Men Who Have Sex With Men in India: An Annotated Bibliography

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Men Who Have Sex With Men (MSM) in India: an Annotated Bibliography

Purpose
The purpose of this annotated bibliography is to explore the available literature describing the plethora of labels applied to, and identities defined by, men who have sex with men (MSM) in India.

Search History
This literature review and annotated bibliography were generated through the systematic search of several online databases including Medline, Sociological Abstracts, and Social Sciences Citation Index to locate peer-reviewed literature, as well as Google.com to locate gray literature. Search terms used include India, men who have sex with men, MSM, hijra, panthi, danga, double decker, kothi, eunuch, transsexual, homosexual, and gay.

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A. Summary

I. Introduction on gender and sexual identities

The complexity of categorizing gender and sexual identities is particularly apparent in the Indian context, where numerous terms exist for the manner in which one engages in sex with other men. However, few of these terms are self-identifying, or even identities within themselves. The terms 'gay', 'homosexual', 'transsexual' and 'eunuch', are often used as means to identify oneself in the West. However in India, the equivalent terms such as 'Hijra', 'Danga', 'Double Decker' and 'Kothi' are only used to label the activities that one participates in (Chakrapani et al, 38). Few men identify themselves as homosexual; rather they claim simply that they take part in "homosex" (Khan, 102). One could argue that even the term "men who have sex with men" is invalid in India as its use, "leads to a greater invisibility of many divergent contexts of male to male sexual behaviors, expressed in an often bewildering variety and range of personal identities, behaviors, gender identifications and practices which defy such a simple categorization" (Khan 3). In many cases there are incredible social pressures against publicly identifying as an MSM. Families may disown members who identify as gay because it means they will not marry a woman nor receive a dowry (Khan, 100). Despite this secrecy, there are numerous terms used to describe the particular way in which one participates in sex with other men.

Due to the great degree of complexity and fluidity in sexual identities and preferences, a complete description of the sexual practices and identities of men who have sex with men defies both the scope of this report as well as the literature more broadly. Additionally, much of the information (or data)

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that has been collected is considered unreliable. The rest of this report attempts to explain identities that are used to explain the practices of most MSM; however, many of the men that fit into such categories do not consider themselves members, nor do they always identify with the group.

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II. Hijra

The group that is easiest to differentiate from other MSM is the Hijra. Hijra have been a distinct subculture in Indian culture for hundreds of years and are considered to have special spiritual powers used to bless or curse others (Chakrapani et al, 1). Because of this, they are often not well liked among in mainstream society. Biologically, Hijra are born male but they choose to live as women, including dressing in saris and wearing jewelry. They can identify with females, or as a third gender, although all have rejected their male status. The closest equivalent word in English to Hijra is 'transsexual' (Asthana and Oostvogels, 12). In the northern parts of India, they are known as Hijra, in Tamil Nadu they are known as Aravani, while health care professionals refer to them as eunuchs (Chakrapani et al, 1).

Hijra tend to live in communal houses in insulated Hijra communities. They often make money through sex work, selling flowers, fruit, etc., or through payments to bless weddings, funerals and births by singing and dancing at the events (Chakrapani, Babu and Ebenezer, 12). Hijra most often perform jobs that require little or no special skills because they typically are not well educated nor supported by family members outside the Hijra community due to the high degree of stigma and discrimination they face.

As sex workers, Hijra are often considered more sexually skilled then female sex workers (Khan, 108). They are nearly always the receptive partner in oral and anal intercourse and cater to the same clientele as female sex workers. Hijra often are trained by gurus who act as the heads of the houses in Hijra communities (Chakrapani, Babu and Ebenezer, 12). Some Hijra get married to men and live in the Hijra community with their "husbands", whom Hijra refer to as 'Panthi' (Chakrapani et al, 5). Typically, Hijra refer to themselves as Kothi because the terms Hijra and Ali increasingly are being considered derogatory.

