DECLARATION

I hereby declare that this dissertation work titled “MALE HAVING SEX WITH MALE POPULATION (MSM) OF KOLKATA, HIGH RISK BEHAVIOUR AND ANALYSIS OF THE SOCIAL FACTORS” is the result of original research and it has not been submitted for the award of any degree in any other institution.

Dr Soumya Sarkar

Thiruvananthapuram, Kerala October 2008

CERTIFICATE

I hereby certify that the work in this dissertation titled "MALE HAVING SEX WITH MALE POPUALTION (MSM) OF KOLKATA, HIGH RISK BEHAVIOUR AND ANALYSIS OF THE SOCIAL FACTORS" is a certified record of original research work undertaken by Dr Soumya Sarkar in partial fulfillment of requirement for the purpose of award of Master of Public Health Degree under my guidance and supervision.

Guide: October 2008

Dr Mala Ramanathan

Additional Professor

Achutha Menon Center for Helth Science Studies

Sree Chitra Tirunal Institute for Medical Sciences and Technologies

Thiruvananthapuram-695011

Kerala, India

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ABSTRACT

The MSM population is termed as the high risk group for the high risk of transmission of HIV amongst them. The high risk has been ascribed to their biological risk factor. But biological risk is only a part of their risk spectrum as there appears to be a significant social risk as well.

Objective The risk of HIV in the MSM population can be assessed by the presence and absence of safe sex behaviour characterised by the use of condom/lubricants, and prevalence of different sexually transmitted disease. So the study proposes to examine and identify the social risk factors namely the adverse reactions from society and family, lack of recognition of homosexuality denying them knowledge of safe sex, violence and examine the influence of these factors in the MSM population.

Methodology Cross sectional study consisting of quantitative survey using structured questionnaire and qualitative survey with indepth interview. The objective of the quantitative survey was to enumerate the social factors of stigma and adverse life events and the risk behaviour present. The objective of the qualitative survey was to bring forward the perception of the MSM regarding their risk. The sample size for the quantitative survey was 126 and 9 indepth interview.

Results and conclusion Social factors like the adverse reactions in public and private spheres, abuse, violence and forced sex, early age of sexual debut and lack of social support are significantly associated with outward stress reaction, precipitating high risk sexual behaviour, namely condom use and episodes of STD.

Recommendations Recognizing and addressing the societal factors is as much important as the biological factors are important for effective intervention of the vulnerability of MSM population.

Abbreviations

STD	Sexually Transmitted Disease
HIV	Human Immunodeficiency Virus
NACO	National AIDS Control Organisation
WHO	World Health Organisation
FHI	Family Health International
WBSAPCS	West Bengal State AIDS Prevention and Control Society
VCCTC	Voluntary Confidential Counseling and Testing service
PPTCT	Prevention of Parent To Child Transmission (of HIV)

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Chapter 1 Introduction

1.1 Background information

The words homosexual and heterosexual were invented in 1868 and first put in print in 1869 by the Hungarian author Károly Mária Kertbeny (1824-1882)[1]. In 1864, the German lawyer Karl Heinrich Ulrichs (1825-1895)[2] had come up with the words "uranism" and "uranian" to describe a similar social reality while "philopedia" was created by the French psychiatrist C.F. Michéa in 1849. These words no longer referred to sexual acts that were sins and crimes and were called sodomy, unnatural intercourse, pederasty and so forth, but to sexual identities and desires that were deeply imbedded in persons. Ulrichs and Kertbeny were predecessors of the gay rights movement and wrote mainly against criminalisation of sodomy. They spoke largely from personal experiences and historical examples. Most medical authors who started to use these new terminologies to discuss mainly the causes of such identities and desires and the question whether they were pathological or normal. They set the standards for the search of a biological basis that continues to this day ("gay gene"). Most physicians started to believe that homosexuality was an innate condition (but not the Freudians) and took the position that it was a disease or abnormality that should be healed and prevented. The early research by psychiatrists was mainly based on case histories of what they called 'perverts'[3]. That sums up the European scenario regarding homosexuality.

With the historical and socio cultural changes that have taken place over the time in India, the meanings associated with sexuality have radically transformed, especially during the last two decades. Since human beings are unique, they are bound to have unique sexual experiences [4].Indian culture is characterised by restricted mingling among sexes, like

many other South Asian cultures, and the expression of physical intimacy with a member of the opposite sex is frowned upon. At the same time homosocial behaviour between men involving body contact, sharing of bed is accepted and seldom raises much question [5]. Much of these relationship is non penetrative in nature and young men indulging in this behaviour do not see it as a homosexual act but view it within perspective of their sexual desire, opportunity and pleasure. Euro American understanding and discourses of gay identities, heterosexuality, homosexuality, bisexuality or even the use of the term "sexual minority" can be misleading. It actually renders invisible the range and level of male to male sexual activities in India and those involved in them [6]. Sex was defined reproductively. Masculinity is defined by the act of sexual penetration and gendered roles and not by sexual orientation. But it generally includes not only the more visible female (feminized identity) who self identifies as kothis but also their male partners who are lesser visible and identify themselves as panthis. Marginalised with a status of sexual minority, public spaces and discourse identify them in a culture of shame, guilt and crime.

Male to male sexual activity comprises a minority group comparable to racial, ethnic and religious minorities and are held in low esteem by the dominant segment of mainstream society. Frequently they receive differential treatment from the heterosexist society which ranges from violence, victimisation and assaults of various natures.

As the men in India do not clearly self identify them as gay-bisexual, so the use of such sexual identities would then serve to leave out many of those do not identify themselves as such. This may be due to the strong understanding of masculine roles within the society which does not recognize other forms of masculine roles, including a sexual role as a receptive sexual partner for a man[6&7].

1.2Classification of MSM identity

As per the World Health Organisation (WHO) [8], a working definition MSM includes-

- Men who exclusively have sex with other men
- Men who have sex with other men but mostly have sex with women
- Men who have sex with both men and women without any particular preference
- Men who have sex with other men for money or because they do not have access to sex with women, e.g. men in prison, men in the military

So, the different sexual roles of men who have sex with men include-

- Men who are exclusively the insertive partner in anal sex
- Men who are exclusively the receptive partner in anal sex
- Men who are both insertive and receptive
- Men who do not have anal sex but practice other activities such as oral sex and mutual masturbation
- Men who assume different roles and practice different activities at different parts of their lives

1.3 *Kothi- Panthi- Hijra – Double decker* framework of sexual identity[9]

These identities are based on the sexual preferences and behaviour and they are particularly important to understand the nature of MSM sex in India.

Kothi- A self identifying label for those males who feminize their behaviour (either to attract a "manly" male sexual partner and /or as a part of their own gender construction and usually in the specific situations and context) and who state that they prefer to be

sexually penetrated anally or orally. Self identified kothis use this term for sexually penetrated males, even when their performative behaviour is not feminized. This is the primary and the most visible framework for MSM behavior in the Indian context. However, many kothis may be married to women as part of their fulfillment of societal expectations of a male role.

Panthi/pareekh- A kothi label for any "manly male". By definition they are men who penetrate the 'other' , regardless of whether the 'other' is a woman or a man. They are most likely to be married to women and /or access women for sex.

Hijra- A term used by males who define themselves as "not men or women but a third gender". They cross dress publicly and privately and are part of a strong cultural, religious and social community. Ritual castration is a part of the hijra identity but not all hijras are castrated. Sex with men is common and such men will see themselves as "real men" and not homosexuals.

Double Decker- In MSM terminology double decker is the male who prefers to penetrate and also get penetrated.

With the advent of the HIV epidemic, the sexual marginalisation assumed new aspect. Homosexuality was believed to be the underlying pathology for the poorly understood disease. High incidence of receptive and insertive anal intercourse, very low condom use, large number of sexual partners, poor health seeking behaviour and concentration of highest number of HIV infection are some of the few factors that made the population as one of the highest risk categories. Commercial sex activities were common. The other problems associated fuelling the spread of the HIV was the different sexual behaviour and identity that made intervention for the MSM a diverse and difficult one.

1.4 Vulnerability of the MSM population

Life experience for adverse events and social attributes construct the vulnerability of the MSM population to form a complex pattern that encompasses biological, behavioural and social factors. All these factors singly or in combination precipitate risk taking behaviour for the MSM group and make them more vulnerable for the spread of HIV.

The vulnerability framework[11]

Stresses	Coping response
SOCIETAL HOMOPHOBIA AND PREJUDICE: Shame, secrecy ,guilt Anti homosexual bias Confusion , denial, self hatred Isolation	Internalized homophobia Tolerate discrimination and abuse Identify favourable support system Seek information Network and support group
LABELLING BY THE OTHERS Emotional and social rejection Isolation and withdrawal	Seek clarification Self blame Accept and neglect labels
FAMILY ENVIORNMENT Individual identity subsumed in family identity Parental reaction for coming out	Non-disclosure to family Self blame Sacrifice personal needs for the family needs
MARRIAGE Familial and societal pressure	Marry and lead double life Coming out in the family Remain unmarried and face eventualities
SEXUAL ORIENTATION AND IDENTITY Perceived change in sexual orientation Incongruence between public and private sexual identity	Seek information Seek help from support system Come out in public
SEX AND SEXUAL HEALTH Lack of safe space Anonymous partners Fear of identifying Perceived risk	Seek help Less intimacy and multiple partners Non-monogamous Safer sex
INTIMACY AND COUPLING Social and legal disapproval Sexual infidelity	Emotional and affectional relationship Sexual non exclusivity Cohabiting or living together with partner
NETWORKS AND SUPPORT GROUPS Diversity of social and sexual preferences and interests Internalized homophobia	Infighting Self enhancement of norms and values
ANTIGAY ADVICE Physical and sexual violence	Seek help from the support system Tolerate abuse and discrimination

1.5 Rationale of the study-

MSM populations, being the high-risk group, are the focus of attention of HIV intervention program in almost all the countries. The varied natures of their sexual identity and the invisibility created by the societal oppression and indifference have made them one of the most crucial targets for intervention. But addressing the biological vulnerability can not cover the whole gamut of vulnerability of the MSM population's risk of HIV transmission. An inclusive policy is needed to be framed to cover the social, cultural and economic factors responsible for the vulnerability of the population. The social intervention needs to address the reasons for the vulnerability, oppression, various forms of violence and rejection faced by the population while the medical intervention needs to bolster STD management, VCCTC and PPTCT. For the Indian context, understanding the social dimensions of the problem will need to take into account the ingrained societal homophobia, emotional and social rejection in the family and society, lack of safe space to public discourse of sexual health matters of the sexual minorities, the legal disapproval of the same sex practices and physical and sexual violence imparted on the MSM in a predominantly anti-gay social setup[12]. Even though the vulnerability has been realized for a long time, prevention efforts are poor, mostly due to the lack of understanding of the nature of the problem.

Understanding of the societal factors and exploring its relations with the high risk sexual behaviour is thus of paramount importance. Preventing the HIV progression is a major social intervention, not merely a medical or health intervention justifying exploration of the social factors associated with the study.

The factors for the vulnerability of the MSM population are multiple and follow a complex social pattern culminating into the high risk for HIV transmission.

1.6 Objectives:

The risk of HIV in the MSM population can be examined by the presence and absence of safe sex behaviour characterised by the use of condom/lubricants, multipartner/commercial sex practice and prevalence of different sexually transmitted disease. So the study proposes to examine and identify the social risk factors and examine the influence of these factors in the MSM population.

Major objective-

Identify the social factors that determine the high risk sex behaviour among the MSM population of Kolkata

Minor objectives-

1. To determine the sexual and reproductive health related morbidity experienced by the MSM
2. To describe the perception of risky sexual behaviour and safe sex
3. To determine the socio-economic and cultural context in the lives of the MSM that facilitates or restricts risky sexual behaviour.

