society or culture. 2. A term for all aspects of the oppression of LGBT people. (See *heterosexism, biphobia*.)

Biphobia (n): The oppression or mistreatment of bisexuals, either by heterosexuals (often called homophobia if it does not target bisexuals separately from lesbians and gay men), or by lesbians or gay men.

Internalized homophobia/biphobia (n.): The internalized oppression of LGBT people. This includes the often-conflicting feelings that we are bad at the core; that the entire world is unsafe, that we can only trust other members of our own group; that members of our group are untrustworthy; that for safety we must stay in hiding; that for safety we must not come out everywhere, all the time, that our love is bad, or is not the same as other people's love.

Transphobia (also genderphobia): The irrational fear or hatred of those who are perceived to break or blur stereotypical gender roles. Expressed as negative feelings, attitudes, actions, and institutional discrimination. Often directed at those perceived as expressing or presenting their gender in a transgressive way, defying stereotypical gender norms, or who are perceived to exhibit “non-heterosexual” characteristics - regardless of individuals’ actual gender identity or sexual orientation. (Also see - *homophobia*.)

Sexism: 1) an individual’s prejudicial attitudes and discriminatory behavior toward people of a given sex, or 2) institutional practices that subordinate people of a given sex.

Heterosexism/ist (n): The oppression of LGBT people. The assumptions that identifying as heterosexual and having sexual and romantic attractions only to members of another gender or sex is the only good and desirable orientation, that other sexual identities and attractions are bad and unacceptable, and that anyone whose sexual identity is not known must be heterosexual. Usually coupled with both unconscious and willful “blindness” to the existence and concerns of LGBT people (Also see - *homophobia, biphobia*). A heterosexist is one who practices heterosexism.

Stereotype: A simplistic generalization about the personal attributes of a group of people. Stereotypes lump a diverse group of individuals into one category – thus they are often inaccurate and resist new information.

Identity: How one sees and categorizes of oneself, as opposed to what others observe or categorize.

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.

Gender n.: One's personal, social, and/or legal status as a male or female. Words that describe gender are feminine and masculine.

Gender role: How one appears/behaves in relation to social/cultural expectations or perceptions of how a man or woman should look/ behave (i.e., how “masculine” or “feminine” an individual should act.) (Also see - *Gender-variant*).

Gender-variant: Displaying gender traits that are normatively more typical of the opposite biological sex. “Feminine” behavior or appearance in men is gender-variant as is “masculine” behavior or appearance in women. Gender-variant behavior is culturally specific (Also see - *Gender role*).

Gender expression or Gender statement: The public expression/statement of one's gender identity. Gender expression/statement is external or socially perceived. It refers to all of the external characteristics and behaviors that are socially defined as either masculine or feminine, such as dress, mannerisms, speech patterns and social interactions.

Gender identity n.: Person's internal, deeply felt sense of being either man or woman, or something other or in between. Gender identity does not always match biological sex; for example, a person may be born biologically male yet identify as a woman. Because gender identity is internal and personally defined, it is not visible to others. In contrast, a person's “gender expression” is external and socially perceived.

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*’).

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 “n-between man and woman”, or “neither man nor woman”. There are no valid data to state how many intersex persons ('hermaphrodites') are living in the Hijra community but they are likely to be extremely

rare. While some consider Hijras as crossdressed homosexuals, they would be more accurately labeled as transgender/transsexual (male-to-female) persons.

Aravanis: In Tamil Nadu, Hijras are called as Aravanis. The term 'Aravani' is recently coined by Hijra activists in Tamil Nadu to replace the derogatory word 'Ali'.

Kothi: Kothis are a heterogenous group. 'Kothis' can be defined as males who show obvious feminine mannerisms and who are involved mainly, if not only, in receptive anal/oral intercourse with men. A significant proportion of Kothis have bisexual behavior and many also eventually get married to a woman. In addition to these feminine homosexual males, most Hijras also primarily identify themselves as 'Kothis'.

Panthi: The term 'Panthi' is used by Kothis/Hijras to refer to those persons whom they consider to be 'real men' - in the sense those who only penetrate.

Intersex persons (Formerly called as '*hermaphrodites*'): "Intersex" is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male. For example, a person might be born appearing to be female on the outside, but having mostly male-typical anatomy on the inside. Or a person may be born with genitals that seem to be in-between the usual male and female types--for example, a girl may be born with a noticeably large clitoris, or lacking a vaginal opening (From <http://www.isna.org/faq>)

Eunuchs: In India, this term is sometimes, incorrectly, used to denote Hijras (who come under transgender/transsexual category). Originally, this term is supposed to have referred to males who have undergone castration not by choice, but by accident, coercion or as a punishment. Hence it is not technically correct to refer Hijras as 'Eunuchs'. E.g., In ancient times, some males were castrated to serve as guards in royal harems. Hijras voluntarily remove their male external genitalia (emasculatation) – both testes and penis. (Note: Castration refers to removal of testes and not the entire male external genitalia)

Sexual minorities or Sexuality minorities: Refers to lesbian, gay, bisexual and transgender/transsexual persons as well as persons with other identities (such as Kothis and Hijras) as a minority group in a predominantly heterosexual total population.

“Come out”(of the closet/“to be out”): 1. To disclose one's own sexual identity to another person. [“I came out to my mother”] 2. (come out to oneself) To discover that one's own sexual identity is different than one previously assumed. [“I came out to myself three months ago”.] 3. To be open about and deal with one's own and others' reactions to the discovery or disclosure of one's sexual identity. [“I am out to my mother”.] [I am out at work.] 4. Opposite of “to be closeted” (when an individual chooses to keep his/her sexual orientation private)

“To be outed”: When a person’s sexual orientation or sexual identity is told to anyone else without his/her consent (“She was outed by that article that failed to change her real name before going to press”)

2. BARRIERS TO HEALTH CARE FOR MSM AND HIJRAS

Many people in our country lack access to quality health care services for various reasons. Men who have sex with men (MSM) and transsexuals face unique barriers when accessing public or private care offered by health care providers (HCP) in India.

Some of these include:

- Fear of bias or prejudice from the HCP
- Past negative experiences from HCP after revealing same-sex behavior.
- Homophobia/biphobia/transphobia from HCP
- Refusal to treat or providing substandard care of persons who revealed their same-sex behavior to HCP
- HCP trying to ‘cure’ same-sex attracted persons from ‘homosexuality’
- Pathologizing of same-sex/bisexual orientation by HCP
- Low self-esteem among the GLBT patients
- Heterosexual assumptions on medical forms and in providing medical information on sexual and reproductive health
- Gender assumptions on medical forms and not thinking about persons who could be transgender/transsexuals.
- Concerns about breach of confidentiality
- Fear of being ‘outed’ to others
- MSM and Hijras stigmatized as ‘risk- groups’ and for spreading HIV infection in to the ‘general population’.
- Refusal to treat or lack of knowledge about how to treat transgender persons who request hormone therapy or sex change operations.
- Exclusion from health promotion campaigns including STD/HIV public awareness programs

Homophobia in Health care

Homophobic incidents can range from an offhand remark to a colleague to refusal of care or provision of substandard care to a GLBT patient. Some incidents might have been witnessed, some overheard and some could be presumed to happen in health care settings.