Among Hijra there are several subgroups: Nirvan Kothi, Aquwa Kothi, Zenana and Bairupi. The Nirvan Kothi live completely as women and have undergone complete castration of the penis and testicles (Chakrapani et al, 5). The Aquwa Kothi also live as women, but have yet to undergo castration and they are still "training" to be women (Chakrapani et al, 5). The Zenana is the least commonly used term, as it describes Hijra who think of themselves as women but will not undergo castration and do not always dress as women (Chakrapani et al, 5). Lastly, the Bairupi pretend to be Hijra to earn money from their singing and dancing (Asthana and Oostvogels, 13). They are disliked greatly by the Hijra because they are considered to behave indecently in public.

Hijra are at a great risk for HIV because of their high-risk sexual behavior as the receptive partners in oral and anal intercourse. Condoms frequently are not used, and when they are, their use is highly inconsistent (Chakrapani et al, 36). Condoms are almost never used in oral sex and often Hijra will not require condom use with regular partners, good looking partners, or partners willing to pay extra (Chakrapani et al, 36). In addition, water-based lubrication is almost never used because it is expensive and usually only comes in large quantities (Dandona et al, 617). This leads to damage of the anal tract and a greater transmission rate of HIV. As many men do not want to get caught soliciting a Hijra, intercourse is usually performed quickly and roughly, which further damages the Hijra's anal tract (Asthana and Oostvogels, 10). Also, since Hijra typically do not receive as much money as a female sex worker, they tend to seek out greater numbers of partners, thus increasing HIV risk (Chakrapani, Babu and Ebenezer, 12). Lastly, Hijra have very limited access to health care and diagnostic centers due to stigma and discrimination, thus impeding the ability of many Hijra to receive HIV testing or treatment (Chakrapani, Babu and Ebenezer, 12-13).

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III. Kothi

The Kothi group has many similarities with the Hijra group, but the main difference is that they tend to be much less feminine then the Hijra (Chakrapani et al, 36). Their main profession is sex work while dressed as females; however, they do not dress as females when they are not working. During anal sex, Kothi are both penetrated and penetrate, while they are also both the givers and receivers in oral sex. Kothi however, do not have intercourse with other Kothi (Chakrapani et al, 4). Kothi tend to not be castrated and in most cases do not ever plan to become castrated (Chakrapani et al, 4). Often, Kothi are married to females. Many Hijra/Ali refer to themselves as Kothi, although mainstream society would refer to them as Hijra (Chakrapani et al, 4). Among the Kothi community there is a wide range in the degree to which Kothi "acts female". Kothi that only dress in women's clothes to solicit sex, are married, do not have feminine mannerisms or wear make-up are considered "simple Kothi" (Chakrapani et al, 4). Kothi that dress in feminine clothes, make-up and only are penetrated are considered Hijras once they consider castration, taking female hormones, marrying men or move into a Hijra community.

The Kothi have the second highest degree of vulnerability behind Hijra to HIV/STI infection. Their risk for HIV is very similar to the Hijra. The most common profession for Kothi is sex work, which subjects them to high HIV-risk associated with infrequent use of condoms and poor lubrication (Chakrapani et al, 4). Their behaviors also tend to transmit HIV at a higher rate because they will also penetrate, while Hijras do not, leaving their sexual partners at a higher risk for HIV. In addition, wives and unborn children of Kothi may also become infected (Chakrapani et al, 4). Kothi tend to have limited access to information regarding safe sexual practices, the risks involved, HIV or STI testing and treatment (Chakrapani, Babu and Ebenezer, 13).