1.7 Research questions

1. What are the adverse reactions and responses faced by the MSM community over the issue of divulging their sexual identity?
2. What is the nature of sexual partnership among the MSM community?
3. What is the prevalence of sexually risky behaviour among the MSM population?
4. What is the perception of risk behaviour among the MSM population?
5. What is the prevalence of different sexually transmitted disease in the MSM population?

6. What are the social and family support mechanisms for the MSM to seek treatment?
7. What are health care seeking behaviours among the MSM population?
8. What are the various forms of the violence faced by the MSM in their family and societal level?
9. What are the life experiences of the MSM respondents regarding the coming out process among the family, friends circle, workplace and society and the sexuality and violence, abuse and neglect faced in public as well as private spheres of life?

1.8 Arrangement of Chapters

The whole dissertation work has four chapters. The first chapter has the background and the rationale of the study. The second chapter outlines the available evidences in the literature. The third chapter details the methodology used in the study. The fourth chapter contains the analysis and the discussion and the fifth chapter contains the conclusions that have been derived from the analysis and the possible policy implications of the study.

Chapter 2 Literature Review

MSMs are considered a sexual minority group. The unique attributes of the MSM respondents like extreme stigma, discrimination, societal rejection and violence as well as the high biological risk of HIV transmission have made them more socially marginalized. The response of the mainstream society to the problem is mostly denial of the existence of the activity, suppression and criminalising. All these factors combine to make them invisible to society, to researchers and to HIV intervention services that is much needed for the population. The extreme variation in sexual identity, partnership profile and other factors make it impossible to make any generalized statement but some very salient facts need to be explored to provide deeper understanding into the problem.

2.1 Incidence of MSM behaviour

The Kinsey report suggested that there was 10 percent homosexuality in the population [13]. Within India, lack of adequate data estimating the incidence of MSM community is a serous problem and the problem is compounded by the criminalization[14] and extreme social marginalization[15]of MSM activity.

A study done in Chennai among male college students showed 16 percent same sex activity. A north Indian study among truckers showed 15 percent male to male sexual activity. Another survey among rural men in Maharastra showed that 10 percent among unmarried men and 3% of married men had unprotected anal same sex acts in the past one year. The overall prevalence of MSM sex was 6.6 percent in this study group. Prevalence of MSM activity in urban slums was estimated to be 5.9 percent. [16].

The vulnerability of the MSM population regarding the risk of transmission of HIV/AIDS in this population stems from the fact that the biological vulnerability of the MSM sex practice (ano-receptive and ano insertive sex) is combined with the widespread stigma, discrimination and

rejection, violence in private as well as public sphere of life. The social factors are instrumental in the development of high risk sex practice like multipartner/clandestine sex, commercial sex, substance abuse, partner violence etc.

2.2 Biological Vulnerability of MSM and Risk of HIV transmission in anal sex

Literature suggest that there is no evidence that MSM populations are more susceptible to HIV/AIDS but certain male- to- male sexual behavior makes them more vulnerable to HIV/AIDS. The risk increases with anal intercourse. Anal epithelium is more susceptible to tear during intercourse. The surface epithelium of rectal tissue is bigger than vaginal epithelium. This therefore, increases the susceptibility to HIV [17]. A complementary cross sectional survey amongst gay men in 1999 and 2002 showed the following result. Of gay men who reported any unprotected anal intercourse (UAI) with regular partners (in the previous 6 months) in consecutive years was 27.9 percent in 1999, 24.3 percent in 2002. Similarly, rates of any UAI with casual partners was 16.3 percent in 1999, 14.4 percent in 2002 [18]. Researchers have found that, receptive vaginal sex was twice as risky as insertive vaginal sex per act and receptive anal sex was five times riskier than receptive vaginal sex, per act. Similarly, insertive anal sex was 1.3 times riskier than insertive vaginal sex, per act. Insertive oral penetration was 10 times less risky than insertive vaginal sex and receptive oral sex was 10 times less risky than receptive vaginal sex, per act. The absolute per-act risk of acquiring HIV was highest (5 per 1,000) when a person had receptive anal sex without a condom with HIV positive partner. For a man who had receptive anal sex without a condom with a male partner of unknown serostatus (in an area of HIV prevalence 10percent), the per-act risk for HIV infection was 5 per 10,000 [19.]

Another risk associated with the male to male sex was the high reported incidence of condom failure(16.6 percent) with an average 2.5 /100 in receptive anal sex and 1.9/100 in insertive anal sex [20].

India has acknowledged the presence of MSM in third stage of National AIDS Control Programme [21]. In India anal sex between men is considered to be no sex at all and is perceived to be “safe” in the absence of knowledge about safe sex practices. So the Indian youth can be said to be more at risk. Such men have poor visibility and do not form part of high risk MSM sexual landscape. The incidence of anal sex according to another researcher is 45 to 55 percent with only 5- 20 percent condom use[22].

2.3 Sexual identity and marital status-

A study conducted in Mumbai reported 22 percent of the MSM respondents were married of whom 27 percent are HIV positive. Seventeen percent of the MSM and 68percent of the trasngenders were HIV positive. 44percent of the MSMs had sex with female commercial sex workers in the last 6 months. All transgenders practiced receptive anal sex in the last 6 months and had more than 10 partners. Only 24percent of the MSMs and 11percent of the transgenders used condoms ‘sometimes’ during receptive anal sex. [23]. A study done in China among the MSM population shows that of all 896 adult male respondents, one-third had ever been married, 59 percent had ever engaged in bisexual behaviors, and 31percent had done so in the past 6 months. High prevalence of inconsistent condom use was reported in heterosexual behaviors (71.9 percent), as well as with those who had engaged in MSM sexual behaviors in the past 6 months (30.8 percent with commercial sex workers and 54.7 percent with noncommercial sex partners). Those who did not use condoms with MSM partners were also more likely than others to not use condoms with their female sex partners (FSP) [24]. The Needs Assessment report of the WBSAPCS in 2003 found that, 77.4% of respondents to the survey questionnaire were unmarried and 20.2% were married. A few were widowers, separated or divorced [25].

These evidences point to the fact that there was a high risk of the MSMs acting as a bridge population for transmission of HIV to general population and there is urgent need to address the vulnerability of the HIV transmission.

2.4 Multiple sex partner and HIV risk

In India, an average of 11-28 casual sex partners per month for MSMs have been reported [22].Among the patients attending a sexually transmitted diseases clinic in New York City multiple sex partners was found among the MSM population[10]. A report by World Health Organization on situation on HIV/AIDS in Asia Pacific acknowledged this finding and express concerns on the issue multiple sex partners of MSM population in most cases[26].A study done in Senegal does showed similar behavioral findings among the MSM population[27]. A similar cross sectional study done across 6 US cities showed that 90 percent of the respondent have more than one partner in past 6 months, 1382 respondents had 2-5 partners in the past 6 months, 750 respondents had 6-9 partners and 1812 respondents have more than 10 partners[28].

A Peruvian study to assess the same sex behavior of low income urban males had demonstrated similar findings. Here, mean life time sex partners for men who never sex with men was 4.5 ±7.06 SE compared 10.1 ± 14 SE in men who had ever sex with men[29]. Moreover, the social stigma of MSM and the related fear of getting exposed may mean that most partners could be anonymous increasing the chance of disease transmission [30].

2.5 Early age of sexual initiation

Studies done in Senegal with self identified MSM respondents has shown early age of sexual initiation [31]. People who had an early sexual debut had more incidence of sexually transmitted infections [32]. Moreover, victimization, verbal and sexual abuse and harassment for the sexual minority youth can manifest chronic stress associated with school-related problems, running away from home, conflict with law, substance abuse, prostitution and suicide [33].

2.6 Sexual identity

MSM communities in Asia differ markedly from the West. Very few MSM adopts gay identity in which sexuality defines identity. Sexual identity here is insertive Kothi or penetrative Panthi [34].The difference in the sexual identity was most of the times equated to gender power inequality and that was another constricting factor to create a safe space for sustained behavioural change [35].

2.7 High incidence of commercial sex activity

The Pitt Men's Study has shown that MSM who exchange sex for money and drugs are at a greater risk for STI and HIV transmission[36]. A behavioural surveillance survey conducted in the truck terminal of Mumbai showed that MSMs had an average of 22.5 male clients in a week. More than four fifths (81.4 percent) of MSM were receptive anal partners and 15percent were insertive anal partners. A small proportion (15percent) of MSM practiced heterosexual intercourse which is non-spousal in nature in 77.3percent of the cases[37].

A study done in Senegal showed that 22.5 percent of the participants had exchanged sex for money and 43percent of it was insertive anal sex followed by 34.3percent receptive anal sex. Receptive or insertive oral sex was practiced by one quarter of the respondents[26]. A study done in Peru has compared men who had either unpaid heterosexual sex or commercial heterosexual sex with men who had ever sex with men in the past one year, life time episode of paid sex was 36.5percent compared with 11.5 percent heterosexual respondents. In both instances use of commercial sexual services was strongly associated with homosexual and heterosexual activity [29]. A study done in Andhra Pradesh also showed a high number in non regular and commercial sex partner for the MSM population[38].

2.8 Incidence of STD among the MSM participating commercial sex

A cross sectional study done in America showed that among all MSM's participating in the commercial sex, 66 percent did not use condom and 26 percent were diagnosed with early

syphilis. Association with commercial sex work was also associated with a two fold high risk of being HIV positive compared to the MSMs who did not access the commercial sex[39].

In a cross sectional study done in Pakistan, STI prevalence in MSMs were as follows (HIV 4 percent, syphilis 23percent, gonorrhea 36 percent, chlamydia 11percent) and in Hijra's (HIV 2percent, syphilis 62percent, gonorrhea 29percent, chlamydia 18percent). It also showed that sexual practices differed with 25 percent MSMs versus 0.5 percent Hijras buying or selling sex to women. 10percent MSMs and none of Hijras had last sex act with a non-paying female partner. Condom use in last vaginal sex was 6 percent among MSMs. Frequencies of receptive anal sex was 38percent and insertive anal sex was44percent in MSM. Hijras engaged in mainly receptive anal sex (87percent). The overall condom use with male sex partners in last sex act was very low, (4 percent for MSMs and <1percent for Hijras).It also showed that the commercial sex networks in the MSMs as not being exclusive but being closely linked with female commercial sexual network and consequential high risk of HIV transmission across the group[40.]. Researches have shown that commercial sex in the MSM respondent were mostly clandestine and power imbalance between the provider and the purchaser had a constraining effects on the space for negotiating safe sex. Similarly violence can be another factor that hampers negotiation of safe sex for the MSM respondents participating in the commercial sexual network [41].

2.9 Substance use among MSM

The risk factors for substance use among the Latino Gay, Bisexual and Transgender were analyzed in US across two US cities. It found the use of club drugs(e.g. cocaine, crystal amphetamine, ketamine, volatile nitrites and other drugs like marijuana, poppers (amyl nitrites), cocaine and methamphetamines nearly doubled the estimates odds of engaging in unprotected anal intercourse [42].A Peruvian study has shown that 17.7 percent of the respondents who were MSM had taken used illegal drugs compared to 7.0percent of the respondents who were heterosexuals[29]. Multiple substance use was also found among the MSM respondents in the US study where 26.2 percent men consumed alcohol. Marijuana was the non-injection drug used by

46.3% of men, followed by poppers amyl nitrate(36.6%) respondents, other drugs that the respondents used were ecstasy, cocaine and amphetamines. Some also used injectable drugs [43]. In a study conducted at Chicago,it was found that alcohol consumption was significantly associated with number of unprotected anal intercourse in MSM [44].