The following are some examples:

- A physician commenting “...homosexual men should not be given medical treatment since they are criminals...”
- A nurse while giving injection to a homosexual man says, “these injections are punishment for having indulged in bad sex”
- To a patient who has hesitation in showing his anal area for examination, the physician says, “Where was this shyness when you had sex with another man? Don’t act smart and show me your back right now”

The above examples are actual anecdotes reported by men who have sex with men (MSM) and transsexuals.

Stigma and discrimination

a. 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.

b. Discrimination ("enacted" stigma):

Unjustifiable negative behavior toward a group or its members that singles them out because they are believed to be inherently ‘bad’.

c. Overt discrimination:

Discrimination by ‘act of commission’ (“by doing”) in the health care system.

- Abuses/Violence – verbal, physical or sexual
- Denial of care once sexual behavior or orientation is known
- Provision of suboptimal care after knowing the sexual behavior/orientation or gender identity/expression

d. Discrimination faced by Hijras:

- Deliberate use of male pronouns in addressing them
- Enrolling them as ‘males’ and admitting in male wards
- Verbal harassment by the hospital staff and co-patients
- Denial of sex reassignment surgery and hormonal therapy in the public hospitals.

e. Covert/Hidden Discrimination:

This is mainly ‘discrimination by omission’ (“not doing”).

Examples:

- not asking about same-sex/bisexual behavior in sexual history
- not involving steady partners in treatment decision-making

3. What the NGOs/CBOs can do to improve access to health care of sexual minorities?

- Build the capacity of NGO staff to effectively deal with the concerns and issues of MSM & Hijras.
- Address same-sex/bisexual behavior in the prevention and care programs of the NGOs.
- Conduct ongoing documentation of stigma and discrimination and use of that information as an advocacy tool. Documentation of best practices and innovative strategies in decreasing stigma and discrimination.
- Do advocacy with the local health management team of hospitals – to organize sensitization/training programs and to have non-discriminatory policies
- Advocate with the state Directorate of Medical Education and Medical University management to include the health issues of sexual minorities in the medical curriculum

- Advocate with the local branches of professional organizations to conduct sensitization programs for health care providers in their constituencies
- Educate the health care providers in one-to-one encounters in an appropriate manner
- Organize sensitization programs for health care providers by themselves or with the help of community-friendly agencies or health care providers.
- Advocate for the formulation of a national health strategy (especially sexual health/HIV) for the sexual minorities – in consultation with the community groups.

3. "INDIAN" IDENTITIES, LABELS AND SEXUAL BEHAVIOR

This is the revised version of a section from the background document: *Venkatesan Chakrapani, Ashok Row Kavi, L Ramki Ramakrishnan, et al. HIV Prevention among Men who have Sex with Men (MSM) in India: Review of Current Scenario and Recommendations*. April 2002. (www.indianGLBThealth.info)

The following description of 'identities'/'labels' are based on informal discussions and in-depth interviews with individual persons with different identities, and informal group discussions with persons with different identities (especially those in Chennai) by the first author. Thus, the following discussion represents the current views on some of the "Indian identities". If any person feels that a particular identity has been misrepresented or vital things of that identity are not expressed adequately, that is not intentional.

Language and terminology in the area of sexuality can be problematic. People's self-perceptions and self-identifications can vary widely from culture to culture, as well as within each culture.

Many women and men whose principal emotional-sexual attraction or conduct is towards people of the same sex will, for many reasons, not necessarily identify as "lesbian" or "gay". Some may identify with other analogous terms that are more meaningful in their particular cultural context. Others may not see their sexuality as a basis on which to construct an identity, or may find it difficult to apply a fixed label to their sexuality (Amnesty International, AI-index: ACT 79/003/1999).

Western typologies (in sexuality) are often not considered to be relevant in developing countries. Though no attempt has been made to 'box' an Indian identity into one of the 'western identities', occasionally however similarities and differences between certain 'Indian identities' and 'western identities' have been noted below.

HIJRAS

(Note: The term 'Hijra' is used in North India, while the term 'Aravani' or 'Ali' is used in Tamil Nadu. Many NGOs/CBOs as well as health care providers still commonly use the term 'Eunuch' to denote Hijras. Almost all Hijras/Alis call themselves only 'Kothis'.)

Hijras have been in India for centuries. In the ancient times, they occupied high political posts in the royal courts. They are believed to have special powers to bless or curse. They are organized into small visible communities (with their 'Guru' [spiritual leader or master] and other Chelas [disciples]) but they may live alone or with their male partners. Their traditional way of livelihood is by singing and dancing in festival occasions, marriages, birth of a male heir, etc. Also, sometimes they go for begging by clapping ("Thali") at market places and shops. They often leave their birth families at a very young age to join

the Hijra community. Lack of education, lack of other job opportunities and lack of economic/emotional support from their birth families compel many to enter into sex work for survival. Thus, Hijra/Ali community has mainly persons belonging to the lower socioeconomic status. There is very limited information about cross-gender identified males who belong to middle and upper class families but they do not tend to join Hijra community. There may be a variety of reasons behind this but one possible primary reason would be the availability of alternative options. Joining the Hijra community means facing a life of stigma and discrimination. It is possible that such persons don't want to join the Hijra/Ali community because of various reasons (Transpal Sentinel, 1998).

Almost all Hijras are born as biological/anatomical males who reject their 'masculine' identity in due course of time to identify either as women, or "not-men", or "n-between man and woman", or "neither man nor woman". There are no valid data to state how many intersex persons ('hermaphrodites') are living in the Hijra community but they are likely to be extremely rare. According to Transpal Sentinel, a magazine for Indian crossdressers and transsexuals, intersex persons may constitute a disproportionately small number, as small as one for 20 thousand or more. While some consider Hijras as crossdressed homosexuals, they would be more accurately labeled as transgender/transsexual persons.

Subgroups among Hijras:

The following classification is a slightly modified version from an article that appeared in a transgender magazine (Transpal Sentinel, 1998) in India.

1. Nirvan (Nirvan Kothi): Those who had undergone "Nirvana" (Salvation - as castration is known) i.e., removal of both testes and penis (voluntarily/willingly) and who are in woman's attire. These persons are usually known as "Nirvan Kothi(s)" or simply as "Nirvan(s)" with in the Hijra community. Traditionally, emasculation is done by a senior Hijra/Ali called 'Daima' (Hindi) or 'Thai-Amma' (Tamil) which literally means 'mid-wife'. These days, many Hijras undergo emasculation operation by quack doctors (fake medical personnel).

2. Ackwa (Ackwa Kothi): Those who wear women's or men's attire, but who have not undergone emasculation and may or may not want to undergo emasculation in the future. Many live as women under a Guru, while training in singing, dancing and other rites of the community, as they wait to attain Nirvana. Some of them are under "Gurus" who teach them about female mannerisms such as how to speak, sit and make gestures like woman. [This is similar to the 'real-life' experience/test in western countries, during which the person who wishes to have sex reassignment surgery has to live as a woman for about one or two years]

3. Zenana: Here even though they think of themselves as woman, these persons don't want to undergo emasculation because they don't want to meddle with nature (i.e., mutilate themselves). These persons may be in men's or women's attire. (Currently this term is not in

common use with in the Hijra community. These days, these persons also come under Ackwa Kothis)

(Note:

- The term ‘emasculatation’ refers to ‘removal of penis and testes’. The term ‘castration’ technically means ‘removal of testes’.
- The above classification is a simplified one and the description given for the subgroups may not be accepted universally by the Hijra/Kothi community.)