IV. Panthi

Another group, known as Panthi are considered "real" men and are always the insertive partner during anal sex with Hijras and the receiver during oral sex (Asthana and Oostvogels, 13). Panthi men do not consider themselves to be homosexual and claim that their predominant sexual orientation is towards women. They also typically argue that they approach male sex workers because they are less expensive and many times will perform sex acts that female sex workers refuse (Asthana and Oostvogels, 13). They are not a cohesive group and do not identify themselves as a community. Most of their activity is limited to 'cruising' for men (Hijras and Kothis included) often for quick sexual encounters (Chakrapani et al, 4). They are either married to a female, or will be married to a female or Hijra. Importantly, they do not consider themselves to be Panthi, and do not refer to themselves by that term (Asthana and Oostvogels, 13). They obtain the label from their interactions with the Hijra and Kothi because both groups usually will only have sex with Panthi (Chakrapani et al, 5).

Panthi are at risk for HIV because condoms are rarely used during their interactions with either male or female sex workers. However, they are rarely the receptive partners in oral or anal intercourse so the risk of HIV for Panthis is slightly lower then for Hijras. The wives of Panthi are also at high risk because their husbands (Panthi) frequent Hijra and other sex workers, and thus HIV may be transferred from Hijras to Panthi and then to their wives (Chakrapani et al, 4).

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V. Danga

Another label, Danga, is a term that is predominantly used in Tamil Nadu as the label that NGOs/CBOs use to describe Kothis (Chakrapani et al, 6). The Kothi are not very familiar with the term, which results in much confusion about the actual definition. Kothi tend to think Danga is the English translation of the word Kothi. However, NGOs and CBOs use it to describe people who cross-dress, are receptive partners in oral or anal sex, and cruise frequently as a social activity (Chakrapani et al, 6).

VI. Double Decker

The term Double Decker is used to describe men who are sexually inclined towards men. Unlike Kothi and Panthi who solicit male sex workers because they are less expensive, Double Deckers tend to also be sexually attracted to male sex workers. The Double Decker label is closest to the Western term 'gay' (Chakrapani et al, 6). Since they cannot be physically identified by cross-dressing, they are often very difficult to identify and approach (Asthana and Oostvogels, 14). They are not necessarily sex workers and in sexual intercourse they both penetrate and are penetrated. In some cases Double Deckers do marry females (Asthana and Oostvogels, 13). Sometimes they identify themselves with being Kothi because they are penetrated by men; but other times they see the title Double Decker as a more prestigious term because it suggests they also penetrate men (Chakrapani et al, 6).

Double Deckers have HIV risk factors that include infrequent and inconsistent use of condoms and water based lubrication. They are particularly at risk when they are penetrated, and may put their wives at risk through unprotected sex with other partners. Typically they do not marry as often as Kothi so the transmission to wives and unborn children is lowest among the Double Decker group (Asthana and Oostvogels, 14). Double Deckers are also less likely to be sex workers than Kothis, which decreases the number of high-risk encounters (Asthana and Oostvogels, 14). Double Deckers tend to seek out other Double Deckers as long-term partners more often then any other group.

VII. Gay Identified

Gay identifying males in India tend to be at lowest risk for HIV transmission because they have the greatest access to information, testing, treatment and money (Chakrapani, Babu and Ebenezer, 13). Gay identified males tend to have higher self-confidence because men who 'come out' are almost always part of the upper class and tend to have higher income levels then the Hijra, Kothi, etc (Khan, 100). Nonetheless, there are very few openly gay identifying males in India because it is still strongly unaccepted (Khan, 100).

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MSM in India: Annotated Bibliography

Articles in this annotated bibliography are organized by alphabetical order of authors.