2.10 Abuse and violence:

An examination of MSM cohorts in a prospective study in 1985-94 showed that the men in the youngest age quartile experienced incidence of assault nearly 3 times greater than MSM in the oldest age quartile. In other words, MSMs who have revealed their sexual identities quite early were subjected to more violence. The overall incidence of violence was 2.6 per 100 person years. Violence was highest against respondents of younger age group[45]. Research on the adverse life experiences showed that sexual minority status was significantly associated with assault perpetrated by strangers, family members and peers-usually males[45]. There were also evidence in the literature suggesting that even apart from the risk of transmission of sexual health morbidities, there are other problems of intimate partner violence [47], like depression induced substance abuse and a gamut of other problems like eating disorders due to depression, societal stigma and internalized homophobia [48].

2.11 Unsafe sex behavior in MSM communities

Although the gay men have changed their sexual behaviour substantially since the advent of AIDS [49], the level of risky sex remains seriously problematic within the gay male populations. Duboi Arber et al [50] reported that 23percent of the research subject practiced unprotected anal sex. In Italy, the percentage is 50 percent [51].

But there is a problem with the behavioural changes being sustained in the population of the MSMs. Research in England for the period January 1989 to July 1998 found that 16percent who were having safe sex practice in July 1989, reported instances of unsafe sex in January 1998 [52]. The Chicago cohort of MACS project reported that after one year of observation, 31percent of

those who practiced safe sex initially, became inconsistent about the risk taking after the project activity was concluded. The authors of this study concluded that "augmented practice of safe sex goes along with an alarming backsliding to unsafe sex" [53].

2.12 Social Stress and high risk sexual behaviour

Stress is considered as a series of phenomenon that occurs over time and include environmental stimulation, perception and interpretation of stimulus by personas well as person's response to perceived stimulus [54]**.**When social stress theory is applied to study the risk behavior of MSM population, it implies that high risk sexual behavior is an outcome of stress. Therefore, one needs to identify the causes of specific stressors, stress mediators and mediating mechanism to explain the high risk sex behavior practiced by MSM population.

Sexual behavior practiced by MSM population arises from the social stress factors determining the well being of MSMs. "Coming out" disclosure is central to this approach. Coming out is defined as the disclosure by an individual on his same-sex emotional and sexual orientation in an individual social milieu and is an important life event. It has widespread ramifications in reactions to an individual by the society in which he lives and also readjusting to his changing sexual desires. In this situation social support is perhaps the most important determinant. Some people may get psychosocial support from within the peer group or in accepting familial environment. Those who do not get this support are in a chronic conflict situation where they struggle for a sense of identity which confirms to their inner feelings and desires [55].

Other researches have also found that social oppression of gay men characterized by withdrawal of social support creates considerable distress, leading to depression and sexual risk behavior[56].

Chapter 3.Methodology

This chapter will include a brief description of the type of the study undertaken, the study settings, the procedure followed for sample size estimation, procedure for the selection of the sample both for the quantitative and the qualitative study, data collection plan and the technique, plan for analysis for the collected data. In the last part of the chapter the ethical issues regarding this study is incorporated.

3.1 Study Type

This is a cross sectional study. Qualitative methods have been used to examine specific causal linkages by identifying specific cases for detailed exploration. Research questions were studied using a quantitative method to provide an understanding of the socio economic and cultural factors behind the risky sexual behaviour. Research question 2,3 and 5 are studied using qualitative methods to provides the understanding of the reproductive and sexual health morbidity and related experiences. Research question 4 answers the perception of risky sexual behaviour and safe sex perception of an MSM. Research question 6,7 and 8 was analysed to provide insight into the socio-economic and cultural context in the lives of MSM which facilitates or restricts their risky sexual behaviour. Research question 7 also partly provides insight to the reproductive and sexual health morbidity.

3.2 Study settings

Criminalsiation and stigmatisation makes the MSM a difficult to access group for research. So to select the respondents, beneficiaries of the NGO network SAATHII and MANAS BANGLA working for STD Intervention Programme under West Bengal State AIDS Prevention and Control Society are included.

Justification of choosing the venue as Kolkata- Being one of the major metropolitan cities of India, Kolkata was one of the focal points of various human rights and gay rights movement and home of various organisations working on the same issue, and it is easier for the MSM respondents to come forward. There are many sexual networks and red light areas with networks for clandestine sex activity. Knowing the local language and key stakeholders of the project was very helpful.

3.3 Sample size estimation

Quantitative study: The sample size was estimated using Epi info stat-cal with an estimated prevalence of STD 9.92(based on the Needs Assessment study) [25]and a sampling frame of 800 (the number of members of the network of NGOs). So with 95% Confidence Interval, the required sample size was 118 which had been rounded to 126. In order to ensure voluntary participation, care was taken to only include those who were over 18 years of age.

Qualitative study: From among those interviewed for the quantitative study, specific persons were identified to explore the issues relating to perceptions of risk and socio-cultural contexts of the lives of the MSMs and included.

3.4 Sample selection procedure

The quantitative study: Every alternate person coming into the clinic on the survey days was chosen for inclusion (for randomisation) in the sample till the required number sample size was fulfilled.

The qualitative study: The respondents were selected from the MSM who had been interviewed for the quantitative survey and had significant life experience of violence and other adverse reactions from others.

3.5 Data collection plan –All data, including qualitative and quantitative, was collected in a 3 month period (10thJuly 2008-10thSeptember).

Quantitative data collection: During this period, respondents (self identified coming to the drop in centre/clinics in clinic days) were accessed and their consent was obtained. The interviews were conducted at the clinic/drop in centres.

Qualitative data collection: Specifically identified MSMs (using the above mentioned sample selection procedure) who consent to being interviewed in depth was asked at the end of the quantitative interview about their willingness to participate in an in depth inquiry. The interviews were conducted at the clinic or the drop in centre.

3.6 Data collection technique

The quantitative data collection includes preformatted interview schedule and was administered by the principal investigator. The questionnaires were developed on a framework of "guidelines of repeated Behavioural Surveillance Survey in Population at Risk of HIV prepared for Project Impact, HIV/AIDS Care Department: Family Health International in 2001.[58]The questionnaire was modified to make it culturally suitable for Indian context. Questions were included to collect some specific data regarding violence and vulnerability. It was field tested in the same area.

The guidelines for the in depth interview was prepared to capture the specific adverse life events and to understand the effects of the adverse events. There were specific open ended questionnaires to understand the vulnerability in the MSM regarding sexual partnership, commercial sex work and sexual health perceptions, the effects of different type of violence faced in private and public sphere.

For the purpose of both type of data collection, four clinics/drop in centres were accessed (Dumdum, Kadapara, Kasba, Ballygunge DIC- of Manas Bangla Project and Kadapara DIC of SAATHI, all located in the Municipal Area of Kolkata). We divided the sample equally across the four centres, but in one centre, two additional interviews were conducted to complete the required sample size of 126. Among the 9 in depth interviews, 2 were done in Dumdum, Kasba, Kadapara and Ballygunge and 3 interviews were done in Ballygunge centre.

Quantitative survey: A pre-structured interview schedule along with a consent form was administered in Bengali (the local language). A validated scale used was called "Rosenberg self esteem scale" with a cutoff of 20 below which self esteem was low and above which self esteem was high.

Qualitative survey: The quantitative survey was done using the in-depth interview guideline described here (also translated into Bengali).

Both of the guidelines and questionnaire are translated and retranslated to and from Bengali to English for validation**.**

3.7 Plan for data analysis

The vulnerability framework identifies the following factors acting as social stressors for the life of MSM- Societal homophobia and prejudice against homosexuality giving rise to shame, secrecy and guilt, and adverse reactions during the coming out process, lack of recognition of homosexuality denying safe sex knowledge and practices, lack of social support and physical or sexual abuse.

To study them, the following predictor variables were chosen-

The Predictor variables for the study

1. socio demographic profile of the respondent including age, sex, education and marital status
2. sexual identity of the respondent
3. The age of sexual debut
4. Substance abuse
5. Different form of adverse reactions or rejection from peer and family and social circle and
6. Violence including partner violence, family and society.
7. Participation in commercial sex networks

The Outcome variables for the study - the social stressors are high risk behaviour which is judged by the following-

1. Sex with multiple (same /opposite sex) partner
2. Pattern of consistent condom use among all sexual partners
3. Prevalence of the sexual morbidity among the respondents.

To understand and enumerate the societal homophobia and social prejudice experienced by the MSM population, specific questions regarding the experience of divulging the identity, age of the sexual debut, educational and income status of the respondents, self esteem and social rejection abuse and violence etc were asked. Sexual health morbidity and treatment seeking behaviour were enquired by asking whether the respondents had the symptom in the last 6 months or the delay before treatment as getting otherwise

accurate information is not possible without any access to clinic records. Questions were asked about the reactions of the partners and family members after divulging the sexual morbidity. To understand the high risk behaviour questions were asked to enquire about their participation in the commercial sex practice and problems and violence associated with the exposure to the network. There are also specific questions regarding condom use across different types of sex partners and negotiation power of the respondents to use condom. There are questions about the substance abuse. To understand the relationship between the adverse reactions and the mental health status of the respondents, questions were asked to enquire whether they suffered from any psychiatric morbidity.

Apart from the emergence of the homosexuality, in the in depth interviews specific guidelines were set for getting understanding of experiences of rejection, abuse, and social marginalisation. Specific questions were also put to understand the reactions of public and private violence and the effects of violence.

Specific guidelines were provided to inquire about the risk and use of condom pattern and negotiation for condom use across different partners.

The in depth interviews also contains specific guidelines about the partnership profile, the partner seeking behaviour and the problems and violence associated with it. Discussions also included treatment seeking behaviour for self and partners.

The data was analysed during the period of Sep-Oct 2008. The quantitative and the qualitative part were analysed together.

The data analysis for the quantitative process includes univariate and bivariate analysis. Chi-square tests were done to examine any statistically significant associations. The data

from the in depth interviews was used to triangulate the findings of the qualitative part and to further analyse the risk perception of the MSM population.

3.8 Ethical considerations- the proposal for the project was submitted and approved by the SCTIMST Institutional Ethics Committee. Informed consent was obtained from all of the respondents. Participant confidentiality was respected during and after the study. The database and the transcripts for the in depth interviews are kept safe. There are no materials which can identify the respondent. The original collected data did not contain any identifiers but only codes as homosexuality is a punishable offence. The original data will be destroyed three years after the completion of the study in keeping with the new requirements of the ICMR guidelines(2006)[57]. The informed consent forms containing the identifiers have been separated and will be destroyed at the completion of the study so as to eliminate any chance of them being used as legal evidence.

3.9 Problems experienced in the field

1. The whole survey was done from the respondents accessing drop in centres or clinics, because of the criminalised nature of the MSM sex work, it was not possible to enlist respondents who are outside the NGO network, even though their experiences may be significantly different from those who came to the drop in centres.

2. There was difficulty in estimating the distribution of the respondents belonging to each of the sexual identity as the numbers of people accessing these centers were not representative.

3. Checking old treatment cards and records of counselling was not permitted for reasons related to confidentiality of records – therefore there was no means of verifying the reported morbidity.

4. There was difficulty in maintaining privacy of the respondents all the time during busy clinic time or when the drop in centre was crowded.

5. For the in depth interviews, sometimes, use of tape recording was not allowed, so only hand written notes had to be used.

Chapter 4 Quantitative and Qualitative Analysis

The study proposes to examine the social factors behind the high risk behaviour of the MSM population. To examine the risk behaviour a structured and pre coded questionnaire was administered. For analysing the perception of the HIV risk, the profile of condom/ lubricant use, multipartner/commercial sex practice and prevalence of sexually transmitted disease was enumerated. To study the constructs of the social risk factors, the general demographic profile of the MSM respondents including age, marital status, self declared identity, educational and income status, adverse life events like neglect, abuse and violence in private as well as in public sphere was assessed. One hundred and twenty six of the respondents were identified in the drop in centres/clinics. To understand the effects of the development of sexuality and the coming out process among the MSM populations and the subsequent adverse life events nine in depth interviews were conducted among the members of the MSM community with pre determined guidelines.