Some Hijras who are yet to be emasculated or don't want to get emasculated may wear male dress. These persons are more likely to be confused for feminine homo/bisexual males (see later). Also this led to the prior misconception that "pure passive" homosexuals exist, since these transgender persons practiced only or mainly receptive anal/oral intercourse. i.e., there is confusion in differentiating between non-emasculated Hijras and feminine homo/bisexual males. (Thus, if we have to say in western terminology, Hijras are a heterogeneous group which include, but are not limited to, pre-operative transsexuals (in male or female dress), transsexuals in transition [under hormonal therapy], post-operative transsexuals and non-operative transsexuals)

It must be understood that even the Hijra community often considers the terms "Hijra/Hizda/Hijde" (or the term 'Ali' in Tamil) as derogatory and demeaning. That term is used here only for discussion purposes and should not be attached any other connotation. ***Hijras usually refer to themselves as "Kothis"*** (both in North and South India) and refer to their [Hijra] community as "Kothi log" (means 'Kothi community' in Hindi). Thus the terms ***"Hijra/Hizda/Hijdes" and "Ali" are gradually becoming more of labels than identities.*** However, within their community certain derogatory words like - 'Pottai (Tamil language)', 'Ombodhu (Tamil language)', and even masculine pronouns are freely used to refer to other Hijras. Some Hijra activists in Tamil Nadu coined the term "***Aravani***" to replace the term "***Ali***" (since the latter term is considered derogatory).

Though Hijras can be asexual, the majority do have sex with men. Some Hijras engage in commercial sex work for lack of other options and are willing to leave this work if they are given alternative jobs (Timothy et al, 1999). Those earning their living as commercial sex workers do practice high-risk sexual behavior with their clients, casual and steady partners (since they practice receptive anal and oral intercourse) (Venkatesan C et al, 1999a). Some Hijras get "married" to a man and cohabit with him. Hijras call that man (or any man who only penetrates) as "Panthi", which (according to them) means 'real man'. A Hijra remarked, "We call those men as 'Panthi' who penetrate us. If we came to know that he is being penetrated by others, we don't like him and don't want to have sex with him...because one day or other he will also become like us". They don't seem to agree that a man can penetrate as well as get penetrated but still regard himself as no lesser than other men. This may be due to the conventional 'Indian way' of thinking, i.e. viewing the penetrator as "man" and those who get penetrated as either female or those who have feminine tendencies. This also reflects the tendency to view the penetrated person as 'inferior'. This follows the simple "heterosexist logic": woman is inferior → woman gets

penetrated by man → any man who is penetrated by other man is like a woman → anything feminine is inferior → penetrated man is inferior.

Some Hijras get married to a female before joining the Hijra/Ali community and may also have children from that marriage.

The emphasis of the sexual role - 'penetrator and person who gets penetrated' - is more likely only to reaffirm their gender identity as a woman. It is also very likely that for the same reason Hijras tend to have multiple male sexual partners. Thus getting into sex work serves a double purpose - not only does it solve the problem of money but it also gives some Hijras a psychological satisfaction since Hijras feel that men are coming to them since these men consider them [Hijras] as women.

Though it is more common that Hijras think of themselves as woman they don't penetrate, there are exceptions to the rule. Ashok Row Kavi says, "We came to know that in some parts of Mumbai Hijras engaging in sex work are getting more money from truck drivers than the female sex workers. On enquiry, much to our surprise, we found that these [non-emasculated] Hijras anally penetrate the truck drivers and that is why they are given more money".

Bairupi or Bairupiya ('Fake Hijras')

In North India, some males mimic Hijras by wearing female dress and go out for begging by clapping so people think they are Hijras and give them money. Hijras claim that these fake Hijras (Bairupi), by their indecent behavior in public spaces and trains, spoil the name of Hijras.

KOTHIS

Kothis are a heterogeneous group. It is unrealistic to expect that a single 'definition' of Kothi-identity will fit everyone with that identity. The meanings attached to Kothi-identity vary according to the region, language, age group, socioeconomic status, educational status, degree of involvement in Kothi community and even from one Kothi-identified person to another. Having said this, one can justify the diverse opinions held by different individuals and CBOs on Kothi-identity.

Traditionally, the 'definition' for 'Kothis' is - "males who show obvious feminine mannerisms and who are involved mainly, if not only, in receptive anal/oral intercourse with men". However, an unknown but significant proportion of these feminine homo/bisexual males who identify themselves as 'Kothis' may penetrate their male partners (Note: The term '***Khada Kothi***' is sometimes used in North India to denote Kothis who also anally penetrate their male partners). A significant proportion of Kothis have bisexual behavior and many also eventually get married to a woman.

Most Kothi-identified males show varying degree of feminine mannerisms/behavior. While some also cross-dress when the opportunity arises others do not cross-dress. These persons are akin to "queens"/"drag queens" in western countries. A frequently asked question from those outside Kothi community is: If Kothis feel and act so feminine, why don't they consider themselves as Hijras? The answers are complex: family support, regional differences, access to opportunities, individual preference and other factors play a role. For some Kothis, the degree to which they identify as a woman may not be sufficient to take on the 'Hijra' label.

As mentioned earlier, most (if not all) Hijras prefer to call themselves only 'Kothi'. Thus there are two groups that share the Kothi-identity. One group is persons with Kothi-identity but those who don't think of themselves as Hijras. For the purpose of discussion, let us call these persons as 'simple' Kothis. Another group is the Kothis who are members of the Hijra community, whom we will call 'Hijras'.

The 'simple' Kothis don't cross-dress publicly except sometimes when dancing, soliciting sex or in the Kootandavar festival in Tamil Nadu. Many are careful not to let their birth families know that they cross-dress. Many don't have an urge to undergo emasculation even though they cross-dress. But some do undergo emasculation and later may cross-dress part-time or full time. They are more likely to be living with their birth families or living with their wives. Some 'simple' Kothis don't socialize well with the Hijras while some may mingle freely with them. Some of these 'simple' Kothis also consider themselves as 'Ackwa Kothi' since they are not emasculated (or don't want emasculation). Others take female hormones for breast development though they don't want emasculation. In Tamil Nadu, 'simple' Kothis differentiate themselves from the Aravanis by saying -"Avanga romba patchaiya irupanga" (which means - "they are more patchai". Note: In Tamil "patchai" literally means 'green'). What they actually want to convey is – Aravanis are those persons who show obvious feminine mannerisms, puts on female make-up, wear female dress most of the time, and who may or may not be emasculated.

(Thus, in western terminology, 'simple' Kothis include, but are not limited to, 'drag queens', feminine gay/bisexual men [who might never cross-dress], male-to-female transgender/transsexual persons, pre-operative transsexuals, non-operative transsexuals and male-to-female transsexuals in transition, i.e., taking female hormones)

In contrast, Hijras are more likely to be in female dress almost all time, and are more likely to have either undergone emasculation or have resolved to undergo it in the near future. They are more likely to have left their birth families (or left their wives, if married prior to joining the Hijra community) and more likely to be living with other Hijras. Most Hijras consider 'simple' Kothis as "Ackwa Kothis in male dress and/or Kothis who don't want to undergo emasculation".