1. Asthana, Sheena and Robert Oostvogels (2001). “The social construction of male ‘homosexuality’ in India: implications for HIV transmission and prevention.” Social Science and Medicine 52: 707-721.
Abstract: Over the past 20 years, there has been a growing recognition of the relativity of sexual norms and of the difficulties of exporting Western conceptions of sexuality to different socio-cultural settings. This view has been most clearly articulated in studies of men who have sex with men (MSM) which suggest that the ways in which male-male sexual activity is shaped and constituted vary significantly from place to place. Despite this, 'homosexuality' continues to be treated as an unproblematic category in HIV/AIDS discourse, epidemiological studies of and HIV prevention strategies for MSM in widely different contexts being based on the North American/West European example of gay men. This paper, which draws upon ethnographic research in Madras, highlights important differences between India and the West, not only in the sexual identities and circuits of MSM, but in their sexual partnerships and practices. These differences, it is argued, are not only significant to the epidemiology of HIV transmission, but have important implications for the development and implementation of HIV prevention strategies.
Notes: This article details the intricate social/cultural influences present in shaping sexual lives and identities in India. Sexual identity can be cultivated at an early age and as women are typically segregated to protect their purity, men occasionally seek sexual opportunities with men. Rather than being a sexual identity, traditional terms are linked more with a gender identity. A range of such identities exist and fall into many different categories, which are detailed in the article. The article also details the implications for HIV transmission, some examples include intercourse from MSM to wives and to unborn children. It also includes implications for HIV prevention, in which the article argues that a typical full scale prevention is impossible due to the lack of unity among the different MSM groups.

2. Chakrapani, Venkatesan, et al (2002). “HIV prevention among MSM in India.” 2002: 14-27.
Abstract: No abstract available.
Notes: This article details the different types of MSM in India. It also stresses that there is great variability in the degree to which men consider themselves to be homosexual. Most men who have sex with transsexual men or cross-dressed men do not consider it to be homosexual behavior. There is little social support for MSM in India and they are greatly stigmatized in STD clinics if they are thought to be homosexual. Health care providers embarrass and harass Hijra.

3. Chakrapani, Venkatesan, et al (2002). "HIV prevention among MSM in India: Review of Current Scenario and Recommendations." Background paper prepared by Solidarity and Action Against The HIV Infection in India (SAATHII) working group on 'HIV prevention and care among Indian GBLT/Sexuality Minority communities', Revised draft, April 2002.
Abstract: No abstract available.
Notes: This article has a comprehensive listing of how and where labels are used, for whom they are used, and how they are defined. The article also stresses that there is great variability across each group. Most men do not identify themselves as being a part of the groups that "outsiders" would label them as, which leads to complications in HIV prevention programs. Since the men do not admit that they belong to such group or participate in homosexual activities, they do not think they are at such a great risk of HIV.

4. Chakrapani, Venkatesan, Priya Babu and Timothy Ebenezer (2004). "Hijras in sex work face discrimination in the Indian health-care system." Research for Sex Work 7: 12-14.
Abstract: "The *Hijra*s of India are born as biological males who reject their 'masculine' identity…. Though they are 'tolerated' by Indian society they are not 'accepted' and are discriminated against in various settings. In this article the authors discuss the discrimination faced by [*Hijra*s] involved in sex work by the public health system in the state of Tamil Nadu, India." [from the article].
Notes: *Hijra*s are biological males who reject their masculine identity to become transgenders or transsexuals. The *Hijra* identity has existed for centuries. In the Tamil language, they are called *Aravani* (a term used by activist *Hijra*s to self-identify) or *Ali* (a more derogatory term). *Hijra*s who identify as women often leave their families at an early age and join *Hijra* communities. Indian society generally identifies *Hijra*s as more male than female, and *Hijra*s are stigmatized for their acting and/or dressing more feminine. While many *Hijra*s engage in sex work, not all do, and society stigmatizes *Hijra*s for their presumed occupation of sex work. The choice to enter sex work is influenced by lack of other opportunity, stigma, and economical need for survival. They are often blamed for spreading HIV. When seeking health care, *Hijra*s often face discrimination and humiliation. They are sometimes registered as females when checking in to health facilities, but are usually considered male if they have urogenital complaints, whether castrated or not. This is difficult for *Hijra*s who self-identify as female and prefer to be identified as such. Many feel that the medical staff do not understand them and do not know how to treat them, act around them, or address them. They often endure abusive language and treatment. They often are not treated delicately when examining genital regions and doctors do not understand any shyness since "they are sex workers anyway." Some *Hijra*s reported that doctors use them as case studies, without consent, in clinical lessons for medical students. They are sometimes forced to wear male clothing in the medical wards, and are abused and harassed by co-patients. Since sex change surgery is not provided in government hospitals, and most cannot afford private care, they often turn to unqualified practitioners for the operation, resulting in post-operative problems.