The findings of these two forms of data collection were included in this chapter. Section 1 will include the general profile of the respondents. Social correlates for the high risk sexual behaviour will be examined in section 2 which will include the morbidity experience and treatment seeking behaviour. The third section will include the social determinants of sexual health related morbidity and will study the adverse reactions associated with coming out process and morbidity, self perception of well being and etc. The fourth section contains the perception of risk of the MSM population and fifth section will describe the vulnerability of the population using the vulnerability framework described in chapter 3.

4.1 Socio economic and demographic profile of the MSM population, Kolkata

In this section the general demographic profile including age, education, income, living arrangements) of the respondents are discussed.

4.1.1 Age and education profile (tables 1 and 2)

Of the MSM respondents, 28.6 percent of the respondents belonged to age group less than 20years. Of the youngest age group, the highest number of respondents belonged to kothi identity (32.9 percent). The highest number of panthi belonged to more than 30years of age group. The kothis identified respondents belonging predominantly to a younger age group may be of significance as the survey may help to capture the more of their vulnerability.

Table 1: Percentage distribution of MSM sexual identity by age, Kolkata, 2008

	%<20 yrs age	s%age20-24yrs	%age25-29yrs	%>30yrs of age	Total (number in each sexual identity)
Kothi	32.9	31.7	17.1	18.3	100.0(82)
Panthi	14.3	28.6	14.3	42.8	100.0(7)
Bisexual	33.4	16.6	25.0	25.0	100.0(12)
doubledecker	9.1	18.2	45.4	27.3	100.0(11)
None	0	0	0	100	100.0(1)
Others	23.1	7.7	46.1	23.1	100.0(13)
All	28.6	26.2	23.0	22.2	100.0(126)

(percentage in each row shows distribution of age group in each sexual identities)

Table 2 shows the educational status of the respondents .It showed that only 2.4 percent were illiterate while the highest had an education up to eighth standard(34.9percent) followed by 33.3 percent of respondents who had an education of before or completed graduation. The percentage of respondents with education upto class eight was found most in kothis and can be due to kothi identity being significant factors for drop out because of the stigma and peer harassment.

Table 2. Percentage Distribution of sexual identity by educational Status, Kolkata, 2008

Sexual identity/Educational level	% of illiterate respondents	% of respondents up to class 8	% of respondents up to class 12	% of respondents with Graduation	% of respondents with professional education
Kothi(82)	2.4	35.4	25.6	35.4	1.2
panthi(7)	0	42.8	28.6	28.6	0
bisexual (12)	33.3	33.3	25	25	8.3
double decker(11)	0	27.	45.4	27.3	0
none(1)	0	100	0	0	0
others(13)	0	30.7	23.1	38.5	7.7
	2.4	34.9	27	33.3	2.4

4.1.2 Income profile (table 3) Almost all of them have some income except very few who are students.

Table 3 . Average monthly income – individual and household for MSMs, Kolkata, 2008

Income/ sexual identity	Average Income of the family(Rs)			Average income of self(Rs)		
	Average income	Maximum	Minimum	Average income	Maximum	Minimum
kothi	7046	45000	500	2850	20000	0
panthi	6642	10,000	2500	4500	8000	1500
bisexual	13000	80,000	2500	7008	46000	0
double decker	8363	17,000	2000	3613	5000	0
none	2300	---	---	2300	---	---
others	9692	35000	1500	3630	9000	1000

4.1.3 Marital status (table 4)

Of all respondents,15.9 percent were currently married. The majority 80.1percent were unmarried. Significantly among the kothi respondents 13.3 percent were ever married (including now currently married, separated, divorced and widowers),71.4 percent of the panthis and 25.0 percent of the bisexuals were currently married. So there was a high chance for transmission of any sexually transmitted disease from the MSM to their wives.

Table 4. Percentage Distribution of MSMs' sexual identity by Marital Status, Kolkata, 2008

	currently married(%)	Separated (%)	Divorced (%)	Unmarried (%)	Widower (%)	Total (%)
Kothi	9.7	1.2	1.2	86.7	1.2	82(100)
Panthi	57.1	14.3	0	28.6	0	7(100)
Bisexual	25.0	0	0	75.0	0	12(100)
double-decker	27.3	0	0	72.7	0	11(100)
None	100.0	0	0	0	0	1(100)
Others	7.7	0	0	84.6	7.7	13(100)
All	15.9	1.6	0.8	80.1	1.6	126(100)

4.2 Correlates of high risk sexual behvaiour

The section contains enumeration of different social correlates of the high risk behaviour of the respondents. The factors considered here were living arrangement of respondents belonging to different sexual identity, age of the sexual debut, sexual partnership and condom use profile of the respondents, morbidity experiences and treatment seeking behaviour.

4.2.1 Living arrangement among the respondents (table 5)

An examination of the living arrangements of the respondents showed that 12.2 percent of the kothis were staying currently with their male partner. This has serious implications for vulnerability, particularly with respect to partner violence. The majority of the kothis (74.4percent) were living with their families may be because majority of the kothi's (64.6 percent) were below 24 yrs of age. Though the number of kothis living separately is very small (8.5 percent), but those may include a very high proportion who faced most of the adversity from family or partners.

Table 5: percentage distribution of sexual identity with living arrangement

Sexual identity with living arrangement	% Currently living alone	% currently living with male partners	% currently living with female partners/wives	% currently living with parents/siblings	Total
kothi	8.5	12.2	4.9	74.4%	82(100)
Panthi	14.3	28.6	57.1	0	7(100)
Bisexual	0	0	25.0	75.0	12(100)
double-decker	0	9.1	27.3	63.6	11(100)
none	0	0	100	0	1(100)
others	7.7	15.4	0	76.9	13(100)
Total	7.2	11.9	11.9	69	126

4.2.2 Age at sexual debut (table 6)

The mean age of sexual initiation of the respondents was 12.2 years. The lowest mean age for the first sex was lowest in the double decker (11.2years) and that of the kothi(11.5years). The mean low age for sexual debut in kothis may be indicative of their being subjected to high risk of exposure

Table 6. Age of early sex initiation disaggregated by sexual identity, Kolkata,2008.

Age of sexual debut with sexual identity	Average age of sexual initiation(years)	Minimum(years)	Maximum(years)
Kothi	11.5	4	20
Panthi	15.4	8	24
bisexual	13.1	6	18
double decker	11.2	8	15
None	13	-----	-------
Others	12.4	8	23

4.2.3 History of risky sexual behaviour (table 7)

It was seen that all of the kothis have unprotected sexual intercourse with their male partners and 50 percent had unprotected sexual intercourse with their wife in the last 6 months. In case of panthis, 42.9 percent did not use condom consistently with their male sex partners in the last six months. None of the panthis used condom with female sex workers, wives and girlfriends. 75.0 percent of bisexuals have not used condom with their male partners, male and female sex workers and wife in all sex acts. However there is use

of condom during the sex act with the girl friend. Of the double deckers, 81.8 percent had history of unprotected sexual intercourse with their male partners and all of them had unprotected sexual intercourse with female sex workers and wife or girlfriends. In case of the respondents belonging to the "others" category, 76.9 percent had a history of unprotected sexual intercourse with his male partner while all of them had unprotected sexual intercourse with male sex workers or female sex workers.

Table 7. Proportion of MSMs by sexual identity and type of partners by usage of condoms consistently during the last six months, Kolkata,2008

Sexual identity with sexual partnership and condom use	Sex with male partner		Sex with FSW		Sex with Male sex worker		Sex with Wife		Sex with girlfriends	
	% having sex with male partner	% use condom consistently with male partner	% who had sex with FSW	%Didn't use condom consistently with FSW	% who had sex with MSW	%Didn't use condom consistently with MSW	%who had sex with wife	% who did not use condom consistently with wife	%who had sex with wife.	%Did not use condom
kothi	98.7	100	0	0	0	0	4	50.0	0	0
panthi	100	42.8%	4	100	0	0	4	100	1	100
bisexual	100	75.0	4	100	1	100	3	100	1	0
double decker	100	81.8	3	100	0	0	3	100	2	100
none	100	100	0	100	0	0	1	100	0	0
others	100	76.9	1	100	1	100	0	0	0	0

4.2.4 Sexual identity with Morbidity Experience (Table 8)

Anal ulcer-Prevalence was highest in kothis (33.7 percent) followed by bisexuals (28.6 percent) and panthi (20.0 percent). Anal ulcer might facilitate HIV transmission, particularly in ano-receptive partner in unprotected intercourse.

Anal discharge- The highest prevalence (30.0 percent) was found in double deckers) followed by kothis (17.5 percent) signified the underlying high unsafe ano-receptive sexual activity.

Genital Ulcer-Prevalence was more in panthis than compared to kothis (40.0 percent in panthis as opposed to 21.3 percent) and same in double deckers(40.0percent) and could facilitate transmission of HIV in unprotected intercourse.

Burning sensation during micturition- Panthis had the highest prevalence (40.0percent) followed by double deckers (20.0percent), bisexual (14.3percent) and kothi (8.7 percent). It signified the unsafe sex practices that transmit the urinary tract infections.

Genital discharge- Prevalence was highest in bisexuals (21.4 percent) followed by double deckers (10.0 percent).The relative high prevalence of genital discharge among respondents who did both same and opposite sex-sex act and receptive as well as insertive anal sex signified that the risk of contracting genital discharge more both from male and female sexual partners in whom vaginal discharge can be common.

Groin swelling- Prevalence was exclusively among kothi identified respondents (5 percent). It could be due to associated anal discharge, anal ulcer or genital discharge in the kothis for which there was delay in treatment or improper treatment.

Lower Abdominal Pain-.The highest incidence of lower abdominal pain is among the kothis (85.7 percent) followed by bisexuals (14.3 percent). The higher prevalence of lower abdominal pain among kothis is explained by the undiagnosed and untreated morbidity present previously in this group.

Table 8 Percentage of sexual morbidity disaggregated by sexual identity, Kolkata 2008

Sexual identity(total number in brackets)	% of Genital Ulcer	% of Genital discharge	% of Groin swelling	% of Lower abdominal pain	% of Burning sensation during micturition	% of Anal Ulcer	% of Anal discharge
Kothi	21.3	6.2	5.0	7.5	8.7	33.7	17.5
Panthi	40.0	0	0	0	40.0	20.0	0
bisexual	14.3	21.4	0	7.1	14.3	28.6	14.3
bisexual	40.0	10.0	0	0	20.0	0	30.0
none	0	0	0	0	0	0	0
others	25.0	16.6	0	0	0	41.7	16.6
Total 121 episodes of STD	23.1	9.1	3.3	5.8	10.7	30.6	17.4

4.2.5 Morbidity condition and treatment seeking behaviour (table 9)

Treatment seeking behaviour in genital discharge- only (36.4percent) sought treatment. Among them, only 25.0 percent sought treatment immediately but there is a delay of 2 to 7 days for 25.0 percent of cases and more than 7 days for 5.0 percent of the cases.

Treatment seeking behaviour in groin swelling-For groin swelling, 75.0 percent sought treatment and the treatment. There was almost equal treatment seeking delay, with 33.3percent seeking treatment immediately, 33.3 percent seeking treatment with 2 to 7 days and 33.3percent seeking treatment more than 7 days later.

Treatment seeking behaviour in lower abdominal pain-Only 57.1percent sought treatment, 75.0 percent have sought treatment immediately and 25.0 percent have sought treatment after a delay of more than 7 days.