Some educated feminine homo/bisexual males who have "Kothi' identity *also* identify themselves as "gay". They have learnt this English term through the organizations that work for Kothis and Hijras, or through their friends. Likewise, some self-identified gay men prefer mainly (if not only) getting penetrated. Some proportion of them, who socialize

with Kothis, thus *also* identify themselves as "Kothis" because of their behavior. Thus one can see "dual identities" in India.

It must be understood that even though feminine homo/bisexual males may call themselves "Kothis" many persons are quick to point out that they are not "Hijras". Also, the very act of including "Kothis" under the transgender umbrella is resisted quickly by some educated feminine homo/bisexual males, as they don't consider themselves as 'transgender' (English term). On the other hand, many Hijras consider the term "Hijras" as synonymous with "Kothis" even though they mostly prefer to call themselves "Kothis". These days, those Hijras who have access to NGOs/CBOs working with GLBT communities know the English term "transgender" and proudly call themselves "transgender" even though they might not have fully understood the meaning of that term.

NGOs/CBOs that work with MSM reach mainly "Kothis" and "Hijras" since they can be easily identified and approached by the outreach workers. Thus these organizations are 'missing' the majority of "men who have sex with men" who look "straight" (masculine) those who don't have a self-conscious sexual identity, and those who don't cruise. Thus a major segment of MSM remains invisible and hard to reach.

Kothi/Kowdi bashai (Tamil) or Kothi/Kowdi basha (Hindi)

This refers to the code language that is used by the Kothis to refer to certain things (mainly sexual acts and partners). Actually this is not a 'language' as such since only certain things are given code words. These code words have been developed so that exchange of information can occur freely in the public spaces without other persons understanding. Usually the code words that are used by 'simple' Kothis are essentially the same as that used by Hijras (who also call themselves as Kothis). These code words may vary from state to state in India.

PANTHIS

The term 'Panthis' is used by Kothis/Hijras to refer to those persons whom they consider to be 'real men' - in the sense those who only penetrate. Though it may also refer to rough and tough appearing men, a man who shows subtle feminine mannerisms may still be regarded as 'Panthis' if he only penetrates and is never the receptive partner. These days, the term Panthis is used more loosely by Kothis/Hijras to denote heterosexual persons as well as any man who is masculine-looking irrespective of whether he has sex with Kothis/Hijras or has sex with women only. This term is also used to denote the 'husband' or 'special boy friend' of a Hijra/Kothi. Some times the 'husband' or the steady partner is referred to simply as '(your) mard' [means man, in Hindi].

The sexual orientation of 'Panthis' is usually believed to be 'heterosexual' in orientation but fluid enough to have sex with Kothis/Hijras. There is a belief that 'Panthis' basically get attracted only to the feminine nature of Kothis/Hijras and they don't have a homosexual orientation. But it is also possible that Panthis have homo/bisexual orientation but prefer to have sex with Kothis/Hijras who are feminine as opposed to masculine-looking men.

'Panthi' is more of a label than an identity since 'Panthis' usually come to know of that term only through Kothis/Hijras and they themselves don't take that term seriously. However, sometimes calling oneself a 'Panthi' is a matter of prestige since those who penetrate are considered superior. While it is possible that Panthi is only a penetrator because he is "lacking interest in experimenting in reciprocal sexual activities" (Asthana and Oostvogels, 2001), it is more likely due to the stigma attached to being a receptive partner. Sometimes even a self-conscious homosexual men (who penetrate as well as receive) prefers the term 'Panthi' rather than the term 'Kothi'. Thus for sexual role-playing somebody has to take the Panthi role (penetrator) and somebody has to take the Kothi role (penetratee). Even a self-identified 'gay' man who socializes with Kothis has to say he is a 'Panthi' if he wants to have sex with a Kothi-identified person.

Panthis are either married to a female or eventually will get married to a female. Some of these 'Panthis' also have sex with other men (of any sexual identity) and may also penetrate as well as get penetrated (oral or anal). Though there is a general assumption that Kothis/Hijras will no longer accept their 'Panthis' if they come to know that their Panthis have been penetrated as well, in reality, as long as he behaves in a 'masculine' in front of Hijras/Kothis, Panthis rarely get rejected.

Some Hijras/Kothis get 'married' to a 'Panthi' even though that Panthi is already married to a female. Some may get 'married' to a Panthi with the understanding that their 'Panthi' wants to get married to a female, while other Hijras/Kothis are very possessive and not willing to 'share' their husbands.

Thus, in general, a combination of the following things can be used to find out whether a person is Panthi or not.

Kothis/Hijras generally believe that:

A Panthi -

- is masculine in appearance
- only inserts and never becomes a receptive partner to anyone.
- does not even touch the male genitalia (if not emasculated) of the Kothi/Ali.
- only gets attracted to Kothis/Hijras and not to other masculine-looking men.
- mainly gets attracted to females and thus has every right to have sex with females and to get married to a female (though some Kothis/Hijras are very possessive).

[Note: Previously, the 'real man who only penetrates' used to be called '**Kowriya**' or '**Giriya**' in the 'simple' Kothi language and 'Panthi' in the Hijra language. These days, the term 'Panthi' is generally used by Kothis/Hijras though the term "Kowriya" is still in usage in North India]

DANGA (this term is used mainly in Chennai, Tamil Nadu)

The term 'Danga' was previously used mainly by the NGOs/CBOs to refer to Kothi. This term is not widely used or known to the Kothi community. Even some researchers (Asthana and Oostvogels, 2001) have used the term 'Danga' rather than the term 'Kothi' while describing the different identities in Tamil Nadu. But 'Danga' is actually more of a label than an identity. Now, only a few Kothis (especially those who work in NGOs/CBOs) know that the term 'Danga' means 'Kothi'. Some mistakenly believe that 'Danga' is the English translation for 'Kothi' or officially Kothi is known as 'Danga'. A related term 'Saree Clad Danga' was also used previously by the NGOs/CBOs in Tamil Nadu to refer to cross-dressed Kothis or Hijras.

"DOUBLE-DECKER" OR 'DD' (the exact term used by Kothis/Hijras)

This refers to persons who get penetrated as well as penetrate, and those who may also have sex with women. It is because these persons get penetrated as well as penetrate other, some Kothis classify these persons as a separate category - "Double-deckers". Since the term being an 'English' one, it means that this term has been only recently coined by the Kothi/Hijra community. The feminine mannerisms in Double-deckers are often overlooked, as they may be very subtle even though in some it would be obvious to any body. Some of these persons usually identify themselves only as 'Kothis' rather than 'Double-deckers' even though they 'accept' that they are 'Double-deckers' if questioned directly (Like - "Yes, that is how sometimes other Kothis call me"). Thus Kothi and Double-decker may not necessarily be mutually exclusive categories. It also may mean that sometimes 'Double-decker' is more of a label than an identity but it could be regarded as a subcategory of 'Kothis'. However, some may not call themselves as 'Kothis' but still accept the label 'Double-decker' (probably because they might think that calling themselves as 'Double-decker' is more prestigious than calling themselves as 'Kothi', since the latter means 'effeminate and passive'). Almost all Double-deckers eventually get married to a female.