5. Dandona, Lalit, et al. (2005). "Sex Behavior of men who have sex with men and risk of HIV in Andhra Pradesh, India." AIDS 19: 611-619.
Abstract: OBJECTIVE: To obtain information on sex behaviour of a large sample of men who have sex with men (MSM) in India that would assist in planning HIV prevention. METHODS: Homosexual/bisexual behaviour of 6661 MSM at 62 urban-rural locations of various sizes in the Indian state of Andhra Pradesh was assessed through detailed interview. Multivariate analyses were performed to understand the associations with unprotected penetrative sex and barriers to condom use assessed. RESULTS: The average number of

different male sex partners in past 4 weeks was six. In last three sex encounters with men, totaling 19 640, anal sex occurred in 16 769, at least once by 6121 (91.9%) MSM of which 3423 [55.9%; 95% confidence interval (CI), 51.7-60.1%] did not use condom at least once. A total of 2785 (41.8%) were currently married to women and 3354 (50.4%) had had vaginal/anal sex with women in the past 3 months, of which 2818 (84%; 95% CI, 81.1-86.9%) did not use a condom. Furthermore, 1585 (25.9%; 95% CI, 22.7-29.1%) had anal sex without a condom with men and also vaginal/anal sex without a condom with women. This was prevalent across urban-rural locations and its strongest association was with currently married MSM (odds ratio 15.1; 95% CI, 12.5-18.2). The predominant reason for not using a condom with women was 'do not use with regular partner' (68.4%). CONCLUSION: This high rate of unprotected penetrative sex by MSM with both men and women suggests that HIV prevention efforts in India should include a focus on MSM as well as their wives across many urban-rural locations and not only in large cities.

Notes: This article details a study that sought to obtain information about the sexual behaviors of MSM in India in order to recommend prevention programs. The study shows that there were very high rates of HIV infection among both MSM and their wives, concluding that the prevention efforts in India should focus not only in MSM, but wives in both rural and urban areas. Of the men studied, only 10% reported that they were sex workers. In intercourse between men and women, the most cited reason for not using a condom was that condoms are not necessary when having intercourse with a regular partner. HIV prevention should encourage condom use among regular partners.

6. Joseph, Sherry (2005). Social Work Practice and Men Who Have Sex With Men. (New Delhi, Thousand Oaks, London: Sage Publications).

Abstract: No abstract available.

Notes: This book details the complicated identity versus label relationship for MSM, which often means that MSM do not identify with any particular MSM identity. They have been made to fit into neat categories by health care professionals. Most terms used to describe the categories of MSM are considered derogatory and not considered socially accepted for use.

7. Khan, Shivananda (2001). "Culture, Sexualities, and Identities: Men Who Have Sex with Men in India." Journal of Homosexuality 40: 99-115.

Abstract: This essay arises from a specific context of working with sexual health issues among males who have sex with males in India, where HIV/AIDS has become an urgent issue. Over the past few years, The Naz Foundation (formerly The Naz Project) has sponsored several consultation meetings, worked with local male sexual networks and organizations, and helped develop locally based service projects in Calcutta and New Delhi focusing on the sexual health needs of males who have sex with males and gay-identified men. The Naz Foundation has also been involved in a variety of research and ethnographic studies among male sexual networks and has published a variety of reports on the cultural, religious, and social frameworks of males who have sex with males in India. It is our belief that understanding frameworks of sexual behavior is the first step towards developing appropriate strategies for encouraging behavioral changes towards safer sex practices. This perspective has also arisen from my work as founder of Shakti, the South Asian lesbian, gay, and bisexual organization formed in 1988 in the UK. Working with this network and articulating its concerns to the broader lesbian and gay communities was to lead me to question some of what I considered the fundamental assumptions that configured these communities. It led me to read, listen, and learn about constructions of sexuality and their historical and contemporary significance. This essay is a part of that learning process, a