Treatment seeking behaviour in burning sensation during micturition-Only 69.2 percent sought treatment. But only 11.1 percent sought treatment immediately, the rest 33.3 percent sought treatment after 2 to 7 days and 55.6 percent sought treatment after 7 days of waiting.

Treatment seeking behaviour in anal ulcer-For anal ulcer 78.4 percent sought treatment but only 6.9 percent sought treatment immediately while for 34.5 percent there is a delay of 2 to 7 days and for 58.6 percent of the respondents the delay is more than 7 days.

Treatment seeking behaviour in anal discharge-For anal discharge, 45.0 percent sought treatment, and among them only 11.1percent sought treatment immediately while 22.2percent waited for 2 to 7 days to seek treatment and 66.7 percent waited for more than 7 days before they sought treatment.

Overall, the treatment seeking behaviour for most of the sexual morbidities reflects that there is a lack of knowledge and lack of ability or inclination for treatment seeking. Even for serious morbidity conditions, there are cases where no treatment was sought and even when they are sought there were long delay. Syndromic management of STD which is based on immediate treatment to reduce the chance of transmission can not be very effective tool if there was such high load of untreated morbidity and delay in treatment seeking along with high prevalence of unsafe sex practices. So conditions seem to ideal for transmission for HIV. Moreover it has to be kept in mind that the MSM respondents are accessed through NGO networks working on health awareness (STD/HIV prevention) amongst other things and still the level of awareness and knowledge – practice gap seems very significant.

Table 9. Distribution of MSMs with specific morbidity conditions by treatment sought, Kolkata, 2008

Sexual health morbidity with treatment seeking	% respondents who sought treatment	% of respondent who sought treatment immediately	% of respondent who sought treatment within 2-7 days	% of respondent who sought treatment after > 7days
Genital Ulcer	75.0	23.8	52.4	23.8
Genital discharge	36.4	25	25	50
Groin Swellings	75.0	33.3	33.3	33.3
Lower abdominal pain	57.1	75.0	0	25.0
Burning sensation during micturition	69.2	11.1	33.3	55.6
Anal Ulcer	78.4	6.9	34.5	58.6
Anal discharge	45.0	11.1	22.2	66.7

4.3 Social determinants of sexual health related morbidity

This section will include a discussion of the social determinant of sexual health related morbidity, the adverse reactions to the coming out process, self perception of well being of the respondent, the adverse experience suffered during reporting the sexual morbidity.

4.3.1(a) Coming out experiences in the family and the society (table 10)

Analysis of the coming out process among the various persons including family, friends, doctors or neighbours shows that among the people with kothi identity, 76.8 percent divulged their identity to their friends. Very few (26.8 percent) divulged their identity to their family. Same can be said about the people they met outside their immediate friends and family circle, like the professional people like the doctors, lawyers and so forth (9.8percent) or their neighbours (34.1percent). Of the other respondents, 57.1percent of the panthis, 33.3percent of the bisexuals and 54.0 percent of the double deckers divulged their sexual identity to their friends .However, none of the panthis and only 16.6 percent

of the bisexuals divulged their sexual identity to their family indicating that bisexuals and panthis perhaps were not identifying themselves with MSM identity in some cases. None of the panthis divulged their sexual identity to neighbours or the professional people. It can be that panthis mostly do not like to be identified with the MSM to the community, thinking themselves to be “male”, at least where interaction with outsider. Bisexuals and double deckers seem to be more secretive with respect to doctors and lawyers as 12.2 percent of the bisexuals and none of the double deckers have divulged their sexual identity to doctors and lawyers. This pattern continues with just about 12.0 percent divulging their sexual identity to neighbours amongst bisexuals and 36 percent among double deckers.

4.3.1(b) Adverse reactions/experiences associated with coming out process (table 10)

Hostile responses were highest in case of Kothis, 72 percent from the family, 12.5 percent from the doctors, lawyer and 78.5 percent from neighbors. Hostile response was very high in others category, 83.3 percent from family 33.3 percent from doctors, lawyers and 100 percent from neighbors. Though it appeared as the percentage of MSM respondents who received adverse reactions from their friends is not very high ,but during the survey process and in depth interview it was generally a common perception that few of the MSM’s, particularly kothis have any friends outside their own circle of MSM groups. So it may be assumed that the responses of their divulging identity were somewhat skewed by this fact. Same can be said about the responses of the doctors and lawyers also as it might refer to the doctors of lawyers of the NGO network itself.

Table 10. Distribution of MSMs who divulged sexual identity to various groups by nature of reactions experienced, Kolkata, 2008

Sexual orientation	% divulged and response (friends)	% divulged and response (family)	% divulged and response (doctors/lawyers)	% divulged sexual identity (neighbours)
% of kothi divulged sexual identity	76.8	26.8	9.7	34.1
% of kothi faced hostile response	38.1	72.7	12.5	78.5
% of panthis divulged sexual identity	57.1	0	0	0
% of panthis faced hostile response	25.0	0	0	0
% of bisexual divulged sexual identity	33.3	16.6	12.2	12.0
% of bisexual faced hostile response	50.0	50.0	50.0	50.0
% of double decker divulged sexual identity	54.5	9.1	0	36.4
% of double decker faced hostile response	50.0	100	No	50.0
none(1) divulged sexual identity	1	0	100	1
% None faced hostile response	0	0	0	0
% of "others"divulged sexual identity (13)	69.2	46.1	23.1	38.5
% of "other" faced hostile response	33.3	83.3	33.3	100

4.3.2 Sexual identity with social wellbeing (table11)

A majority (61.9 percent) of the respondents expressed low self esteem using Rosenberg's scale while 38.1percent of the respondents showed a high self esteem. The low self esteem shown by the other categories of the respondents (61.5 percent) can be

explained by the presence of “hizra” (transgender) respondents amongst them. The low self esteem for the bisexual and double deckers might be due to their suffering from partnership status or any other factor like education and income.

Table 11. Distribution of MSMs by levels of self esteem (using Rosenberg scale) by sexual identity,Kolkata, 2008

Sexual identity with self esteem	Rosenberg self esteem scale	
	%Self esteem High	%Self esteem low
Kothi	41.5	58.5
Panthi	42.8	57.1
bisexual	25.0	75.0
double deckers	18.2	81.8
None	1	0
Others	38.5	61.5
Total	38.1	61.9

4.3.3 Violence faced by the MSM in public as well as in private sphere (table 12)

Highest partner violence (91.6 percent) was faced by bisexuals, followed by double decker (90.9 percent) forced sex by goons is highest in others 61.5 percent. Forced sex by police was highest in kothis and bisexuals (50 percent) workplace violence is highest in bisexuals (41.6 percent). Highest alcohol and substance use was in others (46.1 percent) kothi, bisexuals and others share high degree of public and partner violence probably because they are more feminized and attract violence more.

Table 12. Percentage distribution of the various experiences of violence in the MSM population Kolkata 2008

Sexual identity (no. In brackets)	% experiencing violence of goons	% experiencing forced sex by goons	% experiencing violence by police	% experiencing forced sex by police	% experiencing violence in workplace	% experiencing partner violence	% experiencing violence and multipartner sex	% experiencing use of alcohol/other substance	% experiencing violence and psychiatric disease
kothi(82)	42.7	43.9	41.5	50.0	36.6	79.3	48.8	14.6	39.0
panthi(7)	28.6	28.6	14.3	14.3	14.3	28.6	14.3	14.3	14.3
bisexual(12)	75.0	50.0	50.0	50.0	41.6	91.6	66.6	25.0	58.3
double-decker(1)	54.5	45.5	72.7	18.1	36.6	90.9	54.5	18.2	18.2
others(13)	53.8	61.5	69.2	30.7	7.7	46.1	53.8	46.1	30.7

4.4 The life events of MSM and their perception of risk-

In depth interviews have been conducted to understand the MSM's perceptions of the risks they are exposed to. These interviews included information about the experiences of the MSMs during and after the emergence of same sex attraction, the process of coming out and its impact, adverse life events like violence and rejection and the life experience of the MSMs with respect of partnership, support, threat and violence and their experiences related to sexual health morbidity and treatment seeking behavior. The life events of the MSMs and the risks at each of the stages of the life have been brought forward to provide an understanding of the compendium of risks.

The risk associated with the process of the sexual development and "coming out" -The conflict brought on by the difference in the physical and the perceived sexual identity was one of the major stressors the MSM had to face from the very beginning of their lives. In the absence of parental and family support and by being forced to fit into the rigid gender

norms of the heterosexual world it gave rise to the confusion, self blaming and hatred in most of the cases.

"The first time I felt the same sex attraction was when I was in class 6. It was a feeling that was different from other boys. I felt the same looking at other boys what other boys felt looking at a good looking girl. The feelings some what confused me" –response from a 22year old MSM belonging to Kolkata. (translated form Bengali)

Exploring the new gender identity and early age of sexual debut

In the family and the society there is generally hardly any scope for the MSMs to discuss and learn more about their new found sexual identity. Exploration of the new sexual identity frequently places the MSMs more at risk as because of lacking information regarding safe sex. It may lead to risk of exposure to violence and STD.

"*Since I was around 12 years of age and I came to realize that there was something very abnormal in me…I could not share the feelings with everyone…that was an extremely bad period of my life. There was one boy who befriended me. He could probably understand the problem I had. We became very good friends. I used to go frequently and spend time with him. One day he had sex with me. I enjoyed but at the same time I was confused why and how can a boy a man can have sex together?"*- response from a 23 year old MSM belonging to Kolkata. (translated from Bengali)

Reactions of people after disclosure of sexual identity and experience of abuse and rejection

All the respondents reported that there was abuse and rejection associated with the disclosure of sexual identity. The resultant familial adverse reactions, most of the time occurring quite early in life was one of the major social stressors and contributes to make MSMs more vulnerable.

" I lost the affection of my family members. My father quarreled and left us. One day after I have passed my secondary examination I started talking to my mother. I explained everything including the fact that I have been having sexual relationship with boys. My mother was shocked and from then onwards my relationship with my mother deteriorated like anything. So now, after I have divulged my sexual identity, I am left with all relationship with my family members broken."- response from a 23 year old MSM belonging to Kolkata. (translated from Bengali)

The social rejection of the MSM sexual identity and associated risk

The social rejection of the MSM identity was widespread in its distribution. Starting from the days of schooling, the rejection continues to the workplaces also. The rejection and associated loss of peer socializing is another very important factor that added to the social stressors and made them vulnerable. Moreover the workplace and the society carried a risk of violence and sexual abuse and sometimes risk of forced sex.

"The real problem started when I went to a higher class. The behavior of my batchmates worsened like anything and teasing and harassment became everyday life at school. Same thing continued whenever I used to go out in my locality…the friends stopped seeing me…I dropped out of school at the age of 15 and started working in small hotel near my locality. I used to stay in the hotel premises itself at night. I was harassed by the owner of the hotel and by almost all other staff. The owner and some of the colleagues physically and sexually assault me for quite sometime and that continued till I left the employment of the hotel"- response from a 22 year old MSM belonging to Kolkata. (translated from Bengali)

Partner seeking and associated risk

One of the factors that make the MSM more vulnerable is the process of seeking sexual partners and associated risk of violence, abuse, physical and sexual harassment. In the absence of the safe spaces in the society, the partner seeking behaviour is characterized by clandestine meetings, most of them in public spaces, unanimous partner seeking and commercial sex venues. It restricted their negotiation power and opportunity for safe sex and made them vulnerable to abuse and physical and sexual violence.