'INDIANIZED' GAY IDENTITY

The term 'gay' essentially has the same meanings as that in Western countries for the educated self-identified homosexual males generally belonging to the middle and upper class. But for some self-identified homosexual males the meaning attached to the word 'gay' may be sometimes quite different.

While some well-educated persons, regardless of their sexual orientation, may have never heard the term 'gay', other well-educated self-identified homosexual persons eventually do find a name to identify with - the English term 'gay'. They learn this term either while searching the library to find more information about their 'condition' or through other 'gay' friends. Thus the term 'gay' is not a familiar term even for well-educated persons, whereas the terms 'homosexuals', 'homosex' and 'homo' are usually very familiar. Even these terms

may be sometimes confused with different things (The first author had personally heard a male patient saying - "I had homosex". Only after some time was it recognized that he was actually referring to masturbation as 'homosex').

The less-educated self-identified homosexual persons, who have access to NGOs/CBOs that serve MSM, eventually and inevitably come to know about the English terms - "Gay, Bisexual and Transgender". As these terms are not properly explained to them, these terms are used by these persons with their own personal definitions and they also experiment in equating the western identities with the Indian identities. For example: - the term 'gay' is used to mean all persons who are attracted to same-sex partners regardless of the gender identity of the persons. Thus eventually almost all the Indian identities like - Kothis, Hijra, Panthi, Double-decker, etc. comes under this term 'gay'. However the Hijras (especially those who are always in woman's dress irrespective of the castration status) are usually given the label 'transgender' (English term). Kothi-identified feminine homo/bisexual males are, however, quick to protest that they are not "Transgender". This is not because they fully understand this term but because it has become synonymous with Hijras. The English term 'gay' has been 'translated' by some Kothis as "English Kothi" (Some persons call English-speaking Kothi-identified persons as 'English Kothis'). Or alternatively some times 'translation' of Kothi results in 'Gay'. A Kothi-identified person said, "So what do you call 'Kothi' in English - Gay!".

(Note: In some CBOs, where gay-identified persons may socialize with Kothi-identified persons, gay-identified persons may say that they are 'Panthis' since they don't want the Kothis to call them 'Kothis'.)

WHY IS THERE ALWAYS CONSIDERABLE CONTROVERSY OVER THE DESCRIPTION OF CERTAIN "INDIAN IDENTITIES"?

Unlike the western identities like 'Gay, Lesbian, Bisexual' that have some 'standard' definitions, there are no pre-existing definitions for the "Indian identities". Consequently, whatever a person thinks about his/her identity becomes the true essence of that identity to that person and whatever any other persons have to say about that identity becomes wrong. In other words, regardless of what everybody (researchers as well as the community members) thinks are the correct labels, an individual's identity is their own and no one can tell them they are wrong about this.

Despite this, many researchers/authors may think their description of "Indian identities" is the final word. This conviction is likely to be influenced by many factors like -

- Through whom and by what methods have the information about various identities been collected (E.g.: Whether the researcher really had discussions with persons with different identities or was the information collected through 'key informants'? Or whether the respondents were recruited through 'snowballing' method? - since

- that means persons are more likely to identify with others sharing similar views about that identity and thus the sample is more likely to be 'homogeneous')
- The conscious or sub-conscious influence of the knowledge the researcher has about western identities.
 - The censorship (by the researcher or the community members) of certain issues that may pose certain risks to both the community members with a particular identity as well as the researcher.
 - The meanings attached to the Indian identities, like any other field, changes over time. This means description of 'Indian identities' this year may be 'outdated' a few years later. Even if one thinks that identities are immutable, the meanings attached to those identities are not.

IDENTITIES Vs. BEHAVIOR:

Sexual health outreach should attempt as far as possible, to respect the identities chosen by individuals and not attempt to force upon them western constructs such as gay or transgender. These days, the term "*males who have sex with males*" is used to indicate those biological males who have sex with other biological males. Then, in a strict sense, it includes Hijras, Kothis and other "men who have sex with men". For health interventions, working definitions such as 'males who have sex with males' or 'men who have sex with men' are appropriate for outreach as long as these are treated as behavioral categories which may include people with any of the above identities, males who don't identify as any of the above, as well as males who may subscribe to constructs such as gay and bisexual. However, due respect should be given to the sexual identity assumed by any male who has sex with other males.

SECTION-B. SEXUAL HISTORY TAKING, SEXUAL PRACTICES AND HIV RISK-REDUCTION COUNSELING

4. ADDRESSING SAME-SEX/BISEXUAL BEHAVIOR IN HIV/STI RISK ASSESSMENT (*Venkatesan Chakrapani*)

During STI/HIV risk assessment or in a regular sexual health screening, a significant proportion of doctors and counselors may not take sexual history in detail for a variety of reasons which could be due to:

- Embarrassment
- Feeling that they are not adequately trained in asking sex-related questions
- Fear of the emotions generated by such a discussion
- Awkwardness with sexual language

However, when doctors and counselors do not ask about same-sex/bisexual behavior in their male clients, they are losing crucial opportunities to provide HIV/STI prevention education to these persons from marginalized populations.

Thus, irrespective of whether a person has sex with males, females or both, a detailed sexual history is important for all patients because it provides information that

- Identifies those at risk for sexually transmitted diseases, including HIV;
- Directs risk-reduction counseling; and
- Identifies what anatomic sites are suitable for STD screening.

Subpopulations of men who have sex with men (MSM) in India

‘MSM’ is a behavioral term and denotes all men who have sex with other men regardless of their sexual identity.

For the sake of simplicity, one can classify ‘MSM’ according to their socioeconomic and educational status as follows:

MSM from lower socioeconomic class with poor literacy: Kothi-identified homosexual males are a visible and relatively organized group. One can say that Kothi means feminine homosexual males who are mainly receptive partners. **Kothis** call their masculine partners as ‘Panthi’. **Panthis** are supposed to be “*real men who only penetrate*”. The term ‘**Double-decker**’ is used by Kothis to refer to someone who penetrate as well as receive.

MSM from the 'middle or upper class': MSM belonging to 'middle or upper class' who are well-educated may have identities like **gay** or **bisexual**.

However, the major subpopulation across any Socioeconomic class is likely to be MSM who do not have any conscious homosexual identity.

(Note: Hijras, though biologically born as males, consider themselves as women. Thus many Hijra activists resist including Hijras under the umbrella term 'men who have sex with men or MSM' since they are "not men". However, if agencies providing services to 'MSM' come across Hijras, they should not be denied services.)

Asking about same-sex/bisexual behavior in males

1. Ask about same-sex behavior/bisexual behavior in all male clients

Counselor should not limit asking their clients about same-sex behavior only if they appear 'feminine'. Men who have sex with men can be masculine or feminine and hence one should not consider gender expression (behaving/appearing in a masculine or feminine manner) to be indicative of behavior.

2. Ask about same-sex behavior even in married men

There should be no assumptions that heterosexually married men cannot be having sex with men. MSM may or may not be heterosexually married. Thus even in married men, one has to ask about same-sex behavior.

3. Ask about same-sex behavior across all age groups

Don't assume that only male youth will be involved in same-sex behavior, MSM belong to all age groups just like heterosexual men.