process whose focus continues to be primarily on developing appropriate strategies to promote male sexual health. As a part of this process, The Naz Project was involved in two significant events in India. The first was a seminar held in December 1993 on Alternate Sexualities, organized by Sakhi (a lesbian resource center in New Delhi founded by Gita Thadani) and sponsored by The Naz Project. The second was a consultation meeting on sexual health for men who have sex with men and gay identified men held in Bombay in December 1994, organized by The Humsafar Trust and The Naz Project. This essay focuses on men who have sex with men, and gay men. This is because most of the research and analysis conducted so far by The Naz Foundation has been on the male to male sexual behaviors as a significant factor in STD/HIV transmission in India. This is a different matter than the construction of men's sexualities. While considerable work has been done on female bonding and friendships, gender constructions, and female social roles, very little research has been conducted on female to female sexual behaviors and constructions of lesbianism in India. I fully acknowledge the weakness this lack brings to this essay.
Notes: This article details the fluidity of sexuality and lack of identity with and among the different MSM groups. It also gives several examples of men that live in India and practice different types of MSM. The article argues that many men do not and cannot admit their homosexuality due to familial pressures not to disgrace the family and to marry a woman so they can collect a dowry. The changing meaning of the words that are used to describe MSM such as Ali, Double Decker and Panthi are constantly changing and evolving. None of the terms used to describe MSM are meant to be complimentary, creating a stigma attached to the labels. Also, the word homosexual is just coming into use in India, however there is no equivalent in the Indian language; so many Indian men do not understand it or how to use it.

8. Khan, Shivinanda (2004). "MSM and HIV/AIDS in India." Naz Foundation International.
http://www.nfi.net/NFI%20Publications/Essays/2004/MSM,%20HIV%20and%20India.pdf
Abstract: No abstract available.
Notes: This article gives a complete overview of every aspect of MSM behavior and especially how they are affected by HIV/AIDS. The article also discusses the different labels used for MSM and an estimation of the current size of the infected MSM population compared to the general population through quantitative surveys. The surveys include samples from three cities, Hyderabad, Bangalore and Pondicherry, which showed knowledge of HIV/AIDS in 71% of respondents. Even with the knowledge of HIV/AIDS, an average of less then 50% of men used prevention measures. Most important were the descriptions of stigmatization and discrimination that MSM face from health care providers, government officials, police and other MSM. Recommendations for preventing HIV/AIDS among the MSM populations are made, some of which include free condom and lubricant distribution, free STI clinics, counseling and increased training of the judiciary and other law enforcement officials.

9. Network of Male Indian Sex Workers (2005). "Pilot Study on Male Sex Workers in India, Study of MSW in Kolkata, Ahmedabad and Vijayawada. Kolkata." NIMSW: 1-9.
Abstract: None.
Notes: This article defines male sex workers (MSWs) as persons who have sex in exchange for money, favor, and gifts. The main sub-types of known MSW include *Koti* (feminized males practicing receptive anal sex); *Panthi* ('real' males practicing insertive anal sex); *Dubli* (males practicing both receptive and insertive sex); and *Hijra*s (gender-variant groups considered more male than female in the country). MSWs are extremely stigmatized and marginalized. Male sex work is practiced both indoors and outdoors, with poorer, full-time

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MSW more likely to work outdoors. Since many MSMs in India think HIV cannot be passed male-to-male or through anal sex, there is a very low perception of risk and therefore very low condom use. There is little availability of information, condoms, and health services. MSWs do not necessarily consider themselves homosexual. They are sometimes married and sometimes employed. They generally have little education and low incomes. There is a major need for health services; HIV education; employment opportunities and job training; collectivization; cooperation from law enforcement; protection from violence; and condom, lube, and gel access.

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