In most of the cases the affectional and emotional bonds appeared to be very poor. The outcome of the poor bonding between the partners resulted in having simultaneous or rapid succession of partners. There were instances of more partner violence. There was also worry and anxiety over the breakdown of relation and depression from the loss of partner, sometimes forcing them to adopt unsafe sex as a measure to retain or satisfy their partner. Moreover, the difference in the sexual identity was associated with power imbalance in the relationship which governs safe

sex and treatment seeking. The results of these repressions were loss of self esteem, depression or other psychiatric morbidity, substance abuse and risky sexual behaviour.

"I seldom had very loyal and very caring partner. There is always chance of loosing partners to other boys and girls. So the fear of loosing partners is always there. Sometimes there are quarrels and fight and there are violence. I am always afraid to loose partner and that there may be fights or more problems if there is a break in relationship….. So I think it is better to keep silent and agree to whatever he says."- response from a 26 year old MSM belonging to Kolkata.(translated from Bengali)

Risks Associated with the use of public spaces

Almost all MSMs faced violence and sexual abuse in public spaces sometimes or other. The perpetrators ranged were unknown people, neighbours, goons and even the police personnel. The criminalized nature of the MSM sexuality and the associated social stigma are some of the precipitating factors for the vulnerability of the MSM in the public spaces. Moreover, lacking the social support, there was no mechanism for redressal.

" I have been working in a small shop. Lots of stigma and discriminations have plagued me in my workplace….one night one local goon came forcefully into the shop and raped me…. later on, he started to bring his friends with him and all of them raped me. The local goons have the right of my body and can do anything to me…I never protested because there is no use of protesting alone. There is a threat that protest may bring more violence and loosing face…seeking the help of law is generally useless. The MSM and the transgender like me will be turned out from the door of the police station accompanied with bad words."-response from a 24 year old MSM belonging to Kolkata (translated from Bengali)

Risks associated with morbidity

The morbidity experience of the MSMs was guided by the social vulnerability of the regarding negotiation power for use of condoms, knowledge and ability to practice safe sex, treatment seeking behaviour and access to health care. An analysis of their morbidity experience showed that most of them have suffered from one or multiple episodes of STD. Sometimes they were unaware of the symptoms. Sometimes treatment had either not been sought or were inappropriate and did not resolve the

problem. Embarrassment of disclosure to doctor was a problem. Moreover, there were issues of treatment for their partners as because most of the times the partners had not taken any treatment despite their advice. The nature and the places of sex acts are not congenial for safe sex and it was not easy to detect STD in a partner in such settings

"I have suffered from genital ulcer and bleeding from anus….for myself I generally go to some NGO run clinic but that sometimes take some time. Detecting the disease in a partner is always a problem. Most of the times a quick sex act is done in some dark place… the partners refuse to accept that they are diseased and would not come for treatment. So whenever possible I try not to take any partner without condom who is suffering from STD but it is not always possible"- response from a 21 year old MSM belonging to Kolkata. (translated from Bengali)

4.5 Vulnerability Analysis

The vulnerability framework identifies the major stressors and the coping strategy and it defines the high risk sexual behaviour as one of the outward reaction of the coping strategy against the social stressors.

4.5.1 The vulnerability factors

The following factors were brought out both from the qualitative and the quantitative analysis-

1. Societal homophobia and prejudice against homosexuality giving rise to shame, secrecy and guilt. 2. Adverse labeling giving rise to rejection leading to social withdrawal. 3. Adverse reactions during the coming out process 4. Lack of recognition of homosexuality denying safe sex knowledge and practices 5. Lack of social support 6. Physical and sexual violence

4.5.2 The inference from the quantitative analysis

The analysis of the MSM population profile shows (from the quantitative analysis)

1. A predominantly young population with the highest age group belonging to the age category of less than 20years and the next highest age category of 20- 25 years. Though the average age of sexual initiation is low (12.1 years), but it can be assumed that more of the respondents will be having active sex life with more partners after the some times and that may increase the number of vulnerable people . There can be more number of marriages among the respondents facilitating the spread of HIV.

2. The overall education status was not much significant. The greatest number of the respondents is educated beyond class 12 and above. Still the high incidence of partner violence (near 81percent were subjected to some kind of partner violence) is quite alarming.

3. Marital status of the respondents shows that even among the kothis, 13.9percent were married, signifying the high societal pressure for marriage. Marriage among the panthi's were very high, (more than 70 percent) signifying the fact that these groups may have significant risk of having homosexual and heterosexual relationship and be more vulnerable for the spread of STD and HIV. The significant association of STD with current marital status raises the possibility that marriage being an outcome of social/family pressure on the homosexual respondent to conform to the norms of the predominantly heterosexual society.

4. It was seen that the condom use in homosexual relationship was very low, the lowest being in the kothis, none of whom were using any condom with their male partners (100%). Probably, it was the inequality in the power in kothi –panthi relationship or efforts of partner retention or trust in fidelity in partner that forced them to adopt unsafe sex practice. There was consistent low condom use among

all respondents with all same sex acts. This probably signified that the risk of HIV transmission in the same sex act was not being fully perceived by the respondents. The condom use in sex acts with female was also low and that may cause unchecked transmission of HIV from the high risk homosexual groups to the low risk general population. Perhaps it can be assumed that the real reason for condom use in heterosexual relationship is rather for the risk of pregnancy and not any notion of safe sex.

5. The survey has found that the burden of STD in the MSM was very high, nearly 63 percent having suffered from some kind of STD or other. The total STD episodes were 121, in 126 respondents over a 6 month period. The distribution of the disease across the sexual identity generally confirmed with the sexual roles of the respondents (kothis having the highest prevalence of the anal discharge (17.5percent) and anal ulcer (33.7 percent) which confirms their sexual role as predominantly ano receptive sex partner. There was a high burden of genital ulcer in the kothi respondent also (21 percent) and can be explained by the fact that there syphilis is one of the most prevalent STD in our country and the chance of contracting syphilis in such sexually active population is consequently very high. It can raise another possibility that the sexual identity is rather more fluid in nature than the rigidly imposed western pattern of gay sexuality. There was also possibility that the ulcers may be herpetic in nature. The greater disease burden of groin swelling and the lower abdominal pain in kothi respondents can point to the untreated morbidity. The high burden of anal ulcer in the “other” category of the respondents also signifies the presence of transgender community among them who acted as receptive anal partners.

6. The treatment seeking behaviour of the respondents was poor. With such high prevalence of unprotected sex act per person, there was a chance that the disease may spread to other partners. The highest treatment seeking behaviour was seen in case of genital ulcer (75.0percent) and anal ulcer (78.0percent). The probable reason can be the ulcers are easily noticeable symptoms. The other reason for the poor treatment seeking is the lack of access of the MSM faces(embarrassment to disclose their identity to doctors).Treatment seeking was poor in discharge conditions as they may not be causing much pain in the preliminary stages and without awareness of safe sex practices there is a chance to neglect them. The other significance that is carried by the poor treatment seeking behaviour for (people who are accessing the some dedicated drop in center) may be the lack of awareness in the respondents which points to a poor implementation of the intervention programme.

7. Divulging of the sexual identity was a problem and brought adverse reactions for the respondents. The adverse reactions are highest in case of the kothi identified respondents who faced adverse reactions from everywhere. The hostile response was there in case of the respondents in the other category signifying their stigmatized status(there were transgenders/hizras included in the group)

8. Overall, the score of the social well being was low. The lower self esteem in this population group could be a reflection of the marginalisation of the MSM population. But as well being can be a factor of income or educational status, it is not very conclusive.

9. The proportion of the MSM divulging their sexual morbidity was extremely low signifying the lack of support the MSM's received. Divulging the disease

condition to the family members was low which signifies the double stigma of MSM sexual identity and that associated with STD.

To study the predictors for social risk and the effects of the social stressors the following factors are included. They are adverse reactions suffered during the coming out process, self esteem, incidence of various partner violence, and occurrence of forced sex by partner, forced sex in public spheres and social rejection characterised by hostile rejection from friends, family, neighbours and other persons. The effects of these predictors are studied against presence and absence of sexual morbidity, sex act without condom and participation in commercial sexual activity etc. The risk of adverse reactions (both in public and private sphere) may be more in case of kothi identified MSMs because of their increased visibility. To understand the greater vulnerability of the kothi identified MSMs, the incidence of forced sex by police personnel or partners is studied.

Table13.Chi square tests results showing the association between the social factors and their outcome
(* showed the significant chi square results)

1.Adverse reactions from friends/family/neighbors/any other people like doctors and lawyers with sex act without condom			
	%Adverse reactions	%No adverse reactions	5.247 df 1 P value 0.022* OR 3.51 95% CI 1.142-8.689
%Sex act without condom	90.7	9.3	
%No sex act without condom	72.6	27.4	
2.Adverse reactions from friends, family and neighbors or doctors with commercial sex participation			
	%Commercial sex	%No commercial sex	4.242 df 1 P value 0.036* OR 2.667 95% CI- 1.026-6.928
%Faced adverse reaction present	66.7	33.3	
%Did not face adverse reaction absent	38.1	61.9	
3 Partner violence with living arrangement(living alone or with male partner versus living with parents and family)(*partner violence includes cases including being forced to have sex with partner, being forced to sex in spite of having STD, being forced to have sex in spite of the partner having other/ multiple partner, being forced*			

to have sex when the partner was drunk or under influence states, injured by violence from partner, or when you tried to break away from current partner or beaten up or assaulted by other partner of the partner)			
	%Faced Partner violence	%Did not face partner violence	1.220 df 1 p value 0.499 OR 1.22 95% CI-0.375-3.96
% Living alone or with male partner	83.4	16.6	
% Staying with family and parents	80.3	19.7	
4.Partner Violence with sex act without condoms			
	% Faced partner violence	% Did not face partner violence	5.11 df 1 P value 0.02* OR 2.852 95% CI-1.124-7.233
% who did sex act without consistent condom use	88.0	12.0	
% who did not do Sex act without consistent condom use	70.6	29.4	
5.Age of first sex initiation with STD			
	% with age of sex initiation less than 18 years	% with age of sex initiation more than 18 years	9.204, df 1 p value 0.004* OR 13.65 95%C I 1.623-114.82
% suffered from STD in the last 6 months	98.7	1.3	
% did not suffer from STD in the last 6 months	85.1	14.9	
6.Incidence of Partner violence with STD			
	% Faced partner violence	% Did not face partner Violence	5.607 Df 1 p value 0.01* OR 2.92 95% CI - 1.17-7.28
% suffered from STD in the last 6 months	87.3	12.7	
% did not suffer from STD in the last 6 months	70.2	29.8	
7 Association of participation in commercial sex with STD			
	% Participated in commercial sex	% Did not participate in commercial Sex	22.50 df 1 p value 0.00* O R 6.671(2.93-15.18) 95% CI -1.4-6.9
% suffered fromSTD in the last 6 months	67.9	32.1	

% did not suffer from STD in the last 6 months	23.4	76.6	
8.Current marital status with presence and absence of STD			
	% married	%Not married	5.056 df 1 p value 0.0019* O R 4.022 95%CI (1.11-14.56)
% suffered STD in last 6 months	85.0	15.0	
% did not suffer from STD	58.5	41.5	
9. Accessing pick up spots with STDs(the notion is to aggregate such pick up spots where sex act can also take place and MSMs are vulnerable to forced sex by police, goons is high)			
	% sufererd from STD in the last 6 months	% did not suffer STD in the last 6 months	8.41 df1 OR 3 p value 0.03* OR 3 95% CI 1.412-6.374
% accessing Park/ground space/street (pickup spot)	75.0	25.0	
% accessing Shopping mall/cinema hall/massage parlour/urinals/railway station/bus stand	50.0	50.0	
10. Self esteem scale(Rosenberg scale) with average income			
	% with income < Rs7941(average income)	% with income >Rs 7941(average income)	3.096 df 1 P value 0.008* OR 2.615 95% CI -0.874-7.607
% with low self esteem	66.7%	33.3%	
% with high self esteem	41.7%	58.3%	
11. Highest level of education with self esteem(Rosenberge scale)			