4. Ask about heterosexual behavior in self-identified homosexual men

Even if a male client openly comes out as that he is having sex with men and/or self-identifies as a homosexual man ('Kothi' or 'gay'), the counselor or doctor needs to ask whether he also has female partners. This is because even self-identified homosexual men often have female partners and eventually may get married heterosexually to fulfill family and societal expectations. Knowing about steady female partners of these men are thus important for referral services and discussing about partner treatment/testing if the client has STI or HIV.

5. Ask about male steady partners of self-identified homosexual men

Among those who admit having had same-sex behavior ask whether they have long term steady partners (Kothi-identified MSM may call these steady partners as ‘Panthis’). Again, this has relevance in relation to partner testing/treatment

Eliciting history of same-sex/bisexual behavior in a male: Some scripts

There are a variety of ways to make the male client feel comfortable about talking about his same-sex/bisexual behavior. For this, developing an appropriate level of trust and rapport during the initial interactions is of importance.

One example:

Counselor/Doctor: When did you last have sex?

Male Client: About a week ago

Counselor/Doc: With whom?

Client: ...With a lady in my neighborhood.

Here the interviewer starts with asking when he had sex and with whom. There were no assumptions about the gender of the sexual partners. Even if the male client tells he has had sex with a female it is important to tactfully ask about same-sex behavior in a nonjudgemental manner.

Counselor/Doctor: You said you have had sex with many women. Have you ever had sex with men?

Male Client: (Pauses)....It was about six months ago..

Thus, here the interviewer did not assume that the male client was having sex only with females but asked whether he had sex with any men. If the client feels that the counselor is asking the question in a nonjudgmental manner he is more likely to be honest about whether he has sex with other men.

Now having asked about same-sex/bisexual behavior in your male clients, the next step is to ask about what kind of sexual practices they practice.

Asking about various sexual practices

It is important to know the types of sexual practices and condom use associated with them so that one can assess the risk of STI and HIV associated with various sexual practices and also to provide appropriate HIV risk-reduction counseling.

You can start by saying, “I am going to be more explicit about the kind of sex you have been having over the last three months (can be any relevant time duration) so I understand your risks for STDs and HIV”

“You said you have had sex with women and men. What kind of sexual practices have you had with men (and women).” [You can either list the important penetrative sexual practices or ask individually one by one]

“Do you have vaginal sex, meaning “penis in vagina sex”?

If answer is yes, *“Do you use condoms: never, sometimes, most of the time or always for this kind of sex?”*

“Do you have anal sex with men (and women), meaning “penis in rectum/anus sex” If answer is yes, *“Do you use condoms: never, sometimes, most of the time, or always for this kind of sex?”*

If yes to above:

When having anal sex, do you insert your penis into your partner or does he insert his penis into you? Or both?

“Do you have oral sex with men (and women), meaning “mouth on penis/vagina”?

For condom answers:

If answer is “never”, then: *“Why don’t you use condoms?”*

If answer is “sometimes”, then: *“In what situations, or with whom, do you not use condoms?”*

5. SEXUAL PRACTICES

(Compiled by: Venkatesan C)

For simplicity, we can classify sexual practices as penetrative and non-penetrative.

Penetrative sexual practices

Penetrative sexual practices usually involve contact with semen or vaginal fluid and may lead to minor abrasions in vaginal or anal mucosal membrane, all of which pose a risk of acquiring or transmitting HIV (or STI).

Peno-vaginal Intercourse (“Vaginal sex”)

Insertion of the erect penis into the vagina, followed by rhythmic movement often leading to orgasm.

Anal intercourse (Anal) sex

Insertion of the penis into the rectum/anus. This sexual practice can happen between two men or between a man and a woman. The man who inserts the penis is called ‘insertive partner’ and the person (man or woman) who receives is called “receptive partner”. In sex between men, insertive and receptive roles can change with the same partners or with different partners.

Fellatio (Peno-oral sex, oral sex on a man or simply referred to as “oral sex”)

Stimulation of the penis using the lips, mouth, or tongue. This can be practiced between two males or between a man and a woman. Practice may or may not be continued to orgasm, and the partner may or may not swallow the ejaculate.

Cunnilingus (Oro-vaginal sex or “oral sex on a woman” or simply referred to as “oral sex”)

Stimulation of the external genitals of the woman with lips, mouth, or tongue. This practice may or may not be continued to orgasm.

Anilingus (Oro-anal sex or “rimming”)

Oral stimulation of the anal area.

(Insertion of fingers into the rectum or vagina is called “**fingering**” and Insertion of hands is termed “**fisting**.”)

Non-penetrative Sexual /Erotic practices

Cybersex

Sex-related activities involving the Internet. Includes sexual fantasy between individuals or groups through games, chat rooms, bulletin boards, instant messaging services, and other sources.

Phone-sex:

Using fantasy and erotic talk on the phone with a partner.

Body rubbing (“Body sex”)

Rubbing bodies together, especially sexual organs (“Frottage”), sometimes leading to orgasm.

Interfemoral intercourse (“Thigh sex”)

Inserting and moving the penis between the thighs.

Erotic fantasy

Reading, watching, imagining, telling, or acting out erotic fantasies with or without a partner.

Erotic massage

Sensual and sexually arousing body massage, which sometimes includes stimulation of the sexual organs with hands, body, or mouth.

Foreplay

Sexual activity including caressing, touching, stroking, kissing (dry or French), massaging, breast sucking, and other types of bodily contact that promotes sexual excitement (erection or vaginal lubrication). This type of sexual activity may or may not lead to orgasm and does not necessarily lead to sexual intercourse.

Masturbation (Self/Mutual)

Manual or other nonpenetrative stimulation of oneself (self-masturbation) or a partner for sexual pleasure (Mutual masturbation). Under some definitions, it may also include penetrative stimulation of oneself.

Group sex (Orgy)

Simultaneous sexual activity among more than two people.

Sex toys

Objects used for or designed for enhancing sexual pleasure (including dildos, vibrators, and implements used for bondage).

6. SAFER SEX/ HIV RISK-REDUCTION OPTIONS

(Compiled by: *Dr. Venkatesan C*)

Relative risk of HIV transmission/acquisition in unprotected anal, vaginal and oral sex:

Unprotected anal sex whether between two men or between a man and a woman carries the highest risk of transmission or acquisition of HIV if one of the partners is HIV-infected. In anal sex, the efficiency of transmission of HIV from an insertive to receptive partner is more than that from receptive to insertive partner.

Unprotected vaginal sex, when compared to unprotected anal sex, carries a moderate risk of HIV transmission or acquisition when one of the partners is HIV-infected.

Unprotected peno-oral sex (“oral sex”) carries a relatively lower risk compared to unprotected anal or vaginal sex.

Risk-reduction Options

1. Anal sex

- To always use male condoms during anal sex together with sufficient quantity of water-based lubricants.
- Double condoms may lead to slippage and thus are not necessary. Single good-quality condom if properly used is sufficient.
- Some gay men may try female condoms for anal sex, but they are not widely used.

(Condom-negotiation skills need to be taught to MSM and Hijras)

2. Vaginal sex

- Male condoms to be used correctly and consistently.
- Female condom can be used by females. (Instructions on how to use to be given)
- Water-based lubricants can also be used for additional pleasure.

3. Oral Sex (Fellatio)

- Flavored condoms (in strawberry, chocolate, vanilla flavors) are available, which can be used
- If ordinary pre-lubricated condom is available then after wearing the condom the lubrication can be wiped out with a clean cloth and then oral sex can be performed
- If condoms are not used, then the following are the various options with different degrees of risk: sucking the shaft of the penis only with out touching the glans penis (thus avoiding contact of pre-cum and semen); taking out the mouth before the

partner ejaculates (but keep in mind there is some risk of HIV through contact with pre-cum); swallowing the ejaculate; and spitting out the ejaculate.

Note: It is better not to brush teeth immediately before (and after) oral sex since it may lead to minor abrasions in the oral cavity facilitating the entry of HIV.

4. Anilingus: (“Rimming” or Oro-anal sex)

Dental Dam or Oral dam can be used. May be available at the dental pharmacies.

5. Cunnilingus (Oral sex on female)

Dental Dam or Oral dam can be used.

6. Fingering

Finger gloves (“finger cots”) can be used. (Not widely available in India). Some may use thin hand gloves.

Sexual risk-reduction counseling for HIV-positive persons

Safer sex counseling is the same for persons who are HIV-negative or positive (or whose HIV status is unknown).

Identify and correct misconceptions among HIV-positive persons regarding risk of HIV transmission.

Convey the following messages:

- Highly active antiretroviral therapy (HAART) does not eliminate the risk of transmitting HIV to others.
- A person with undetectable viral load can still transmit HIV infection
- A person with HIV-2 infection needs to use condoms even though HIV-2 is “less infectious”.
- “Nonoccupational postexposure prophylaxis” (taking antiretrovirals after an unprotected sex so as to prevent HIV infection) is of uncertain effectiveness for preventing infection in HIV-exposed partners.

Explain how safer sex practices will help HIV-positive persons

- Prevention of acquiring new STDs since STDs can accelerate progression to AIDS
- Prevention of superinfections with other HIV type/strains (virulent and drug-resistant)

7. DO'S AND DON'TS FOR DOCTORS AND COUNSELORS **While counseling male clients who report any same-sex behavior**

(Compiled by: *Paige Passano, Venkatesan Chakrapani*)

THINGS TO DO

1. Risk Reduction:

- Ensure that he understands the difference in risk of acquiring HIV from unprotected anal and oral sex. (High vs. low risk.)
- If he practices anal sex, explain and demonstrate lubricant use with condom.
- If he practices anal sex, besides information about consistent condom use and lubricants, also provide information about alternative ways to enjoy sex – like mutual masturbation, thigh sex, and oral sex with condom.
- Make sure he understands that applying oil on condoms can increase the chances of slippage or breakage.
- Oral sex: Provide various options - Talk about using ‘ordinary’ condoms (suggest wiping off the lubrication with a cloth); talk about using flavored condoms; if condoms not used - to avoid ingesting semen; and not to brush teeth before having oral sex (if unprotected)
- Provide all safer sex options, even if the client says he is going to follow abstinence.

2. Sexual Partners

- Assume all males are bisexuals and question about bisexual behavior irrespective of whether they first mention about having had sex with same-sex or opposite sex partner.
- Provide safer sex information for various penetrative practices (at least for vaginal and anal sex) even if the client has mentioned about having had only vaginal or anal sex (Since past sexual practices do not predict future sexual practices and some may hide information about having had anal or vaginal sex)
- Emphasize that condoms should be used in penetrative sexual practices with male or female even if the client has mentioned about having had sex only with male or female (Since past sexual behavior do not predict future sexual behavior and some may hide information about having had sex with males or females)
- Find out if he has a primary partner (male or female or both) and discuss condom use and negotiation with those partner(s).
- Encourage him to refer his partner(s) to a voluntary counseling and testing center.

3. Comfort Levels of Client

- Tell him that he doesn't have to answer questions that make him uncomfortable.
- If client feels ashamed of his sexual behavior, let him know that it is fine to talk about it, and that having anal/oral sex with a male or female is not abnormal.
- Talk to him about his support network (family/friends/steady partner)

4. STIs

- Tell him STI symptoms can appear on the genitals, around the anal area, or in the back of the throat (from unprotected oral sex) and are sometimes not noticed by the client. Encourage visit to STI doctors.
- If our doctor is not available, discuss with the client about the importance of seeking STI treatment from a qualified doctor.

THINGS NOT TO DO

(Remember 'counseling' is about assisting clients in taking decisions and not to take decisions for them. Also, we do 'risk-reduction' counseling and not aiming at 'risk-abolition'.)

1. DON'T probe too deeply about **why** he has sex with other men or **how** he started this behavior. Focus on his current situation and **how** to reduce his risk.
2. DON'T 'recommend' homosexual men to stop having anal sex since unprotected anal sex is riskier. Note: Whether it is vaginal or anal sex, if unprotected, both carry risk. Hence counsel about safer sex irrespective of the type of sexual practices.
3. DON'T 'recommend' homosexual men to stop having sex with men since 'it is risky' and hence asking him to start having sex with females.
4. DON'T 'recommend' to bisexual men that since sex with men is risky, it is better to have sex only with female partners.
5. DON'T offer 'getting married to a female' as one of the risk-reduction options. However, do talk about practicing safer sex with any type of partner even if he gets married to a female.
6. DON'T make him feel that his sexual behavior is unusual. If he says something that surprises you, respond objectively.
7. DON'T probe too deeply about the risk behavior of his partners if it is clear that he doesn't know many details about his partners (i.e., he had anonymous partners)

SECTION-C: LEGAL ISSUES

8. LEGAL STATUS OF HOMOSEXUALITY IN INDIA

This section taken from: Venkatesan Chakrapani, Ashok Row Kavi, L Ramki Ramakrishnan, et al. HIV Prevention among Men who have Sex with Men (MSM) in India: Review of Current Scenario and Recommendations. Apr 2002. www.indianGLBThealth.info

Indian culture has been familiar with same sex eroticism for centuries. But the former British rulers found this repulsive, and declared it a crime in the Indian Penal Code (IPC), which was enacted in 1861. IPC Section-377, originally drafted by Lord Macaulay in the early 1830s, reads:

“Unnatural offences: Whoever voluntarily has carnal intercourse against the order of nature with either any man, women or animal shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to 10 years, and shall also be liable to fine. *Explanation -* Penetration is sufficient to constitute the carnal intercourse necessary to the offence described in this section" (ABVA, 1991, Lawyers collective, 2000).

The exact scope of this vague definition - "Carnal intercourse against the order of nature" - has generally been interpreted to include acts of anal sex as well as oral sex between males. The possibility of this definition being extended into heterosexual acts of anal or oral sex also exists but has not been tested. Consent of the other party is completely irrelevant for conviction but it may be a relevant consideration while fixing the quantum of punishment. It must be pointed out that homosexuality *per se* is not an offence, and an "act" of unnatural intercourse has to be proved. Though the law makes only anal (and possibly oral) intercourse between two individuals a crime, in practice and in effect it criminalizes homosexuality.