	Illiterate	Upto class 8	Upto class 12	graduation	professional	3.53 df 4 p value 0.473
Low self esteem	2.6%	35.9%	29.5%	28.2%	3.8%	
High self esteem	2.1%	34,0%	21.3%	42.6%	0	
12. Self esteem(by Rosenberg Self Esteem Scale) with presence or absence of STD						

	% with low self esteem	% with high self esteem	9.43 df 1 p value 0.002* OR 3.01 95% CI 1.11-5.0
% Presence of any STD in last 6 months	71.8%	28.2%	
% Absence of STD in the last 6months	45.8%	54.2%	
13.Forced sex by partner with sexual identity(* non kothi include-panthi, bisexual,double decker, other, none category)			
	% suffered forced sex by partner	% did not suffer forced sex by partner	10.381 df 1 P value 0.001* OR 5.048 95% C I 2.197-11.599
% of kothi	57.3%	42.7%	
% of non kothi*	27.3%	72.7%	
14.Forced sex in public spheres(police/goons/workplace) with sexual identity((* non kothi includepanthi, bisexual,double decker, other and none category)			
	% who suffered forced sex	% who did not suffer forced sex	34.39 df 1 p value 0.000* OR 11.27 95% CI (4.714-26.962)
% of kothi	76.8	23.2	
% of non kothi*	22.7	77.3	

So adverse experiences had been found to be significantly associated with sex without consistent condom use ($p < 0.05$, OR3.51) and commercial sex ($p < 0.05$, OR2.667).MSMs living alone is more likely to do sex without condom ($p < 0.05$, OR 2.85). Respondents of partner violence are more likely to suffer STD ($p < 0.05$,OR 2.92). STD is more with early sexual debut($p < 0.05$,OR 13.85) , married MSM ($p < 0.05$,OR 4.022) and low self esteem ($p < 0.05$,OR 3.01),with commercial sex ($p < 0.05$, OR 2.667) and use of park, ground, open space for pickup ($p < 0.05$,OR 3). It also shows that kothis are more vulnerable to public violence ($p<0.05$, OR 11.27) and partner violence ($p<0.05$, OR 5.048). Self esteem was also found to be associated with income status ($p < 0.05$, OR 2.615).

Chapter5. Conclusion and Policy Recommendations

The study aimed to examine the factors behind the social vulnerability of the MSM population that exists beyond their biological vulnerability. The factors were examined with the help of quantitative survey amongst 126 MSM respondents in Kolkata. Aim of the survey was to identify the factors behind their social vulnerability. Nine in depth interview conducted in the course of the study and analysed to understand the vulnerability and risk perception of the MSM population. Vulnerability framework was used to analyse these factors. The conclusion, limitation and policy recommendations had been included in this chapter.

5.1 CONCLUSION

The life events of the MSM showed a compendium of risk. The social pattern of vulnerability construct is inextricably interwoven with the biological risk for transmission of HIV. Their sexual identity leads to towards a stigmatised labeling which in turn draws a wide spectrum of violence, rejection and abuse. Their universe of violence, rejection, harassment and abuse act as a social pressor which in turn leads to an outward reaction of risky sexual behaviour. The study undertaken aimed to find their social risks and it's reflection on the high risk sexual practices and how they are socially constructed. The finding gained from the study was as follows.

1. High episodes of family ostracization and rejections points to definite lack of awareness and empathy of the family members to the MSM sexuality. Withdrawal of the family care and support was one of the major factors for making the MSM more vulnerable to the risks and threats in the outside world.

2. There was definite lack of awareness among the general population regarding MSM sexuality as the abuse and violence incidences were very high.

3. The violence and the “hate” crimes prevail in the public spaces. Violence by police and local goons were still part of the problem of MSMs. Moreover, being crminalised and stigmatised, there were no social mechanism available for redressal and support.

4. The MSMs experiences of revealing their sexual preferences and through that their sexual identity to family members and others was not rewarding. On the contrary, ostracism often forces them to leave the safety of their homes afterwards.

5. The perceived risk of the MSM population was still poor. Some of the MSMs practices place them at a higher risk for different kinds of violence and abuse. But it may be a response of the MSMs being denied safety and privacy of homes because the homophobic society has forced them to use unsafe spaces for sexual activity.

6. There was a definite gap in the promotion of safe sex practices and the treatment seeking behaviour in the MSM population, even though various networks were working for their well being.

7. Their sexual debut was not always pleasant as the nature of their relationship with the first partner seems largely exploitative as they were inevitably older experienced males.

9. These problems cause them to seek sexual partners in unsafe settings and accede to unsafe sexual practices. As a consequence, the sex act does not always occur in private spaces but in public ones where the risk of exposure is greater

10. Further, all of these render them vulnerable to non-use of condoms and STDs but health care seeking is also hampered due to the unhelpful health system. It was also clear that the existing mechanisms put in place through NGOs were not sufficient to empower the MSMs to address sexual morbidity through appropriate health care seeking.

11.From the study it has been shown that even long after they have been put in place, programmes for the empowerment, sexual health and well being of the MSMs, still had a

significant gap in the empowerment as well as the knowledge –attitude –practice in the treatment seeking behaviour of the population.

12. High incidence of forced sex and harassment by police and goons block their way to access safer sites for partner selection.

13. Violence from intimate or commercial sex partner was also a common phenomenon rendering them vulnerable to high risk sex practice.

14. Also there are presences of untreated morbidity for a long time as evidenced from some of the disease symptoms that was seen in survey like cases of lower abdominal pain.

So enough evidence was found to conclude that the programme implementation has not been effective enough to reach out effectively to the population that they were supposed to reach. The same can be said about the programme's failure to create the necessary social awareness.

5.2Limitation of the Study:

1. Estimation of the sample size: The sample size was calculated based on the STI prevalence of 9.92% among the MSM respondents in the community needs assessment survey. But the population accessed for the present survey was from STD clinics and drop in centers. This might have lead to an overestimation of the STI in the respondents as the people with some reproductive health morbidity are more likely to access these centers.

2. The prevalence of the reproductive health morbidity: for the survey only the self reported reproductive health morbidity was chosen as verification of clinic record for was not allowed.

3. The survey was done among the respondents accessing the support networks. So they may be having higher baseline knowledge about STD and HIV prevention and may be more aware of the rights issues of the MSM. So there might be an erroneously lower reporting of the violence.

4. The nature of the study being a cross sectional one, the causality of any of the factors could not be assessed.

5.3The policy implications

1. MSMs are being stigmatized both within the family and within the society and consequently neither are safe sites for the MSMs. Moreover, MSMs are targeted by law enforcers themselves who should serve as protectors. They are also not able to resolve many of the reproductive and sexual health conditions such as STDs even through the specifically targeted interventions. So there was a need to at least make the health system the first line of defense for the MSMs by universalizing sensitization of the doctors regarding the health issues of the MSM population.

2. Targetted interventions need to be strengthened, and in order to address the health needs of the MSMs all the health care providers are sensitized and provided with the skills to treat morbidities for this population. They will then not be forced to delay health care seeking and this will improve their access to treatment.

3. To create the enabling conditions for MSMs not to be victimized by neigbourhood goons and law enforcers, there was a need to de-criminalise homosexual activity. This may not serve to provide social acceptance through change of norms, but will be a step in the right direction towards creating a safe environment where MSMs may exercise their sexual rights like all other members of the society do.

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Annexure 1

Questionnaire for the quantitative analysis

Title of the study MALE HAVING SEX WITH MALE POPULATION (MSM) OF KOLKATA, HIGH RISK BEHAVIOUR AND ANALYSIS OF THE SOCIAL FACTORS.

Identifier code:	clinic serial No	contact no:
Name of the drop in center/ clinic		
Name	Date:	

101

Age in completed years.	

102.

What is the highest level of education you have achieved?	Illiterate	1	Upto 12th	3	Professional	5
	Upto class 8th	2	Graduation	4		

103. What is the monthly income of your family (by this, I mean the family with whom you have lived with in the past 6 months/ currently living with)?(In Rupees)	
104.What is your monthly income? (taking into account of various sources of income)? (In Rupees)	

105. Current marital status :(Family status)

What is your current marital status	Currently married	1	☐
	Separated	2	
	Divorced	3	
	Never married	4	
	Widower	5	
	No answer	6	

106. What is your present profession:_____

107. Have you divulged your sexual identity/behavior? If you have divulged then to whom you have divulged and what was their response and how do you rate their feelings towards your sexual identity/behavior?

Persons	Have you divulged your sexual identity/behavior to this person? (Response: Yes:1; No:2)	What was their response: (Tried to counsel me out of it:1, Mostly became shocked and angry:2; Mostly became withdrawn and angry:3; Agreeable and supportive:4; No response: 5 Not applicable =0)	How do you rate the feelings of these persons about your sexual identity? (No problems:1; Somewhat tolerates:2; Intolerent: 3; very angry:4 Not applicable =0)	Have you felt that this person was less caring because of your sexual identity? (Yes:1; No: 2 Not applicable =0)
Friends	108. ☐	109. ☐	110 ☐	111 ☐
Family members	112 ☐	113 ☐	114 ☐	115 ☐
Doctor/Lawyer whom you have met?	116 ☐	117 ☐	118 ☐	119 ☐
Any others: (specify example- neighbours)	120. ☐	121 ☐	122 ☐	123 ☐

How do you rate your relationship with the following category of people who know your sexual preference? (Overall response of the people)

Persons	Is this person aware of your sexual identity? Yes:1, No: 2	Rating of relationship with the person: Good:1; As usual:2; I face threats:3; I face physical/mental abuse:4; I face sexual abuse: 5 Not applicable =0
Family members	124 ☐	125 ☐
Neighbours	126 ☐	127 ☐
Educational settings	128 ☐	129 ☐
Workplace settings	130 ☐	131 ☐

132. Who is the partner you first had sex with?	Some family members (Immediate or extended) 1	☐
	Friends 2	
	Some unknown partners 3	
	household help 4	
	Others 5	

133.What was your age at that time?(in completed years)	_____ Yrs

134. How do you describe your first encounter? Coerced, or mutually pleasurable?	Coerced	1	☐
	Mutually pleasurable	2	

135. Who are you currently living with?	Alone	1	
	Male partner	2	
	Female partner/wife	3	
	With parents	4	

.Please indicate your choice for the places of socializing, picking up of partners and places of having sex.(please mention the one option that happens most frequently for you).

Places for socialising	136. Park/ground/open spaces: 1; Railway station/busstand: 2; Friend's partner's home: 3; Own home: 4; Cinema hall: 5; Others(specify):…… ... 6	137.Have you faced any problems using this site for this purpose? Yes: 1 No: 2 If yes: what problem:…… ……
Places for picking up partner	138.Park/ground/open spaces: 1; Railway station/busstand: 2;Urinals: 3;Moving train/bus: 4; Cinema hall: 5; Streets: 6.Shopping Mall. 7.Massage parlours 8.Internet 9.Others(specify)……:	139.Have you faced any problems using this site for this purpose? Yes: 1 No: 2 If yes, what problem?..... ……..
Places for having sex	140.Friend's / partner's home:1; Own home: 2; Hotel:3; Park/ground/open space: 4; Urinal: 5;	141Have you faced any problems using this site for this purpose? Yes: 1 No: 2

142. I have a series of questions that may describe your feeling about your sexual orientation and identity/behavior. Please read of the options from the card and choose one that describes your feelings best about the statement.

S. No.	Statement	Rating: Strongly agree:4 agree:3; Disagree: 2; Strongly disagree: 1			
1.	On the whole I am satisfied with myself	4	3	2	1
2. *	At times, I think I am no good at all	4	3	2	1
3.	I feel that I have a number of good qualities	4	3	2	1
4.	I am able to do things as well as most other people.	4	3	2	1
5. *	I feel I do not have much to be proud of.	4	3	2	1
6. *	I certainly feel useless at times.	4	3	2	1
7.	I feel that I'm a person of worth, at least on an equal plane with others.	4	3	2	1
8. *	I wish I could have more respect for myself	4	3	2	1
9. *	All in all, I am inclined to feel that I am a failure.	4	3	2	1
10.	I take a positive attitude toward myself.	4	3	2	1

Total Score ……

Asterik marked scores are reverse scores). The cut off point is 20.
A score below 20 is considered low and above 20 is high.

143.What is the predominant sexual behavior you identify yourself with?	Kothi 1	☐
	Panthi 2	
	Bisexual 3	
	Double decker 4	
	None 5	

Reproductive and sexual health related morbidity of the MSM populations:
Have you ever suffered from the following diseases/symptoms in the last six months and what did you do when you were diseased and what did you do then?

		Mentioned it to others: Not applicable =0	Did you report it to your family? Not applicable =0	Did you report it to your partner Not applicable =.	Did you face any ill response from your partner when you reported your illness? Not applicable =0	Did you face any ill response from your family when you reported this? Not applicable =.	Did you seek any treatment? Not applicable =0	Where did you seek treatment from? Not applicable =0	How many days did you wait before you sought treatment? Not applicable =0
	Yes :1/ No 2	Yes :1/ No 2 0=not applicable	Yes :1/ No 2 0=Not applicable	Yes :1/ No 2 0=Not applicable	Yes :1/ No 2 0=Not applicable	Yes :1/ No 2 0=Not applicable	Yes :1/ No 2 0=Not applicable	government run clinic ……1 NGO run clinic..2 / Private clinics …3 / Indigenous practitioners/medicine shop	Immediately …1/ within 2-7 days ..2/more than 7

								….4 0=Not applicable	
Genital Ulcer	144	145	146	147	148	149	150	151	152
Genital discharge	153	154	155	156	157	158	159	160	161
Swelling in the groin	162	163	164	165	166	167	168	169	170
Burning sensation of urine	171	172	173	174	175	176	177	178	179
Lower abdominal pain	180	181	182	183	184	185	186	187	188
Anal discharge	189	190	191	192	193	194	195	196	197
Anal ulcer/anal rupture/ fissure	198	199	200	201	202	203	204	205	206

207. How many partners have you had sex with in the last 6 months? ☐

Who are the persons you had sex with in the last 6months and how many times have you used a condom?

Partners you had sex with in the last 6 months			Use of condoms in the last 6 months: Always:1; Quite often:2; Almost never:3; never: 4 Not applicable=0	Forced by partner not to use a condom: Always:1; Quite often:2; Almost never:3; never: 4 Not applicable=0	With this partner have you ever faced incidence of violence because you asked him/her to use a condom? Yes:1 No:2 Not applicable=0
208Male partner	Yes 1 No 2		209.	210.	211
212CSW(female)	Yes 1 No 2		213	214	215
216Male sex workers	Yes 1 No 2		217	218	219
220wife	Yes 1 No 2		221	222	223
224Girlfriends	Yes 1 No 2		225	226	227.

228 Where from have you faced violence?	From a steady and known partner..1 from any unknown partner…2/ Both….3	

229	Have you ever been in a sexual encounter where there was exchange of money, gifts or favours? Yes..1/No.2	
	IF YES THEN -	
230	Have you recourse to this type of relationship in the past 6 months? Yes=1/No=2/Not applicable=0	
231	Have you ever faced beating/threats etc. in this type of sexual encounters? Yes..1/No.2/Not applicable=0	
232	Have you faced more difficulty in accessing condom/lubricants in this scenario because of violence? Yes..1/No.2/Not applicable= 0	

233. Have you ever faced any hesitation or discomfort asking for a condom in a shop	Yes 1 No 2	

Often,some MSM face many risks in public spaces and elsewhere. I have a list of some of these incidents. Can you please say whether this has ever happened to you and if so, how frequently has it ever happened to you?

	Always - 1	Frequently -2	Sometimes -3	Never-4
Societal violence				
234. Beaten up by local goons around the cruising spots?				
235. Beaten up by police?				
236. Been forced into sex by local goons?				
237. Been forced into sex by police and other law agency people?				
238. Been sexually assaulted in the workplace?				
239. Asked for protection from other family and friends and been refused because you are an MSM?				
240.Felt sad on account of social violence?				
241. Been forced to have sex with your partner?				
242. Refused your partner because he had STD?				
243. Refused to have sex with your partner because he had other/multiple partner?				
244. Forced sex on you in drunk/under influence state?				
245. Injured by violence from your partner?				
246. Beaten up/ assaulted by other partners of your partner?				
247. Threatened by your current partner when you tried to break away?				
248. Became apathetic and started on drugs/alcohol etc?				
249 Became apathetic and started on multi				

partner sex?				
250. Have you required psychological assistance from any counselor or had to take medicine from a doctor due to any of these problems?				

Annexure 2

Guidelines for the indepth interview:

MALE HAVING SEX WITH MALE POPULATION (MSM) OF KOLKATA, HIGH RISK BEHAVIOUR AND ANALYSIS OF THE SOCIAL FACTORS

Guidelines for the in depth interview

I have a few questions about your experiences with society at large and your family in particular, relating to your sexual identity. There is no right or wrong answers and I am only interested in understanding your own experiences and your feelings regarding them. If at any time you feel that you do not want to answer any particular question, please do not hesitate to let me know. I would like to record this interview for convenience. As has already been mentioned, I will not let the recording be heard by any others except those involved in research supervision and your identity will be kept safe during all research activities.
Can we continue with the interview now? Or would you prefer to come back at some other time.
Interview now: continue

Interview later: Fix a appointment for later.

When did you feel the same sex attraction and what was your feeling about it? Did you have sex with anyone? What was your age and how did you felt about it?

How did you feel about the same sex attraction? Did you feel any problem with the interaction with your peer group at school, college and other boys of your locality Did you face any harassment or adverse experience in your childhood? What are the experiences and how did it affect your life?

Have you managed to come out among your family members? What was the response of the family members? Did you face any adverse reaction from your family when you divulged your sexuality? How did it affect your relationship with family?

Have you managed to come out among your peer group and colleagues? Did they used bad languages before or after you came out to them or harass you? How did you feel about it?

Did you face any stigma and discriminations or violence in your workplace? Did you ever protest? What happened after you protested against it?

Where do you select your partner from? Do you live with any of your partners? Do you use condoms and lubricants all the time with all the partners you have or used to have before? Have you ever been in any relationship which was an exchange of gift and favours or money-like that? What do you like most about the relationship and what do you fear about the relationships?

Have you ever used any drugs/alcohols/other toxic substances or did you have a partner who used these substances? If you used it,then why? What happened when either you or your partner took them?

Have you ever faced physical assault or sexual assault? Who was the perpetrator/s? How do you feel about it? Did you feel bad about the incident? What did you do afterwards? Did you seek the help of law?

Did you ever had an STD? What did you do about it? What do you do when your partner gets an STD?

How do rate your relationship with your partners? Are you ever afraid of loosing a steady partner? Who is the decision makers in the partnership and how much can you negotiate with him regarding his decisions?

Annexure 3

Confidential:

Only for research purpose

Consent form for the survey of the MSM respondents

Informed consent agreement:

Achutha Menon Center for Health sciences studies
Sree Chitra Tirunal Institute of Medical Sciences and Technology
Trivandrum
MPH dissertation

MALE HAVING SEX WITH MALE POPULATION (MSM) OF KOLKATA, HIGH RISK BEHAVIOUR AND ANALYSIS OF THE SOCIAL FACTORS

June - August 2008
Informed consent agreement

Namaste- my name is Dr Soumya Sarkar and I am presently studying for Master of Public Health at Sree Chitra Tirunal Institute of Medical Sciences and Technology, Trivandrum . As part of my dissertation , I am conducting the surveys and interview with the MSM population of Kolkata to assess the social factors for the high risk behavior . The purpose of the study is to gather information that is going to make behavioral intervention efforts more specific and in the long run help to reduce the risk of transmission of HIV infection among the MSM populations. There will be no direct benefits to you, monetary or otherwise for the participating in this interview. You may chose to answer all or some of the questions that I put to you. Everything you will say will remain private and confidential. I will answer all your queries and if you have any further queries you can address them to my research supervisor Dr Mala Ramanathan at the AMCHSS, (email: mala@sctimst.ac.in) or the Member secretary of the Ethics Committee: Dr Anoopkumar Thekkuveettil (email id:anoop@sctimst.ac.in) for any further clarification that you need.

The approximate time I will take is about 20-30 minutes. If you agree to participate in the interview please indicate your agreement. Your name will not be used in any report but your ideas and experiences will be of great help us to make better behavioral changes strategies for HIV interventions which will be better for the MSM populations in future.

_____ Yes, the respondent has agreed to the interview(signature)

I would like to record this interview as it will facilitate my memory to keep track of the various discussions that I have. May I please record this interview? In case you do not mind being interviewed, but do not want to be recorded, I can take detailed notes of the discussions that I have with you. Please do let me know if you will permit me to record:

yes, you may record: Signature ……

No, you may not record: Signature……..

_____ No, the respondent did not agree to the interview

If you are not willing to participate , then thank you for your time .

Name_____

Id NO_____

Date_____

Name of the project_____

Local contact no. of self :

Confidential:

Only for research purpose

Annexure 4

Consent for the in-depth interview with the MSM respondents

Informed consent agreement

Achutha Menon Center for Health sciences studies
Sree Chitra Tirunal Institute of Medical Sciences and Technology
Trivandrum
MPH dissertation

MALE HAVING SEX WITH MALE POPULATION (MSM) OF KOLKATA, HIGH RISK BEHAVIOUR AND ANALYSIS OF THE SOCIAL FACTORS

Namaste- my name is Dr Soumya Sarkar and I am presently studying for Master of Public Health at Sree Chitra Tirunal Institute of Medical Sciences and Technology, Trivandrum . As part of my dissertation , I am conducting the surveys and interview with the MSM population of Kolkata to assess the social factors for the high risk behavior . The purpose of the study is to gather information that is going to make behavioral intervention efforts more specific and in the long run help to reduce the risk of transmission of HIV infection among the MSM populations.

I am doing interviews to understand the life events and the social factors associated with sexual behavior of MSMs .
There will be no direct benefits to you, monetary or otherwise for the participating in this interview. You may chose to answer all or some of the questions that I put to you. Everything you will say will remain private and confidential. I will answer all your queries and if you have any further queries you can address them to my research supervisor Dr Mala Ramanathan at the AMCHSS, (email: mala@sctimst.ac.in) or the Member secretary of the Ethics Committee: Dr Anoopkumar Thekkuveettil (email id:anoop@sctimst.ac.in) for any further clarification that you need.

The approximate time I will take is about 20-30 minutes. If you agree to participate in the interview please indicate your agreement. Your name will not be used in any report but your ideas and experiences will be of great help us to make better

behavioral changes strategies for HIV interventions which will be better for the MSM populations in future.

_____ Yes, the respondent has agreed to the interview (signature)

I would like to record this interview as it will facilitate my memory to keep track of the various discussions that I have. May I please record this interview? In case you do not mind being interviewed, but do not want to be recorded, I can take detailed notes of the discussions that I have with you. Please do let me know if you will permit me to record:
yes, you may record: Signature ……
No, you may not record: Signature……..
_____ No, the respondent did not agree to the interview
If you are not willing to participate, then thank you for your time.

Name_____

Id NO_____

Date_____

Name of the project_____

Local contact no. of self :