The legal status of homosexuality in the Indian Armed Forces follows the model set by section 377. Section 46 of Chapter VI Offences, of the Army Act, 1950 states: "Any person subject to this act who is guilty of any of the following offences, that is to say - a) is guilty of any disgraceful conduct of a crude, indecent or unnatural kind - shall on conviction by court-martial, be liable to suffer imprisonment for a term which may extend to seven years or such less punishment as is in this Act mentioned." Similar provisions exist in the Air Force Act, 1950 (ABVA, 1991).

Sec.377, which criminalizes homosexual behavior, is today responsible for the denial of various fundamental rights like life and liberty, health, privacy, speech, movement, etc., to

the sexual minorities. The denial of these fundamental rights to sexual minorities lead to their enhanced vulnerability to HIV/AIDS by making them highly invisible and unreachable for HIV prevention education and for providing sexual health related services. It has also resulted in low self-esteem (which indirectly decreases condom use and increases risky sexual behavior), discrimination in employment, vilification, threats of physical violence, extortion of money from police, etc.

It is now an accepted postulate that the only way of protecting vulnerable populations from HIV/AIDS is by protection and promoting their rights, so that they are in an empowered position to protect themselves. However, due to S.377 IPC, effective interventions are rendered difficult because dissemination of information on anal and oral sex, distribution of condoms, etc. could be construed as abetment of a criminal act.

Many countries including the United Kingdom have decriminalized adult consensual homosexual acts. In India, however the same old British law is being followed blindly without any inclination to reexamine it. Recently, the Law Commission of India (LCI) has examined this issue while reviewing 'rape laws' and recommended changes to the existing laws. The LCI 172nd report has included in its recommendation the repeal of section 377 and has expanded the term 'rape' i.e., penetration of the vagina, anus or mouth with the penis, to any other part of the body. This report is a mere beginning and has not comprehensively dealt with this issue. Many human rights groups, GLBT groups, Child rights groups, and Women's groups are debating upon the LCI deliberations. They are trying to find out inadequacies in the LCI recommendations and to propose necessary changes.

Elimination of sodomy laws and legalization of marriage among gay men and lesbians are considered as one of the environmental structural interventions in HIV prevention (Kim M Blankenship et al, 2000). Hence it is high time that all discriminatory legislations on homosexual behavior be repealed in India in line with many European countries.

9. LEGAL STATUS OF TRANSSEXUALISM AND SEX REASSIGNMENT

SURGERY IN INDIA (Dr. Venkatesan C, Dec 2004. www.indianGLBThealth.info)

In 1871, the British enacted the Criminal Tribes Act, 1871, under which certain tribes and communities were considered to be ‘addicted to the systematic commission of non-bailable offences’. These communities and tribes were perceived to be criminals by birth, with criminality being passed on from generation to generation (PUCL-K, 2003). In 1897, the Criminal Tribes Act of 1871 was amended and under the provisions of this statute, a eunuch was ‘deemed to include all members of the male sex who admit themselves or on medical inspection clearly appear, to be impotent’. The local government was required to keep a register of the names and residences of all the eunuchs who are ‘reasonably suspected of kidnapping or castrating children or of committing offences under Section 377 of the Indian Penal Code’. Any eunuch so registered who appeared ‘dressed or ornamented like a woman in a public street.....or who dances or plays music or takes part in any public exhibition, in a public street.....[could] be arrested without warrant and punished with imprisonment of up to two years or with a fine or both’. (PUCL-K, 2003). Even now these archaic laws remain in the Indian Law books. Hijras are also harassed by police by threatening to file a criminal case under Sec- 377 IPC (see above).

Currently the Indian legal system is silent on the issue of sex change operations. Section 320 of the Indian Penal Code (IPC), ‘emasculating’ (castrating) someone is causing him ‘grievous hurt’ for which one can be punished under Sec 325 of the IPC. Thus technically speaking even if one voluntarily (with consent) chooses to be emasculated, the doctor is liable for punishment under this provision and the person undergoing emasculation could also be punished for ‘abetting’ this offence. However under Sec 88 of IPC an exception is made in case an action is undertaken in good faith and the person gives consent to suffer that harm. The section reads: “Nothing which is not intended to cause death is an offence by reason of any harm which it may cause or intended by the doer to cause any person whose benefit it is done in good faith, and who has given a consent...to suffer that harm, or to take the risk of that harm.

In reality, however, the legal process is set in motion by someone filing either an FIR in the concerned police station or by filing a private complaint. This does not happen in the case of SRS/castration as both the doctor and patient are consenting parties to the transaction, and it is extremely unlikely that they will activate the criminal law process. Thus there is no documented case in India of doctors and patients having been prosecuted for causing grievous hurt or abetting the causing of grievous hurt through SRS. In the unlikely case that such a process is activated, a qualified doctor who does SRS would be protected by the general exception under the section 88 of the IPC. But emasculation is considered a criminal offence – whether done by oneself or another person and irrespective of the consent. The legal status of sex change surgery should be clarified and this surgery should be offered in government hospitals so that Hijras do not need to go to unqualified medical practitioners for having their sexual organs removed. This can prevent complications because of bad surgical procedures followed by quacks.

SECTION-D: GUIDELINES FOR AGENCIES PROVIDING CLINICAL OR COUNSELING SERVICES TO MSM AND/OR HIJRAS

(Compiled by: *Venkatesan Chakrapani*)

1. Creating a welcoming environment:

- Posters suggesting that it is safe to disclose sexual orientation, gender identity and sexual practices of all kinds.
- Make available brochures and other materials that are also appropriate to MSM and Hijras.
- Visible non-discrimination statement stating that equal care will be provided to all patients, regardless of age, physical ability, sexual identity, gender identity and sexual practices.
- Visible statement on confidentiality issues.
- Positive attitude and warm welcome by the reception staff.

2. Guidelines for intake forms and client-provider interactions:

- Have inclusive intake and assessment forms and procedures suitable to meet the needs of MSM and Hijras.
- Encourage openness.
- Developing rapport and trust with some proportion of MSM/Hijras may take longer and require added sensitivity from the provider.
- Do not make assumptions about understanding ability of the clients. If in doubt, ask.
- Reflect clients' language and terminology about their partners and behaviors.
- Discuss sexual health issues openly with any clients.
- Be aware that sexual identity and sexual behavior of a client may or may not correlate.
- Be aware of possible heterocentric (heterosexist) or discriminatory language when discussing sexual practices and safer sex.

3. Language:

- Listen to your clients and how they describe their own identity, partner(s) and relationship(s), and reflect their choice of language.

- The key is to follow the client's lead about their self-description (which builds respect and trust)
- Respect transgender patients by using appropriate pronouns for their gender expression.

4. Specific issues:

- Determine the degree to which the client is 'out' to their family members, friends, employers, etc.
- Conduct violence screening.

5. Other:

- A unisex 'restroom' may be beneficial in the clinic or counseling waiting room
- Having openly gay/Kothi or Hijra staff (of any rank) may be helpful.
- Have and review written policies, procedures, and forms regularly to ensure that they explicitly address issues of clients and staff who are MSM/Hijras.
- All employees need to understand that discrimination against sexual minorities (or any client), whether overt or subtle, is as unacceptable as any other kind of discrimination
- Provide ongoing training to staff on sexual diversity, harassment and anti-discrimination training as they pertain to an agency's services.